

Cultural Brokers: A strategy for promoting health equity among newcomer women

A quality improvement study for BC Women's Hospital and Health Centre

Andrea Bever

Supervisor: Dr. Robert Hogg

Contents

Executive Summary	2
Background	3
Methodology	4
Overview of Selected Program Frameworks	8
The Multicultural Health Brokers Cooperative Model – Edmonton, Alberta	8
The Community Health Workers Program Model – Hamilton, Ontario	10
The Community House Calls Program Model – Seattle, Washington	13
Evidence Review: Considerations for developing a Cultural Broker Program	15
Organizational structure	15
Recruitment, training, supervision and retentions of cultural brokers	16
Program activities and the role of the cultural broker	19
Strategies for program uptake	20
Key Informant Consultations	21
Focus Group Discussions with Newcomer Women	25
Discussion and Limitations	27
Recommendations	30
Critical Reflection	33
References	35
Appendix A - Program Models	38
Figure 1: The Edmonton Model of Multicultural health brokering	38
Figure 2: The Women’s Health Educators Model	39
Table 1: The Role of Women’s Health Educators	40
Table 2: Guiding Values and Principles of the Women’s Health Educators	42
Table 3: Criteria for identifying target communities for Women’s Health Educators	42
Table 4: The multiple roles of cultural brokers in North Carolina	43
Appendix B – Key Informant Interview Guide	44
Appendix C – Focus Group Discussion Guides	45

Executive Summary

Each year approximately 40,000 newcomer women arrive in British Columbia (BC). Newcomer women represent a diverse population with a wide range of settlement experiences. Variations in migration circumstances make it challenging for health institutions to provide services that are both accessible and culturally sensitive. A cultural broker program could provide a novel approach for meeting the health promotion and health seeking needs of newcomer women in BC. This study explores the strengths and limitations of such an approach, and recommendations are proposed based on analysis of the existing literature and findings from discussions with newcomer women and service providers. Focus groups were conducted with newcomer women with a range of immigration and settlement experiences to better understand their health seeking experiences, needs and challenges. Consultations were also conducted with newcomer service providers. Focus groups confirm that health is a determinant in successful settlement. Barriers to health services vary according to immigration status: women with precarious, or no, immigration status experience greater barriers. Consultations with service providers highlighted tension between cultural competency and cultural safety. A cultural broker program should support providers in adopting a stance of cultural humility, which is better suited to meeting the health needs of a highly diverse, mobile and constantly evolving population. In addition, programs must go beyond teaching knowledge and skills to navigate the health system in order to confront systemic barriers and to promote health equity among newcomer women.

Background

The Newcomer Women's Health Clinic (NWHC)¹ was opened at BC Women's Hospital and Health Centre (BCW) in 2014 in response to the substantial number of newcomer women arriving in BC, and findings from the literature suggesting that newcomer women experience adversities in seeking access to health care services. One year after opening, however, the clinic was only operating at 50% capacity. An evaluation of the NWHC in 2015-2016 sought to identify reasons for underutilization and potential barriers to accessing the clinic. Interviews conducted with newcomer women as part of the evaluation highlighted common themes, including: confusion about how to navigate the health system; fragmented services for health and settlement; lack of awareness of available services including the NWHC; different understandings and expectations about health (e.g. a focus on acute care vs. prevention); and the importance of social networks and support systems to facilitate access to care. In addition to these issues, service providers identified language barriers; concerns about confidentiality and security for newcomers with precarious immigration status; and the need to prioritize families' basic needs and social determinants of health when delivering services to newcomer women.

Research from both the Canadian and international context indicates that cultural broker programs have the potential to increase the accessibility and acceptability of health services among newcomer groups (Shommu et al., 2016; Crawford et al, 2015; Najafizada et al., 2015; Cosgrove et al., 2014; Rotich & Kaya, 2014; Torres et al., 2014; Henderson & Kendall, 2011; South, Raine & White, 2010). However, best practices for implementing a cultural broker program can be difficult to identify. Cultural brokers are referred to by many different names, such as community navigators or community health workers, and there is considerable diversity

¹ The Newcomer Women's Health Clinic (NWHC) offers primary care services to women who have been in Canada less than five years, are 18 years of age or older, and do not have a regular health care provider. Throughout this report, the term newcomer women is used to refer to women who have been in Canada less than five years.

in the role that a cultural broker may occupy. A common theme in the literature suggests that cultural brokering is an act of bridging the divide between different cultures in order to achieve change (Torres et al., 2014; National Center for Cultural Competence, 2004). As a health promotion strategy, cultural brokers advocate on behalf of individuals or communities in order to improve access to culturally responsive health care (Torres et al., 2014). By working at multiple levels, from offering one-on-one support to promoting integration of social services, cultural brokers may provide a solution for addressing many of the barriers identified through the evaluation of the Newcomer Women's Health Clinic (NWHC). This study explores the potential challenges and benefits of developing a cultural broker program at BCW, and recommends strategies that BCW could pursue for improving health equity among newcomer women.

Methodology

Methodological Framework:

An intersectional feminist framework provided the theoretical foundation for the analysis and subsequent recommendations. Intersectional theory recognizes that when an individual experiences multiple axes of oppression due to factors such as race, ethnicity, immigration status, gender identity, or sexual orientation, the intersection of these factors produces heightened conditions of social inequity. An intersectional feminist perspective emphasizes that systemic gender inequities must be examined using a comprehensive approach that acknowledges the complex ways in which numerous power imbalances and facets of marginalization impact experiences of gender discrimination (Morris & Bunjun, 2007). Therefore, strategies for promoting health equity among newcomer women must acknowledge the immense diversity in immigration experiences, including variations in immigration status, which affect one's ability to

access health and other social services. In addition to acknowledging diversity in experiences of newcomer women, an intersectional feminist framework requires that research, policy, and program responses to social inequities involve challenging the underlying societal and social structures that perpetuate them.

Environmental Scan and Evidence Review:

A search of academic and grey literature was conducted to identify best practices and key considerations for developing a cultural broker program at BCW. Medline, PubMed, CINAHL, Google Scholar and Google searches were conducted for the term “cultural broker” as well as terms that are sometimes used to refer to the same role, including: “cross cultural broker,” “cultural health broker,” “cross cultural health broker,” “knowledge broker,” “health navigator,” “community navigator,” “patient navigator” and “community health worker.” These terms were combined with other key terms including: “women,” “immigrants,” “refugees,” “Canada,” “North America,” “women’s reproductive health,” “reproductive health” and “health promotion.” Once relevant articles were identified, a snowballing method was employed: reference lists from initial articles were used to locate additional sources. Studies, reviews or resource guides that focused on immigrants, refugees, or ethnic minorities as the target population were reviewed. BCW’s commitment to improving women’s health was reflected in the inclusion criteria by favouring programs that emphasized women’s health issues. Preference was given to publications from the last five years; however, exceptions were made for literature that was deemed to be particularly important. For example, foundational documents for the three programs that were selected as sample program frameworks were included despite earlier publication dates. Overall, the literature search was an iterative process, and much of grey

literature was identified by contacting program managers of initiatives that were referenced in peer-reviewed publications.

Three program frameworks were selected for detailed analysis based on their potential relevance for a cultural broker program operating at BCW. Factors that influenced selection were evidence of program effectiveness, location, organizational structure, and women or family-centered approach. The success of the selected programs has been demonstrated through monitoring, evaluation and research activities (Crawford et al, 2015; Torres, 2013; Ortiz, 2003; Jackson-Carroll, Graham & Jackson, 1998; City of Hamilton Public Health Services, N.D.), and is also evidenced by program sustainability and expansion. All three programs have been operating for over a decade, with two of the three operating for over two decades. They have expanded their reach in regards to communities targeted as well as services offered. Two of the selected programs are situated within the Canadian health care system. The third program is based in Seattle, Washington, and while geographically the closest to BCW, differences in health systems may pose some limitations to the model's applicability. Nonetheless, several local service providers referenced this program as an important model for consideration, and therefore it was included in the analysis. Organizational structure was an important consideration because cultural broker programs in Canada frequently operate at a grassroots level and are independently governed. For example, the Multicultural Health Brokers Cooperative in Edmonton, Alberta is the both the most cited and the largest program operating in the Canadian context; however, it operates using an independent model that is potentially less practical for developing a program at BCW. Therefore, an effort was made to also include models that are integrated into publicly funded health infrastructure.

Key Informant Consultations:

Consultations with service providers took place over-the-phone or in-person. The purpose was to seek expertise and guidance from individuals who have experience developing or managing cultural broker programs, or other similar models that aim to address health inequities among newcomer populations. An interview guide is found in Appendix B; however, consultations were informal and open to focusing on issues deemed most important by the informant. Consultations provided an opportunity to learn more about past and present programming in Metro Vancouver, and offered insight into the views of local stakeholders regarding the development of a new program at BCW. In addition to one-on-one consultations, the convening of a working group, “Bridging Health and Settlement for Newcomer Women,” prompted further discussion of challenges and strategies for meeting newcomer women’s health and settlement needs. This working group consisted of local stakeholders working in health and settlement, several of whom had the additional perspective of having been newcomer women themselves.

Focus Groups:

Focus groups with newcomer women discussed health seeking experiences in Canada and explored perspectives about the best methods for making services accessible. Group discussions provided a mechanism for understanding whether or not a cultural broker program offers a relevant strategy for supporting newcomer women by providing a platform for women to share their needs and experiences with each other. Focus group discussion guides can be found in Appendix C.

Four focus groups were used to represent a range of settlement experiences, including newcomer women with secure immigration status², newcomer women with insecure immigration status³, women who immigrated to Canada at least five years ago, and newcomer refugee women⁴. The purposeful sampling method for recruiting participants was informed by previous research demonstrating the importance of immigration status as a factor for facilitating or barring access to health services (Campbell et al, 2012). Diverse immigration circumstances were represented in the focus groups in hopes that potential programming will avoid reinforcing inequities, recognizing that women with insecure immigration status may face distinct or compounded barriers to health care. The aforementioned criteria for selecting focus group participants was also meant to provide a safe space for women with precarious status to discuss their challenges and experiences. In addition, women who have been in Canada the longest (at least five years) may have the ability to reflect back on their settlement experience, and to discuss what they wish they had known or what resources might have facilitated their settlement process. For this reason, only women who immigrated to Canada as adults were recruited.

Overview of Selected Program Frameworks

The Multicultural Health Brokers Cooperative Model – Edmonton, Alberta

The Multicultural Health Brokers Cooperative (the Co-op) uses a comprehensive, multi-dimensional framework for its cultural broker program. The Co-op has been offering services in Edmonton, Alberta since 1994 and has demonstrated success in improving access to health and social services, community capacity building, integration of newcomer women and families into

² Newcomer women with secure immigration status had access to the Medical Service Plan of BC (MSP).

³ Women were considered to have insecure immigration status if they were undocumented or in the process of attempting to claim status, these women did not have access to MSP.

⁴ Newcomer refugee women included both government and privately sponsored refugees.

Canadian society, and collaboration of local systems and community-based organizations (Torres, 2013). The Co-op's mandate is: "To support immigrant and refugee individuals and families in attaining optimum health through relevant health education, community development and advocacy support, based on principles of democratic governance, direct responsiveness and accountability, and facilitating equity and social justice" (Chiu et al., 2009). Key strategies for fulfilling this mandate include emphasizing the social determinants of health, building cross-sector partnership, increasing the capacity of health providers and health systems for cultural responsiveness, and maximizing leadership and participation of newcomers in program activities and decision-making processes.

The cultural brokering practice of the Co-op operates at five different levels:

1. **Individual:** Holistic one-on-one support that emphasizes the social determinants of health, family needs and connecting newcomers with services and resources. Activities involve building awareness of how to navigate the health system and promoting health literacy in a supportive, non-controlling way.
2. **Family:** Connecting families and building social networks through activities such as mothers' support groups, workshops, collective kitchen and recreational activities for families.
3. **Community:** Mobilizing communities by delivering information through culturally relevant strategies (e.g. specific news channels or media), engaging with community leaders and building community capacity to voice concerns.
4. **Health providers/institutions:** Cultural brokers act as a bridge between newcomer clients and health providers/institutions by supporting clients in voicing concerns and

developing relationships with service providers, ensuring culturally responsive care and building partnerships across sectors.

5. **Health systems:** Improvements at the health systems level are realized through more appropriate policies, programs and practice.

Specific tasks carried out by cultural brokers may include facilitating communication between clients and providers, connecting clients to services and resources, providing emotional support, follow-up and case-management. A visual representation of the model used by the Co-op, including the dimensions of cultural brokering practice and corresponding activities is shown in Appendix A, Figure 1.

The Co-op is the most widely recognized program of its kind in Canada. In a recent systematic review of the role of community navigator in promoting newcomer and ethnic minority health in Canada and the U.S (Shommu et al, 2016), a doctoral thesis about the Co-op was the only Canadian study to be included. The Co-op has grown from twelve to over seventy-five brokers that represent twenty-five cultural-linguistic communities. It continues to expand its services, and has also provided training for the development of a cultural broker program in Vancouver through the BC Multicultural Health Services Society, which is a partner organization of the Umbrella Multicultural Health Co-op.

The Community Health Workers Program Model – Hamilton, Ontario

The Community Health Workers Program, formerly known as Women’s Health Educators, was established in 2003 and is housed in the public health unit of Hamilton, Ontario. The program promotes cancer screening and healthy living among immigrant women and their families through peer support and culturally relevant chronic disease prevention education (City of Hamilton Public Health Services, 2009). The primary strategy of the program is to overcome

linguistic, cultural and systemic barriers to health by training peer health educators to work with women from the same cultural-linguistic community. Public health nurses working in chronic disease prevention are responsible for training and supervising the peer educators. The program framework consists of six major components (see Appendix A, Figure 2 for a diagram of the model):

1. **Culturally tailored health education:** Peer educators and public health nurses collaborate to develop and deliver chronic disease prevention messages (e.g. workshops called “tea parties” and promotional media) that are culturally relevant.
2. **Skill building among program staff and partners:** Public health nurses mentor peer educators by providing expert health knowledge, facilitation skills and information about how to navigate health systems, while peer educators promote cultural competency by teach public health nurses about the target communities’ needs and expectations. Both public health nurses and peer educators develop skills in partnership building. Community partners increase knowledge about accessing public health services, and health sector partners improve their capacity to offer culturally safe services.
3. **Bridging the gap between the health system and communities:** Public health nurses engage health sector partners to address service barriers and tailor programs, while peer educators provide one-on-one support by arranging appointments, conducting follow-up and accompanying women to appointments when necessary.
4. **Community capacity building:** Immigrant women build navigation skills through peer support and peer educators develop skills in advocacy and service navigation,

leading to development of increased community capacity for planning of initiatives and voicing concerns.

5. **Advocacy:** The advocacy component of the peer educator-public health nurse partnership aims to address the social determinants of health and work with diverse partners to improve service integration.
6. **Collaboration:** Partnerships contribute to program sustainability through “a more organized process of working together for a set purpose with specific roles and outcomes that would be beneficial to all partners” (City of Hamilton Public Health Services, 2009).

The peer educator role and the core competencies required to support this role were developed by a working group of health professionals including two public health nurses and two faculty members from McMaster University School of Nursing. A list describing the peer educator role is found in Appendix A, Table 1, and a list of guiding values and principles in Appendix A, Table 2. The working group also developed the criteria for selecting target communities (Appendix A, Table 3). Focus groups were conducted with members of the target communities in order to assess acceptability of the peer educator model, knowledge and beliefs related to cancer screening, and learning needs and barriers. Focus group findings were also incorporated in the development of the training curriculum. Due to limited funding and a strong belief that the peer educator position should be paid, only two target communities were selected. The two communities were selected based on the availability of peer educator candidates who matched the described role (Women’s Health Educators Project Report, N.D.).

While the original program focussed on increasing availability and accessibility of breast and cervical cancer screening among immigrant women, today the project has expanded to

include a broader range of health promotion goals. The change in program name from Women's Health Educators to Community Health Workers reflects the program's work with children and men. The program initially targeted Chinese and Vietnamese women, but now also serves Punjabi, Hindi, Urdu and Arabic-speaking communities.

The Community House Calls Program Model – Seattle, Washington

The Community House Calls program was established at the Harborview Medical Center in Seattle, WA in 1994 as a response to growth in the area's immigrant and refugee communities and an observed gap in the delivery of care among these populations. The program aims to promote the well-being of immigrants and refugee individuals, families and communities by improving communication between newcomer clients and health providers. In order to accomplish this goal, interpreter cultural mediators are trained to provide a bridge between health provider and client expectations and practices (American Hospital Association, N.D.). Interpreter cultural mediators are familiar with the health system, and often have experience working as interpreters in a health care setting; moreover, their shared cultural-linguistic background allows them to build trust and advocate on behalf of immigrant and refugee families from the same community.

Primary activities that an interpreter cultural mediator engages in include:

1. Interpret and mediate for families and service providers in targeted primary care clinics, emphasizing cultural and social factors that influence care as well as translating health information.
2. Make home visits and coordinate care with social service agencies.
3. Provide cultural competency training and resources to service providers and work with clinics to remove barriers to care.

4. Collaborate with community leaders to provide social support to families, strengthen community social networks, and facilitate community health education according to identified needs.
5. Track activities through data collection and reporting mechanisms to allow for program monitoring and evaluation.

Nurses with experience working in cross-cultural settings provide daily supervision for interpreter cultural mediators, support health education activities in communities, contribute to problem solving to address service barriers, and act as a liaison for service providers. An administrative team comprised of a program administrator and medical directors oversee the project. A community advisory board provides consultation in designing program activities. The community leaders that serve on this board are also important contacts for interpreter cultural mediators because of their ability to access and help strengthen community social networks and to assist families experiencing social isolation. Additional program partners include health providers, ethno-cultural community associations and social service agencies. Community associations can perform important functions such as recruiting interpreter cultural mediators or community leaders to participate on the community advisory board, providing a location for community outreach and health education activities, or facilitating integration of interpreter cultural mediators into the community.

Physicians at the Harborview Medical Center developed a manual that provides a step-by-step guide for implementing their program model (Jackson-Carroll, Graham & Jackson, 1998). The manual provides comprehensive details on recruitment and selection processes, training content and structure, organizational structure, and program activities. Another initiative undertaken by the Community House Calls program is the development of EthnoMed

(<http://ethnomed.org>): an online database of information about refugee groups in the Seattle area which is designed to assist health professionals in providing culturally safe and relevant care.

Evidence Review: Considerations for developing a Cultural Broker Program

Organizational structure

The previously discussed Multicultural Health Brokers Cooperative employs an independent model for its organizational structure. Although the Co-op partners with and receives funding from the local public health unit, the organization was established by newcomer women and all decision making is controlled by the organization's membership using a co-operative structure. Other examples of independent organizational structures include cultural broker programs operating in the local context: Umbrella Multicultural Health Co-op in New Westminster and the REACH Multi-Cultural Family Centre in Vancouver. An important strength of this organizational structure is that the program is likely to have a strong foundation within the community. This may help reduce barriers experienced by marginalized groups when accessing formally institutionalized services, ensure that perspectives of community members are represented, and increase opportunities for developing rapport and credibility through greater accountability to communities served (Findley & Matos, 2015; Torres et al., 2014; Ortiz, 2011).

However, an integrated model for a cultural broker program in which the program is housed by a public health unit or primary care institution, also has some distinct advantages. This model may allow for more sustainable funding; extensive opportunities for training, mentorship and support of cultural brokers; comprehensive program monitoring and evaluation; integration of cultural brokers within the health system in order to facilitate referrals and promote recognition of the cultural broker role; and capacity to reach a diverse range of newcomer

populations (Findley & Matos, 2015). The Community Health Workers program in Hamilton and the Community House Calls program in Seattle provide examples of successful integrated models.

Research and evaluation conducted through the Multicultural Health Brokers Cooperative suggests the relevance of both independent and integrated models within the Canadian context. The importance of strong cross-sector partnerships and meaningful collaboration between health institutions and communities is of critical importance regardless of the organizational structure used. Program success depends both on the ability of cultural brokers to develop strong relationships with a variety of stakeholders from hospitals and health authorities to community-based service providers (Torres, 2014). Furthermore, the credibility of cultural brokers depends on their ability to sustain a strong presence in the communities they serve (National Center for Cultural Competence (NCCC), 2004).

In light of these findings, a cultural broker program at BCW should strive to increase communication and collaboration between BCW, community-based organizations, health and settlement service providers, and newcomer community members. The development, implementation, and evaluation of the program should maximize participation of newcomer women, and efforts must be made to ensure that the perspectives of the most marginalized newcomer groups are represented in decision-making.

Recruitment, training, supervision and retentions of cultural brokers

A study of community health workers in Canada and other high income countries, including cultural broker programs, found that community health workers in Canada are most often recruited by public health institutions, followed by community-based organizations. Programs using either recruitment model stressed the importance of selecting health workers

who are from or closely associated with the community they serve (Najafizada et al., 2015). Evidence suggests that best practice for recruitment is to ensure community involvement in the selection process (Findley & Matos, 2015; Henderson & Kendall, 2011; South, Raine & White, 2010). In the context of developing a program at BCW, a feasible strategy would be to share recruitment responsibility with a variety of community partners. This would allow organizations that represent the interests of newcomer communities to lend credibility to the recruitment process and help to ensure that the interests of a wide range of newcomer groups, including women with precarious immigration status, are represented. Potential community partner organizations include multicultural member co-operatives and organizations that are strongly based within newcomer communities. Involvement of these organizations in the recruitment of cultural brokers can support community participation and capacity building. Furthermore, specific strategies for recruitment should be informal, such as using community initiatives, newsletters and informal networks, which may also promote the inclusion of difficult to reach groups (South, Raine & White, 2010).

On-the-job training that focuses on identified needs, e.g. pregnancy, cancer screening and prevention, or general health promotion is the most common form of training for all types of community health workers in both Canada and the U.S. (Najafizada et al., 2015). According to the World Health Organization (WHO), best practices for training of community health workers include adapting or developing a training to fit specific needs, opportunities to practice skills, an emphasis on developing competencies, and on-going education and training opportunities (Lehmann & Sanders, 2007). Although the WHO's recommendations are oriented towards addressing the shortage of health professionals in low-income countries, many of the findings are applicable to initiatives that target underserved populations in diverse settings. As with the

recruitment process, community-based organizations and newcomer communities should be involved in the process of developing or adapting training modules (Findley & Matos, 2015). Training programs should be flexible and iterative so that they can address training needs as they arise.

Collaboration and mentorship are important considerations to ensure that cultural brokers are provided with reliable support that enables them to perform their responsibilities. It is recommended that support is provided on a one-to-one basis by a non-medical staff member, such as a program manager or senior cultural broker (Findley & Matos, 2015). In Canada, public health nurses have played an important mentorship role in cultural broker programs (Torres, 2013; Richardson, 2006). For example, public health nurses working in chronic disease prevention have successfully trained and supervised cultural brokers in the Community Health Workers Program in Hamilton, Ontario. At the Co-op in Edmonton, public health nurses were responsible for providing perinatal health training to cultural brokers in the context of specific outreach programs; however, more comprehensive and on-going mentorship by public health nurses was desired (Torres, 2013). The Community House Calls program provides an example from the American context in which nurses play a central role in program operations. Nurses act as daily supervisors for interpreter cultural mediators and provide a connection to other health professionals working in the hospital.

Retention of cultural brokers is a critical consideration for program sustainability and cost-effectiveness (South, Raine & White, 2010). Appropriate financial compensation for cultural brokers is an important component of program sustainability (Najafizada et al., 2015; Henderson & Kendall, 2011; South, Raine & White, 2010). Providing financial compensation is particularly relevant when engaging low-income groups as cultural brokers. In addition to

financial compensation, programs should consider incentives such as education and skill development, and opportunities for advancement and recognition (South, Raine & White, 2010). Formal recognition of cultural brokers within the health system is likely to make their role more effective by increasing their credibility among both health service providers and community groups. Recognition also promotes access to equitable and sustainable compensation (Najafizada et al., 2015), which will in turn contribute to improved retention rates.

Program activities and the role of the cultural broker

Throughout the evaluation of the NWHC, multiple services providers highlighted the value in delivering information in a group setting via workshops. Workshops can serve the dual purpose of relaying important information, while creating opportunities for developing social networks among newcomer women. A potential approach to community outreach could involve cultural brokers identifying health-related topics of interest among newcomer women and facilitating workshops on those subjects. This model is supported by evidence from Canadian and international contexts (Shommu et al., 2016; Torres, 2013; Lee, 2008; Richardson, 2006).

A study of cultural brokers working with immigrant and refugee communities in North Carolina provides a comprehensive list of roles and responsibilities of cultural brokers. Eleven roles emerged from in-depth interviews and focus groups with cultural brokers, many of which are relevant to the development of a program within the Canadian health system (see Appendix A, Table 4). However, the roles of interpreter and translator that were identified in the study are not necessarily applicable to a cultural broker program at BCW for a number of reasons.

Local services providers emphasized that interpretation services are critical to reducing barriers to health care among newcomer populations; however, the role of interpreter is distinct from that of cultural broker. Cultural brokers perform a mediating role that is much more

comprehensive than interpretation. Although many models emphasize that cultural brokers come from the same ethnic or linguistic group as those they serve, this is not universally the case. It is possible for cultural brokers to base their connection with community members on common experiences of immigration or barriers faced (Lee, 2008). Moreover, in some circumstances it may be preferable for a cultural broker to come from a different community than the individual being served due to confidentiality concerns. In the context of developing a program at BCW, interpreter services are already available through the Provincial Language Services (PLS). Access to PLS facilitates a distinction between the cultural broker and interpreter, which can help ensure that programming does not exclude any newcomer communities based on the ethnic or linguistic background of the cultural brokers that are recruited and trained. Moreover, by not assuming cultural homogeneity within communities, as well as embracing a broader definition of culture as a system of shared meaning that is not limited to a common language or ethnicity, the program will increase its capacity to provide culturally safe and responsive services.

Strategies for program uptake

A common theme throughout the literature is the importance of community involvement in program planning and development in order to achieve successful program uptake (Findley & Matos, 2015; Henderson & Kendall, 2011; Ortiz, 2011; South, Raine & White, 2010; Lee, 2008; Lehmann & Sanders, 2007). Participation enhances program credibility and ensures that program activities are responsive to community needs and priorities. It has been noted that cultural broker programs may be more successful when strong social networks are already in place (South, Raine & White, 2011); however, building social networks and developing community capacity is also viewed as program outcomes (Cosgrove et al., 2014; Chiu et al., 2009).

Finally, interviews with newcomer women and service providers that were conducted through the evaluation of the NWHC at BCW emphasize the need to build awareness of programs and services being offered for newcomer women. The success of a cultural broker program at BCW will ultimately depend on awareness of the program's activities. This may be achieved through community participation in program development, implementation, and evaluation as well as through strategic outreach activities, such as events held within communities and promotion using social media.

Key Informant Consultations

Consultations with key informants who have experience in developing or managing a cultural broker program highlighted additional challenges and considerations for developing a program at BCW. An issue that prompted a great deal of discussion was whether or not cultural brokers are required to be from the same ethnic or linguistic group as the community they serve. Conversations revealed that while it is often assumed that a cultural broker shares a common culture with their clients, there is a lack of clarity regarding what is meant by the terms such as culture and community. Some informants felt very strongly that being from the same culture enables cultural brokers to advocate on behalf of their clients due to their first-hand understanding of their clients' religion, traditions and norms. According to this perspective, the concept of cultural congruency is a foundational component of a cultural broker program. On other hand, the need for programs to be flexible to changes in the communities accessing services was raised. As a result, a program that is not based on cultural congruency could be more sustainable. A common connection based on shared language or country of origin was understood to facilitate the development of a trusting relationship between cultural brokers and their clients; however, several informants also stated that a common interest or experience could

serve as a basis for developing this relationship. Moreover, the definition of shared community is not always related to place of origin, and individuals may wish to connect with different communities over their life course. For example, a mothers' support group or a seniors' group represent communities related to life-stage that may share a common culture. One informant suggested that while a broader understanding of the concepts of culture and community could make for a very effective program, the term cultural broker may no longer be applicable.

A related issue was the distinction between cultural brokering and interpreting. It was widely agreed that brokering is different from interpreting, and a consistently identified distinction was that cultural brokers form a long-term relationship with their clients. While most informants felt that offering cultural broker services in the client's preferred language was an important strength of cultural broker programs, several informants cited examples in which an interpreter and a cultural broker successfully collaborated to meet a client's needs. There was a lack of agreement on this issue: views ranged from a belief that any separation of the brokering and interpreting role was an irreconcilable departure from the culture broker model, to the idea that interpreters could offer an appropriate solution in situations when a culture broker who spoke the same language as the client was either unavailable or unwanted. Differences of opinion on this subject reveal an underlying contention about the role of the cultural broker: are brokers engaged solely in navigating, interpreting, and other similar functions that coincide with accompaniment to appointments, or can cultural brokers provide support for structural-level interventions?

Recruitment criteria also raised conflicting views. While some informants purposefully recruited cultural brokers with a health background, others felt that this could lead to overstepping the boundaries of the brokering role. Regardless of desired educational background

or training, informants frequently stated that connection to community was the most important trait that they looked for. Informants emphasized that cultural brokers should be trusted within their community. If a program embraces a more comprehensive and inclusive definition of culture (i.e. any system of shared meaning opposed to a set of ethnic, linguistic and/or racial traits), then more creative strategies for recruiting cultural brokers will be required and cultural brokers may require greater support in building community connections. Ultimately, the ability of cultural brokers to make people feel comfortable, be empathetic, and offer emotional support is what allows them to be successful in their role.

There is a need to narrow the focus of a cultural broker program, especially in the pilot phase. One informant suggested that rather than narrowing the scope of the program to target specific communities within the population of newcomer women, BCW could specify a health topic. Consulting with newcomer women could help identify a priority area of health need or interest, such as reproductive health, which would also shape the training that cultural brokers receive. A program model of possible interest is Centering Pregnancy: a group-based prenatal care model that has been shown to reduce poor pregnancy and birth outcomes among women who face greater risk due to economic and social determinants of health, including language barriers and other factors related to immigration (Benediktsson et al, 2013). Through this model, women have an opportunity to build social networks with other women in the same stage of pregnancy, receive prenatal care and education in the same session, and are able to direct the content of group discussions. This program model could be adapted to meet the needs of newcomer women in the Greater Vancouver area, with a cultural broker facilitating group sessions and acting as a bridge between newcomer women and health care providers.

Informants identified a number of additional considerations. Community participation should be maximized so that newcomer women are formally incorporated into decision making processes, and the role of the cultural broker should be flexible in order to meet group needs. For example, one informant found that different cultural brokers working in the same organization performed different roles based on the needs of the particular community they worked with. Services should be trauma-informed, meaning that service providers recognize signs of trauma and take action to create conditions that are safe for individuals who are survivors of various forms of trauma. Services should also provide support to women who are not literate, and include multiple channels for referral, including potential for self-referral. One informant noted that having the program housed in a public health institution increased the cultural brokers' credibility within communities. Partnerships with community-based organizations are an important part of the cultural broker model; however, the program's integration with the formal health system can be an asset rather than a barrier.

A working group discussion with stakeholders in health and settlement raised the question of how the role of cultural broker is distinguished from that of settlement workers. If the roles are generally similar, then supporting the work of settlement workers may be a greater priority than developing a new program. However, it was also suggested that settlement workers find it challenging to navigate the health system for their clients, and cultural brokers could have a role to play in bridging the gap between health providers and settlement workers. Furthermore, one health provider emphasized their interest in a program or resource that could help them respond to their clients' needs and provide more culturally sensitive care. A cultural broker program should not only focus on developing knowledge and skills of newcomer women to

navigate the health system, but rather focus on improving the health system's capacity to offer culturally safe and relevant services to newcomer women.

Focus Group Discussions with Newcomer Women

Focus group discussions confirmed that different immigration pathways are associated with distinct settlement experiences, including variations in health needs and access to resources for meeting those needs. Both refugee women and women with insecure immigration status experienced significant financial barriers to accessing health services. In particular, women with insecure immigration status did not have a medical insurance plan, and therefore, health concerns were inextricably linked to stress over how one would afford treatment. Illegality presented an additional source of anxiety for this group of women, since seeking health care might involve disclosing one's immigration status. Although some programs or clinics will provide health services for women without MSP (e.g. the NWHC at BCW), these exceptions generally cannot be advertised, and as a result, many women in need are not aware that such services exist.

While refugee women might have greater access to health services through MSP or the Interim Federal Health Program, the ability to afford essential medications and dental procedures was a major concern. Women worried about how they would afford both current and future health expenses, and noted a need for health providers to consider financial constraints when advising clients. Moreover, women explained that after visiting health providers their health concerns remained unresolved. This was often related to experiences of not being heard by their health care provider, including difficulties getting referrals or prescription medications for health conditions. Women noted that language barriers undermined their independence and their ability to obtain high quality care. Lack of interpretation services or not having enough time with an

interpreter were common experiences. Finally, this group of women reflected that as refugees, they may have greater mental health needs related to their histories of trauma.

Newcomer women with access to MSP and women who immigrated to Canada at least five years ago spoke of additional challenges that characterized their health-seeking experiences. Newcomer women described their need for reproductive health services as a key motivator for accessing health services in Canada. However, experiences of trying to make an initial appointment were often confusing, and women found that available information about how the Canadian health system works was unclear. They experienced a lack of integration of services, and insufficient communication between different health care providers. The process of identifying and navigating services caused fear and anxiety, and women expressed the need for a safe environment to address their reproductive health needs. They also noted that discussing these challenges as a group was a very positive experience.

Immigrant women expressed feeling a lack of control over one's health due to adverse experiences when accessing care. They described experiences of prejudice on the part of health service providers; and as a result, they perceived a need for enhanced cultural competency within the health care system. Service providers should focus on active listening and meaningfully engaging with their clients.

Focus group findings confirm that while all levels of newcomer women may experience multiple barriers to accessing health services, these barriers are compounded by factors related to immigration status or lack thereof. This is an important consideration for developing effective programming because failure to reach the most marginalized groups of newcomer women will reinforce existing health inequities. Nevertheless, a number of common themes between focus

groups should be highlighted. Newcomer women consistently emphasized that health is a priority concern, since maintaining good health is a prerequisite for successful settlement in a new country. Another common theme was the value of social networks and support. As mentioned above, newcomer women with secure immigration status found it beneficial to discuss their health seeking experiences with peers who faced similar challenges. Newcomer women of diverse immigration circumstances indicated that their social networks were facilitators of health in numerous ways, from helping them with systems navigation to providing emotional support.

Discussion and Limitations

Findings from the literature, key informant consultations, and focus groups have important implications for developing a cultural broker program at BCW. Recurrent themes indicate potential focus areas around which a program could be structured. Moreover, discrepancies in findings both between and within research methodologies highlight issues that require carefully developed, context-specific approaches, as well as some areas that may require further research.

The need to improve integration of services was a key finding from the NWHC evaluation, and findings from the literature support the idea that a cultural broker program is a feasible strategy for addressing this gap. Existing program models, such as the Multicultural Health Brokers Cooperative in Edmonton, have worked to build cross- sector partnerships as a means to address complex health and social challenges. Furthermore, despite a variety of possible organizational structures identified throughout the literature, program success appears to be partially dependent on the ability to bridge the communication gap between various

stakeholders, including health institutions, community-based organizations and newcomer communities. This finding was re-iterated in key-informant consultations, and in the working group meeting it was suggested that cultural brokers might have a key role to play in bridging the gap between health providers and settlement workers. Newcomer women, regardless of differences in immigration status or settlement process, spoke about challenges of systems navigation, many of which have the potential to be addressed through improved service integration across sectors as well as within the health sector.

The importance of social support was another finding from the NWHC evaluation that was reinforced throughout the results of this study. Both the literature and key informant consultations confirm that the development of support groups or group workshops is viable focus for a cultural broker program. Moreover, discussion with newcomer women provided especially strong support for this strategy, as women indicated that these social opportunities could be beneficial in their own right, in addition to facilitating greater access to health services.

The literature frequently emphasizes the role of cultural brokers in providing culturally appropriate health services or promoting cultural competency within the health system (Shommu et al, 2016; Najafizada et al, 2015; Torres et al, 2014). This idea was reiterated in some key informant consultations and focus group discussions. However, some conversations either directly or indirectly emphasized the concept of cultural humility over that of cultural competency. In other words, rather than employing a cultural competency model that focuses on teaching service providers about the specific beliefs and practices of clients from diverse backgrounds, health institutions should strive for a comprehensive shift in their approach towards provider-client interactions. Newcomer women often spoke about difficulties “being heard”- a problem that could be addressed through a cultural humility approach which

recognizes and confronts power imbalances within the health system. Cultural humility promotes continuous learning and meaningful engagement between health professionals and clients. As an approach, it involves offering health professionals resources and tools that support them engaging in critical self-reflection and seeking to understand rather than making assumptions about their clients (Tervalon & Murray-Garcia., 1998).

Findings regarding the issue of cultural congruency, or whether cultural brokers are required to come from the same ethno-linguistic background as those they serve, revealed conflicting views among service providers as well as inconclusive findings within the literature and among newcomer women. In some respects, this question is related to whether one takes an approach of cultural competency or cultural humility. While cultural congruency is a common feature in many existing program models, a shift away from this model could be highly successful if accompanied by an emphasis on integrating cultural humility into the health system. Further research could help to identify specific strategies for promoting cultural humility using a cultural broker program.

Finally, focus group discussions made it apparent that some newcomer women experience great adversity in meeting their health needs due to financial and/or legal barriers. This issue receives relatively little attention in the literature on cultural broker programs, since programs tend to define populations by place of origin but do not discuss differences related to immigration pathways. Steps must be taken to reach women who face the greatest barriers to health. Further research should aim to clarify the dual impact of immigration pathways in both impeding access to care and contributing to greater health needs, and most importantly, should elucidate viable action plans for redressing this gap between need and access to services.

Limitations:

The environmental scan and evidence review was not comprehensive due to limited time and resources. Furthermore, existing cultural broker program models that were identified may not incorporate the same comprehensive understanding of culture that is embraced at BCW, i.e. culture as a system of shared meaning that is not limited to a focus on language and ethnicity. As a result, some components of these models may be less relevant to a program at BCW, and creative solutions will need to be developed.

Another limitation is the difficulty of including the most marginalized groups of newcomer women in focus group discussions. All newcomer women were recruited through their previous contact with either the health or settlement sector, and therefore, women who are completely barred from accessing services were not represented. However, representativeness of marginalized women was improved by the inclusion of women who do not have MSP but were still able to visit the NWHC. The sample of women who participated was not representative of all languages and ethnicities, with all focus groups but one conducted in English. While every effort was made to include a variety of perspectives and experiences, there are certainly voices missing.

Recommendations

Based on findings discussed throughout this report, the following recommendations are proposed for developing a cultural broker program at BCW:

1. Cultural brokers as a resource for service providers:

Rather than “teaching” newcomer women to adapt to the health system, a cultural broker program should focus on enhancing the health system’s capacity to meet the health needs

of a diverse and varied population of women. Cultural brokers can play a key role in directing the culture of health care towards an equity-driven, cultural humility approach. A fundamental objective of a cultural broker program should be to address power imbalances within provider-client interactions, to which certain groups of newcomer women may be especially vulnerable due to the intersection of any number of factors including, but not limited to, immigration status, experiences of trauma, cultural or language barriers, sexual orientation or gender identity, and various other determinants of access to social and material resources. Training and support for health service providers should avoid simply relaying information about different cultural groups. An emphasis must be placed on reflexivity on the part of the service provider, as well as working in partnership with clients to meet their needs rather than making assumptions based on the client's association with a particular racial, ethnic or linguistic group. This structural approach to addressing the gap in health services for newcomer women should not only involve nurses and physicians but also gatekeepers to health services, such as individuals who schedule appointments and work at receptions. In recognition of the finding that not only is settlement a determinant of health, but health is also a major contributor to a positive settlement experience, cultural brokers may also serve as a bridge across sectors such as health, settlement, housing and employment. In this way, a cultural broker program could promote more equitable, integrated, holistic, and culturally sensitive health care and support services for newcomer women throughout the Greater Vancouver region.

2. Social support for newcomer women:

Creating opportunities for women to develop social networks and receive social support is an important component of a comprehensive strategy for promoting newcomer women's health and settlement. Not only does social support promote mental health and wellbeing, but social networks also contribute to one's ability to access a variety of services. One option for addressing this need is to integrate support groups within a cultural broker program. Cultural brokers could facilitate support groups for newcomer women based on needs and interests identified through their involvement in newcomer communities. For example, a support group might be developed for pregnant newcomer women or new mothers, which would strive to build a community based on shared experiences and challenges faced by group members. Offering informal and low-barrier support groups within the hospital setting that are responsive to community needs has the added benefit of helping BCW to move towards a community model of care, which may contribute to reducing health seeking barriers that are associated with the current professionalized model. However, in some cases it may be necessary to bring support groups (and other health services) to places where newcomer women already meet. This consideration is particularly relevant for groups of newcomer women that are likely to face compounded barriers to accessing services, for example, newcomer women with precarious immigration status. In either case, the creation of welcoming spaces for newcomer women to expand social networks and develop systems of support should be done in consultation with communities and be flexible to changing needs.

3. Guiding principles:

A cultural broker program should embrace an inclusive definition of culture as a system of shared meaning rather than targeting specific ethnic or linguistic groups. There is a tension between the need to provide contextually specific and culturally sensitive care and the reality that health providers cannot possibly know everything about the cultural groups they serve, which are themselves neither homogenous nor static. Health providers therefore require tools and programs that allow them to support diverse and varied client populations while avoiding making assumptions or generalizations about any one cultural group. As such, a cultural broker program should be founded on the concept of cultural humility, which “incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic and to developing mutually beneficial and non-paternalistic partnerships with communities” (Tervalon & Murray-Garcia, 1998). Newcomer women should be included in program decision-making structures, and the program should be dynamic and flexible. Most importantly, a cultural broker program must avoid placing an onus on marginalized individuals to adapt to the current health system – cultural brokers are distinct from navigators in that they take a systemic approach to promoting health equity.

Critical Reflection

This capstone project was a highly rewarding process given the opportunities it provided to engage with various individuals and communities of practice within the health and settlement sectors. I was fortunate to benefit from being exposed to diverse perspectives regarding challenges and solutions to a timely and complex public health issue. Providing accessible and culturally safe services for BC’s heterogeneous population of newcomer women requires

coordinated response from a range of actors. As a result, the importance of cross-sector collaboration, as well as strategies for engaging in collaborative problem solving, were a central learning outcomes of my capstone project.

The reflexive discussions I engaged in with my preceptor and others at BCW helped me to recognize and interrogate my own assumptions regarding the health needs and expectations of the target population. As someone who does not have first-hand experience of being a newcomer to Canada, it was critical that I acknowledged this limitation. In response, I sought to incorporate the principles of cultural humility not only in the final recommendations of this study but also throughout the entire research process.

Furthermore, ongoing dialogue with my preceptor regarding interpretation of the research findings and their implications for developing a cultural broker program challenged me to identify solutions at a structural-level. Developing concrete and practical strategies for promoting newcomer women's health that address systemic barriers is a great deal more difficult than focusing on providing information and resources for health system navigation at an individual-level. While such resources are important, alone they are inadequate and may serve to reproduce inequities by placing the onus on marginalized individuals to adapt to the current health system. Instead, program recommendations must take a systemic approach to promoting health equity both in theory and in practice by offering strategies that strengthen the capacity of the health system to meet the needs of a diverse population.

References

- American Hospital Association (N.D.) *Eliminating Disparities in Care: Improving Care by Bridging Gaps between Expectations and Practices of Patients and Providers*. Retrieved from <http://www.aha.org/content/00-10/09dispcase-harborview.pdf>
- Benediktsson, I. et al. (2013). "Comparing Centeringpregnancy® To Standard Prenatal Care Plus Prenatal Education." *BMC Pregnancy and Childbirth*, 13(1). Retrieved from <http://www.biomedcentral.com/1471-2393/13/S1/S5>
- Campbell, R. M. et al. (2012). "A Comparison of Health Access between Permanent Residents, Undocumented Immigrants and Refugee Claimants in Toronto, Canada." *Journal of Immigrant and Minority Health* 16.1.
- Chiu, Y., Ortiz, L. & Wolfe, R. (2009). "Beyond Settlement Strengthening Immigrant Families, Communities and Canadian Society Through Cultural Brokering Our Diverse Cities." Edmonton: Metropolis.
- City of Hamilton Public Health Services. (2009). *Women's Health Educator Program*.
- City of Hamilton Public Health Services. (N.D.) *Women's Health Educators Project Report*.
- EthnoMed: Integrating Cultural Information into Clinical Practice. (2016). Retrieved from <http://ethnomed.org/>
- Cosgrove, S. et al. (2014). "Community Health Workers as an Integral Strategy in the REACH U.S. Program to Eliminate Health Inequities." *Health Promotion Practice* 15.6: 795-802.
- Crawford et al. (2015). "A Peer Health Educator Program for Breast Cancer Screening Promotion: Arabic, Chinese, South Asian, and Vietnamese Immigrant Women's Perspectives." *Nursing Research and Practice*, vol. 2015, Article ID 947245, 13 pages. doi:10.1155/2015/947245.
- Findley, S. E., & Matos, S. (2015). *Bridging the gap: How community health workers promote the health of immigrants*. New York, NY: Oxford University Press.
- Henderson, S., & Kendall, E. (2011). "Community navigators': making a difference by promoting health in culturally and linguistically diverse (CALD) communities in Logan, Queensland." *Australian Journal Of Primary Health*, 17(4), 347-354. doi:10.1071/PY11053.
- Jackson-Carroll, L., Graham, E. & Jackson, J.C. (1998). *Beyond Medical Interpretation – The Role of Interpreter Cultural Mediators (ICMs) in building bridges between ethnic communities and health institutions*. Seattle, WA: Harborview Medical Center. Retrieved from <http://ethnomed.org/about/related-programs/community-house-calls-program/icm-manual98.pdf/view>

- Lee, S. (2008). "Alcohol, Tobacco and Other Drug Concerns of Newly Arrived 'CALD' (Culturally And Linguistically Diverse) Women in Perth." PhD Dissertation. Curtin University of Technology.
- Lehmann U, Sanders D. (2007). *Community Health Workers: What Do We Know About Them?* The state of evidence on programmes, activities, costs and impact on health outcomes of using community health workers. Evidence and Information for Policy, Department of Human Resources for Health. Geneva, Switzerland: World Health Organization.
- Morris, M., & Bunjun, B. (2007). Using intersectional feminist frameworks in research. *Ottawa, ON: Canadian Research Institute for the Advancement of Women*, 1-9.
- Ortiz, L. M., & The Multicultural Health Brokers Co-op. (2011). "Advocacy and Social Support: The Multicultural Health Brokers Co-op's Journey towards Equity of Access to Health." In Spitzer D. (Ed.), *Engendering Migrant Health: Canadian Perspectives* (pp. 169-192). University of Toronto Press.
- Ortiz, L. M. (2003). "Multicultural health brokering: Bridging cultures to achieve equity of access to health." (Ph.D., University of Alberta (Canada). *ProQuest Dissertations and Theses*, Retrieved from <http://search.proquest.com.proxy.lib.sfu.ca/docview/305264056?accountid=13800>
- Najafizada, Said Ahmad Maisam et al. (2015). "Community Health Workers in Canada and Other High-Income Countries: A Scoping Review and Research Gaps". *CJPH* 106.3.
- National Center for Cultural Competence (NCCC). (2004). *Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs*.
- Richardson, E. (2006). *Women's Health Educators Information Report*. Hamilton, ON: Public Health Services, 2006.
- Rotich, J.P. & Kaya, A. (2014). "Critical role of lay health cultural brokers in promoting the health of immigrants and refugees: A case study in the United States of America." *International Journal of Human Sciences*, 11(1), 291-302.
- Shommu, N. S. et al. (2016). "What Is The Scope Of Improving Immigrant And Ethnic Minority Healthcare Using Community Navigators: A Systematic Scoping Review." *International Journal for Equity in Health*, 15(1).
- South J., Raine G. & White J. (2010). *Community Health Champions: Evidence Review*. Centre for Health Promotion Research, Leeds Metropolitan University.
- Tervalon, M. and Murray-Garcia, J. (1998). "Cultural humility versus cultural competency: a critical distinction in defining physician training outcomes in multicultural education." *JHealth Care Poor Underserved*, 9(2) 117-125.

- Torres, S., Labonté, R., Spitzer, D., Andrew, C. & Amaratunga, C. (2014). "Improving health equity: The promising role of community health workers in Canada." *Healthcare Policy*, 10(1), 73.
- Torres, S. (2013). "Uncovering the Role of Community Health Worker/Lay Health Worker Programs in Addressing Health Equity for Immigrant and Refugee Women in Canada: An Instrumental and Embedded Qualitative Case Study." PhD Dissertation. University of Ottawa.

Appendix A - Program Models

Figure 1: The Edmonton Model of Multicultural health brokering

Chiu et al., 2009

FIGURE 1

Dimensions of the multicultural health brokering practice

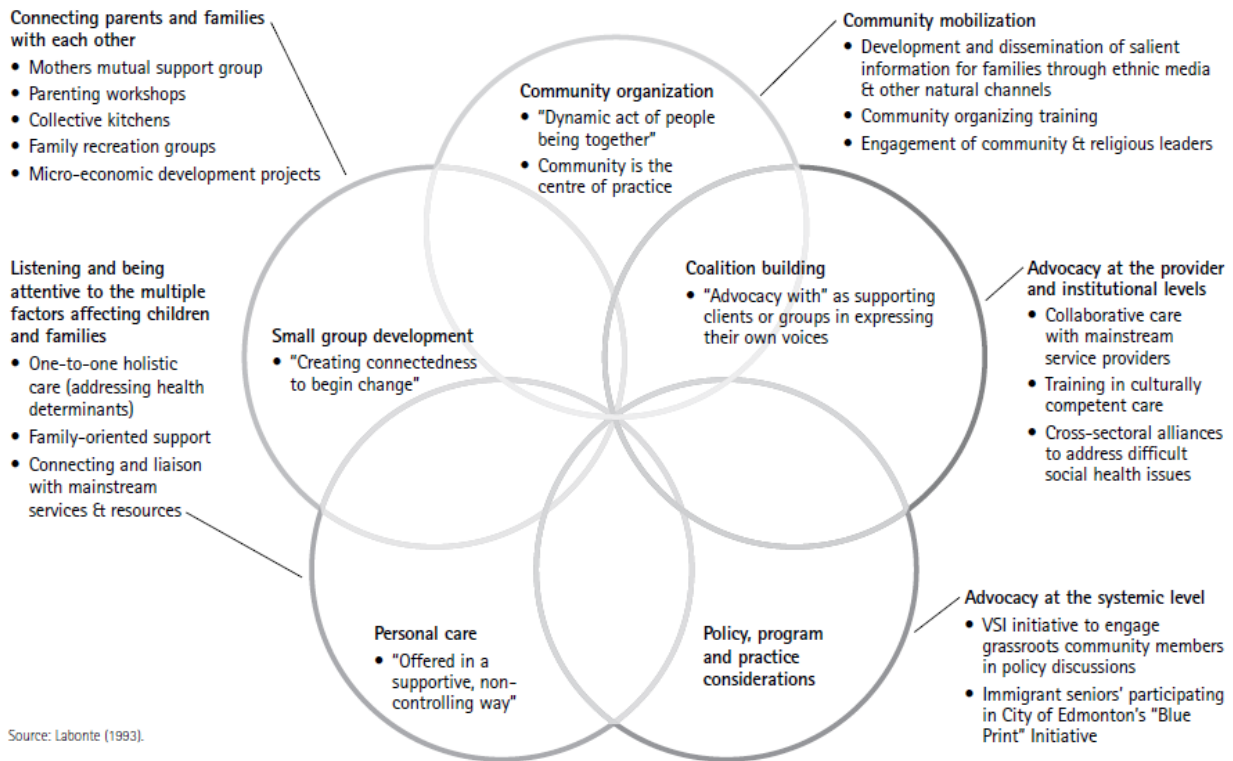


Figure 2: The Women's Health Educators Model

City of Hamilton Public Health Services, 2009

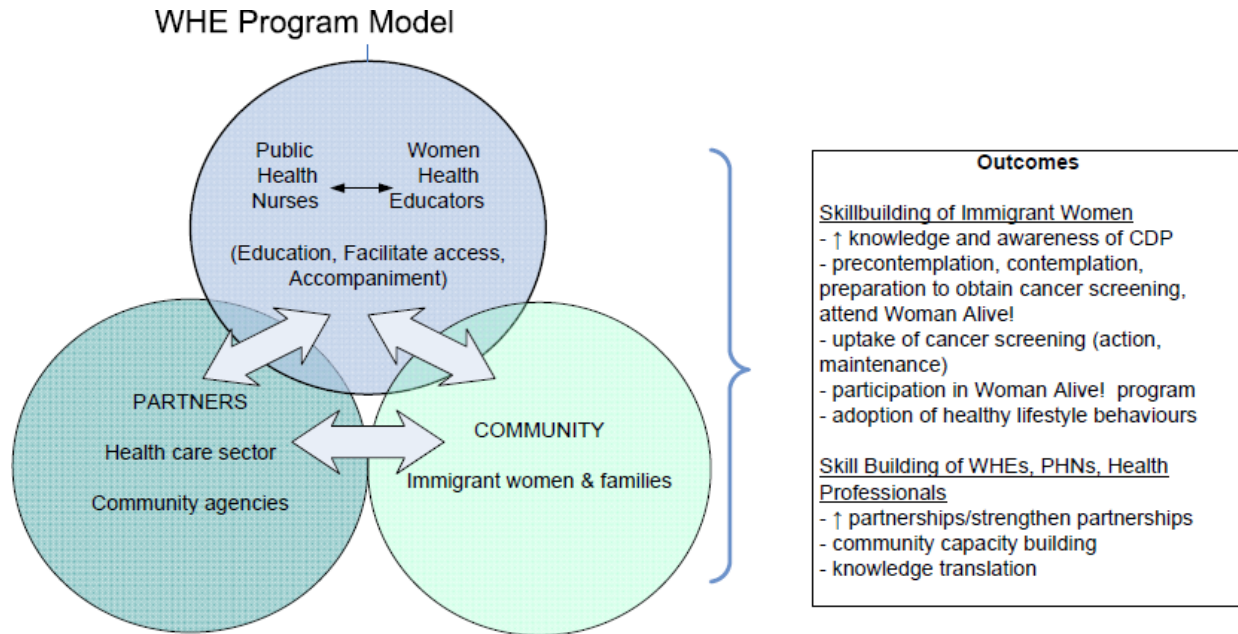


Table 1: The Role of Women’s Health Educators

Women’s Health Educators Project Report, N.D.

Functions	Activities	Outcomes
Deliver Education Sessions	<ul style="list-style-type: none"> -Working with community groups to plan the session -Delivering free community education sessions -Customizing presentation materials so that they are culturally sensitive and relevant -Presenting correct information on cancer screening guidelines for breast and cancer of the cervix -Gathering copies of resources needed for the sessions -Gathering session evaluations 	<ul style="list-style-type: none"> -Women will go for pap tests and clinical breast exams and/or mammograms depending on their age -Women will indicate that they learned through the use of the education sessions (awareness) -Women will indicate they will make a behavioural change -Participants will indicate that they felt that the facilitator was culturally sensitive during the presentations
Translate and Distribute Educational Materials	<ul style="list-style-type: none"> -Reviewing focus group report looking for cultural themes -Translating English presentation and/or educational materials using culturally sensitive approaches and ensure quality control of translation -Distributing translated printed materials as appropriate 	<ul style="list-style-type: none"> -Information will be offered in a language that best suits the cultural group -Cultural sensitive approaches will aid in enhancing respectful relationships
Identify Community Groups	<ul style="list-style-type: none"> -Consulting with the WHE work group -Developing relationships, links, and contacts with community leaders and groups -Gathering information from the community and providing specific feedback on the WHE project -Serve as an informal leader who assists women to link to appropriate community service 	<ul style="list-style-type: none"> -Better relationships and increased linkages to the WHE project -Promote sustainability of the project
Assist women to overcome the barriers	<ul style="list-style-type: none"> -Identifying barriers for accessing services 	<ul style="list-style-type: none"> -Women will obtain screening by overcoming barriers

	<ul style="list-style-type: none"> -Assisting women to find solutions for barriers (including transportation, childcare, fear or mistrust, lack of experience/confidence) -Assisting women to participate in screening practices (e.g. facilitate transportation to site, etc.) 	<ul style="list-style-type: none"> -By overcoming barriers WHEs will help shape health policy and in turn this will have a greater impact on the health of identified communities
Report on WHE Activities	<ul style="list-style-type: none"> Reporting to the Principle Investigator -Completing and compiling tracking forms and appropriate documentation according to the guidelines for the project -Collecting group education evaluation forms -Attending and actively contributing to WHE meetings -Each WHE will participate in post survey for the project evaluation -Consulting with PHNs in the Chronic Disease Prevention Adult Program as required 	<ul style="list-style-type: none"> -Ongoing communication with Principal Investigator related to their role, schedule and activities -Complete all documentation according to project guidelines -Review job progress with the Principal Investigator -Discuss issues with the Principal Investigator and/or Project Lead that are beyond the WHE scope of practice -Documentation will demonstrate the effectiveness of the project

Table 2: Guiding Values and Principles of the Women’s Health Educators

Women’s Health Educators Project Report, N.D.

1.	There are many barriers for immigrant and refugee women to access appropriate health care
2.	Important to recognize women’s skills adequately and appropriately,
3.	Through increased skill and leadership development, women gain increased confidence and self-esteem,
4.	We envision a holistic approach that enables women to develop and enhance their skills, which in turn, may lead to sustained employment, recognition of their skills and increased satisfaction in their work.
5.	Committed to the creation of supportive environments for racially and culturally diverse communities.
6.	Learning about overall women’s health is more importance than cancer screening on its own.
7.	We are aware that perceptions of health, illness and medical practices are very different in many countries.
8.	The women’s health educator project needs to create supportive environments that address broader women’s health issues, among which one could be cancer screening.

Table 3: Criteria for identifying target communities for Women’s Health Educators

Women’s Health Educators Project Report, N.D.

1.	A community with a large proportion of immigrant women over 40 years of age that were appropriate for receiving information about cancer screening as perceived by key informants and local community agencies and government reports;
2.	Incidence rates of cancer that were high with low screening rates in Hamilton based on local, provincial and national statistics;
3.	Length of time since arrival in Canada of at least 3-5 years, as a large proportion of immigrants would have completed the settlement process. Informants stressed that priorities during the first three years are with settlement and employment issues and not necessarily with health care;
4.	Communities with existing relationships with Public Health Services and interested in promoting health. Given the pilot nature and limited resources of the project, we initially aimed to work with communities who had existing relationships with other health and social agency partners.

Table 4: The multiple roles of cultural brokers in North Carolina

Adapted from Rotich & Kaya, 2014

Role	Description
1. Facilitate cross cultural competency trainings	Increase health providers' understanding of needs and challenges faced by newcomers to improve care
2. Develop training materials	Develop online or print resources for consumption by health providers
3. Provide a service road map	Provide immigrant and refugee community leaders with information on how to navigate health systems, protocols and eligibility requirements for services
4. Interpreter services	-
5. Translate materials	-
6. Strengthen diversity of health workforce	Due to limited culturally and linguistically diverse workforces in the health field, cultural brokers provide potential to increase diversity if they are trained and supported in pursuing career advancements within the health system
7. Mentorship for young or newly arrived immigrants and refugees	Mentorship role extends beyond the health care setting
8. Represent their communities	Promote collaboration between health providers and newcomer communities to ensure that all communities receive quality services
9. Increase cultural responsiveness of health system	Provide guidance about how to make environments more culturally inviting
10. Community education and awareness	Health promotion through workshops or media channels
11. Provide on-going trainings for newcomers	Increase knowledge about services and resources, navigating the health care system, health promotion, and create opportunities for community building

Appendix B – Key Informant Interview Guide

1. How do you define a cultural broker?
 - What characteristics make someone a good fit for the position?
 - What are the most important activities that a cultural broker engages in?
 - What are the priority needs that are addressed through a cultural broker program?
2. How do you engage community partners?
 - What strategies, if any, are used to involve communities in program decision making processes?
 - How can we integrate newcomer women into the program's organizational structure?
3. Through what processes do you recruit, train, and support cultural brokers?
4. Through what process are clients referred to the cultural broker program? How are clients and cultural brokers matched?
5. What are some of the challenges you face in beginning and/or sustaining a cultural broker program? What strategies did you use to address these challenges?
6. Any additional recommendations for implementing a cultural broker program?

Appendix C – Focus Group Discussion Guides

For Newcomer Women in Canada less than five years

Guiding Questions:

1. When do you look for health services?
 - How do you know it is time to go see a doctor or other health care provider?
2. Since arriving in Canada what has your experience of accessing health services been like?
 - Have you faced challenges in accessing health services?
 - Based on your experiences, what could have made accessing health services easier? (probe for services, information, tools or social supports)

For Immigrant Women in Canada a minimum of five years

Guiding Questions:

3. Tell me about your experience accessing health services in Canada...
 - When did you first need to access services and what was that like?
 - Did you face challenges in meeting your (or your family's) health needs?
4. Given your experiences, what could have made accessing health services easier?
 - Is there anything that would have been helpful to know?
 - Can you think of any resources, tools or services that might have facilitated better or faster access to health services?