



IMPROVING THE HEALTH & WELLBEING OF REFUGEES IN CALGARY

Promising Practices, Programs, and Approaches; Community Consultation Findings

**Healthy Diverse Populations
Alberta Health Services – Calgary Health Region
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CONTENTS

Executive Summary	i
Promising programs, practices and approaches for improving refugee health and wellbeing	
Introduction	1
1. Decreasing language and cultural barriers to care: Stand-alone approaches	3
1.1 Cultural competency	3
1.2 Bilingual staff	3
1.3 Written and other materials in diverse languages	4
1.4 Interpretation in the health care setting	4
2. Refugee health clinics	7
3. Community-based programming and initiatives	9
3.1 Health outreach workers or “brokers”	11
3.1.1 Health outreach workers	11
3.1.2 Multicultural health brokers	13
3.2 Mental health programming	16
3.3 Sexual and reproductive health programming	20
3.4 Community based programming for target population groups	21
3.4.1 Programming for seniors	21
3.4.2 Programming for families	22
4. Making it happen: Community collaborations and community development to design and deliver health initiatives and to address the broad determinants of health	24
4.1 Community (inter-agency) collaborations	24
4.2 Community development	27
Box 1. Promising language interpretation programs	6
Box 2. Promising clinic programs	9
Box 3. Model community outreach programs	12
Box 4. Health brokers in a promising combined clinical/community model	15
Box 5. Promising community-based mental health interventions	18
Box 6. Promising community-based mental health interventions	19
Box 7. Promising program in HIV Education	21
Box 8. Promising mental health programs for families, adults, children and youth	23
Box 9. Model program for community collaboration	26
Box 10. Effective partnerships between mental health services & the refugee community	27
Box 11. Public Health Agency of Canada’s Community Capacity Building Domains & Indicators	29
Box 12. Guidelines for Planning the Sustainability of Community-Based Health Programs	31
Community Consultation Findings	
Background	32
The Issues	32
Feedback on Strategies	33
Strategy 1. Continue to build language and cultural competency within the health care system	33
Strategy 2. Expand health services/programs for refugees	34
Strategy 3. Health outreach workers or “brokers”	35
Strategy 4. Provide community-based programs to address issues identified by refugee communities	36
Strategy 5. Community development	37
Summary	38
Recommendations	40
Appendix 1. Invitation to participate in consultation	42
Appendix 2. Interview participants	43
Appendix 3. Community consultation background document	44
Appendix 4. Community consultation protocol	50
References	52

Executive Summary

In 2007, the Calgary Health Region, Healthy Diverse Populations, and the Calgary Catholic Immigration Society (CCIS), Calgary Refugee Health Program (CRHP), began a capacity-building initiative to improve the health and well-being of refugees. Both organizations recognized that much more needed to be done to address the physical and mental health needs of refugees, along with the determinants of health (e.g., education, income, social support networks, etc.) that influence health status; and that there is limited existing capacity in the city to address these issues. Funding through the Calgary Health Trust enabled the Calgary Health Region, along with the assistance of other community organizations working with refugees, to work together to give this population the support they need to positively impact their health and wellbeing. This report documents an investigation of new approaches and options for moving forward and serves as a foundational document for the Refugee Health and Wellbeing Project.

First a research paper on promising practices, programs, and approaches for improving the health of refugees from elsewhere in Canada and around the world was commissioned. Next, consultations with key informants were completed to assist with the development of a made-in-Calgary strategy to improve the health and wellbeing of the refugee population. An independent researcher was then commissioned to draft recommendations which reflected both the research and the feedback from key informants about the shape and dimensions of a refugee health strategy for the city, as a starting point to guide discussions for the development of the initiative.

Research Paper

A review of the literature revealed that in Canada and elsewhere around the world, while both immigrants and refugees face enormous settlement and integration challenges, it is widely recognized that refugees are among the most marginalized members of society and carry additional burdens as a result of their past and ongoing life experiences. Research shows that in their host countries, including Canada, refugees often experience significant problems in obtaining the basic determinants of health, including adequate income, food security, appropriate and affordable housing, and transportation.¹ This is in part due to many refugees' inability to obtain ESL training, employment opportunities, legal services, social supports for adults, affordable childcare, sufficient settlement services, various educational and other supports for children and youth, and other supports and services that help newcomers along the road to self-sufficiency and a reasonable quality of life.

In addition, refugees often arrive in Canada and other host countries with a wide range of physical and mental health problems.² In 1993, a study revealed that common physical health problems experienced by refugees upon arrival in Calgary included respiratory infections, impaired visual capacity, dental problems (which are extremely common among children), ear infections, hearing problems, gynecological problems, and emergency hospitalizations.³ Furthermore, mental health issues often arise from the cumulative impact of experiences that refugees have undergone, including the loss of home and possessions; the deaths of children, family and friends; internment at refugee camps; and, sometimes torture, which often results in survivor guilt, depression and post traumatic stress disorder.⁴ However, it is now recognized that post-migration experiences, including social factors such as poverty, racism,⁵ unemployment, immigration status, and isolation, also contribute to the poor mental health status of many refugees.⁶ Children, women, seniors and victims of trauma are at particularly high risk for developing mental health difficulties due to their experiences prior to migration and their situation during resettlement.⁷

Despite these health concerns, research from around the world shows that immigrants and refugees do not generally use physician and hospital services to the same degree as native-born citizens. Countless studies have documented and analyzed the many barriers experienced by refugees in accessing appropriate health care.⁸ These include cultural barriers (e.g., gender relations, stigmas, different understanding of health and illness), educational barriers (some refugees are illiterate in their home languages, so translated materials are not helpful), informational barriers, and language barriers that impede their presentation to the health or social system for care when they are in need. Barriers experienced within the health encounter include language barriers, the brief duration of appointments with health care providers, and practitioners' cultural responsiveness.⁹ Language barriers are not limited to communication within the medical appointment; they are encountered at every stage of the health care process. Appointments, prescription instructions, and communications from hospitals are usually conveyed in the official language of the host country.¹⁰ It is also recognized that refugees' concerns about physical and mental health issues, particularly those which are not acute, may be superseded by concerns about day-to-day survival in the host country.¹¹

With a view to improving the health of refugees, host countries have introduced various initiatives to improve access to health care for and the living conditions of refugees. Key strategies for improving refugee health based on the literature and an environmental scan include: reducing linguistic and cultural barriers to care; establishing health clinics specific to refugees (or to immigrants and refugees); delivering health programming in refugee communities; and using health outreach workers or "brokers" to help refugees to access the health and other services they require. In most cases, strategies include more than one of these approaches, and many reflect a community development approach to program development and delivery. More often, however, efforts to improve the health of refugees blend several strategies.

Key Informant Consultations

The first phase of consultations with key informants was completed between April and July, 2008 to help develop the foundation of a strategy to improve the health of refugees in Calgary. Originally, 22 individuals from 16 organizations received a letter of invitation to participate in the process, resulting in 27 individuals from 13 organizations participating in the interview process. Participants were asked to provide feedback on which strategy, or strategies, identified in the literature review would be most appropriate and effective in assisting refugees, to recommend necessary actions to develop the strategies, and to identify those who would be able to collaborate in developing, implementing, and sustaining these or other new strategies.

Overall, participants did not single out any one of the five proposed strategies as the most essential for improving the health of refugees in Calgary. Rather, most people envisioned a multi-faceted approach encompassing all of the strategies because they are so inter-dependent. It was stressed that system-wide cultural competence is required to effect meaningful improvements for refugees, and efforts to improve competency among service providers in both the public and non-profit sectors should continue. Moreover, health programming should be provided to all classes of refugees for several years via health brokers, community-based programming, and community development initiatives, in conjunction with mainstream health delivery mechanisms, to build the capacity of refugees to collectively identify and find solutions to problems and barriers.

Participants also identified the need for all service providers to work in collaboration to reduce gaps and barriers in service delivery, maximize resources, and avoid duplication. Many participants also stated that they wished to play a role in building a comprehensive and effective health and social service system for refugees in Calgary through a collaborative approach.

The following recommendations are based on the literature review and compilation of feedback from interview participants around priorities for action to guide the development of this initiative:

1. Financial support for the development, implementation, and maintenance of a long term refugee health strategy in Calgary be secured.
2. A clear vision for the initiative along with a concrete action plan and timelines be developed with the involvement of representatives from immigrant and refugee-serving agencies, leaders of refugee communities, and include a strong voice from individuals who are or who have been refugees.
3. The CRHP expand service delivery to refugees at or through the Margaret Chisholm Resettlement Centre, Calgary Catholic Immigration Society, to two years at least or more with more emphasis on transition into the mainstream health care system.
4. Alberta Health Services - Calgary Health Region continue its efforts to reduce the language and cultural barriers encountered by refugee clients/patients.
5. Alberta Health Services - Calgary Health Region and the Calgary Catholic Immigration Society, CRHP, build on its current partnership to provide community-based health care services and health brokers/outreach workers within a community development context.
6. The Refugee Health and Wellbeing Project and other stakeholders work to raise awareness of the provincial government about the health and social issues faced by refugees, along with the social and economic consequences of failing to fully address these issues, and to influence the provincial government to increase the scope and duration of financial, health, and other supports to refugees, including those who are not government-sponsored refugees.

This document provides the background research paper on promising practices, programs and approaches for improving the health and wellbeing of refugees, the findings from the community consultations, along with draft recommendations to guide the initiative. Alberta Health Services - Calgary Health Region and the CRHP look forward to future discussions with key informants in the course of developing a refugee health action plan for Calgary.

¹ See, for example, Raphael, D. (Ed.) 2004. *Social Determinants of Health: Canadian Perspectives*. (Toronto: Canadian Scholars Press); Renaud, J.; et al. 2001. *Ils sont maintenant d'ici!, Les dix premières années au Québec des immigrants, admis en 1989*. Numero 4. Available at <http://publicationsduquebec.gouv.qc.ca>.

² Public Health Agency of Canada. 2006. *Canadian Guidelines on Sexually Transmitted Infections. Specific Populations. Immigrants and Refugees*. 2006 Edition. (Ottawa: Public Health Agency of Canada).

³ Dillmann, E.; Pablo, R.; Wilson, A. 1993. "Patterns of health problems observed among newly arrived refugees to Canada." In Masi, R.; Mensah, L.; McLeod, K.A. (Eds.), *Health and Cultures. Exploring the Relationships. Vol 2. Programs, Services and Care*, 253–258. (Oakville, Ont.: Mosaic Press). Cited in Hyman, I. 2001. *Immigration and Health*. Health Policy Working Paper Series, No. 01-05. (Ottawa: Health Canada). See also Hyman, I. 2004. "Setting the stage: Reviewing current knowledge on the health of Canadian immigrants: What is the evidence and where are the gaps?" *Canadian Journal of Public Health*, 95(3), 14-19.

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- ⁴ See, for example, Gorst-Unsworth, C.; Goldenberg, E. 1998. "Psychological sequelae of torture and organized violence suffered by refugees from Iraq: Trauma-related factors compared with social factors in exile." *British Journal of Psychiatry*, 172, 90–94; Pernice, R.; Brook, J. 1996. "Refugees' and immigrants' mental health: Association of demographic and post-migration factors." *Journal of Social Psychology*, 136, 511–519; Silove, D.; et al. 1997. "Anxiety, depression and PTSD in asylum-seekers: Associations with pre-migration trauma and post-migration stressors." *British Journal of Psychiatry*, 170, 351–357.
- ⁵ See, for example, Gee, G. C. 2002. "A multilevel analysis of the relationship between institutional and individual racial discrimination and health status." *American Journal of Public Health*, 92(4), 615-623; Harrell, J. P.; Hall, S.; Taliaferro, J. 2003. "Physiological responses to racism and discrimination: An assessment of the evidence." *American Journal of Public Health*, 93(2): 243-248; Noh, S.; et al. 1999. "Perceived Racial Discrimination, Depression, and Coping: A Study of Southeast Asian Refugees in Canada." *Journal of Health and Social Behaviour*, 40(3), 193-207; Women's Health in Women's Hands Community Health Centre (WHWHCHC). 2003. *Racial Discrimination as a Health Risk for Female Youth: Implications for Policy and Healthcare Delivery in Canada*. (Toronto, Ontario: The Canadian Race Relations Foundation).
- ⁶ See, for example, Keating, F.; Robertson, D.; Kotecha, N. 2003. *Ethnic Diversity and Mental Health in London*. (London: King's Fund Working Paper); Beiser, M.; Hou, F. 2001. "Language acquisition, unemployment and depressive disorder among Southeast Asian refugees: a 10 year study." *Social Science and Medicine*, 53, 1321-1334; Pernice R.; Brook J. 1996. "Refugees' and immigrants' mental health: association of demographic and post-immigration factors." *Journal of Social Psychology*, 136(4), 511–519; Goodkind, J. 2005. "Effectiveness of a Community-Based Advocacy and Learning Program for Hmong Refugees." *American Journal of Community Psychology*, 36(3/4), 378-408.
- ⁷ Nerad, S.; Janczur, A. 2000. "Primary Health Care with Immigrant and Refugee Populations - Issues and Challenge." *Australian Journal of Primary Health*, 6(3/4), 222-229.
- ⁸ See, for example, Reitz, J. G. 1995. *A Review of the Literature on Aspects of Ethno-Racial Access, Utilization and Delivery of Social Services*. (Toronto: Multicultural Coalition for Access to Family Services and the Ontario Ministry of Community and Social Services). Available at: http://ceris.metropolis.net/frameset_e.html.
- ⁹ Magoon, J. 2005. *The Health of Refugees in Winnipeg*. (Winnipeg: Winnipeg Regional Health Authority).
- ¹⁰ Lawrence, J.; Kearns, R. 2005. "Exploring the 'fit' between people and providers: refugee health needs and health care services in Mt. Roskill, Auckland, New Zealand." *Health and Social Care in the Community*, 13(5), 451-461.
- ¹¹ See, for example, Access Alliance Multicultural Community Health Centre. 2002. *Advancing Knowledge, Informing Directions: An Assessment of Immigrant and Refugee Needs in Toronto*. (Toronto: Access Alliance); Khamphakdy-Brown, S.; et al. 2006. "The Empowerment Program: An Application of an Outreach Program for Refugee and Immigrant Women." *Journal of Mental Health Counseling*. 28(1), 38-47.

Promising Practices, Programs and Approaches for Improving the Health and Wellbeing of Refugees

INTRODUCTION

As defined by Canada's Immigration Act, a refugee is a person with a well-founded fear of persecution based on race, religion, nationality, political opinion or membership in a particular social group.¹² Because of conditions in their home country and their fear of persecution, refugees are unwilling or unable to return. Canada recognizes two types of refugees: (i) Persons who have been sponsored by the Government of Canada or a private group, often before their arrival in Canada, and who are granted permanent residency status when they arrive in Canada; and (ii) Persons who flee a country, arrive in Canada, and apply for asylum, who are referred to as refugee claimants, non-status refugees, or asylum seekers. Those with valid identity documentation are allowed to live in the community while awaiting a refugee hearing, after which they may or may not be granted refugee status. Persons with no documentation may be held in detention pending an investigation. Refugee claimants can spend up to five years waiting for landed immigrant status. During this time they cannot sponsor family members, get a bank loan, work in certain professions, vote, or travel across international borders. Of the refugees whose claims are rejected, a small number are granted permission to stay in Canada for "humanitarian and compassionate reasons;" others are deported or "go underground," living without legal status in Canada.¹³

It is important to distinguish between immigrants—people who have chosen to leave their home countries and build a new life in a new country—and refugees—who were forced to leave their home countries and may have had little choice about the country in which they would land. While both immigrants and refugees face enormous settlement and integration challenges, it is widely recognized that refugees are among the most marginalized members of society and carry additional burdens as a result of their past and ongoing life experiences. Research shows that, in their host countries, including Canada, refugees often experience significant problems in obtaining the basic determinants of health, including adequate income, food security, appropriate and affordable housing, and transportation.¹⁴ This is in part due to many refugees' inability to obtain ESL training, employment opportunities, legal services, social supports for adults, affordable childcare, sufficient settlement services, various educational and other supports for children and youth, and other supports and services that help newcomers along the road to self-sufficiency and a reasonable quality of life.

In addition, refugees often arrive in Canada and other host countries with a wide range of physical and mental health problems.¹⁵ Although the information is somewhat dated, in 1993, Dillmann, Pablo and Wilson found that common physical health problems experienced by refugees upon arrival in Calgary included respiratory infections, impaired visual capacity, dental problems (which are extremely common among children), ear infections, hearing problems, gynecological problems, and emergency hospitalizations.¹⁶

Mental health issues often arise from the cumulative impact of experiences that refugees have undergone, including the loss of home and possessions; the deaths of children, family and friends; internment at refugee camps; and, sometimes torture, which often results in survivor guilt, depression and post traumatic stress disorder.¹⁷ However, it is now recognized that post-migration experiences, including social factors such as poverty, racism,¹⁸ unemployment, immigration status, and isolation, also contribute to the poor

mental health status of many refugees.¹⁹ Children, women, seniors and victims of trauma are at particularly high risk for developing mental health difficulties due to their experiences prior to migration and their situation during resettlement.²⁰

Despite these health concerns, research from around the world shows that immigrants and refugees do not generally use physician and hospital services to the same degree as native-born citizens. Countless studies have documented and analyzed the many barriers experienced by refugees in accessing appropriate health care.²¹ These include cultural barriers (e.g., gender relations, stigmas, different understanding of health and illness), educational barriers (some refugees are illiterate in their home languages, so translated materials are not helpful), informational barriers, and language barriers that impede their presentation to the health or social system for care when they are in need. Barriers experienced within the health encounter include language barriers, the brief duration of appointments with health care providers, and practitioners' cultural responsiveness.²² Language barriers are not limited to communication within the medical appointment; they are encountered at every stage of the health care process. Appointments, prescription instructions, and communications from hospitals are usually conveyed in the official language of the host country.²³ It is also recognized that refugees' concerns about physical and mental health issues, particularly those which are not acute, may be superseded by concerns about day-to-day survival in the host country.²⁴

In some Canadian cities, comprehensive health services are available to refugees for a period up to one year following their arrival. The Calgary Refugee Health Program, for example, is a primary health care program for new refugees and those from refugee-like situations in the Calgary region. The aim of the program is to maximize the health and well-being of new refugees by providing early health interventions and facilitating access to existing health services in Calgary in their first year after arrival in Canada. Services include a medical clinic five days per week, specialist clinics, screening, vaccinations, health promotion programs, interpreters, referrals, and supportive services. It is delivered under the auspices of the Calgary Catholic Immigration Society through their Resettlement Services Division. The program exists as a unique partnership between non-governmental agencies, private service providers, community members and groups, Alberta Health Services - Calgary Health Region, the Alberta Medical Association, and Alberta Health & Wellness.

However, it is recognized that the litany of challenges and barriers that can affect health status may be experienced by refugees for many years. In response, a wide range of programs and initiatives have been developed around the world to improve refugees' access to health services and the nature and quality of those services. Initiatives include language interpretation and translation services, comprehensive refugee health clinics, a range of community-based initiatives, some of which target specific health issues or refugee communities and others which provide extensive programming including health care, health promotion, community development programming, and social, cultural, and other settlement services.

This section provides an overview of promising initiatives and model programs, with a focus on those which are community-based, that seek to improve refugees' health over the longer term. Particular attention has been paid to programs and approaches in Canada, the United States and, especially the United Kingdom, as it has longer and more diverse experience than Canada and the United States in addressing refugees' health care issues and needs due to immigration histories and patterns. Australian models have also been thoroughly

investigated because, despite the extensive criticism the country has received from human rights groups for its stance on refugee claimants, the Australian health care system has introduced several initiatives of interest in this section. Where possible, promising practices in program and service delivery have also been identified. Finally, community development as a key component in the design and delivery of community-based health initiatives for refugees is discussed.

1. DECREASING LANGUAGE AND CULTURAL BARRIERS TO CARE: STAND-ALONE APPROACHES

Health care providers use a wide spectrum of strategies for overcoming linguistic and cultural barriers to care, including cultural competency training and guidelines for health care providers, bilingual providers, translated written materials, interpreters, and, as discussed in more detail in subsequent sections of this paper, various types of community outreach and community development programs, community liaison workers, and cultural brokers.

1.1 Cultural Competency²⁵

The importance of cultural competence among health care professionals is highlighted throughout the literature on refugee health as crucial to improving the health of refugees; definitions, resources, training programs, and curricula on cultural competence abound. A full discussion of cultural competency is beyond the scope of this paper, but its relevance to all aspects of health promotion, illness prevention, and health care should not be overlooked. Cultural competence reduces disparities in health services and increases detection of culture-specific diseases, helps to ensure equitable access to primary health care, and contributes to the improved health status of ethnocultural communities. Cherfas' concise explanation of the cultural competency of health professionals is helpful here:

“Essentially, cultural competency is a lens through which healthcare workers may gain deeper understanding of their patients' perceptions regarding health, and also a way of service provision that systematically incorporates cross-cultural sensitivity. It is a method of bridging different traditions to improve the quality of care, not a way of bringing the patient into line with the biomedical model. It is important to remember that 'culture' is not to be understood as a monolithic, homogenous concept and to avoid genetic explanations of ailments affecting certain racial/ethnic groups. As such, cultural competency is an approach to listening, rather than a method of healthcare provision pre-fabricated to target certain groups. This view is especially salient to healthcare provision in societies with populations from different regions.”²⁶

There is debate in the literature about the need for cultural specificity versus the need for cultural sensitivity in treating diverse populations.²⁷ However, in cities where there are diverse refugee populations, culturally-sensitive, rather than culturally-specific services, have been identified as the most pragmatic solution.²⁸

1.2 Bilingual Staff

Strategies for recruiting staff for bilingual positions include retraining foreign-trained health care workers to serve in paraprofessional roles,²⁹ bringing in traditional healers to bridge language and cultural gaps, and using nursing and medical students to deliver care, as this

group is often more ethnoculturally and linguistically diverse than the larger body of established health care providers.³⁰ However, it is generally not possible to employ a sufficiently diverse staff to meet the language needs of clients, and it is generally recognized that lay interpreters and family members, particularly children, should not be used as medical interpreters.³¹ Family, friends and other individuals called upon as *ad hoc* interpreters may lack appropriate language skills and knowledge of medical terminology, leading to gross errors in communication. Also, confidentiality is compromised, vital information may be censored, and internal family dynamics may be jeopardized. Potential liability costs and undesired health outcomes may be more expensive than providing well-trained interpreters.³²

1.3 Written and Other Materials in Diverse Languages

Ideally, written materials about the health care system, health promotion issues, and specific illnesses and treatments should be available in refugees' first languages. And, as stressed by Fortier, "written materials in other languages should reflect the dialectic and cultural nuances of the local target population." Documents that reflect an awareness of these details and the educational and literacy level of the target audience demand a more sensitive approach than mere text translation. There is no point in debating the best possible direct translation of 'patient responsibility in a managed care environment' for Somali refugees who may only have been to a three-room clinic a few times in their life."³³ Fortier recommends that materials be developed from scratch *in the target language* based on discussions with focus groups, and should incorporate an appreciation of the cultural norms of the community. They can then be translated into English for review and reference purposes by the health care provider.³⁴

Audio cassettes and videos are also identified in the literature as useful tools for communicating health information, but "attention must be paid to the quality of presentation, the appropriateness of the images and situations, the sensitivity of the language used, and the heterogeneity of the likely audience."³⁵ Ethnic media is also recommended as a good vehicle for communicating health information, as they often have a good reach into target communities, and radio and television are accessible to people with limited literacy skills,³⁶ given that refugees may not be literate in their home languages.

Some researchers have suggested that support and training be offered to refugee organizations to enable them to convey information, provide advice, and produce health-related materials in their own language.³⁷ In addition, research suggests that word of mouth is one of the best ways to get messages across, as oral traditions are strong in many refugee cultures.³⁸

1.4 Interpretation in the Health Care Setting

Some of the best language interpretation service models have emerged in the U.S. in response to Title VI discrimination complaints that led to reviews and corrective consent agreements between the U.S. Department of Health and Human Services and the health facility.³⁹ A review of model American hospital- and clinic-based programs indicated that features and programming that contribute to success include:⁴⁰

- an organization-wide commitment to develop, staff, and fund formal interpreter programs with administrative staff and in-house or contract interpreters;
- 24-hour access to onsite interpreters or telephone backup services;

- computerized tracking of patient language characteristics, interpreter scheduling, and utilization;
- clear and consistent definitions of role and practice standards and formal assessment of interpreter skills and/or training;
- provider education on working with interpreters;
- program evaluation; and
- support from clinical staff for maintaining a trained interpretation staff adequate to meet patient demand.

Extensive and additional training is particularly important within the field of mental health care. Problems with objectivity and accuracy, and limited technical knowledge, make interpreting difficult in the case of complex treatments.⁴¹

Programs at the University of California-Davis, Stanford University Hospital, Santa Clara Valley Medical Center, and Cedars-Sinai Medical Center in California were identified as model programs that incorporated these features. It should be noted, however, that most model programs in the U.S. work to address the needs of a specific ethnocultural group, rather than a broad range of cultures and languages.⁴² Many other clinical and community programs using a bank of interpreters to address multiple language needs have not been comprehensively evaluated.

Telephone lines are often used as a stand-alone service or a supplement to in-person interpretation. Hospitals often use such services for emergencies when it will take too long to get an interpreter in-person or for rare languages where a local interpreter is not available. Telephone interpretation may also be used for simple communications that are normally conducted by phone with English-speaking patients, such as setting up appointments and giving lab results. Finally, telephone services are often used as a means of providing basic health and social service information. For example, B.C. offers translation services for various groups, including a toll-free multilingual health information line. Calgary and Area Child and Family Services provides a multilingual one-stop telephone contact centre to assist members of diverse ethnocultural communities, most of whom are immigrants and refugees, to obtain culturally appropriate resources. The service is currently being evaluated.⁴³ The Winnipeg Regional Health Authority has recently initiated a Health Interpreters Project which is a call centre staffed 24 hours a day by a multilingual pool of interpreters who provide “neutral” (i.e., no cultural interpretation) language services. This base service is supplemented by salaried staff who provide services such as support, advocacy, or education for members of vulnerable communities on an as-needed basis.⁴⁴

It is generally agreed that more complex communications are best left to in-person interpretation services, where non-verbal cues are an important part of the communication process and accuracy of the interpretation is critical.⁴⁵ “A ‘one-to-one’ language service is essential to communicate with those who do not speak English or whose English is limited. Without one there is a danger of misdiagnosis, inappropriate use of medicines and patients being forced to go from pillar-to-post trying to be understood and to understand. This is distressing and costly for all concerned.”⁴⁶

There is no clear consensus about the best role for a health interpreter. Bowen reports that neutral interpretation, where the interpreter seeks to ensure communication and understanding but no effort is made to “broker” cultural differences, is most appropriate because it engenders the respect and confidence of the medical community and provides

greater protection to all parties. Cultural brokering, she argues, may be resisted by health professionals, is not acceptable to all language groups, may lead to stereotyping and the interpreter speaking for the patient, and may result in conflicted roles for the interpreter.⁴⁷

However, the use of language and cultural interpreters in health care consultations with physicians and other health care providers is extensive,⁴⁸ and its effectiveness appears to be quite well established.⁴⁹ In the U.K. and Australia, for example, professional interpreters who have experience in interpreting the traumatic histories provided by refugees are often used to facilitate both intake and subsequent meetings between clients or patients and health care providers. Of course, caution is exercised to avoid situations in which the interpreter is an immediate member of the community, or where the patient and interpreter come from conflicting political or ethnic groups within the home country. This can be challenging if the refugee group is small.⁵⁰ Likewise, cultural brokers have been successfully used to mediate cultural and language challenges between immigrant and refugee patients with mental health concerns and their caregivers. Three forms of services are provided: (1) the consultant completes an assessment of the patient, the results of which are relayed to the physician or other health care provider; (2) the consultant confers with and provides relevant cultural information to the clinician without seeing the patient; or (3) the consultant conducts a clinical conference with a community organization about issues it has encountered while serving a specific ethnocultural community.

Evaluation reveals that medical cultural interpreters/brokers require extensive training, along with ongoing skills assessment and supervision. Mental health practitioners also require training to work with the consultants, along with cultural education, to make it an effective process. Clear identification of each party's roles and responsibilities—a challenging task—is required from the outset. Overall, it is generally agreed that there are benefits to using language and cultural brokers to facilitate communication, but they are often insufficient to address the complexity of the cultural divide among groups.⁵¹

Box 1. Promising Language Interpretation Programs

Community Health Services Program, Seattle, Washington⁵²

The Community Health Services Program (CHS), sponsored by the Center for Multicultural Health, serves a group of community health centers in the greater Seattle area. The program uses both on-call contract interpreters, who provide neutral interpretation services and do not have a continuing relationship with patients or health care providers, and multilingual family health workers who rotate through six community clinics in Seattle/King County. The family health workers are an integral part of the clinic health care team, playing an expanded role that goes beyond interpreting, although interpretation lays the foundation for the work they do. They work in partnership with providers to offer comprehensive, culturally and linguistically appropriate care to patients, and are called upon to do health education, outreach, and provider education in the culture of their patients.

Asian Counseling and Referral Services, Seattle, Washington⁵³

Asian Counseling and Referral Services recruits staff from different Asian ethnic groups and provides training in interpreting and basic mental beliefs and practices for both Asian and American cultures. Once trained, individuals act as co-providers with a licensed mental health professional.

2. REFUGEE HEALTH CLINICS

Refugee health clinics generally seek to provide a “holistic” response to the needs of refugees by offering a broad range of services including advice and advocacy, social and emotional support, physical and/or mental health care, health promotion, system navigation, and access to specialized health services and community and social support services. Holistic support is acknowledged to be an appropriate way of delivering quality care to refugees.⁵⁴

Refugee health clinics often work in close partnership with refugee and immigrant community groups and organizations. As noted by Aldous and colleagues, among others, community groups often serve as refugees’ primary connection with their host country. These groups can be involved in or deliver refugee education and training, can help health clinics to help develop and support culturally competent services, and may be able to provide accredited bilingual interpreters who can represent the needs and desires of individual refugees.⁵⁵ Moreover, providing effective services requires a high degree of trust between client and provider, which may be difficult to establish⁵⁶ and can be partially facilitated by involving members of refugee communities in service design and delivery, and ensuring that practical help is offered to address the range of settlement and integration challenges faced by refugees.⁵⁷

In Canada, some health clinics have developed to provide holistic health care services to refugees, including those who have been in the country for more than one year, and including those without health care coverage. Rejected refugee claimants who continue to reside in Canada while they pursue legal avenues of appeal lose their eligibility for public insurance, either provincial or federal. And, as explained by Coulford and Vali, despite Canada’s universal health care system, many immigrants and refugees who reside here legally are never granted public health insurance. Others are granted coverage, but only after long delays: Four provinces impose a mandatory three-month waiting period although, in fact, refugees may wait more than two years to receive coverage. These people are, understandably, reluctant to seek medical care, and when they approach mainstream providers, they are sometimes turned away due to lack of proper identification or evidence that they reside in the clinic’s prescribed area, inability to pay, or lack of knowledge regarding the health benefits to which they are entitled.⁵⁸

Access Alliance Multicultural Community Health Centre (Toronto), the North Hamilton Community Health Centre Refugee Program, and the Bridge Community Health Clinic (Vancouver) are examples of Canadian clinics providing long-term, holistic care to refugees.

- Access Alliance provides a range of settlement and health services to newcomers, including refugees. It also provides community interpretation services, delivered by certified interpreters, which are available to clients for free and to community service providers, which include health care providers, for a fee. This service is used frequently by primary health service providers. In addition, Access Alliance offers a health promotion program, staffed by multilingual health promotion workers, who use various health promotion strategies including health education and communication, community development, advocacy, and intersectoral collaboration. The Centre’s health promotion goals are to improve community knowledge, behaviours and skills; to increase community participation in decision making; to promote health promotion and disease prevention as priorities for the health care system and to enhance health promoting policies and practices.

- The North Hamilton Immigrant/Refugee Health Program operates within a community health centre and addresses settlement and integration needs and provides community development and translation and interpretation services, along with health services and assistance in navigating the health care system and obtaining appropriate care from other service providers. The main goal of the program is to provide accessible, comprehensive primary care that addresses the social issues of new immigrants and refugees. Community health workers serve as the primary program contacts, organizing workshops on topics suggested by participants, peer counseling, support groups, and group activities around a specific theme, such as cooking.⁵⁹
- The Bridge Community Health Clinic, located within a mainstream community health centre in Vancouver, provides primary and preventative health services for refugees (with or without legal status) and new immigrants. In addition to primary care, the clinic provides screening for infectious and/or chronic diseases, immunization, chronic disease management, pediatric consultation, outreach/health education, mental health services, and settlement services. On site interpreters are available and clinic staff speak a variety of languages. A phone interpretation service is also available.⁶⁰
- Although it does not provide the breadth of services offered by the clinics described above, a health clinic affiliated with the Scarborough Hospital Medical Centre, in Scarborough, Ontario, uses volunteers to provide free health care to refugees without insurance. Of the patients without medical insurance who attend the Scarborough Clinic, 46% are awaiting a decision on their immigration status, 36% are immigrants in their three-month waiting period, 6% are sponsored immigrants, and 12% have other reasons, such as a lost or stolen health card, expired visa, and/or status unknown. Two-thirds of these patients are women, many of whom are well into a pregnancy. Many were declined services at community health centres.⁶¹

It is not clear that any of these clinics have been evaluated, although the services that they provide are consistent with promising practices established by research.

Refugee health clinics are certainly not the exclusive province of Canadian cities. In fact, they are prevalent in the U.S., many European countries, New Zealand, and Australia, and some have been evaluated and identified as model programs.

- The Hauora o Puketapapa/Roskill Union and Community Health Centre (HoP) in Auckland, New Zealand is a non-profit, community-owned and -operated health clinic designed to deliver accessible, affordable and appropriate primary health care services to low-income individuals, many of whom are refugees from diverse backgrounds. Qualitative evaluation of the Centre, based on in-depth interviews with community representatives, clinic users and health service staff members, revealed that HoP has successfully established itself as a well-regarded place of primary health care and has strengthened the capacity of the local community to respond to the changing policy environment. The Centre's success in these two areas is partially attributed to the Centre's ability to be responsive to demographic and other changes in the community by keeping an "ear to the ground," continuously monitoring and soliciting feedback about its services, and maintaining an elected board comprised of both community and clinic representatives to foster trust and bridge what otherwise might be a gulf between clinic and community.⁶²

Promising Practices in Clinic-Based, Health Service Delivery Identified in the Literature Include:

- Provide free health care to uninsured refugees.
- Design and provide services in partnerships between public services, community groups or organizations and, in some cases, private practitioners.⁶³
- Define health from a broad health promotion framework and provide a range of services.
- Facilitate client engagement and trust and lay the foundation for good health by helping clients to meet basic needs.
- Provide activities that develop confidence and self-esteem and create a non-threatening space within which clients can begin to develop and re-build their identity (e.g., user-led sewing workshops, art classes, music sessions, creative writing, poetry and dance).⁶⁴
- Evaluate services on an ongoing basis with methods that include client questionnaires and feedback sessions, and in-house team meetings.⁶⁵
- Involve clients in planning activities to build trust and understanding and allow clients the opportunity and a safe space within which to express their individual and specific needs.⁶⁶
- Use culturally-sensitive, female health workers to address women's obstetric and sexual health needs.⁶⁷
- Incorporate traditional healing practices in treatment approaches.⁶⁸

Box 2. Promising Clinic Programs

St. Pancras Refugee Centre, King's Cross, London, England⁶⁹

St. Pancras Refugee Centre has been recognized by the Home Office as an example of good practice and has received awards in 2004 and 2005 for its successes in working partnership with health professionals with a view to providing effective health promotion, especially in aspects of information and education, and community and empowerment. The Clinic works with all the refugee communities in the borough and provides advice and advocacy, social and emotional support, and access to health services, and education and training. The Project also advocates more broadly for refugees in Camden, providing input to strategic and planning forums, training for front-line mental health professionals, and undertaking research. Services are provided both at the office in King's Cross and through a number of outreach offices in both primary and secondary care health services. The Centre mainly targets refugees in Camden, many of whom are homeless and living with friends or family or in hostels and bed and breakfast hotels. Fifty-eight percent of clients suffer from mental health problems and receive treatment from primary and secondary care services and other specialist refugee agencies.

3. COMMUNITY-BASED PROGRAMMING AND INITIATIVES

Community-based refugee health initiatives take many forms. Some target specific health issues, refugee communities, or individuals (such as seniors) within one or more communities; others provide extensive programming including health care, health promotion, community development programming, and social, cultural, and other settlement services. Approaches to and mediums of service delivery also vary widely, as do staffing models. This section provides an overview of the types of community-based initiatives, including the use of health outreach workers and “brokers,” programming in the areas of

mental health and sexual and reproductive health, and programming targeting senior and families. Approaches to community development are discussed in the following section.

Whatever the form of the initiative, as emphasized throughout this paper, research confirms that extensive consultation with and the engagement of members of refugee communities is vital to the design, delivery, and sustainability of effective, culturally-appropriate health and social service programming. It is cautioned, however, that refugee community organizations are typically under-resourced, overworked, and restricted by short-term funding. In addition, they may reflect religious and political divisions amongst refugees, and may be dominated by particular interests or individuals. These factors may interfere with their ability to provide health-related support across an entire community.⁷⁰ Such concerns are unlikely to arise when working with larger, more established settlement organizations that serve all ethnocultural groups although, in light of government downsizing and “downloading” in recent years, many foundations, policy think tanks, academics, and advocates have argued that the capacity of such organizations to function effectively and meet burgeoning client and stakeholder demand has been compromised.⁷¹

Regardless of the form of the community-based initiative, the following overarching best practices in design and delivery have been identified in the literature:

- Refugees need assistance beyond the initial resettlement period. The challenges of adjusting to a new place persist for many years for some people, particularly those who have limited education and English proficiency.⁷²
- Interventions should be community-based. The expertise of individual immigrants and refugees, along with refugee organizations, immigrant-serving organizations, and faith-based organizations, should be reflected at all stages of planning and delivery.⁷³
- Interventions should reflect collaboration with service users and feature open communication, a means of recognizing and addressing “turf” disputes, and a capacity-building agenda.⁷⁴ Community collaboration is essential to gain credibility with, visibility among, and access to refugee women.⁷⁵
- Interventions should use existing resources wherever possible, with a focus on inter-agency coordination and community coalitions.⁷⁶
- Peer education, support, and therapeutic groups are recommended as mediums for health promotion and health education for women, and hence, for the community, as women are often the gateway to both families and the community as a whole.⁷⁷
- Services must be accessible to clients, and thus home- and community-based services, or transportation must be provided to the program.⁷⁸ In order to reach refugee women in particular, it is often necessary to take the service to them via, for example, home visits and workshops close to home, rather than expecting them to attend a service.⁷⁹
- In addition to providing services for their clients, staff must consistently advocate for the needs of their clients, including increasing the capacity of mainstream agencies to address the needs of refugees.⁸⁰
- Community-based health promotion projects should facilitate the development of a range of skills such as networking, project management, policy formation, and advocacy within refugee community groups.⁸¹
- The feasibility of contracting refugee organizations to provide health promotion services should be considered.⁸²
- Financial and other incentives may be required to engage community members to assist with program development, outreach, and delivery.⁸³

3.1 Health Outreach Workers or “Brokers”

Refugee health workers are used extensively and effectively around the world to link refugees to health and social services, provide education and health promotion, deliver specific programs, advocate on the part of both individuals and communities, provide cultural and language interpretation, engage in community development, and increase the cultural competency of health service providers, along with the appropriateness and quality of services provided.

The need for refugee health workers has been identified in Canadian cities that do not already have them. For example, in consultations completed by the Winnipeg Regional Health Authority, representatives of immigrant-serving organizations stated that the best way to access the immigrant and refugee communities would be to have volunteer or paid outreach workers from communities who were able to share knowledge with their own cultural groups. The potential of community-based cultural groups and their leaders to transfer knowledge to immigrants and refugees and to champion certain ideas or practices was highlighted, along with the capacity of community leaders to pull people together and catalyze change.⁸⁴

Different labels and, sometimes, different job descriptions, apply to various types of refugee health workers, who may be employed by hospitals or clinics, regional health authorities, or immigrant-serving organizations. The workers may be lay members of refugee communities and/or professional health care providers in their home countries who cannot practice in their host countries, or they may be medical or nursing students, undergraduate university students, or public health nurses.

3.1.1 Health Outreach Workers

The term “health outreach worker” is often applied to workers engaged by hospitals, clinics, and health departments, and whose job involves facilitating access to that particular service through outreach and health promotion activities. In some cases, nurses or physicians are involved in providing direct health care services in community locations. For example:

- The Public Health Nursing Outreach for New Americans (PHNONA) program in Denver, Colorado provides health care to refugees, particularly victims of torture or war trauma, both at a clinic in an immigrant-serving organization and in patients’ homes. The program is primarily staffed by nursing students under the supervision of a faculty member who speaks both English and Spanish, the most common language of the target client population. Trained interpreters accompany students on home visits as required. Evaluation of the program showed statistically significant improvement for clients from admission to discharge in the areas of knowledge, behavior, and status.⁸⁵
- In Boston, Massachusetts, refugee health workers emerge from the refugee communities and are formally trained by Boston University School of Public Health and then employed as interpreters and outreach workers by the Massachusetts Department of Public Health. Their ability to interpret, translate, advocate, and educate provides an important service, linking the refugees to services and helping providers understand the special circumstances of refugees’ lives. Although details are not available, it appears that both the training program and the service delivery program have been very successful.⁸⁶

Box 3. Model Community Outreach Programs

Dallas County Refugee Outreach Program⁸⁷

A refugee outreach program offered by The East Dallas Health Center (EDHC) and the Dallas County Hospital began with efforts to provide health care to large, underserved Kurdish community in North Dallas. Attempts to connect the Kurds with the EDHC were unsuccessful because of cultural barriers and transportation issues. EDHC responded by sending a physician and refugee program coordinator, an anthropologist, to the Kurdish community one day/week. The Midpark Place Apartment's "rec room" was the first outreach clinic site and has served as an enduring model for this work. A subsequent partnership with the Dallas County Health Department allowed the program to expand to include a cooperative refugee screening and follow-up program. The goal of the program has been to link the screening procedures with the primary, ongoing treatment and care for the refugee patient, in a flexible and culturally-appropriate manner. The traveling team presently operates out of three outreach sites, determined in coordination with settlement agencies. Outreach sites include apartment "recreation rooms," vacant apartments, and an "interactive community police" building. While none of the sites is ideal as a health care facility, each is accessible on foot, low tech and staffed by familiar people, (as often as possible with community people themselves, hence easier to access administratively), and surrounded by native speakers when a translation need cannot be covered by the team.

Baylor University School of Nursing Community Care Program⁸⁸

Baylor University School of Nursing operates the Baylor Community Care program every Thursday and Friday in a medically underserved Latino and Asian refugee neighborhood in East Dallas. Home base for the program is the East Dallas Police Storefront. Cooperating organizations are the East Dallas Health Center (EDHC) Refugee Outreach Program, Dallas County Health Department, Vietnamese Mutual Assistance Association (VMAA), Dallas Police, and Common Grace Ministries. The program is based on community needs and because support and funding is broad-based and in some cases internal (e.g., Baylor), the program is able to respond to changing community circumstances. The program has contributed to a growing corps of volunteers and a strong network of concerned individuals whom the program helped equip to reach out and help their neighbours. The services provided include:

- Door-to-door outreach through the apartments in the district. Students, volunteers, and lay health promoters carry flyers in English, Khmer, Spanish, and Vietnamese about clinic services. Standard procedure for each contact is to talk with people about health problems, check blood pressures, vaccination records, medications, and address any other health issues that arise during the contact. Always, as much as is possible, problems are addressed on the spot.
- Primary Care at a weekly clinic in conjunction with case management and home health care delivered in partnership with a church-based clinic;
- Community services provided by students, including immunizations, instruction and assistance with family planning and prenatal care, and screening events for health problems (e.g., breast cancer, diabetes, hypertension, colon cancer, HIV).

3.1.2 Multicultural Health Brokers

The term “multicultural health broker” applies to a wide range of roles and positions, but the approach is usually from the perspective of the refugee community. The broker’s job may be narrowly defined—as in a program in which Spanish-English bilingual nurses blend the profession of nursing with Hispanic folk healing to assist Mexican immigrant mothers in the U.S.⁸⁹—or it may be very broad, including advocacy and community development. Health brokers seek to improve the delivery of health care services, or, in some models, seek to improve access to services, with systemic change within the health care system as a secondary objective. Most health brokers do not provide direct medical services, although they may work in collaboration with health service providers. For example:

- As part of its refugee health strategy, New South Wales, Australia uses multicultural health workers to improve refugees’ access to responsive health care. Workers are charged with
 - identifying the main health issues for local communities and provide advice for service planning;
 - working with local communities to strengthen social support and self help networks;
 - providing verbal and written information on the health services available in their area;
 - organizing health education and promotion programs in community languages;
 - referring to other health professionals and services which are appropriate to their needs;
 - performing advocacy work for clients and community groups in providing expert advice to health services to ensure accessible and equitable service delivery; and
 - working in partnership with health services to plan and promote services, developing needs assessments; and providing team based reorientation and models for culturally appropriate approaches in community development and health promotion.⁹⁰

Subcategories of multicultural health workers in New South Wales include Bilingual Community Educators, who provide health promotion programs for people in a variety of community languages; Ethnic Obstetric Liaison Officers, who work with specific language groups to improve access to appropriate services associated with childbirth and pre- and post-natal care, and provide information and support to service clients, before and after the baby is born; Health Care Interpreters, who provide free and confidential professional interpreter services for people with communication difficulties when accessing the public health system and, as required, provide cultural advice and translation services to health professionals; and Multicultural Health Education/Promotion Officers, who plan and conduct health promotion programs directed to all ethnic communities. Health Officers work with both ethnocultural communities and mainstream health workers to ensure all health promotion and education is appropriate to the specific culture and life circumstances of the community groups to which they are directed.

- The National Center for Cultural Competence in the U.S. (NCCC) seeks to improve the delivery of health care services, but nonetheless pays great heed to patient needs and realities. Efforts are made to engage community members who have a natural instinct

for listening to, leading, and organizing their peers as cultural brokers, with a view to integrating a brokering program within the community, ensuring that the brokers truly understand the unique needs of the community, and building collaborative relationships with the community. The NCCC concludes that cultural broker programs can facilitate clinical encounters with more favorable outcomes, enhance the potential for more rewarding interpersonal experiences, and increase the satisfaction with services received. It is not clear, however, that the outcomes of any NCCC broker programs have been rigorously assessed, although anecdotal and qualitative feedback has been positive.⁹¹

- The Multicultural Health Brokers Co-operative in Edmonton seeks to provide equal access to healthcare services for ethnoculturally diverse individuals, families, groups and communities, most of whom are immigrants and refugees. Brokers provide health education and early parenting support to women and families from other immigrant communities. Specifically, they provide prenatal education and hospital tours, post-natal support, health and sexuality education, telephone counseling and referrals, home visits when necessary, translation and resource material development, community development and health promotion, and consultation concerning cross-cultural issues. As well, they serve as health brokers between health institutions and immigrant communities.
- Similar to health brokers, Aboriginal cultural liaison workers have been used with anecdotally-reported success in Australia to negotiate and reduce barriers to access to mainstream health services for Aboriginal women and engage key community members in systemic change efforts. One evaluation reported improved use of health services by the community, increased capacity within the health service to address community needs; and increased community capacity, defined here as building personal and community strengths that can be mobilized into action for the good of the community.⁹²

Box 4. Health brokers in a promising combined clinical/community model

Community House Calls, Seattle, Washington

The Community House Calls program delivered by the Harborview Medical Center (HMC) in Seattle, Washington began in 1994 with the goal of decreasing socio-cultural barriers to health care for non-English-speaking ethnic populations receiving care at Harborview. The program has received awards from the American Public Hospital Association, the Foster McGaw Foundation, and the Ambulatory Pediatric Association, although it is not clear that the program has been comprehensively evaluated.⁹³

The goals of the program are to:

- Create a common fund of knowledge between medical and ethnocultural groups;
- Decrease language barriers to care;
- Change institutional practices that particularly decrease patient satisfaction for non-English speaking families;
- Improve cross cultural health care education for providers and trainees; and
- Enhance efficient utilization of resources by “high risk/high need” families.

The program provides a variety of health care and educational services, including continuity of interpreter services; case management for families with complex social or medical needs; home visits by “interpreter cultural mediators” and health care providers; training for families, enabling them to make their own clinic appointments and obtain pharmacy refills; community health education; and training for health care providers in the practice of intercultural medicine.

Interpreter cultural mediators (ICMs) liaise between hospitals, community and institutions with a view to identifying and removing barriers to access to healthcare services, and serve as medical interpreters and cultural advocates, not only for their own clients, but for other patients within the community, meeting with language and cultural barriers. Cultural mediation is combined with case management, in which problems such as poor housing, lack of child care or support for new parents, depression, isolation, and mental health issues are addressed.

ICMs are bicultural, bilingual persons who are familiar enough with the biomedical and American cultures that they can act confidently within the health care system, be known and trusted by the institutions and have influence with providers and clinic teams. The ICMs’ bicultural, bilingual background at the same time enables them to serve as a trusted contact and advocate for non-English speaking families of the same ethnic background. Often, the ICM has worked before as an interpreter in a medical setting. The ICMs’ work is overseen by a nurse supervisor.

ICMs’ work focuses on families and children in both the clinic and the community, where they provide broad health education in areas including parenting, intergenerational conflict, family planning, and medical issues such as parasites, malaria, hepatitis B, TB, asthma, rickets, and infant feeding.

The program also employs community advisors from each ethnic group to serve as cultural informants and program assistants. They were selected on the basis of their knowledge of traditional forms of healing, their role in decision-making within the families and larger community, their strong presence in the community, and the fact that they retained much of their former culture. It is not known whether the program achieved its goal to integrate community advisors into the overall treatment plan for families being cared for at the primary care clinic.

The Harbourview ICM program claims many benefits, including improved dialogue between patients and health care providers, increased cultural and social feedback for providers, increased inter-cultural experience for medical residents, and, from the patients' perspective, improved access to culturally knowledgeable service providers, encouragement to use appropriate medical services and increased visits from patients who otherwise not be seen.⁹⁴

3.2 Mental Health Programming

Canadian research shows that many refugees begin but do not complete traditional counseling for a variety of reasons, including cultural taboos/stigma about mental illness; lack of faith in the benefits of mental health services; previous negative experiences with counseling; professionals' lack of attention, care, interest, and relevant expertise. In addition, some refugees do not understand the purpose of counseling, and expect to receive assistance from the counselor with respect to practical matters such as income support or family reunification.⁹⁵

One Canadian study found that community peer groups may be more helpful than professional counseling for refugee women. The groups may form around a specific interest or purpose, such as cooking or sewing but, with support from a community or health worker, they can evolve to become meaningful support groups. Benefits identified by group participants included reducing isolation, providing a place to talk about their problems and to receive support, being understood, learning about their rights, finding friends, getting advice, and learning about community services. Groups may be particularly beneficial for survivors of war and torture. It is cautioned that the establishment of such support groups can be complex due to the stigma attached to support groups and the possibility of political, ethnic, clan, and religious divisions among members, which can contribute to lack of trust. The second problem may be avoided or mitigated by involving participants from different countries.⁹⁶

Other research suggests that professionally-led counseling groups appear to be less threatening than individual sessions for refugee women and, as in the peer group model, provides a way for them to socialize and support each other.⁹⁷

Holistic approaches, including counseling from a multicultural framework, home visits, psycho-educational workshops, and support and advocacy from other refugee and immigrant women, have been found to be successful in addressing refugee women's mental health needs. A successful program in Kansas, identified below as a promising program, found that educational workshops are especially successful when they include presenters such as refugee women who have lived in the country for an extended time, bicultural and bilingual advocates who are refugee or immigrant women themselves, and advocacy and case management to address a variety of needs including housing, social services, employment, language training, and health care.⁹⁸

Community mental health services are often very broadly defined. For example, the Community University Research Alliance (CURA) will be funding demonstration projects that reflect a "cultural empowerment model" to improve mental health services for members of diverse ethnocultural communities. It is likely that demonstration projects will be funded under the following primary themes: education and awareness about the issue of mental

health and available supports and services; multidisciplinary holistic approach to services and supports (involving family and informal support networks); information for new immigrants about Canadian way of life, police and legal system, social and employment services, accreditation process; anonymous help line (in different languages) for basic mental health support and information about services; community capacity building/leadership building (instruction/training/activities relating to, for example, messaging and communication, civics, public policy, etc.; participation and/or leadership development initiatives; development of formalized inter-organizational partnerships and collaborative); and professional mental health training for community members (identifying signs, providing initial support and referrals. Demonstration projects must reflect partnerships among some combination of cultural-linguistic communities, mental health service providers, immigrant services organizations, hospitals, policymakers, and funders.⁹⁹

Promising Practices in Mental Health Service Delivery to Refugees

- If therapeutic services are used, they should be supplemented with individual or group peer support.¹⁰⁰
- Before embarking on therapy, do the groundwork to establish trust between patient and provider.¹⁰¹
- Educate survivors, their family and community, and service providers about the effects of war and torture, the role and benefits of mental health care, and the mental health services available in community in order to raise awareness about the symptoms of trauma and provide them with a knowledge base to understand those symptoms as trauma effects.¹⁰² Community groups should be empowered to do their own work in the area.¹⁰³ Research shows that supportive resources such as family members, friends, ethnic community, caring professionals, and accessible and adequate services can protect refugees who have experienced war and torture from the risk of mental disorder and help them in their attempt to make a successful adjustment.¹⁰⁴
- Simply applying an existing mainstream intervention or model to the refugee community is unlikely to be effective. Refugees are unlikely to participate in programs that are not culturally relevant or appropriate.¹⁰⁵ However, evidence-based best practice models can be effectively used with refugees if there is considerable room for cultural adaptation of the model.¹⁰⁶
- Consider that social and material needs often take priority over the emotional needs of refugees. A holistic approach to survivors' mental health is recommended, that is, using a team of psychologists, social workers, nurses, medical doctors, and lawyers that addresses not only the emotional needs but also the social and economic needs of refugees.¹⁰⁷
- Any mental health strategy for refugees should be based on a multi-agency approach, with mental health promotion seen as part of the package of services provided to refugees.¹⁰⁸ It is sometimes necessary for counselors to step outside the traditional counseling role and provide psycho-educational information and case management in order to address problems that stem from a combination of personal, social, and cultural factors.¹⁰⁹
- Bicultural-bilingual advocates should be used when providing mental health services to refugee communities.¹¹⁰

- Peer groups are an effective way of addressing mental health issues. The involvement of service providers in the establishment of peer groups is recommended. Survivors do not always have the resources necessary to form such groups on their own.¹¹¹ Presenting mental health information and providing support and counseling in a group format appears to be less threatening for the women and provides a way for them to socialize and support each other.¹¹² For instance, a women's depression group used traditional Hmong quilting as a way to begin developing trust with one another and to share their stories. Gardening groups for seniors has been found to be very therapeutic as opposed to "talking" therapy groups.¹¹³

Box 5. Promising Community-Based Mental Health Interventions

Empowerment Program for Refugee and Immigrant Women, Kansas, U.S.A.¹¹⁴

The Empowerment Program was developed as collaboration among three partners: a university counseling psychology department and its clinic; a not-for-profit organization whose mission is to provide outreach, education and shelter to refugee and immigrant women concerning domestic violence and reproductive health; and a local domestic violence shelter.

The program services are broad, including psycho-educational workshops, counseling, psycho-educational home visits, advocacy and case management, informal meetings that provide one-on-one attention, and interpretation. We offer workshops approximately once a month in a two-hour time span to provide culturally sensitive psycho-education in a group setting, focusing on topics such as mental health, acculturation/adjustment, physical health, family and gender roles, parenting, health, loss and grief, legal issues, unemployment and career barriers, and stress-self care.

Advocacy and case management address a variety of needs including housing, social services, employment, language skills, health care, immigration law, and family transitions (e.g., divorce). Refugee and immigrant women are given better access to community services via the use of interpretation and in the availability of personal informal contacts with advocates on an as-needed basis.

Bilingual and bicultural paraprofessionals to serve multiple roles, including interpreter, translator, liaison, caseworker, resource specialist, and community advocate. These bicultural-bilingual advocates are refugee or immigrant women themselves and are active in their own communities. Other staff members include graduate students and faculty in a counseling psychology department, members of the not-for-profit organization, and staff at a local domestic violence shelter. Graduate students offer psycho-educational home visits, individual counseling, and serve as facilitators or child care providers at monthly workshops. Faculty and board members offer leadership and clinical supervision.

Box 6. Promising Community-Based Mental Health Interventions

Program for Hmong refugees in Michigan, U.S.A.¹¹⁵

A unique community-based intervention with adult Hmong refugees in Michigan sought to improve participants' emotional well-being through "learning circles," which involved cultural exchange and one-on-one learning opportunities for Hmong adults, and advocacy, which involved undergraduate students advocating for and attempting to transfer advocacy skills to Hmong families to increase their access to resources in their communities.

The intervention was fully based in the communities of the Hmong participants. The learning circles were held at the community centres of two public housing developments where many of the participants lived. They involved two components: cultural exchange and one-on-one learning. Cultural exchange occurred for the first 30–45 minutes of the each meeting and was facilitated together by an undergraduate and a Hmong participant. In order to enable all participants to share in the discussion, two Hmong co-facilitators translated Hmong to English and English to Hmong throughout the cultural exchange discussions. The purpose of the cultural exchange was to provide a forum for Hmong participants and undergraduates to learn from each other, share ideas, develop plans for collective action, and realize the important contributions they were capable of making. One-on-one learning occurred in the remaining 1.5 hours of the learning circles. During this time, undergraduates and Hmong participants worked in pairs and focused on whatever each Hmong adult wanted to learn (e.g., speaking, reading, and/or writing English, studying for the U.S. citizenship exam, learning to complete employment applications, writing checks). Materials, such as citizenship study guides and ESL materials, were available to facilitate learning.

Once relationships began to form between Hmong participants and students, each undergraduate was matched with a Hmong adult, with whom they had been working during the Learning Circles, to serve as an advocate for that person and her family. Each advocate spent an additional four to six hours each week (outside of the Learning Circles) with the Hmong adult and her family to provide advocacy on any issues the family wanted to address. Advocacy continued for 5 months, with some undergraduates mainly working with the adult participant and some undergraduates working closely with both the Hmong adult and her children. The undergraduates first worked with the families to identify the specific issues each family wanted to focus on during the advocacy. Often these discussions occurred during Learning Circles, so that translators could assist with communication. Advocacy was provided to assist participants to access health care; obtain material goods and services, housing, and employment; and to address issues in areas including finances, domestic violence, transportation, social support, law, and children's education and recreation. Because most families had multiple unmet needs, the advocate and family were most often engaged simultaneously in several phases of the advocacy process, in order to address the various needs the family had identified. In addition, undergraduates continually worked to transfer advocacy skills to the Hmong participants and their families.

Pre-post quantitative evaluation revealed statistically significant increases in participants' quality of life (attributable to improved access to community resources and services) and English-language proficiency, and decreased levels of distress. However, many of the positive impacts the project demonstrated began to erode once it ended, indicating that, while the program was successful at the individual level, its duration (six months) was insufficient to increase community capacity.

The success of this intervention was attributed to its holistic focus, the fact that it was community based and culturally appropriate, and the synergy between the two program components.

3.3 Sexual and Reproductive Health Programming

Sexual and reproductive health care and education are vital issues for many refugees: for youth, who may lack basic information about anatomy, birth control, communicable disease, and sexuality; for pre- and post-natal women, who may be unfamiliar with the rudiments of health care, such as prenatal visits and infant care; and for refugees who have or are at risk of contracting sexually transmitted infections, such as HIV.

Obstacles to effective health promotion and disease prevention work include cultural restrictions on discussions of sexual behaviour and conservative views about women and sexuality, along with the other language, cultural, and access barriers encountered by refugees in the health care system.¹¹⁶ Sexual and reproductive health programs, particularly for youth, sometimes provoke opposition from community members, including parents, elders, and religious leaders, who fear that increased awareness will promote promiscuity.¹¹⁷ Also, these programs (and, possibly, many types of health and social programming) tend to attract more male than female participants, because girls in some ethnocultural communities have less personal freedom, more domestic duties and by their late teens, are often employed as domestic workers or married.¹¹⁸ Finally, HIV carries its own unique stigma within many refugee communities, as in society in general, which means that some refugee communities are resistant to health promotion efforts around HIV and other sexually transmitted infection, and refugees infected with HIV often avoid being tested or only seek testing upon the onset of physical symptoms,¹¹⁹ which can place others at risk of infection.

In the U.K., Australia, and New Zealand (and, quite possibly, elsewhere) refugee organizations are often used to bridge the gaps between community members and mainstream health care providers with respect to sexual and reproductive health programming. It is cautioned, however, that without appropriate training, community members should not serve as brokers in a health care setting; that refugee organizations often lack the capacity to take on long-term programming responsibilities without additional funding and support; and that there will be members of refugee communities who do not want others in the community to know about their health status (e.g., HIV) and would prefer to deal directly with mainstream health care providers.¹²⁰

Promising Practices in Sexual and Reproductive Health Community Programming

- As also demonstrated in other areas of research, awareness-raising in itself does not appear to affect behaviour. For example, research shows that increased awareness of sexual and reproductive health issues does not translate into changes in practice for refugees¹²¹ (or Canadian-born for that matter). Risk reduction is not generally a realistic goal for awareness-raising programs.
- Diversifying sexual and reproductive health initiatives to include other health and social issues can help to diffuse opposition from the community.¹²²
- Teaching and engagement methods such as focus group discussions, role play sessions, and drama should be considered for sexual and reproductive health programming.¹²³
- Refugee community leaders should be consulted about sexual and reproductive health promotion and disease prevention programming in their communities and, if possible, engaged in program design and delivery.

Box 7. Promising Program in HIV Education

National HIV/AIDS Refugee Health Education Program, New Zealand¹²⁴

The National HIV/AIDS Refugee Health Education Program facilitates HIV/AIDS health promotion activities through training community educators, facilitating community initiatives, and supporting the establishment of culturally appropriate community support structures through de-stigmatization activities and the development of community support networks for refugees with HIV/AIDS. The program was developed in partnership with African refugee communities in three phases: (i) extensive community consultation and collaboration with key community and religious leaders, (ii) train-the-trainer workshops to provide community educators with basic information to use with the communities, and (iii) regional HIV/AIDS health promotion activities, developed in consultation with community leaders. Community-based learning is based on the Tuelimishane (“let’s learn together”) model, approaches to learning and sharing include role-plays, story-telling, drama, songs and dances; group discussions; cultural group exercises; and minimal use of reading and writing. The success of the program in engaging and retaining high numbers of participants is attributed to “buy-in” from communities, partnerships and alliances with refugee communities, and collaboration and commitment from all members involved.

3.4 Community Based Programming for Target Population Groups

3.4.1 Programming for Seniors

The experience of receiving formal support from government or community organizations may be unfamiliar to older refugees, and they may be reluctant to use them. Research shows that the biggest barrier to refugee seniors’ use of social services is the belief that their children will fully support them, followed by distrust of government or the view that reliance on government for elder care is shameful. Muslims may be particularly uncomfortable seeking or receiving help from outsiders because, within the ethnocultural community, it is critical that the family be viewed as capable of taking care of its own problems and needs.¹²⁵ On the other hand, the high degree of dependency on family can also be a health risk, as older refugees may be extremely isolated and even abused within the family.

In addition, elder refugees may be reluctant to discuss health issues, because they may have failed to mention problems upon arrival in Canada for fear of rejection by immigration authorities, because they feel that a health problem may be a burden on the family, or because they conceptualize the health problem in a different way.¹²⁶ They may also be unable to communicate health problems of which they are aware due to language barriers, which may be compounded by dementia.¹²⁷

Promising Practices in Community-Based Health Care for Refugee Seniors

- Language classes are an excellent means of engaging older refugees in social activities and exercise, reduce isolation, and provide an opportunity to assess their health on a regular basis. Community outdoor gardening can also be an effective engagement tool, especially for former agrarians who feel estranged in an urban environment.¹²⁸
- Establish congregate meal programs, paying attention to the menu and cultural appropriateness.¹²⁹
- Consider inter-generational activities to foster contact and understanding between elders and children/youth. Older refugees can also service as tutors or teacher's assistants in child care facilities and elementary schools, and as cultural interpreters in places where adolescents spend their time.¹³⁰

3.4.2 Programming for Families

Research indicates that reaching refugee families, particularly those with young children, is best accomplished through outreach to mothers. As observed by the U.K. Health Education Authority's Working Group on Refugee Health and others, refugee "[w]omen are the prime providers of health care to other family members. Thus the health of other members of the family will be directly related to [women's] knowledge or interest in promoting a healthy environment and taking preventive action against disease."¹³¹ The Working Group goes on to comment that health promotion and health education targeting refugee women benefit the whole community.

As observed by Weine and others, the immigrant and refugee literature presents little empirical research on outreach with refugee families or family-focused health interventions. We do know that American research indicates that focusing on the family is also important in refugee mental health. Issues and relationships in refugee families may be distinct from immigrant families because of the extreme traumas and losses that refugees have endured.¹³² "[I]n refugee families, parents regard children as vitally necessary resources for their own survival. The extraordinary intensity that is carried by the parent-child relationship in refugee families is often not matched by existing interventions in refugee trauma, which focus primarily on mental health consequences for either adults or children, and far less on the parent-child relationship. [This suggests] the need for interventions that focus primarily on the parent-child relationship, and include addressing areas of concern regarding school, cultural transition, parental monitoring, and high-risk behaviors."¹³³ With respect to mental health interventions, Weine recommends multiple-family group interventions, with deliberate efforts to engage families,¹³⁴ although this appears to be in tension with the literature suggesting engagement in health programming via mothers.

Two promising practices have been identified with respect to community health programming for refugee youth:

- Refugee youth attendance at health care programs may be facilitated by offering other, unrelated activities in which they are interested. For example, sports have been used successfully as the "hook" to engage boys and young men in other health and social programming.¹³⁵
- All guidelines and research findings from work with young refugees stress the importance of peer input¹³⁶ although this can be difficult where the refugee community is transient and dispersed.

Box 8. Promising Mental Health Programs for Families, Adults, Children and Youth

The Social Adjustment Program for Southeast Asians (SEA), St. Paul, Minnesota, U.S.A.¹³⁷

Saint Paul, Minnesota, has one of the largest populations of Southeast Asians in the country. Because of trauma experienced in their home countries or refugee camps, some refugees suffer from post-traumatic stress, depression or other emotional problems. Many more face challenges assimilating to the U.S. culture.

The Social Adjustment Program for Southeast Asians (SEA) was developed in 1984 to address such needs, providing a variety of mental health treatment and support services for adults, youth and families. The program has received national recognition for the way it combines western mental health practices with the traditional healing methods of the Southeast Asian cultures it serves. Its core services, provided to both adults and youth, include mental health assessment; individual, group and family counseling; case management; and school-based youth services.

The goal of the SEA Program is to address mental health and social adjustment issues of Cambodian, Hmong, Vietnamese and Lao immigrants and refugees of the greater St. Paul metropolitan area in a culturally and linguistically appropriate manner, thereby improving the mental health of the target populations. Services are provided by bilingual and bicultural counselors trained in Western mental health practices. Staff include 32 mental health staff, 11 program service aides, and 4 administrative services staff.

- Family services include: Hmoob Koom Siab (Hmong Working Together/Families and Schools Working Together); Family Connect - a parent education program for Cambodian & Vietnamese parents using the promising practice "Parenting Across Cultures" model to help participants integrate traditional and Western parenting styles; and Functional Family Therapy, an in-home family therapy that uses the Functional Family Therapy best practice model.
- Child and youth services include: Youth Mental Health, which provides mental health screening, individual and group counseling at schools and in-home visits for family counseling; and Children's Mental Health Case Management, which assists youth under 18 with a diagnosis of severe emotional disturbance to achieve stability in their families, communities and schools.
- Adult services include: Adult Mental Health and Social Services, which helps adults with mental health and acculturation difficulties to reduce stress and mental health symptoms; Adult Mental Health Case Management, which helps seriously and persistently mentally ill (SPMI) clients to reduce their symptoms and maintain stability in their communities; Assertive Community Treatment framework - a nationally recognized "evidence-based practice" which uses a multidisciplinary team and reduced case load size to work with the seriously and persistently mentally ill client who is most at risk.

Programs have been culturally adapted to serve members of the Southeast Asian community. Evaluation indicates that 50% of the clients improved in withdrawal, depression and anxiety; 90% improved in family functioning; 56%-63% improved in other common problems.

Keys to success:

- Employ staff that share a common culture and language with the clients;
- Provide culturally competent mental health services that integrate western mental health with traditional healing practices of Southeast Asian culture;
- Provide both community-based and office-based services; and
- Collaborate with the community.

4. MAKING IT HAPPEN: COMMUNITY COLLABORATIONS AND COMMUNITY DEVELOPMENT TO DESIGN AND DELIVER HEALTH INITIATIVES AND TO ADDRESS THE BROAD DETERMINANTS OF HEALTH

Community collaboration and community development are related but distinct constructs. Both are means of improving the health status of refugee (and other) communities. It is possible to work within a collaboration paradigm and include community development as one of the desired outcomes of the collaboration, along with improvements in the health status of community members via immediate changes in health promotion and health service delivery. It is also possible to begin with a community development approach, which requires community participation and some degree of collaboration, and works to increase community capacity to achieve various outcomes, in this case, the improved health of a community's members.¹³⁸

The literature on refugee health tends to focus on one of the two approaches to the exclusion of the other. In addition, the term “community collaboration” is often used interchangeably with “inter-agency collaboration” in the health literature, although there are important differences between the two. The general term “collaboration” refers to structural working arrangements among any number of participants, and such arrangements are usually formed to achieve specific objectives; community collaborations by definition, may or may not include agencies as members; they may be entirely “grass roots,” with leadership emerging from community members to initiate change. In the health literature, “community collaboration” generally refers to inter-agency partnerships that are formalized either immediately or over time.

It is not clear that either the community collaboration approach (with community development) or the community development approach (with community collaboration) is definitively better than the other: Considerations such as funding, pre-existing community capacity, and which communities or organizations have taken a leadership role may encourage the adoption of one of the two approaches.

4.1 Community (Inter-agency) Collaborations

Community collaborations for health promotion and/or health delivery are usually premised on the idea that it is virtually impossible to develop a health program that is sufficiently comprehensive to meet all the needs of refugees, and that interagency collaboration is the best—and, perhaps, the only—means of ensuring the development and delivery of effective services.¹³⁹ Community collaborations are usually spearheaded by one community, health care, or other government organization, generally in response to a need observed at the community level or identified by community members, which then seeks out other partners to provide pieces of the more comprehensive puzzle. An excellent example of this sort of collaboration is the Survivors of Torture Program provided by the Calgary Catholic Immigration Society, highlighted below as a best practice model of community collaboration.

Promising Practices in Community Development and Mobilization¹⁴⁰

- Planners recognized that the community development process is time consuming and resource intensive.

- Planning began with the development of a shared vision that reflected broad recognition of a need in the community. It has been understood throughout the process that working together as a community was the way to succeed in achieving a common goal.
- The agency brought the right people to the table to develop the program: (1) high-level members of ethnocultural and immigrant-serving organizations with decision-making authority, (2) from organizations that involve their constituencies in defining, confronting, and responding to problems, and work to broaden their members' interests, develop their leadership skills, and involve them in social change efforts, and (3) other experienced and committed professionals with connections and credibility in their fields and the power to influence change.
- The program development process involved ongoing input from the community from needs identification to inception to ongoing development and expansion. Program beneficiaries were involved in the analysis of community needs and the best ways of addressing them.
- Efforts to build trust and working relationships, and to nurture and sustain the cross-organizational, inter-disciplinary collaboration continue, referred to in the literature as "organizational cultural mediation."
- The program reflects community capacity and resources and allows for increasing community self-determination.

Box 9. Model Program for Community Collaboration¹⁴¹

Survivors of Torture Program, Calgary, Alberta

The Survivors of Torture Program offered by the Calgary Catholic Immigration Society (CCIS) has been identified by researchers as a best practice model for community collaboration in the development and delivery of a community-based program for refugees. Launched in 1996, the program is modeled on a pre-existing Host Program offered by CCIS, in which hundreds of experienced host volunteers befriend newcomers and provide assistance in critical areas including orientation to Canadian customs and routines, pursuing educational and job opportunities, and developing language skills. Over time, the volunteers began to report that they were unprepared to handle some of the complex issues presented by refugees, and they requested more help and support.

Survivors of Torture program development began with a comprehensive, six-month community and needs analysis on the issue of torture, which included input from survivors of torture, ethnocultural community groups, government resettlement services, and medical and counseling professionals. Community members who had expressed an interest in program development were invited to form an advisory team to plan and implement the program. The group included members from diverse ethnocultural communities and the most experienced advocates from the volunteer, professional, and refugee communities, all of whom had the authority to make decisions on behalf of those they represented.

The objectives of the program are to facilitate survivors' access to appropriate physical and mental community health services; provide social support through host volunteers; provide practical support through CCIS with respect to resettlement, ESL programs, vocational training, and employment services; and advocate for survivors to access social services outside of CCIS.

Services gradually expanded from social support and access to community health and social services to include therapy and other services through a broad network of specially-trained psychologists, medical doctors and other health professionals, social workers, and lawyers. Today the program is the centre of collaborative efforts among various service providers.

This program has succeeded because it used best practices in community development and mobilization (delineated above) to develop, establish, and maintain the program.

Box 10. Effective Partnerships between Mental Health Services and the Refugee Community

BRICKS (Bosnian Resource Information and Kosovo Support), London, England¹⁴²

BRICKS has developed a culturally competent counseling service in London, England, undertaken by a bilingual Bosnian trained in trans-cultural mental health. Being bilingual and bicultural has helped to establish trusting relationships with clients and to alleviate much of the stress, stigma and alienation associated with accessing current mainstream health and social care services. This effective way of building trustful relationships has been reported to help services empower their clients to take part in planning and delivering services which meet their individual and specific needs.

The Tavistock and Portman National Health Service Trust, London, England¹⁴³

The Tavistock and Portman NHS Trust has been cited by the U.K. Commission for Health Improvement as an example of good practice in user and community involvement in providing services to refugees. The Trust works with communities to develop health services that are accessible to black minority ethnocultural groups and refugee communities. An example of good practice highlighted by the Commission is the Peace of Mind Project, which raises awareness about and addresses the mental health issues of Somali children. The Project was developed in partnership with the Somali community in response to a need identified by the Somali community.

4.2 Community Development

Ethnocultural communities and, by extension, refugee communities, may be broadly defined as “group[s] of people who are socially interdependent, who participate together in discussion and decision making, and who share certain practices that both define the community and are nurtured by it.”¹⁴⁴ As such, they provide “informal links of companionship and mutual aid that provide sense of belonging and emotional and other support... [and] the outward linkages of networks that provide people with ladders to change their situations (i.e., jobs, houses) and levers (politics, lobbying instruments) to change their social locations.”¹⁴⁵

Community development involves increasing the capacity of communities, and usually centres on social capital and cohesion, resource development, and collective skills to bring about desired changes within the community. “Community capacity building” refers to increasing the capacity and skills of the members of the community in question to work with other community members to meet their own needs in some way. Although there is no single model for community development or capacity building, this generally involves equipping people with skills and competencies which they would not otherwise have, realizing existing skills and developing potential, promoting increased self-confidence, promoting people’s ability to take responsibility for identifying and meeting their own and other people’s needs, and encouraging people to become more involved in their community and the broader society.¹⁴⁶ Within the health context, community capacity has been defined as “an approach to the development of sustainable skills, organizational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over.”¹⁴⁷

It is generally recognized that, “although ethnic support networks and mutual assistance associations are important sources of resources and support for many refugees, they are not necessarily adequately prepared and funded to meet all of the needs of refugees or to connect them with resources in the larger community.”¹⁴⁸ In short, refugee communities—at least in Canada—rarely have the capacity to unilaterally develop new initiatives of value to the community, and this includes initiatives to improve the health of and health service delivery for refugees. But “[if] one agrees that the best outcomes derive from community input into programs that serve them, promoting community capacity building for advocacy and program development in multicultural health is essential.”¹⁴⁹

The main vehicle for increasing community capacity is participation. Seminal research completed by Rifkin and colleagues defined community participation as “a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs.”¹⁵⁰ This is essential to community-based health initiatives that reflect a health promotion approach and the belief that lasting, widespread behavioral change is best brought about by changes in norms of acceptable behaviour at the community level. Change is most likely to occur when the people who are affected by an issue, in this case health, are involved in the change process.¹⁵¹

In its recent research on community capacity building, the Public Health Agency of Canada (PHAC) identified nine domains in which local efforts could conceivably have an observable and measurable impact within a relatively short time frame. These domains include participation; leadership; community structures; asking why; resource mobilization; links with others; role of external supports; skills, knowledge and learning; sense of community. With a view to evaluating capacity building projects, PHAC has delineated potential indicators of progress for each domain, as shown in Box 11 below.¹⁵²

Box 11. Public Health Agency of Canada's Community Capacity Building Domains and Indicators¹⁵³

Domain	Indicators
Participation	<ul style="list-style-type: none"> • Engaging community groups in the project • Engaging a representative range of target population members in the project
Leadership	<ul style="list-style-type: none"> • Overcoming barriers to participation in the project • Effective methods of communicating with target population, community members and other stakeholders about the project • Key roles and responsibilities of project and community leaders • Project leaders' accountability to the project team and the target population
Community structures	<ul style="list-style-type: none"> • Nurturing informal leaders • Linking with pre-existing community structures • Improving our community structures • Creating new community structures that help community members
Role of external supports	<ul style="list-style-type: none"> • Providing project-related information • Providing project-related technical expertise • Being accessible when the project needs support • Open and ongoing communications
Asking why	<ul style="list-style-type: none"> • Addressing root causes of the issue(s) targeted by the project • Involving the target population in the process of 'asking why' • Involving the target population in problem solving
Resource mobilization	<ul style="list-style-type: none"> • Accessing internal resources needed for project success • Accessing outside resources needed for project success
Skills, knowledge and learning	<ul style="list-style-type: none"> • Project team's skills or access to skills needed for the project's success • Providing the target population/project team/community members with opportunities for learning
Links with others	<ul style="list-style-type: none"> • Networking with diverse sectors • Sharing information among links • Sharing and receiving resources among links • Working with project links to take collective action on project issues
Sense of community	<ul style="list-style-type: none"> • Increasing awareness in the issues that are targeted by the project among community member

Shediac-Rizkallah and Bone, among others, observe that “considerable resources are spent implementing community-based health programs that are discontinued soon after initial funding ends. The objective is to develop programs that are sustainable in terms of their longevity and beneficial effects, and this depends on the extent to which the program is incorporated in the public health care system and in community organizations, which in turn depends on community capacity.”¹⁵⁴

They explain that planning for sustainability requires, first, a clear understanding of the concept of sustainability and operational indicators that may be used in monitoring sustainability over time. Important categories of indicators include: (1) maintenance of health

benefits achieved through an initial program, (2) level of institutionalization of a program within an organization and (3) measures of capacity building in the recipient community. Second, planning for sustainability requires the use of programmatic approaches and strategies that favour long-term program maintenance. They suggest that the potential influences on sustainability may derive from three major groups of factors: (1) project design and implementation factors, (2) factors within the organizational setting, and (3) factors in the broader community environment (Box 12 below).¹⁵⁵

In addition, they identify criteria which funders should consider to enhance the sustainability prospects of community-based health initiatives, as follows:¹⁵⁶

- Community health programs must be driven by the needs of communities, not those of external donor agencies or technical experts.
- Sound planning for sustainability dictates that programs be designed with local capability in mind. A program is more likely to be sustained when its host community can afford it. Considerations of affordability must include not only financial aspects, but also other costs such as time and technical resources.
- Unless *enough* resources are allocated to yield initial success, long-term sustainability is unlikely.
- Allocate resources to cover the maintenance and recurrent costs of existing programs or services with a proven track record rather than making investment decisions that are biased toward spending on new programs

Box 12. Guidelines for Planning the Sustainability of Community-Based Health Programs¹⁵⁷

Project design and implementation factors

- Project negotiation process. Are project approaches and goals discussed with recipient community members, as equal partners? Are the needs of the community driving the program or those of external donor agencies and technical experts? Is a negotiation or consensus-building process in place to reach a compromise for addressing everyone's (including donors, community, technical experts) needs?
- Project effectiveness. Is the project (perceived as) effective? Is it visible? What are the (desirable and undesirable) secondary effects of the program?
- Project duration. What is the project's grant period (number of years in operation)? Is it a new project or is it an existing program that is acquiring additional funds?
- Project financing. What are the sources of funds for the program (internal, external, a mixture)? What are the community's local resources? Can the community afford the program (e.g. is it able to pay maintenance and recurrent costs)? How much are community members willing/able to pay for services? What strategies are in place to facilitate gradual financial self-sufficiency?
- Project type. What type of project is it (e.g. preventive versus curative)?
- Training. Does the project have a training component (professional or para-professional)?

Note: Most researchers agree that effective collaboration is essential for the long-term survival of community-based programs. The "climate of collaboration" contributes to a program's continuation and these collaborations need to include all relevant community leaders and agencies and active community participation at all levels.¹⁵⁸

Note: Most researchers agree that demonstrating the effectiveness of a program and marketing these successes supports efforts toward institutionalizing community-based programs. There is a need for continuous monitoring and evaluation efforts to not only facilitate program modification but for the ability to leverage prior success for future commitment and funding.¹⁵⁹

Factors within the organizational setting

- Institutional strength. What organization will be implementing the program? How mature (developed, stable, resourceful) is this organization? Is it likely to provide a strong organizational base for the program?
- Integration with existing programs/services. Is the program vertical (categorical) or is it a horizontal (comprehensive or integrated) program? Are goals, objectives and approaches pre-specified or are they adapted to the local population and setting and over time? Is the program integrated into the standard operating practices of its host organization? Is the mission of the program compatible with the mission and activities of its host organization? Is the implementing organization the recipient of program funds or is there an intermediary organization?
- Program champion/leadership. Is there a program champion? What are his/her attributes? If not, can one be identified/nurtured so that he/she may serve as an advocate for the continuation of the program? Is the program endorsed from the top? How well is it supported?

Note: Leadership competence includes the ability to develop clear goals and a vision for the future of the program while also striking a balance between short and long term needs including planning for sustainability and developing multiple strategies for survival.¹⁶⁰ Adequate, effective, and committed staff—ideally from the target community—is also an important factor for sustaining community-based programs.¹⁶¹

Factors in the broader community environment

- Socio-economic and political considerations. How favorable is the general socioeconomic and political environment for the sustainability of the program to be a realistic goal?
- Community participation. What is the level of community participation? What is the depth (amount) of involvement? What is the range of involvement (types of activities)?

Note: Most researchers recommend active community participation at all levels of project design and implementation for sustaining those programs. Locally initiated programs may be more sustainable so it might be necessary to develop some level of local institution building. Involving all relevant community leaders and agencies facilitates sustaining programs.¹⁶²

COMMUNITY CONSULTATION FINDINGS

Background

Between April and July, 2008, Healthy Diverse Populations, Alberta Health Services - Calgary Health Region completed the first phase of consultations with key informants to help develop the foundation of a strategy to improve the health of refugees in Calgary. Originally, 22 individuals from 16 organizations received a letter of invitation to participate in the process (Appendix 1), and 27 people from 13 organizations ended up agreeing to and participating in the interview process (Appendix 2). In advance of the meetings, interview participants were provided with a background document outlining five strategies based on promising practices from around the world to improve access to health care, quality of health care, health promotion and illness prevention, access to the basic determinants of health, community capacity and, ultimately, the health and well-being of refugees (Appendix 3). Participants were asked to provide feedback on which strategy or strategies would be most appropriate and effective in assisting refugees, what needs to happen to develop the strategies, and who would be able to collaborate with Alberta Health Services - Calgary Health Region and Calgary Catholic Immigration Society in developing, implementing, and sustaining these or other new strategies. (The interview protocol is provided in Appendix 4). Alberta Health Services - Calgary Health Region and the CRHP thank all the interview participants for their helpful guidance and insights, and look forward to future discussions with the participants and other key informants in the course of developing a refugee health strategy for Calgary.

The Issues

Interview participants confirmed that refugees in Calgary face a range of barriers and issues within and beyond the health care system that can compromise their health and well-being. Most refugees are challenged to obtain the basic necessities of life—adequate income, appropriate housing, and sufficient, nutritious food—due to lack of income benefits, English-language skills, and employment in multiple, low-wage, insecure jobs. Participants explained that poor living conditions, chronic stress, and social isolation can cause family tensions and parenting problems. For example, refugees rarely have extended family in Calgary and childcare is often beyond their financial means, so children may lack adult supervision and care while parents are working long hours. This can contribute to many family problems including issues with children's school attendance and performance, which can have serious long-term implications for the educational outcomes of refugee children and youth. Also, lack of supervision sometimes prompts child and family services involvement, which is terrifying for refugee families who have often experienced government-sanctioned abuse in their home countries.

Moreover, poor living conditions, chronic stress, and social isolation can both cause and exacerbate pre-existing physical and mental health issues. Several participants commented that physical and mental health problems, such as post-traumatic stress disorder, often emerge well beyond refugees' first year in Canada. After a period of living in poverty and isolation in Canada, some people lose hope, realizing that, until they are able to improve their English-language proficiency, understand Canadian culture and systems, and obtain Canadian work experience and credentials, they will be trapped at the bottom end of the labour market. Yet, opportunities for refugees to attend English Language Training (ELT), complete an often expensive and lengthy foreign credential recognition process, or upgrade their education are limited, so they remain isolated from the economic and cultural

mainstream. In addition, their children are acculturating and acquiring English-language skills faster than their parents are, sometimes fostering cultural and language rifts within refugee families.

Refugees' difficulty obtaining health care makes matters even worse. Participants identified the one-year cap on income and other supports for government-sponsored refugees, limited health benefit coverage provided through the Interim Federal Health Benefit, and the total lack of support for other refugees, such as refugee claimants, as the greatest obstacles to physical and mental health. In addition, many refugees are, understandably, too pre-occupied with basic survival during their first few years in Canada to pay attention to their health needs. Other barriers to access include health care providers' lack of cultural sensitivity and knowledge about the past and current living situations of refugees, or even what it means to be a refugee and the trauma that a refugee may have experienced. In addition, interview participants explained that many refugees have a different cultural orientation to both health and health care: preventive health care is not always understood, and negative past experiences in their home countries can make refugees very apprehensive about the health care system.

Feedback on Strategies

Strategy 1. Continue to Build Language and Cultural Competency within the Health Care System

Interview participants agreed that ongoing and heightened efforts are required to increase the cultural competency of health care providers, as well as service providers in other agencies and organizations, to increase refugees' access to the services that they require. Participants stressed that "cultural competency" includes increased knowledge about and acceptance of other cultures, sensitivity about the realities associated with being a refugee, treating patients as equals, and not making assumptions about either individuals or cultures. However, it should also go much further and reflect the understanding that cultural competency includes a shift in thinking about, communicating with, accepting, and respecting people from other cultures, and a recognition of the need to make changes within Canadian culture and systems to accommodate different beliefs and practices. Several participants stressed that *all* people working in *all* aspects of the health care system need to be able to work effectively and sensitively with patients with different ethnocultural backgrounds and personal histories. Most participants called on the health care and other public systems, such as the education system, to do a better job of collecting and sharing refugees' personal information, while continuing to respect and protect confidentiality, so that individuals are not repeatedly asked for the same information and all service providers can access a complete history. In addition, key issues facing refugees should be top of mind for health care providers in their work with refugees. To cite only a few examples, these include recognizing that, because of their past and current experiences, poor mental health is prevalent in the refugee population; that some refugees can only receive services from same-gender health service providers; that illness is kept secret in many cultures and some conditions, including mental illness, carry a huge stigma; that some people are unaware that medical conditions can be inherited, so the notion of "family medical history" may be incomprehensible to them; and that some people may be illiterate in their home languages, so translated materials will not be helpful. One participant also cautioned that provided written materials in a range of languages can give the false impression that services will be available in those languages, creating further confusion and disillusionment among refugees.

Participants also talked extensively about the need for qualified interpreters to ensure that refugees are accurately diagnosed and understand and adhere to treatment regimens. Medical terminology is hard to interpret, particularly in light of different cultural conceptions of physical and mental health, health promotion and preventive care, and treatment. Of immediate concern is the use of refugees' own children as interpreters between patient and health care provider, which is inappropriate and likely to result in miscommunication and withholding of sensitive information by the patient. Using adult family or community members can also be problematic; in addition to the problem of miscommunication, patient confidentiality can be compromised.

In addition, using bi-lingual Alberta Health Services - Calgary Health Region employees who are not trained as interpreters is not always helpful for patients. Moreover, efforts to communicate with patients by telephone are not always appropriate or helpful, because personal contact and visual cues are often required to both understand and convey messages and to demonstrate sensitivity to newcomers. One participant also added that issues of liability and compliance can slow the responsiveness of Alberta Health Services - Calgary Health Region interpreters and take precedence over service delivery to patients. Several participants observed that linguistic and cultural competency are not synonymous, and successful interpretation requires both.

Suggestions were offered about the best means of addressing the above barriers and issues. First and foremost was the recommendation that properly-trained, culturally-competent interpreters be hired and used more extensively throughout the health care system. One participant disagreed, suggesting that ELT services should be increased to improve refugees English-language abilities, rather than investing heavily in interpretation services. This individual described interpreters as contributing to a long-term dependency among refugees, rather than increasing their independence, self-reliance, and sense of empowerment

Participants also indicated that increasing the ethnocultural diversity of Alberta Health Services - Calgary Health Region staff would be beneficial at all levels (not just interpreters, but manager, senior management, policy makers, etc.), along with the ongoing provision of cultural competency training. One participant indicated that there may be some situations in which the use of traditional healers and blended healing approaches may be appropriate, although they would need to be consistent with Canadian law and practice. Audio-visual materials rather than printed information tracts should also be used whenever possible, and this may be especially important when dealing with refugee seniors, who often have language difficulties.

Strategy 2. Expand Health Services/Programs for Refugees

Interview participants universally agreed that providing one year of support to refugees through the CRHP is inadequate and does not reflect refugees' needs and realities. The inter-relationships between living in poverty and stress, and poor physical and mental health should be explicitly recognized. Most participants felt that a minimum of three years of support by the CRHP is required, which reflects current settlement support provided through government policy and practice, and some people recommended that the period of support be extended to as many as five years. Moreover, participants stressed that the health services provided through the CRHP should focus on capturing all refugees, not just

primarily government-sponsored refugees, who currently constitute the majority of the refugee patients assisted by the CRHP.

Participants stated that a clear priority in refugees' first year in Canada should be thorough assessment of their mental and physical health issues. Continuing over the following few years, programming should include more extensive and comprehensive physical and mental health care services, including oral health, family counseling, and individual counseling and mental health treatment for refugees of all ages. Several participants explained that many refugees "fall through the cracks" after their first year of arrival, so outreach through community organizations, schools, and faith groups will be essential to finding and re-engaging these people in the health care system. A few participants indicated that the focus beyond the first year of arrival should be on helping refugees to transition into the mainstream health system by ensuring that people's health needs—broadly defined—are addressed and then ensuring that they are under the care of a family doctor for the long term. As part of the strategy, it was recommended by several participants that improved foreign credential recognition and educational upgrading for foreign-trained health care providers would increase the health care system's capacity both to meet the needs of Calgary's burgeoning population and to provide culturally-appropriate care to newcomers.

Two participants firmly rejected the idea of a specialized health clinic for refugees on the grounds that this could lead to a parallel system of care which could foster dependency and dissuade refugees from integrating in Canadian society. Most participants, however, agreed that refugees could be better served through specialized health programming and delivery systems, which may include a health clinic or clinics. One participant recommended that services currently provided by immigrant-serving organizations could be expanded to include more health care and linkages to the mainstream health care system. As discussed in more detail under Strategy 4, health education and support in areas such as schools, housing complexes, and other places known and frequented by refugees may be more physically and culturally accessible for some people, particularly those who do not have access to transportation.

It was broadly agreed that any plans to expand health care services and programs for refugees should be made in partnership with or driven by refugee community members: One participant stated that "the community has to have a voice and be on top of the decision-making structure and the leaders should be guiding us."

Strategy 3. Health Outreach Workers or "Brokers"

Interview participants endorsed the notion of using one or more kinds of health outreach workers or "brokers" to improve health care for refugees. Health brokers would provide similar services to settlement workers, although their focus would be refugee health, broadly defined.

It was widely agreed that health brokers would need to work very closely with settlement and other community-based workers to best address the health, social, and economic needs of refugees, and to ensure that services are enhanced rather than duplicated. Several interview participants cautioned that collaboration with and endorsement from the community and agencies and organizations whose clients include refugees will be required to avoid "turf wars" and other tensions among service providers.

One participant suggested that health brokers or outreach workers could be employees of hospitals or other existing health care programs who could serve as a bridge between refugees and service providers and also work to improve service providers' cultural competency through policy change and education. In other words, they would be centered at health clinics or other venues and serve as "consultants" who provide training and guidance to the staff, rather than working out in the community. Another suggestion was to engage health care workers and/or practicum students who are culturally competent and can speak the refugees' home languages, but who also understand the Canadian health care system, to serve as brokers. All in all, these brokers or outreach workers could connect with refugees, including "complex" families to assess their needs via community or home visits, and develop a plan that sets goals for these families, and educates them and links them with the services they require.

Many interview participants suggested that bilingual members of refugee communities, ideally, health, community or social service professionals whose credentials are not recognized in Canada, should be hired and adequately compensated for their expertise and skills. Suggestions for the role of the broker included one or more of the following components: navigating the health system and linking people to resources; serving as a case manager and advocate to ensure that individuals receive the services they require; acting as cultural intermediaries between refugees and service providers; providing health promotion education in the community (e.g., post-partum care, healthy relationships); and identifying community development opportunities. Several participants suggested that the Best Beginning model be considered for this project. One participant stressed that the brokers' hours of work must be flexible and include evenings and weekends to meet the needs of clients; a few others observed that home visits may or may not be required or desired by refugees, but flexibility needs to be considered and this should be determined on a case by case basis.

Overall, participants generally agreed that the model of service delivery used should be driven by the refugee community itself. One person stressed that any model should be piloted before it is fully rolled out. It was also pointed out that there can be political tensions and power issues within refugee communities, so a broker may be called upon to serve as a mediator within a community, and therefore has to have a high level of integration and participation in the community. In fact, one participant suggested that brokers should be hired from outside the ethnocultural community that a refugee represents to help avoid political tensions and confidentiality issues arising from knowing the members of the community.

Strategy 4. Provide Community-Based Programs to Address Issues Identified by Refugee Communities

One participant felt that refugees should receive services along with everyone else at community health centres because this would encourage them to move beyond their comfort zone and build their capacity to go out into the broader community. Otherwise, all participants endorsed the notion of providing programming to members of refugee communities at sites within the community that are frequented by refugees. It was generally believed that settlement and transition must precede integration, and providing services to people in their own environments, where they are comfortable and supported and where barriers to access are reduced, can help to bring people into the broader community. Participants identified the need to be sensitive to the needs of refugees as they move along the spectrum of belonging and integration.

Suggested locations for health programming and services included mosques, community health centres, community resource centres, LINC classes, Calgary Housing complexes, and schools, or through festivals or events. Refugees could be connected to these services through a combination of media outreach (e.g., multicultural television programs and newspapers), community advocates and leaders, school nurses and outreach workers or brokers. A few people suggested that a mobile health unit staffed by nurses should be considered. It was widely recognized that a range of strategies and locations would be required.

When asked whether there should be any specific age groups or populations that should be targeted, two participants talked about aging population and identified seniors as a priority for service delivery. Several individuals identified youth as being particularly at risk and should be targeted because of high drop out rates in school and the involvement of many in drugs, gangs, violence and crime. Most people, however, felt that women should be the priority target population, as they are typically the primary caregivers in families and they would benefit from programming in areas including nutrition and cooking, breastfeeding, hygiene, physical activity for their children, domestic violence, oral health, contraception and family planning, postpartum depression and mental health in general. One participant reported that the immigrant-serving organization she works for already offers community-based programming for women on issues such as HIV, breast cancer, cervical cancer, and diabetes, and this should be enhanced.

Programming via peer groups and support groups was identified by several participants as a way of building social ties among and reducing the isolation of refugees, women and seniors in particular. In addition, group sessions are an ideal medium for addressing multiple issues at once. For example, ELT classes are sometimes used to provide participants with information about other community services. Other good methods of engaging and teaching refugees identified by interview participants also fall outside the traditional medical model, such as art therapy, theatre projects, community gardens, and collective kitchens. Health-enhancing initiatives, such as collective kitchens, were singled out by one participant as particularly important because they address the broad determinants of health and build on people's existing skills and knowledge, resulting in increased confidence and sense of efficacy.

Strategy 5. Community Development

Most interview participants agreed that a community development approach is the best way to develop skills, programs, and resources to improve the health and well-being of members of refugee communities. By working in collaboration with community members, through processes including needs assessments, consultations, and partnerships with community leaders, health programs and services can be developed and delivered in ways that are most effective for and responsive to the context of the needs of refugees. In the words of one participant, "if they value it, then it's worth it." At the same time, the process of working in collaboration strengthens the capacity of community members to collectively identify and address the issues faced by refugees. It was repeatedly stressed by many participants that people with the "lived experience" of being a refugee should be involved in program planning and implementation. Community development can be encouraged but not led by people outside of the community. The idea here is to help build the capacity of community members, and then move on.

Participants noted that engaging refugee community members in the discussion will require structures (e.g., advisory groups with nominated members from the community) and a clear development and implementation plan. Work may need to begin on an individual, one-on-one basis to build trust with community leaders. The involvement of schools (particularly school social workers and nurses), community associations, settlement workers from the immigrant-serving organizations, and service providers from other sectors will be required to build these foundational relationships, and also to ensure that efforts are not duplicated. Several interview participants indicated that their organizations would like to collaborate and connect to enhance the existing spectrum of services for refugees.

Some participants recommended that efforts begin with the Karen, Iranian, Iraqi, Sudanese, Somali, and Ethiopian communities, as they are currently experiencing the greatest physical and mental health needs. Members of these communities tend to be quite young and they are often single or newly married, with no support systems in Calgary. Again, community development approaches would need to be tailored to each specific community and may include social action (advocating around specific initiatives such as ELT, housing, and employment); organizational planning (working with Calgary's CARE Strategy for Children and Youth of Immigrant Families¹ to coordinate services, supporting organizations to be culturally competent); and locality development (working to address specific community issues, such as youth not attending school and having a great deal of unstructured time). It was noted that significant systemic improvements generally result from changes at the policy, rather than programmatic level, highlighting the need for social action-driven community development in the longer term.

In addition, several participants observed that community development is unlikely to address refugees' urgent income, housing, and childcare needs, at least in the short term. These participants argued that it may be most effective to blend Strategies 3 and 4 by putting community members into the health care system as health brokers to help individuals to access the services they require, in conjunction with broader community development strategies, involving brokers and other partners that emerge from this work. One participant suggested that it may also be helpful to begin building the capacity of individuals working within existing programs.

A few participants cautioned Alberta Health Services - Calgary Health Region against making promises that it may not be able to fulfill. They said that it should be recognized from the outset that community development is a long-term process; it may take many years for changes to occur. Therefore, Alberta Health Services - Calgary Health Region must be committed and willing to provide adequate, long-term resources for programming and health broker or outreach positions so that relationships can be established, supported, and sustained.

Summary

Interview participants did not single out any one of the five proposed strategies as the most essential for improving the health of refugees in Calgary. Rather, most people envisioned a multi-faceted approach encompassing all of the strategies because they are so inter-dependent. It was stressed that system-wide cultural competence is required to effect meaningful improvements for refugees, and efforts to improve competency among service

¹ Calgary communities working collaboratively to enhance and coordinate strategies that promote the positive socio-economic, academic and cultural well-being of children and youth from immigrant families.

providers in both the public and non-profit sectors should continue. Moreover, health programming should be provided to all classes of refugees for several years via health brokers, community-based programming, and community development initiatives, in conjunction with mainstream health delivery mechanisms, to build the capacity of refugees to collectively identify and find solutions to problems and barriers.

That being said, interview participants most strongly endorsed the idea of using community-based health outreach workers or brokers, along with community-based programming and services, to improve health care for refugees.

Although participants had somewhat different conceptions about the roles of health brokers, most felt that they should serve as case managers to ensure that individuals receive the health services they require, act as cultural intermediaries between refugees and service providers, provide health promotion education in the community (e.g., post-partum care, healthy relationships), and/or assist in identifying community development opportunities. Many interview participants suggested that bilingual members of refugee communities, ideally health, community or social service professionals whose credentials are not recognized in Canada, should be hired and adequately compensated for their skills and expertise.

With one exception, all participants supported the notion of providing programming to members of refugee communities at sites within the community that are frequented by refugees. It was generally believed that settlement and transition must precede integration, and providing services to people in their own environments can help to bring people into the broader community. Most interview participants identified refugee women as the appropriate target for programming, as they are often the primary caregivers in families and tend to be the most isolated. Suggestions for programming for women to reduce isolation, build skills and knowledge, and address the basic determinants of health were offered.

A strong and consistent theme throughout the interviews was the idea of extending current health care services and programs for refugees provided by the CRHP to at least three years. It was generally recognized that, despite the challenges associated with engaging refugees in a community development process, successful community development initiatives are supported, but not driven, by non-community members. Participants also noted that it could take many years and many partners to implement the five strategies, individually or collectively, and noted that commitment is required, along with sufficient, long-term financial and human resource support, to see them through.

In addition, interview participants identified the need for greater involvement of immigrant-serving organizations and schools, which already play a vital role in connecting with and serving refugees in all areas, in building a long-term, comprehensive system of health care for this population. Representatives of immigrant-serving organizations explained that they are already providing some health broker services, health programming, and community development support to refugee communities, arguing that it would be both effective and cost-efficient to build on these existing services, although Alberta Health Services - Calgary Health Region would need to help support any expansion of services.

Overall, participants identified the need for all service providers to work in collaboration to reduce gaps and barriers in service delivery, maximize resources, and avoid duplication, and many people stated that they wished to play a role in this collaboration. The issues faced by refugees are complex and multi-faceted but participants felt that, by building on the

excellent work that is already being done and the collective expertise of stakeholders in the community and the non-profit and public sectors, it will be possible to build a comprehensive and effective health and social service system for refugees in Calgary.

Recommendations

The following recommendations are based on the literature review and compilation of feedback from interview participants around priorities for action to guide the development of this initiative:

1. Financial support for the development, implementation, and maintenance of a long term refugee health strategy in Calgary be secured.
2. A clear vision for the initiative along with a concrete action plan and timelines be developed with the involvement of representatives from immigrant and refugee-serving agencies, leaders of refugee communities, and include a strong voice from individuals who are or who have been refugees.
3. The CRHP expand service delivery to refugees at or through the Margaret Chisholm Resettlement Centre, Calgary Catholic Immigration Society, to two years at least or more with more emphasis on transition into the mainstream health care system. Elements of the model used and programming provided by the Access Alliance Multicultural Community Health Program in Toronto should be considered (see page 8 for more information).
4. Alberta Health Services - Calgary Health Region continue its efforts to reduce the language and cultural barriers encountered by refugee clients/patients, by:
 - i. improving interpretation and translation services in ways consistent with best practices identified by research;
 - ii. training health care staff to work with interpreters;
 - iii. working to culturally diversify its workforce;
 - iv. developing high-quality, audio-visual materials in simple English to explain health issues;
 - v. providing comprehensive cultural competency training with a cultural sensitivity, rather than cultural specificity, focus to health professionals; and
 - vi. allowing health brokers/outreach workers to advocate on behalf of, and provide interpretation and translation services for, refugee patients.
5. Alberta Health Services - Calgary Health Region and the Calgary Refugee Health Program, Calgary Catholic Immigration Society, build on its current partnership to provide community-based health care services and health brokers/outreach workers within a community development context, as follows:

Governance and management

- i. For the health brokers/outreach workers, the governance and management model used by the Calgary Bridge Foundation for Youth's In-school Settlement (ISS) Program should be considered. In this model, an immigrant-serving agency works in partnership with the two school boards to provide settlement services to new immigrant families. In the ISS Program, staff are employed by the immigrant-serving agency but

work out of schools and other school board venues, and the program manager is accountable to all three partners, each of whom plays a genuine role in overseeing the program.

Delivery model and programming

- i. Unlike the workers in the ISS program, who provide only short-term assistance, the health brokers/outreach workers should provide longer-term support in ways similar to Alberta Health Services - Calgary Health Region's Best Beginning program.
- ii. Ideally, health brokers/outreach workers should be hired from the refugee communities. However, culturally-sensitive, rather than culturally-specific services, provided by refugees who may or may not be a member of a specific ethno-cultural community, may be the most pragmatic solution.
- iii. The health brokers should work very closely with CRHP medical staff, who provide community-based health programming, including non-traditional health programs such as collective kitchens and art and theatre projects, particularly targeting refugee mothers and, possibly, adolescents and seniors. Sexual and reproductive health, mental health, and nutrition and child care and development should be programming priorities.
- iv. Together, the health brokers and the CRHP staff should assist refugee communities to build their capacity to collectively identify and address the issues faced by their members. Whether to use (a) a community development model, with inter-agency collaboration, or (b) an inter-agency collaboration model, with community development, should be determined on the basis of the each community's pre-existing capacity, available funding, the nature of and degree of commitment from the agency partners and, most important, the will of community leaders.

In either case, capacity building should include the following elements:

- Needs identification and program design and delivery that is driven by the community, not funders or technical experts;
 - A focus on accessibility that includes transportation, child care, and home-based services as required;
 - Facilitation of the development of a range of skills such as networking, project management, policy formation, and advocacy within refugee community groups;
 - The possibility of using financial and other incentives to engage community members to assist with program development, outreach, and delivery;
 - A goal of increasing community members' capacity for self-determination, individually and collectively.
6. The Refugee Health and Wellbeing Project and other stakeholders work to raise awareness of the provincial government about the health and social issues faced by refugees, along with the social and economic consequences of failing to fully address these issues, and to influence the provincial government to increase the scope and duration of financial, health, and other supports to refugees, including those who are not government-sponsored refugees.

**APPENDIX 1
INVITATION TO PARTICIPATE IN CONSULTATION**



23 McDougall Court NE,
Basement
Calgary, AB T2E 8R1
Telephone: 265-3410

Email: valerie.kiss@calgaryhealthregion.ca

Re: Invitation for your participation in the consultation to improve the health of refugees in Calgary

You have been identified as a valuable contact in your field of expertise. The Alberta Health Services - Calgary Health Region, in partnership with the Calgary Refugee Health Program, Calgary Catholic Immigration Society (CCIS), would like to bring your expertise into the process of developing strategies to improve the health and wellbeing of refugees in Calgary. Your knowledge, along with other key stakeholders from immigrant serving agencies, ethnocultural community associations, and Alberta Health Services - Calgary Health Region will help us determine the best ways of moving forward.

Five strategies have been identified from an extensive literature review that was conducted early in the year looking at promising practices from around the world to improve access to health care, quality of health care, health promotion and illness prevention, access to the basic determinants of health, community capacity and ultimately, the health and wellbeing of refugees.

In the consultation meeting we hope to have with you, we would like to talk about:

- which strategy or strategies identified would be most appropriate and effective in assisting refugees;
- what needs to happen to develop the strategies; and
- who would be able to collaborate with Alberta Health Services - Calgary Health Region and the Calgary Refugee Health Program, in developing, implementing, and sustaining new strategies to improve the health and wellbeing of refugees.

You will soon be receiving a phone call from myself, the Refugee Health Project Coordinator, Healthy Diverse Populations, Alberta Health Services - Calgary Health Region, to set up a consultation meeting with you. The meeting will take about 1 hour.

You are also welcome to call me at 265-3410 to set up a meeting or to obtain more information. If you feel that you are not the most appropriate person to consult with, please direct me to the appropriate individual in your area who would be able to assist with this request.

Sincerely,

Valerie Kiss
Refugee Health and Wellbeing Project Coordinator
Alberta Health Services - Calgary Health Region

APPENDIX 2 INTERVIEW PARTICIPANTS

Sultana Assar, Calgary Catholic Immigration Society
Wendy Auger & Esau Torres, Immigrant Services Calgary
Fariborz Bhirjandian, Calgary Catholic Immigration Society
Peter Both, The City of Calgary, Family and Community Support Services
Sybil Braganza, The City of Calgary, Seniors' Services
Yvonne Chiu and Ruth Wolfe, Edmonton Multicultural Health Brokers Co-operative
Ida Grainger & Marion Christensen, Calgary Catholic Immigration Society
Rosalind Kang, Immigrant Sector Council of Calgary
Ivan Mihaljevich, Calgary Bridge Foundation for Youth, In-School Settlement Program
Anne-Marie Pham, Human Resources and Social Development Canada
Kamal Seghal, Alberta Network of Immigrant Women
Jill Sharpe, Alberta Health Services - Calgary Health Region, Seniors Resource Nurse
Beba Svirig, Calgary Immigrant Women's Association
Hieu Van Ngo, Coalition for Equal Access to Education
Carolyn Wilkinson, Calgary Board of Education, Educational Support Services
Nicola Youle, Rebecca Lewis, Kim Wallace, and Elaine Grapentin, Calgary Learning Village Collaborative, Alberta Health Services - Calgary Health Region
Marichu Antonio, Jason Klinck, Hayat Amer, Bukurie Mino, and Trina Rahimi, Centre for Newcomers

APPENDIX 3 COMMUNITY CONSULTATION BACKGROUND DOCUMENT

Background

Refugees often experience a wide range of physical and mental health problems. Their physical health has been often been compromised by inadequate health care, nutrition, housing, and education, and many have suffered torture, trauma, and rape in their home countries. Mental health issues can arise from the cumulative impact of experiences that refugees have undergone, but also from their living conditions in Canada.

Refugees encounter many cultural, language, information, and educational barriers in accessing appropriate physical and mental health care. In addition, their concerns about physical and mental health issues may be superseded by concerns about day-to-day survival. Refugees often experience significant problems in obtaining the basic determinants of health, such as adequate income, food, appropriate and affordable housing, and transportation. This is in part due to many refugees' inability to obtain sufficient ESL training, employment opportunities, legal services, social supports for adults, affordable childcare, sufficient settlement services, various educational and other supports for children and youth, and other supports and services that help newcomers along the road to self-sufficiency and a reasonable quality of life.

Healthy Diverse Populations, Alberta Health Services - Calgary Health Region, and the Calgary Refugee Health Program (CRHP) want to improve the health and well-being of refugees. At present, Alberta Health Services - Calgary Health Region and CRHP work in partnership to improve the health outcomes of refugees. The CRHP maximizes the health and well-being of new refugees by providing early health interventions and facilitating access to existing health services in Calgary. Alberta Health Services - Calgary Health Region, Healthy Diverse Populations, is working together with the CRHP at building community capacity and strengthening relationships with immigrant serving organizations and other sector partners to explore additional ventures with the common purpose of giving refugees a helping hand during the critical settlement period so they can integrate effectively.

Both organizations recognize that much more needs to be done to address refugees' physical and mental health needs, along with the determinants of health (e.g., education, income, social support networks, etc.) that influence health status; and there is currently limited existing capacity to affect the health of the refugee population. Typically refugees do not seek medical or health services until they are ill. Health promotion is underutilized while costly emergency and acute care services are overutilized. The many challenges and barriers that can affect health status may be experienced by refugees for years and, sometimes, indefinitely.

But improving the situation cannot be accomplished by Alberta Health Services - Calgary Health Region and the CRHP alone. Hundreds of studies and examples of successful initiatives from around the world have shown that it is virtually impossible to develop an initiative to improve the health outcomes of refugees that is sufficiently comprehensive to meet all their needs, and that interagency collaboration is the best—and, perhaps, the only—means of ensuring the development and delivery of effective services.

What is the purpose of the consultation meetings?

The purpose of the consultation meetings is to bring your expertise into the process of developing strategies to improve the health and well-being of refugees in Calgary. You, along with other key stakeholders from immigrant serving agencies, ethnocultural community associations, and Alberta Health Services - Calgary Health Region, have been identified as a valuable contact. We need your input and ideas to determine the best ways of moving forward and your support to make our collective vision a reality.

In the consultation meetings, we hope to talk about

- which strategy or strategies would be most appropriate and effective in assisting refugees,
- what needs to happen to develop the strategies, and
- who would be able to collaborate with the Alberta Health Services - Calgary Health Region in developing, implementing, and sustaining new strategies to improve the health and well-being of refugees.

Strategies for Change

The following strategies reflect promising practices from around the world to improve access to health care, quality of health care, health promotion and illness prevention, access to the basic determinants of health, community capacity and, ultimately, the health and well-being of refugees. These strategies are provided to stimulate your thoughts about what kinds of models and approaches would work best in Calgary. It should be stressed that, while each strategy could work on its own, we may need to build a “made-in-Calgary” solution in which one strategy is tailored to meet local needs, or an approach that blends components from different strategies, along with your ideas.

Strategy 1 – Continue to Build Language and Cultural Competency within the Health Care System

Many of the barriers encountered by refugees in the health care system stem from lack of communication between patients and health care providers. Refugees may be unfamiliar with formal, structured health care systems like we have in Canada and they may think about health and illness in ways that are unfamiliar to Canadian health care providers. And, of course, refugees encounter language barriers at every turn, from trying to find and make an appointment with a doctor to obtaining a prescription and/or following up on referrals. For some refugees, even the best written translated materials are not helpful, as some refugees have never had any formal education and may not be literate in their native language(s). At the same time, health professionals may lack the cultural competency to try to understand things from the perspective of the refugee patient. While it may be unrealistic to expect every member of the health profession to understand all cultures from around the world, it is reasonable to think that they can learn to listen to members of other ethnocultural groups with an open mind and a flexible attitude.

Alberta Health Services - Calgary Health Region values diversity and is committed to becoming a model Diversity Competent Health Care Organization, one which has the ability to respond respectfully and effectively to people of all backgrounds who experience health disparities, such as refugees. Currently, the Region is working to reduce language and cultural gaps between refugee patients and providers through six priority focus areas. These include: connecting with organizations that represent diverse communities; providing a diverse perspective to Regional programs and services to positively impact the community we serve; providing interpretation and translation services; reducing system based barriers to ensure access to programs and services; establishing infrastructure that supports the development of diversity competent employees; and attaining a workforce at all levels within the organization that is representative of the community we serve.

EXAMPLE

Community Health Services Program, Seattle, Washington

The Community Health Services Program (CHS), sponsored by the Center for Multicultural Health, serves a group of community health centers in the greater Seattle area. The program uses both on-call contract interpreters, who provide neutral interpretation services and do not have a continuing relationship with patients or health care providers, and multilingual family health workers who rotate through six community clinics in Seattle/King County. The family health workers are an integral part of the clinic health care team, playing an expanded role than goes beyond interpreting, although interpretation lays the foundation for the work they do. They work in partnership with providers to offer comprehensive, culturally and linguistically appropriate care to patients, and are called upon to do health education, outreach, and provider education in the culture of their patients.

Other methods of reducing barriers that have been successful in other cities and countries include:

- bringing in traditional healers to bridge language and cultural gaps and blend treatment approaches
- using language and cultural health brokers in the health care setting and in the community (more on this in Strategy 3)

Strategy 2 – Expand Health Services/Programs for Refugees

Refugee health clinics work to provide a holistic response to the needs of refugees by offering a broad range of health, social, and advocacy services. They may be stand-alone entities or located within an existing mainstream health service or a refugee-serving agency. Professionally-trained language and, sometimes, cultural interpreters help to bridge the gap between the client and the doctor and other health professionals. Clinics work in partnership with immigrant and refugee groups, organizations, and settlement agencies to help refugees access the broad determinants of health, such as food, shelter, transportation, legal assistance, education, and employment. These support services can be provided by community health nurses, community workers, university students, lay or paraprofessional members of the refugee community, or some combination thereof. However, like the Calgary Refugee Health Program, most of these clinics only provide services to refugees for a limited amount of time: during their first year after arrival in Canada.

EXAMPLE

**Access Alliance
Multicultural
Community Health
Centre, Toronto**

Access Alliance provides a range of settlement and health services to newcomers, including refugees. It also provides community interpretation services, delivered by certified interpreters, which are available to clients for free and to community service providers, which include health care providers, for a fee. This service is used frequently by primary health service providers. In addition, Access Alliance offers a health promotion program, staffed by multilingual health promotion workers, who use various health promotion strategies including health education and communication, community development, advocacy and intersectoral collaboration. The Centre's health promotion goals are to improve community knowledge, behaviours and skills; to increase community participation in decision making; to promote health promotion and disease prevention as priorities for the health care system and to enhance health promoting policies and practices.

Strategy 3 – Health Outreach Workers or “Brokers”

Health outreach workers are used extensively and effectively around the world to link refugees to health and social services, provide education and health promotion, deliver specific programs, advocate on the part of both individuals and communities, provide cultural and language interpretation, help community members to obtain access to basic services, engage in community development, and increase the cultural competency of health service providers, along with the appropriateness and quality of health services.

The term *health outreach worker* is often applied to workers engaged by hospitals, clinics, and health departments whose job involves facilitating access to that particular service through outreach and health promotion activities. In some cases, nurses, doctors, medical or nursing students, and/or undergraduate university students are involved in providing direct health care services in community locations. The term *multicultural health broker* applies to a wide range of roles and positions, but the approach is usually from the perspective of the refugee community. Most health brokers do not provide direct medical services, although they may work in collaboration with health service providers.

EXAMPLE

**Multicultural Health
Brokers Co-operative,
Edmonton**

The Multicultural Brokers work to provide equal access to healthcare services for ethno-culturally diverse individuals, families, groups and communities, most of whom are immigrants and refugees. Brokers provide health education and early parenting support to immigrant women and families. Specifically, they provide prenatal education and hospital tours, post-natal support, health and sexuality education, telephone counseling and referrals, home visits when necessary, translation and resource material development, community development and health promotion, and consultation concerning cross-cultural issues.

Strategy 4 – Provide Community-Based Programs to Address Issues Identified by Refugee Communities

Research shows that health programming delivered in accessible community locations is often the best way to reach refugees. Just getting to a clinic or a hospital can be very difficult for refugees, especially for refugee women with children. Reaching refugee families, particularly those with young children, is often best accomplished through outreach to mothers. Targeted health clinics (offering, for example, vaccinations, instruction and assistance with family planning and prenatal care, screening for health problems such as breast cancer, diabetes, and hypertension) may be more user-friendly and effective when they are provided at places of worship, community centres, and other community locations. In addition, outreach programs with a dual focus, such as community gardening along with health care for seniors, or soccer in addition to healthy living training for youth, are often good ways of engaging specific age groups in health programming.

Likewise, peer groups, support groups, and counseling groups are often good ways of providing refugees with the support and guidance they need to deal with the challenges of life in Canada, along with the trauma they have experienced in the past. Research indicates that community peer groups may be more helpful than professional counseling for refugee women. The groups may form around a specific interest or purpose, such as cooking or sewing but, with support from a community or health worker, they can evolve to become meaningful support groups. Groups can help to reduce isolation, provide a place to talk about their problems and to receive support, be understood, learn about rights, find friends, get advice, and learn about community services. Groups may be particularly beneficial for survivors of war and torture.

EXAMPLE

Empowerment Program for Refugee and Immigrant Women, Kansas

The Empowerment Program provides broad services, including psycho-educational workshops, counseling, psycho-educational home visits, advocacy and case management, informal meetings that provide one-on-one attention, and interpretation. Advocacy and case management address a variety of needs including housing, social services, employment, language skills, health care, immigration law, and family transitions (e.g., divorce). Refugee and immigrant women are given better access to community services via the use of interpretation and in the availability of personal informal contacts with advocates on an as-needed basis.

Bilingual and bicultural paraprofessionals to serve multiple roles, including interpreter, translator, liaison, caseworker, resource specialist, and community advocate. These bicultural-bilingual advocates are refugee or immigrant women themselves and are active in their own communities.

EXAMPLE

National HIV/AIDS Refugee Health Education Program, New Zealand

The National HIV/AIDS Refugee Health Education Program facilitates HIV/AIDS health promotion activities through training community educators, facilitating community initiatives, and supporting the establishment of culturally appropriate community support structures through de-stigmatization activities and the development of community support networks for refugees with HIV/AIDS. The program was developed in partnership with African refugee communities in three phases: (i) extensive community consultation and collaboration with key community and religious leaders, (ii) train-the-trainer workshops to provide community educators with basic information to use with the communities, and (iii) regional HIV/AIDS health promotion activities, developed in consultation with community leaders. Community-based learning is based on the Tuelimishane (“let’s learn together”) model, approaches to learning and sharing include role-plays, story-telling, drama, songs and dances; group discussions; cultural group exercises; and minimal use of reading and writing. The success of the program in engaging and retaining high numbers of participants is attributed to “buy-in” from communities, partnerships and alliances with refugee communities, and collaboration and commitment from all members involved.

Strategy 5 – Community Development

It is generally agreed that community health programs must be driven by the needs of communities, not those of external agencies or technical experts. The participation of the community is essential to ensuring that the “right” programs are developed and delivered in the “right” ways to community members. But refugee communities are often very under-resourced and rarely have the capacity to develop new initiatives on their own.

Therefore, initiatives to improve refugee health often include a community development component. Within the health context, community capacity has been defined as “an approach to the development of sustainable skills, organizational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over.” The idea here is to bring in the pre-existing skills and knowledge of community members to help shape programming, but to also use the collaborative process to strengthen the refugee community as a whole. Ethnocultural organizations, faith groups, and settlement agencies can play a big role in helping to engage community members and leaders to move the collaboration process forward.

What happens next?

You will soon be receiving a telephone call from Valerie Kiss, Refugee Health Project Coordinator, Healthy Diverse Populations, Alberta Health Services - Calgary Health Region, to set up a consultation meeting with you. The meeting will take about 45 minutes to one hour and will be with Valerie and Halima Mohamed, the Health Promotion/Program Development Coordinator for the Calgary Refugee Health Program, Calgary Catholic Immigrant Society.

You are also welcome to call Valerie at 265-3410 to set up a meeting or to obtain more information.

EXAMPLE

Survivors of Torture Program, Calgary Catholic Immigration Society, Calgary

This program has been identified by researchers as a best practice model for community collaboration in the development and delivery of a community-based program for refugees. Program development began with a comprehensive community and needs analysis on the issue of torture, which included input from survivors of torture, ethnocultural community groups, government resettlement services, and medical and counseling professionals. Community members who had expressed an interest in program development were invited to form an advisory team to plan and implement the program. The group included members from diverse ethnocultural communities and the most experienced advocates from the volunteer, professional, and refugee communities, all of whom had the authority to make decisions on behalf of those they represented.

The objectives of the program are to facilitate survivors’ access to appropriate physical and mental community health services; provide social support through host volunteers; provide practical support through CCIS with respect to resettlement, ESL programs, vocational training, and employment services; and advocate for survivors to access social services outside of CCIS. Services gradually expanded from social support and access to community health and social services to include therapy and other services through a broad network of specially-trained psychologists, medical doctors and other health professionals, social workers, and lawyers. Today the program is the centre of collaborative efforts among various service providers.

APPENDIX 4 Community Consultation Protocol

1. **Does the discussion in the background document about the kinds of barriers encountered by refugees in accessing and obtaining good health care seem accurate to you.** *(Prompts: Are these the kinds of problems that your clients experience in Calgary? Did we miss anything – are there any other unmet barriers/issues (specifically around health)? What is different in Calgary?)*

2. **The background document describes five strategies to improve health and social supports and services for refugees: (i) continued cultural competency training for health care professionals, (ii) expanding health programs and services for refugees, (iii) health care outreach workers and “brokers”, (iv) providing community-based programming, and (v) community development.**
 - 2.1 What do you think about each of these strategies? Are there any agencies in Calgary currently implementing any of these strategies? Should we be considering any of these strategies, or any parts of these strategies, to use in Calgary? Why/why not? Are there any barriers/challenges/ gaps in implementing any of the strategies?
 - 2.2 Based on your knowledge and experience, are there other kinds of models or programs that are not identified in the background document that might work in Calgary?
The following questions as applicable:
 - 2.3 Alberta Health Services - Calgary Health Region currently provides cultural competency training and guidelines for health care professionals, written materials in multiple languages, and using video and audio training materials. Do you think this is effective? Are there other things that we should consider?
 - 2.4 Should the current refugee clinic be expanded to provide services after one year, to provide more comprehensive services? If yes, which services (e.g., health brokers)?
 - 2.5 Should some thought be given to providing mini-clinics (e.g., vaccinations, blood pressure checks) in community locations, such as community centres, schools, libraries, or places of worship? If so, which health needs should be addressed? Where would be good places to hold these mini-clinics?
 - 2.6 What about health programs or workshops in the communities (e.g., well-baby care)? What kinds of issues would be most important to address? What would be the best models and modes of delivery for these programs or workshops, e.g., peer support groups, interactive theatre, what? What about home-based services? *(Prompt: may be different issues for different refugee communities; would we need to target different refugee communities?)*
 - 2.7 Are there specific age groups that we should target, e.g., pregnant/parenting moms, youth, seniors?
 - 2.8 What kinds of characteristics would we want community workers to have? *(Prompts: shared cultural background, languages, gender, live in community, education/training background. If not possible to find people with all of these characteristics, would using mainstream community health nurses and hiring community people to work in partnership with them?)*
 - 2.9 If we did use health brokers, do you think they should be providing cultural interpretation as well as language interpretation? Pros and cons?

- 3. What would we need to do to make all of this happen?**
 - 3.1 Would any more consultation be required? If yes, with whom? Could you help with this?
 - 3.2 Establish relationships with people in communities? Who? How could we connect with them? Could you help with this?
 - 3.3 Who/which agencies/which organizations/which professions should be involved with program development and implementation? What kinds of expertise would be need? Which organization should take the lead?
 - 3.4 Would you be willing and able to collaborate with us? What kinds of support would you or your organization need to be able to participate?
 - 3.5 (*Depending on above answers*) Which organizations/individuals/professionals would need to be involved to deliver and to sustain these kinds of services? Could your organization contribute?
 - 3.6 Since it wouldn't be feasible to start with everyone and everything all at once, what would you identify as the immediate priorities for action?
- 4. Do you have anything else to add? Suggestions? Ideas?**
- 5. Is there anyone else/any other organization that we should talk to as well? Do you have their contact information?**

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