

**Ethno-Cultural External Consultation  
Regional Diversity Steering Committee Project  
Calgary Health Region**

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Calgary Health Region, Regional Diversity Steering Committee**

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## **Executive Summary**

This report presents findings from a series of focus groups and interviews conducted by Word on the Street Consulting and Arnold Health Communications on behalf of the Regional Diversity Steering Committee, Calgary Health Region (CHR). The project was designed to assess the response of ethno-cultural communities to diversity services already undertaken and those planned for the future. More specifically, the research was to:

- 1) provide the CHR with feedback on the changes made to services
- 2) provide input regarding future plans to address issues identified by ethno-cultural communities
- 3) identify ways that ethno-cultural communities and individuals in those communities can contribute to CHR's planning

Representatives from the following communities were recruited, with the assistance of host agencies/individuals, to participate in the focus groups and interviews: Hispanic (n=12), South Asian (n=16), Vietnamese (n=10), Chinese (n=10) and Iraqi (n=15). A focus group was also held with members of immigrant serving agencies (n=8). All data were analyzed qualitatively using the constant comparative method.

The focus group guide asked participants to share their personal experiences and views on topics such as service awareness, priority issues, future services and participation. Focus groups took place in gathering places in the various communities. All interviews (Iraqi participants) were carried out in the homes of the participants.

A summary of key concepts is provided below. For further information on common themes and recommendations, refer to *10.0 General Themes Across All Groups*.

### **Language**

Access to interpretation is the single most significant barrier to effective health care for many people in ethno-cultural communities. The Language Line is shockingly under-utilized—none of the participants in the focus groups and interviews had used the Language Line, only two had heard about it and none had been offered it. The participants who were unaware of the Language Line included representatives of immigrant agencies, many of whom are asked by CHR staff to provide interpretation services in the hospitals. All participants agreed they would find the Language Line very useful and recommended that it be made available throughout the health care system, particularly in physicians' offices. Clearly there is a need for the Language Line, and other diversity services, to be promoted within CHR, to immigrant serving agencies and to members of the non-English speaking public.

Translated materials were considered valuable by members of ethno-cultural communities. Many did not know of the translated materials currently available. Adequate promotion and broad distribution of translated materials is essential.

Accurate interpretation by trained medical interpreters was considered essential. Immigrant serving agencies have assisted with interpretation and translation in the past, but funding is diminishing and concerns around liability are increasing. Family and friends are often burdened by the need to provide interpretation in health care situations and are worried about making mistakes.

### **Staff and Services**

Hiring more ethno-cultural staff would help to reduce some language and other cultural barriers. In particular there is a critical need for female physicians who speak the language (Arabic, Spanish) and are culturally competent. Immigrant serving agencies and ethno-cultural communities are more than willing to become involved in a two-way exchange of cultural information with CHR staff.

Many participants reported a lack of understanding about how the health care system works and what services are available. There is a need for a mechanism to present/distribute information on the health care system to new immigrants and immigrant serving agencies. Reference materials in multiple languages would be helpful.

## **Participation**

Immigrant serving agencies welcome the opportunity to share their ideas and skills with the CHR in relation to diversity planning and programming. In addition, many members of ethno-cultural communities are eager to participate at different levels, but they require education on how the system works and what is required of them.

## **Priorities**

Addressing language barriers was considered by all groups and interview participants to be the highest priority. Promoting diversity services, especially the Language Line, was also thought to be a top priority.

Educating ethno-cultural communities and organizations and immigrant serving agencies about the health care system in general, and diversity services specifically, was considered critical by all of the groups.

Other priorities identified by many of the participants are:

- recruiting and training staff from various cultures (particularly female physicians)
- facilitating active ethno-cultural involvement that would include participation at all levels of planning, policy and decision-making
- providing outreach in the form of members of specific ethno-cultural communities hired to educate and make connections

## **Recommendations**

A number of recommendations were made in relation to language barriers and interpretation, translated materials, staff and services, participation, education and delivery of diversity services. The key recommendations have been incorporated into the preceding categories and additional recommendations are outlined in *10.0 General Themes Across All Groups*.

## **Conclusions**

This research identified many opportunities for the CHR to enhance current diversity services to reduce cultural and language barriers for members of ethno-cultural communities. Focus group and interview participants placed significant emphasis on issues of language and various aspects of staffing and services. Key to successful diversity programming is the need to involve immigrant serving agencies and members of ethno-cultural communities at different levels through an information exchange.

## **1.0 Introduction**

The vision of the Calgary Health Region (CHR) includes the statement, "Respect for diversity will be fundamental and integral to the Calgary Health Region workplace and to the populations served." To achieve this the CHR has enhanced service delivery to increase its ability to address issues related to diversity. The CHR's diversity efforts have included identification of interpretation needs of staff and the planning and delivery of resources and services to fill identified gaps (see Appendix A: Description of Diversity Services). A Regional Diversity Steering Committee has been charged with the responsibility of developing a guiding framework, receiving input from stakeholders and monitoring progress.

The CHR contracted Word on the Street Consulting and Arnold Health Communications in January 2002 to assess the response of ethno-cultural communities to diversity services already undertaken and those planned for the future. The purpose of the research was to:

- 4) provide the CHR with feedback on the changes made to services during the past three years
- 5) provide input regarding future plans to address issues identified by ethno-cultural communities
- 6) identify ways that ethno-cultural communities and individuals in those communities can contribute to CHR's planning

Representatives from the following groups were recruited to participate in the focus groups: immigrant serving agencies, the Hispanic community, the South Asian community, the Vietnamese community and the Chinese community. These communities were selected because of their large populations in the city, previous history in collaborating with the CHR, and capacity to actively participate. Key informant interviews were conducted with members of the Iraqi community because Arabic was identified as one of the top language groups as well as a large number of Iraqi refugees came to Calgary.

## **2.0 Methodology**

### **2.1 Focus Groups**

The CHR selected focus groups as a method of data collection for the more established ethno-cultural communities (Hispanic, South Asian, Vietnamese and Chinese) and representatives of immigrant serving agencies.

The focus group guide was first developed by the CHR project team and then revised by the consultants (see Appendix B: Focus Group Guide). Group participants were asked to share their personal experiences and views on topics such as service changes, priority issues, future services and participation. Focus groups took place in gathering places in the various communities.

A consultant moderated the focus groups while a CHR representative documented the proceedings. At all of the sessions a University of Calgary researcher was present as an observer and did not participate in the discussion.

The consultants analysed the proceedings based on recorded documentation (notes and flipcharts) and by referring to taped session recordings as required.

### **2.2 Interviews**

Key contact interviews were selected as a method of data collection for the newer, less established ethno-cultural community of the Iraqi people. Nine separate interviews were conducted involving a total of 15 participants. Participants were recruited by the Iraqi interpreter/host through his contacts in the community.

The focus group guide was used to direct the interview process with some flexibility allowed for the intimate nature of the data collection. All interviews were carried out in the homes of the participants. Although participants were given the option of meeting the interviewer at a neutral

location, all waived the opportunity to do so. Interviews were documented via written notes taken during the interview. The interviews were not audio taped.

## **2.3 Data analysis**

Data were analyzed qualitatively. The total of all participants was n=71 (40 females and 31 males). Responses to the focus group and interview questions were grouped into major themes using the constant comparative method, in which new data is analyzed in the context of earlier data. This enabled the consultants to see how the emerging categories that described the data were similar to, or different from, the categories derived from earlier data. Data from the Iraqi interviews were analyzed separately from the focus group data, however, the themes across both were similar. Thus, the findings have been combined for the purposes of this report.

## **2.4 Limitations of the Study**

Focus groups are generally limited by the following:

- sample sizes are usually small and randomization is almost impossible
- participants usually self-select by agreeing to attend, drawing only those who are interested and able
- group interaction can influence individual perception and opinion

The focus groups on which this report is based include the following specific limitations:

- small sample sizes (due to time and budgetary limitations, only one focus group was conducted with each representative group)
- limited age spread in some groups

Key contact interviews are limited by features similar to focus groups (excluding group dynamics), but can benefit from the intimate rapport established during the in-person interview process.

## **3.0 Sample**

Early on the project team identified several key considerations related to the ethno-cultural external consultation project:

- there existed an opportunity to build on existing relationships developed between CHR staff and community stakeholders
- there appeared to be agency/community readiness to play an active role in assisting with organizing the consultation/recruitment process
- there was an opportunity to further build the capacity (skills, awareness and interests) of key community leaders and members

A convenience sample was used for each of the five focus groups, as well as the interviews, and was drawn from contacts within various ethno-cultural communities through the CHR. Details of the sample are attached to each group summary.

## **3.1 Recruitment**

The recruitment process was undertaken with the assistance of host agencies/individuals who were identified by the CHR project team. An honorarium was provided for each host organization to be used by the organization for programming, or shared with participants. Non-profit agencies usually have limited resources and rely heavily on volunteers. Providing an honorarium showed the CHR's commitment and appreciation for the organization and time required.

Host agencies/individuals were asked to assist with the following:

- recruit focus group participants
- determine date, time and location for focus group
- identify an appropriate interpreter

- coordinate welcoming of participants, organize food and refreshments
- ensure invitations, summary sheets, and thank you notes were translated and culturally appropriate
- disperse participant honorariums according to host agency needs (either kept for programming/services or partially or fully distributed to participants)

Part of the recruitment process involved discussing the consent forms that participants were required to sign (see Appendix C: CHR Consent Form and Appendix D: U of C Consent Form). This helped to prepare participants and sped up the consent process at the focus groups.

Hosts reported some difficulties and solutions in recruiting. Passive approaches like letters of invitation and working through others were less likely to succeed. More active strategies, such as personal networking and telephone calls, worked far better. Advertising on community language radio and talking to people about the purpose of the groups also brought positive results. The consultant who facilitated the groups felt the groups were extremely successful due to the eagerness of participants to cooperate and the excellent attendance, even in foul weather.

The project team also felt that giving each community the opportunity to make decisions regarding who to invite, when and where to conduct the group and the sharing of the meal was empowering. Relationships were also strengthened because the CHR made sure that community concerns and issues were validated, allowing them to work at the pace suitable for their community, and accommodating and respecting their customs and traditions.

The CHR provided:

- coordination and support for all functions listed above including timelines
- honorarium to interpreter
- honorarium to agency host organizer
- honorarium to host agency (for programming or to share with participants)
- honorarium to cover costs of transportation and parking
- costs for refreshments and food

## 4.0 Themes: Immigrant Serving Agency Focus Group

*“I had one experience where one of the staff was called and she was working in the radiology...and she was educated here and had come out of her country when she was sixteen. So, while she can communicate [in her language of origin] she couldn't interpret. The translation of what she said was [paraphrasing doctor about biopsy] ‘I am going to slice your leg and put it under the microscope’ and the patient was just running away.”*

*“Recently we had a request to do more immunizations in the Indian Seniors population in the northeast around the Temple and we worked with the staff in the CHR over a two-year period with the agreement that the third year we could pull out and move forward. This partnership was designed with sustainability.”*

*I would say that it is important to build slowly and to build for the bigger picture. I think that a comment made earlier, that people have a right to health care in their language, is important and perhaps, in the beginning, it is important to focus on that.*

### 4.1 Sample

This sample of eight employees of immigrant serving agencies consisted of seven females and one male. Most of the participants were in front-line positions, while only one person represented a managerial position. Two representatives from each of the following organizations participated: Calgary Mennonite Centre for Newcomers, Calgary Catholic Immigrant Society, Calgary Immigrant Aid Society and the Calgary Immigrant Women's Association.

### 4.2 Language

#### Language Barriers and Interpretation

Language was considered to be the biggest barrier to good health care for non-English/ESL speakers. Participants felt strongly that everyone should have the right to professionally trained medical interpretation for medical care. They stressed that people should not have to rely on family members to interpret.

*When a young patient who was going to have a baby in the CHR (Rockyview) staff phoned us [immigrant serving agency] for interpretation services, but they wanted it after hours. I followed up the following day and the staff said that it was okay because the husband spoke a bit of English, but I worry that the husband did not interpret to the wife. The wife should have been interpreted to.*

No one in this group had heard about the Language Line, or that this form of interpretation was available. Participants had not heard of anyone using this service. They do believe the Language Line would be very useful in addressing many of the concerns listed below, especially issues related to accuracy and consistency. They cautioned that in-person interpretation was still required in some situations. They would like to see training of local interpreters.

Current interpretation available in hospitals and through immigrant serving agencies was described in the following way:

- In-person interpretation at hospitals is usually done by non-medical staff pulled from various departments, or immigrant serving agency staff requested by the hospital.
- These “lay” interpreters were considered helpful but unlikely to be trained in medical interpretation and not consistently available.

- Currently the number of languages that can be interpreted are limited (special concerns about uncommon African languages).
- Participants worry that they (and others) do not have the skills to interpret correctly (education, familiarity with medical terms/procedures, competency in English or language being translated).

Participants have experienced and heard about instances where people were not suitably trained or proficient enough to interpret correctly/safely. They worry about making mistakes or endangering people when interpreting in the medical setting and are concerned about liability. They feel that training and standards are necessary in order to interpret medical terms and procedures correctly.

*Sometimes when we go as a volunteer interpreter to a medical service they [we] have limited medical understanding and as a result [we] don't accurately reflect the person's medical history. This is a big risk . . . sometimes it can go wrong.*

Many immigrant serving agencies are no longer able to offer interpretation services (in a medical setting) due to concerns around liability, staff time constraints and limited funding. In direct contrast to this, participants say they go through all kinds of documents with clients, including medical related forms, and they do encourage this. Clients often have a level of trust and comfort with agency staff, so limiting staff interpretation is frustrating. Staff have mixed feelings about this issue.

There was also concern around the use of agency and other staff in a volunteer interpreter capacity instead of paying them for services rendered. Participants question why these are so often volunteer interpretation hours and not paid hours as in any other specialized position. They suggested use of local expertise, more training, and that these local resource people should be hired, used and paid well. There is potential for political problems related to volunteer and paid interpretation, who is hired, who trains, associated agencies, and so on.

Since many of the requests for interpretation services come from hospital staff it appears that CHR staff are unaware of Language Line and possibly other diversity services.

Participants thought that interpretation should not be limited to the hospitals—it should be available in the offices of family physicians, specialists and other clinics.

The group also mentioned that there are sometimes concerns about interpretation with regard to sensitive issues and gender/culture taboos.

### **Translated Material**

Participants would like to see more translated materials. Translation of immunization materials was considered very successful, as it is information that can be given out easily without a great deal of staff explanation. It is exact and clear.

Diversity services and translated pamphlets are not well known to participants and, they think, fellow agency staff. Additionally, it appears that CHR staff are also unaware of services and resources.

## **4.3 Staff and Services**

### **Recruiting Staff**

Participants reported that they were aware of representatives of various ethno-cultural communities being hired as nurses (speaking various languages) and that this was working well. Some reported that they were aware of an AARN program that offered immigrant nurses a refresher course. They wanted a similar program for physicians. Some were aware of a few immigrant physicians who were going through an internship program.

Some participants felt that ethno-cultural representatives were needed as Home Care workers. Frustrations were voiced around the restrictions of an eight-week training program (students need to be on unemployment insurance) and wanted more access with fewer restrictions.

### **Cultural Competency**

Participants felt that finding a family doctor willing to accept new patients was difficult enough, but there are extra difficulties of taking the time to serve immigrants with language and cultural barriers.

*I do have concerns about families visiting family doctors who are only taking a couple of minutes for the families . . . they are rushing clients and do not finish spending time with the people. They need more understanding . . . sometimes you have a gut feeling that something is wrong and the doctor doesn't listen or see them as people who know themselves best and says that there is nothing wrong and later you discover that you have cancer.*

### **Navigating Health Care System**

Immigrants do not understand how the health care system works and do not know what is available within the system, including charges for services (ambulance).

There is a lack of understanding by participants (and they think other agency staff) about who to contact within the CHR about various diversity services (where to get written translated material, interpretation, what services are available in what languages)

### **Pregnancy, Childbirth and Parenting Issues**

The needs of new immigrant mothers are being met by Best Beginnings but the waiting list is long. Most considered the program successful but that it needed to be expanded and better funded.

*There is a very good program around new moms. I know for some clients they are talking about post partum depression, how to take care of their baby, etc. and that is working well. The Best Beginnings program is going well.*

## **4.4 Participation**

Participants offered to assist (and offered their various agencies) in principle with continuing diversity service projects and research. More specifically, they suggested that immigrant agency staff be used to disperse information about diversity services to other staff and clients. They advised contacting community development and outreach workers, settlement and family counselors. Some participants volunteered that they themselves would be a good contact.

It is important to identify and access the agencies, resources and people in the various communities who are connected to those communities. Participants advised the CHR to contact the immigrant serving agencies to identify these people and resources. Agency staff would be able to assist the CHR in accessing immigrant groups and individuals. They thought it would be useful to also use community leaders to connect with communities and offer small honoraria.

Participants also suggested that the CHR connect with agency staff at different levels, including frontline staff and organizational levels around specially designed projects. This helps to alleviate problems with lost organizational history, knowledge, networks and connections due to high staff turnover. There is a need for an information bank so contact can be made on both sides to share information and resources.

Another point raised by the group was to use established networks to connect with others doing similar work (best examples, Survivors of Torture and immigrant seniors' networks).

Participants advocated longer-term sustainable efforts but views differed on whether funds should go into narrower intense projects, or broader-based objectives involving more communities/agencies/goals.

#### **4.5 Priorities**

Agency participants generally agreed with CHR priorities. In addition to the listed priorities, they stressed that people should have the right to personal (not using family member as they may filter) and professional interpretation for medical care. To this end, participants lobbied for a training program for professional medical interpreters. Participants also thought that current diversity services, especially the Language Line, should be advertised and promoted to immigrant serving agencies, ethno-cultural communities and, maybe most importantly, the CHR. Another priority that agency informants added was to inform and educate immigrants about the health care system, how it works, what is available, associated costs, and how they can access services and resources.

#### **4.6 Recommendations for Future Plans**

##### **Language Barriers and Interpretation**

Members of immigrant serving agencies made a number of recommendations related to language interpretation:

- Work toward fulfilling the right to professional interpretation for medical care.
- Advertise Language Line and other diversity services to agency staff, communities and CHR staff.
- Expand Language Line system-wide to include doctors' offices and clinics (in addition to hospitals).
- Consider staffing the Language Line service with local people.
- Develop criteria, standards, and a training program for training professional medical interpreters. Involve doctors and nurses in training and in interpretation programs. Consider involving language bank (CIAS) in training.
- Clarify liability issues for those volunteering to interpret, and their agencies. Also clarify liability for professional, paid interpreters.
- Identify and use local immigrants/agency staff with expertise (for example, medical training from other countries) who could interpret for people in their own ethno-cultural community. Train and pay local interpreters to provide valuable in-person interpretation.
- Be aware of the diminishing ability of immigrant serving agencies to furnish interpretation.

##### **Translated Material**

Participants saw a number of areas to improve the provision of translated material. They offered their agencies and staff as translators/interpreters for written health information.

- Provide translations on medical procedures as well as general health education material.
- Provide translated materials that are clear and exact, requiring little staff explanation, (like the immunization material).
- Research literacy levels in the languages to be translated as not all are literate in their language of origin.
- Inform immigrant serving agencies and CHR staff about translated materials and diversity services in a routine manner. Connect with immigrant serving agency staff at various levels (frontline, administrative, managerial) in various ways (mail, email, Website, presentations).
- Approach immigrant serving agencies to distribute translated materials through various programs and services.

## **Staff and Services**

Several recommendations were made regarding staff recruitment:

- Recruit more ethno-cultural staff.
- Advocate for increased access to (or development of) refresher course (internship) for foreign trained physicians similar to AARN program offered to immigrant nurses.
- Advocate or develop Home Care Worker training program for immigrants; ideally with no unemployment insurance or other restrictions.

## **Pregnancy, Childbirth and Parenting**

Members of this group suggested the CHR expand successful programs that are in demand (Best Beginnings).

## **Mental Health**

Participants said new immigrant mental health issues need to be addressed. Consider home visits as part of the strategy.

## **Education**

Members of immigrant serving agencies made a number of recommendations related to education:

- Develop and disseminate a list of patient rights.
- Inform and educate immigrants about the health care system, how it works, what is available, associated costs, and how they can access services and resources.
- Develop a brochure on diversity services for immigrant serving agencies, relevant public and CHR staff.
- Use CHR outreach workers to educate and develop relationships with immigrant serving agencies and immigrant communities. Increased funding to immigrant serving agencies would allow them to hire Outreach Health Workers.
- Develop and conduct health care system and health prevention awareness workshops for new immigrants and for agency staff. Use credible ethno-cultural representatives as speakers.

## **Participation**

Members of this group were personally interested in participating in CHR diversity planning and programming and recommended the following:

- Connect with immigrant serving agency staff at different levels, including frontline and managerial staff. This helps to alleviate lost organizational history, knowledge, networks and connections due to high staff turnover. Frontline positions that are good contacts included: community development and outreach workers and settlement and family counselors.
- Approach immigrant serving agencies to disseminate information, access immigrants groups and individuals, identify and develop networks and identify community organizations.
- Develop a mechanism to exchange information, ideas, resources and community connections between the CHR and immigrant serving agencies (information bank).

## **Community Connections**

Participants offered a few recommendations for connecting with ethno-cultural communities (they would be willing to offer many more):

- Include all age groups in diversity efforts (connect with seniors)

- Connect with communities through community leaders, insiders with passion for welfare of community, and those working to assist community members. Offer honoraria to acknowledge/honor contribution.

### **CHR Communication**

Participants recommended ways in which the CHR could communicate with immigrant serving agencies:

- Provide a recognizable contact person at the CHR so agencies can build a relationship. Participants have experienced problems with not knowing whom to contact in the CHR to get information.
- Develop a mechanism to distribute diversity materials and information from the CHR to immigrant serving agencies. Suggestions included: mail-outs (traditional and email), website, and through gatherings of some kind (in-house sessions best). Presentations with a CHR representative thought powerful as questions can be answered.

### **Delivering Diversity Services**

Participants offered some recommendations on the process of developing and delivering diversity services:

- Identify and involve diversity champions within the CHR, such as Dr. John Woo, who have established commitment and connections with ethno-cultural communities (establish an Advisory Group to ensure they have input and are aware of diversity activities).
- Commit, where possible, to longer term sustainable projects.

## 5.0 Themes: Hispanic Focus Group

*One participant reported that she had been given a card in the Peter Lougheed Centre saying, "I speak Spanish." There were several staff that spoke Spanish and she was also given printed material in Spanish. She felt lucky and she was grateful.*

*One elderly, non-English speaking participant shared her strategy of communicating during a hospital stay. Her bilingual son wrote basic questions and answers in both Spanish and English, side-by-side. For example, the doctor could point to "Do you have pain?" with the Spanish equivalent written beside it so the patient could understand. In this way the woman said she could communicate fairly well when her family were not there to interpret for her.*

### 5.1 Sample

This sample of twelve Spanish speakers from various Central and South American countries consisted of eight women and four men. Four were in the age range of 50 to 64; eight were 65 or older. About half of the participants needed interpretation so the entire proceedings were interpreted. Many of the participants were involved in immigrant or community agencies as either employees or volunteers. This group was very interested in this process and would be willing to participate in similar groups and learn of findings and future plans.

### 5.2 Language

#### Language Barriers and Interpretation

Several people had experienced, first-hand or second-hand, interpretation at hospitals with lay interpreters (usually non-medical staff). Most reported satisfactory results, but felt that more professional and consistent interpretation should be available.

Language was considered the biggest barrier to effective health care. No one was aware of the Language Line interpretation service, or any other changes to services, although one participant did recount a story of a friend who asked for telephone interpretation and waited forty minutes for a connection. Participants reported that the onus is placed on patients to bring their own interpreter (friend or family member). Sometimes this is not possible. It is also not always appropriate for family to interpret, especially with sensitive women's issues. Several people did not feel comfortable interpreting, even for family, because of medical jargon and worries about accuracy. Participants felt that professional interpretation should be more accessible, especially in emergency rooms.

Participants speculated that waiting times in an emergency room might be exacerbated by language difficulties. For example, an inability to explain symptoms in detail may inhibit the ability of staff to triage properly. Many felt that this happened to them, or those known to them, to some degree.

Participants thought that it would be useful to share strategies to cope with, for example, a hospital stay as a non-English speaker.

Interpreters used here have typically been volunteers, but some immigrant agencies charge \$35.00 per hour. This cost can be prohibitive and the interpreter does not get paid. Accountability is a problem, as is liability. It is understood that immigrants get funding support for language interpretation for the first three years after which they are considered settled and have to pay.

#### Translated materials

All participants supported translating health education material into Spanish. It was felt that the literacy level among Spanish speakers was quite high and translated material was thought

suitable. One participant reported that in the United States all medical information used in hospitals is available in Spanish and that may be a resource for some translated material.

### **5.3 Staff and Services**

#### **Recruiting Staff**

Participants felt that hiring ethno-cultural staff went further than offering health services in various languages. They believed that it strengthened communities, developed more professionals (strengthening the community as a whole) and brought new perspectives to medicine. Issues such as gender, language and culture should be considered when hiring staff.

#### **Cultural Competency**

Positive or negative experience with staff was felt to depend on when the services are accessed (busy times more problematic) and which staff were on duty. Participants reported that some staff are very respectful and responsive, but it depended on individuals.

#### **Physician Gender**

Participants reported that there are cultural issues related to female patients' comfort level with male physicians. Many women from Spanish speaking countries are not comfortable with male doctors because of cultural embarrassment surrounding gynecological issues. Participants thought that it would be helpful to hire qualified female doctors who speak Spanish. They felt that a review of accreditation of foreign-trained doctors was required to allow more of them to practice in Canada.

#### **Navigating the Health Care System**

Immigrants do not always have a clear understanding of how the health care system works and what services and resources are available. They need to know about the various health-related services and costs associated with them (often offered at a sliding scale so affordable).

#### **Mental Health**

Mental health issues need to be addressed in a culturally appropriate manner. Participants also felt there was a need to increase awareness of mental health issues within Spanish speaking communities. Many cultural biases exist in relation to mental health.

### **5.4 Participation**

Participants felt that in order to effectively participate and inform changes for ethno-cultural communities the CHR would have to welcome representation from these communities onto board of directors and other policy bodies. Those responsible for policy development need to be aware of the issues.

Some of the participants were volunteer or employed representatives of community organizations (Immigrant Women's Aid Society, Canadian Hispanic Senior Citizen Services Society). They suggested that these immigrant serving agencies and community organizations would be suitable and willing participants in any future activities.

### **5.5 Priorities**

Participants generally agreed with CHR priorities. They included four more priorities focused on interpretation, participation, and recruiting staff. Participants wanted to: increase access to trained professional medical interpreters (also consider issues of gender and culture); inform ethno-cultural communities about diversity services and other CHR services; include ethno-cultural communities in policy development and decision-making at all levels; and hire more female, Spanish speaking physicians.

## **5.6 Recommendations for Future Plans**

### **Language**

Participants made several recommendations related to language:

- Increase access to trained professional medical interpreters (also consider issues of gender and culture).
- Increase health services available in different languages and translated material.
- Provide Language Line interpretation consistently across the health care system/CHR (all hospital sites, family physician and specialist offices, etc.).
- Inform ethno-cultural communities of Language Line interpretation service and other diversity services.

### **Education**

Recommendations around education included training and information distribution:

- Use established “train the trainer” programs, now existing through immigrant agencies, to educate people on diversity services and health care system in general.
- Provide education about mental health issues in the ethno-cultural communities.
- Use the public library to disseminate information.
- Use Spanish newspapers and radio to disseminate information.
- Facilitate a way for immigrants to share strategies of coping with the health care system (hospital stays).

### **Staff and Services**

Recommendations related to staff and services included provision of diversity services and hiring Spanish speaking staff:

- Provide diversity services, especially the Language Line, consistently across health care system/CHR (all hospital sites, family physician and specialist offices, etc.).
- Develop more clinics like the Alexandra Community Health Centre or 8th and 8th Health Center in northeast or southeast (east of Deerfoot Trail) that have salaried doctors, do not require health care coverage, focus not only on treatment but also on prevention of illness. These centres need to be welcoming even for those with no money or coverage.
- Hire more female Spanish speaking physicians and other staff who are sensitive and educated in issues of gender, language and culture.

### **Participation**

Recommendations related to participation included provision of diversity services and hiring Spanish speaking staff:

- Involve ethno-cultural communities in policy making, throughout and at the highest decision-making level
- The CHR and immigrant and community agencies should be involved in an exchange of information; active relationships to exchange diversity information.
- Continue to involve ethno-cultural communities, develop partnerships with them and exchange information, involve immigrant serving agencies as well.
- Identify key people in various communities who can disseminate information and offer connection to the community.

### **Delivering Diversity Services**

- Consistently fund diversity services for all Canadians, not just new immigrants.

## 6.0 Themes: South Asian Focus Group

*Participants reported mixed experiences and perceptions of discrimination and quality of care. There was a realization that individuals make the difference. A few participants said that they felt they were treated as equals at the Foothills, while visits to the PLC made them feel discriminated against. "In PLC you get treated as a 2nd class citizen."*

*The physician participant, recently practicing at the PLC emergency, commented that his experience would suggest that language barriers do influence triage. You need someone to interpret accurately, and in a timely manner, or your care is delayed. Both interpreters for this group echoed this sentiment with their own stories of interpreting in the hospital setting.*

*One of the interpreters relayed a story of a patient she was able to help, but worried that this woman may have not been helped unless she knew the interpreter personally and was able to ask for her. Use of the Language Line would have helped this women get proper treatment much sooner, but no one knew about it.*

*Many of the older participants said they needed to take an English speaker with them in the ambulance or to emergency, the doctor's office, etc. and that this can be difficult.*

### 6.1 Sample

This sample of sixteen Sikh, Punjabi speakers consisted of seven males and nine females. Two were in the age range of 18 to 29, four were 30 to 49, eight were 50 to 64 and two were 65 or older. One was a young physician who recently worked at the PLC emergency.

### 6.2 Language

#### Language Barriers and Interpretation

Interpretation that is accurate, timely, and professional was considered the most important priority for serving Punjabi speakers in health care settings. Participants report that it can be difficult accessing friends, neighbours and family members to take with them:

*When I go in the ambulance I have to take one person along with me to speak English . . . sometimes they have to take time away from their work to go to the hospital with me.*

No one was aware of the Language Line, including a physician who had recently worked at the PLC Emergency. There was some anger and incredulity that the Language Line has been available for three years, is seemingly easy to use, and yet no one has offered it to them and no one seems to know about it. No one had been offered this service even though several were recently in hospital, or had relatives in hospital. All thought that Language Line would be helpful as the wait for interpreters can be lengthy (some have reported days of waiting).

*I work in PLC emergency and I find that because you require translation you get triaged later.*

Participants strongly suggest that the Language Line and other interpretation services need to be advertised to the public and to CHR staff, and staff must be encouraged to promote and use the services.

Participants expressed concerns about not using locally available people for interpretation (Language Line). There is a perception that the USA-based Language Line is overly costly and does not use local resources and people. One participant voiced concerns that a USA-based

company supplying 140 languages represents a monopoly. It seems important to some participants that local people be involved in interpretation.

The two interpreters for this group commented that, even if ESL speakers are able to make themselves understood in English, they could be limited and not truly articulate. Both interpreters have seen numerous examples where people have not been able to express their pain, symptoms or concerns and this hinders their care. Examples given were labour and childbirth, post-partum depression, and pain.

### **Translated Material**

Translated material was thought to be valuable, but participants cautioned that people still need to be told things—they may choose to not read the information (although they can read).

It was thought that translated material on osteoporosis, cervical cancer, prostate cancer, diabetes, breast cancer, plus screening protocols, would be beneficial.

Participants cautioned that literacy levels vary and need to be considered.

## **6.3 Staff and Services**

### **Recruiting Staff**

Participants thought it was important that more staff be hired from various cultural groups. Hiring both doctors and nurses from various cultures was considered important.

### **Cultural Competency**

There were mixed experiences of discrimination with CHR staff. They were not common and seemed to depend on individuals. They commented that if more staff were trained in language and cultural issues, this will make the system more efficient and less discriminatory.

The interpreters for this group (both work in the hospital setting) noted that beyond the language barriers, patients or caregivers are sometimes not viewed as credible by CHR staff. The interpreters feel (and have experienced) that CHR staff view what the interpreters say as more credible even though they are simply interpreting what the patient says.

Some participants have experienced staff making meaningful efforts in the form of greeting patients in Punjabi and asking them to move their body in Punjabi. These efforts were considered very important and were appreciated.

Both interpreters also brought up the issue of cultural competency and that staff need to understand how others view the world, medicine and especially issues of gender. Language barriers can grow into issues that are much bigger if there are misunderstandings and cultural barriers as well.

### **Navigating the Health Care System**

People that have come from India have a different view of health care and participants thought they would benefit from education about the health care system in Canada (how it works and how they can access it). Community outreach, awareness workshops and health fairs would be helpful to educate them. They also want education about health prevention and screening.

Widespread walk-in practices create problems for patients with long waiting times, inconsistent care and mistrust, which exacerbate language and culture barriers.

Some participants noted that their doctors defer their questions and refer them to a pharmacist. They have misgivings about leaving a doctor's office so ill informed about medications, side effects, and allergies. They complain that they may not be able to communicate with the pharmacist. They also worry that they are responsible for too much of their own health information, which they may not communicate correctly (allergies).

## **6.4 Participation**

Participants suggested that there are more than twenty organizations that serve the Sikh communities who could also support diversity activities. They suggested that organizations that work within the community are the best messengers (Council of Sikh Organizations). One participant connected to the World Job and Food Bank suggested this, and other immigrant serving agencies, could help reach immigrants and offer other assistance.

Health information and education would be welcome in the northeast Sikh Temple. About 4000 members can be reached on Sundays.

Community members could be involved through a health promotion committee to assist in diversity activities.

## **6.5 Priorities**

In general the group agreed with the CHR priorities. They considered the language barrier to be the most important issue to be addressed. They felt the Language Line needs to be promoted to the relevant public and CHR staff. In addition they felt that the public (especially ethno-cultural communities) needed to be informed of their rights in reference to the health care system, including the care they are entitled to and recourse if something goes wrong. They were especially concerned for those with little or no education and/or money, and those vulnerable in other ways. In a similar vein, participants felt that educating the public (especially ethno-cultural communities) about the health care system (how it works and how they can access it) should be a priority.

## **6.6 Recommendations for Future Plans**

### **Language**

This group made a number of recommendations related to language:

- Increase access to interpretation services.
- Provide interpretation through a combination of services (telephone and in-person support) to be most effective.
- Provide CHR staff with cultural training (including how to work with interpreters and ESL speakers). This would increase the effectiveness of interpretation efforts.
- Promote/advertise the Language Line and other diversity services to relevant public and CHR staff. Signs advertising the Language Line and how it works should be written in multiple languages and posted in emergency rooms and other locations.
- Utilize more local people to provide interpretation (including Language Line).
- Provide translated material on osteoarthritis, cervical, breast and prostate cancers and diabetes and screening protocols.
- Make materials available in Punjabi but be aware of literacy limitations.

### **Education**

This group made a number of recommendations about the South Asian community:

- Educate people on their rights within the health care system.
- Conduct workshops and educate people about the health care system, how it works, what is available and how to access.
- Develop and conduct culturally appropriate awareness workshops and health fairs stressing health promotion, prevention and screening (also osteoporosis, cervical cancer, prostate cancer, diabetes, breast cancer) in Punjabi.
- Use pamphlets to inform and educate people of the importance of regular physical examinations and screening. Advertise clinical guidelines.

- Inform women of the value of prenatal classes (offer classes in various languages and make culturally sensitive).
- Translate some medical terms and situations and use this to create a display in the hospitals.
- Develop diagrams of the body and label in different languages.
- Inform the public about any telephone information health lines, even in English (pink pages in front of phone book).
- Use doctor's visits and offices to inform patients about translated materials (offering translated pamphlets).
- Explore the use of the Internet as a teaching tool but be aware that usefulness of this tool will be limited by who is able to access.

### **Staff and Services**

A few recommendations were made regarding staff and services:

- Recruit more staff from various cultures.
- Educate staff on culture issues, other views of medicine/illness, gender issues, working with interpreters and ESL speakers.

### **Participation**

Participants in this group were willing to become involved in further diversity planning and programming:

- Continue to communicate with the South Asian community and involve them in solutions. Develop a health promotion committee of people in the community to assist in diversity activities.
- Use organizations that work within the community to disseminate messages and provide assistance. There are more than twenty organizations serving Sikh communities (Council of Sikh Organizations).
- Use the Sikh Temple to reach up to 4,000 people with health information and education.
- Use immigrant serving agencies to reach people (World Job and Food Bank).

## **7.0 Themes: Vietnamese Focus Group**

*One participant recounted visiting a clinic ten years ago when he first arrived in Canada and notices recent positive changes in recognition of language as a barrier and attempts to understand culture. He noted there were pamphlets in Vietnamese and other languages and the staff were more sensitive to culture and language issues.*

*Another participant noted that he has had to interpret for his seriously ill mother and this was very difficult. Even though he can communicate in English, he found it difficult to communicate in medical language and communicate to his mother.*

*Another participant spoke of taking his mother to PLC and having to wait for a long time. They called her name but did not repeat it. He did not understand she was being called because of the language limitation. By missing the announcement of her name, his mother missed her turn and had to go back to the end of the list.*

*Another person related that he waited at the PLC for eight hours to have a back problem examined and then was disappointed by the care he received. This man felt that language and culture negatively influenced his wait time and quality of care.*

### **7.1 Sample**

This sample of ten representatives of the Vietnamese community included three females and seven males. Four were in the age range of 30-49, five were 50-64 and one was 65 or older. The session was conducted primarily in English with participants seeking assistance from the interpreter as required. This group was very interested in the planning process but time limitations made them hesitate to commit.

### **7.2 Language**

#### **Language Barriers and Interpretation**

None of the participants knew of the Language Line or had heard of anyone using it.

Language limitations were considered important barriers to good health care for this community. Participants thought the Language Line service would be very helpful. Even those conversant in English question their ability to comprehend medical terminology or even clearly articulate complex problems. They believed it would be better to communicate in their own language.

Participants thought the idea of the Language Line is good, but limited, as doctors and patients cannot be on the phone during a long procedure, for example. It was suggested that CHR staff should be educated as to when to use in-person, or telephone interpretation, and when to offer written material. CHR staff also need to know that these interpretation services are available.

Participants felt that in-person interpreters need to be specially trained in medical language and issues.

Participants expressed concern that so much time is taken up waiting for interpretation that treatment can be seriously delayed by this wait.

Another concern voiced by participants was related to the possibility of patients being discharged and they, or their caregivers, not clearly understanding how to follow through with care at home. Language can be a serious barrier to understanding this information. In addition, people may not know how, or who, to contact for clarification or help if they need it. Translated discharge material, or interpreted instructions, would be helpful. So would a telephone help line (ideally with interpretation). Follow-up procedures need to be in place so people receive proper care.

## **Translated Material**

One participant was involved in the translation of material and thinks this is a valuable contribution to health care. He and others noted that there are many in the community who could translate materials. Unfortunately, community volunteers cannot always be relied upon as they have other commitments, so professionals may be needed.

Participants stressed that people need to be aware of materials and services in order to access them.

## **7.3 Staff and Services**

### **Staff Recruiting**

Participants stress the value of recruiting health professionals from various cultures, who can speak the language and understand the culture.

### **Cultural Competency**

A participant suggested that there be an exchange of cultural information. CHR staff would benefit from experiential learning and may find new ways to care for patients. They also need to understand some of the “traditional ways of medicine.”

*Understanding and caring more is needed. Different cultures have different expectations.*

*I am not sure that health professionals are aware of services available to them. This is a two-way street. We can help them. You need to advertise to staff, not just ethnic community, that these services to them are available as well.*

Participants thought some staff seemed more aware of culture and language issues, but that number is small. They felt that it is important that staff understand the priorities in their (Vietnamese) life (solve health problem of the moment, but be aware of the pressures of daily life). They also realized that staff may not have the patience to deal with language and culture issues because they are very busy and under pressure.

### **Navigating the Health Care System**

There is a need to inform and educate the Vietnamese community about health care system (what is available and how to access resources and services).

One participant gave the example of being referred to the diabetic centre. She knows that not everyone with diabetes is referred to the centre. She wonders if this reveals inconsistencies with community physicians and their level of knowledge of services. This is a vital service for diabetics and should be offered to everyone.

## **7.4 Participation**

Many people would like to participate in future planning and activities, but time is an issue. They would like to find a way to participate as individuals and as a community.

*The CHR needs to find a way to tap into that passion for serving the community, while finding the balance of time and availability. Starting with leaders and find ways for people to participate that they are comfortable with.*

Participants said they would like to get involved at different levels (including board and committee levels). Barriers to participation include potentially intimidating processes and procedures (formal meetings, board activities). They commented that potential participants need education in processes and procedures too.

Participants noted that they would like to receive more information about the CHR's plans before they committed to anything.

## **7.5 Priorities**

This group generally supported CHR priorities. They felt that educating the public (especially ethno-cultural communities) about health care services and publicizing diversity services (especially the Language Line) was critical. They wanted education to stress health promotion/prevention as they viewed this as more cost effective. Additionally, participants thought that ethno-cultural communities should be involved at all levels of planning and decision-making. Hiring community members to undertake community outreach was viewed as important. Finally, participants stressed the importance of long-term, rather than short-term, commitments in achieving these goals.

## **7.6 Recommendations for Future Plans**

### **Language**

A number of suggestions were made related to language issues:

- Train interpreters in medical interpretation and in handling medical issues.
- Educate CHR staff on when and how to use interpretation services (telephone and in-person). Encourage them to use services, as they have control over services.
- Promote/advertise Language Line and other diversity services.
- Print language information on health care cards so that when people present their cards, staff would be alerted to the fact that they speak only Vietnamese and need interpretation support.
- Develop wallet size calendars that list CHR diversity services, such as Language Line.

### **Translated material**

Participants made a few suggestions regarding translated material:

- Translate discharge material, or interpret discharge instructions. Also, develop a telephone help line (ideally with interpretation provided) for follow-up concerns.
- Translate pamphlets explaining diversity services and disseminate through places where people access health care.
- Develop diagrams of the body labeled in Vietnamese for use in doctors' offices and hospitals. Use a lot of visuals.

### **Staff and Services**

Recommendations related to staff and services included recruiting, education and exchange of cultural information:

- Recruit staff from ethno-cultural communities and hire more ethno-cultural physicians.
- Educate staff on cultural issues, including priorities in Vietnamese life.
- Facilitate an exchange of cultural information between communities and CHR staff. Encourage experiential learning for staff so they can find new ways to care for patients.

### **Participation**

Participants in the Vietnamese group had many suggestions related to participation:

- Approach members of the Vietnamese community to translate, as there are many volunteers in this community.
- Hire more professionals to help, such as community/outreach coordinators. Suggest professionals come from the community so that they care for, and have connections within, the community. People filling these positions need passion for community.
- Educate the CHR staff and coordinators about the different strengths and resources of each community. These can be tapped into and used to benefit ethno-cultural communities and the health care system.

- Have the community coordinator work with professionals from the CHR to increase that health professional's (and CHR's) connections to the community. This would reduce problems of being compartmentalized so that the health professional can make things work well. Consider having the community coordinator and CHR coordinator work side by side in communities because there are benefits for both.
- Ask Vietnamese doctors to help, as they are key leaders in community. Doctors' offices are also a good point of information dissemination as people spend time waiting in those offices.

### **Networking and Connecting**

This group's recommendations about networking and connecting were:

- Assist in developing a health care interest/network in communities, to communicate with members, inform about services, provide a bridge to CHR and develop their own services. This is an opportunity to empower communities.
- Work through community leaders and pursue a two-way exchange of information. View the community as a valuable source of information and activity.
- Use the train-the-trainers approach, but make sure that students can be reached.
- Develop projects that are sustainable because projects that are helpful, but are not sustained, are so disappointing. Issues of trust and credibility seemed linked to sustainability.
- Communicate with the Vietnamese community through Vietnamese mass media (newspaper, radio and television), information disseminated in temple or church, and other community agencies/associations.
- Conduct surveys at community gatherings or community events to assess or evaluate. Using fun incentives might increase participation.

### **Education**

A few recommendations were made regarding education:

- Develop a prevention culture, as people are not accustomed to seeing a doctor every year. Annual checkups are not a tradition in Vietnamese culture—they only go to the doctor when really sick. Education is very important for mothers and adults who were born in Vietnam.
- Develop/offer health awareness sessions for the Vietnamese community. Education is needed in two areas: how the health care system operates and education about one's own health issues (prevention, early detection and caring for self or others during illness). Provide health information sessions to seniors once to four times a year.
- Use the Internet as a tool to share information. This could be interactive, as many people and agencies are capable of using it.

## 8.0 Themes: Chinese Focus Group

*In the Chinese community, many grown children care for their non-English speaking parents as they age. They feel the burden of interpreting for them in all medical settings (visits to doctors, hospital stays and during testing). These grown children report that this commitment to their elderly parents interferes with work and home life. Some comment that their jobs have been jeopardized at times.*

*One participant expressed his concern: “My father had a problem with his liver and I had to take him to the hospital all the time and family is getting pulled in all directions. Every time we go there they expect us always [to] bring an interpreter and it is much strain on family members.”*

*Grown children feel they are often unable to interpret accurately for their parents in relation to medical jargon and descriptions. It was also noted that in some cases it is uncomfortable to interpret for parents around sensitive topics.*

*Another participant recounted a situation when he called 911 on his cell phone and was unable to make himself understood in English. He noted that he would have benefited by being able to communicate in his first language.*

### 8.1 Sample

This sample of ten participants from the Chinese community, seven females and three males, consisted of seniors, some in the company of their grown children, community support people who were sometimes asked to interpret or refer people to resources, and other adults from a range of circumstances, including some caring for elderly parents. One participant was in the age range of 18 to 29, five were 30 to 49, one was 50 to 64 and three were 65 or older. Less than half of the participants were comfortable in English so the entire session was interpreted in Cantonese and, when required, Mandarin.

### 8.2 Language

#### Language Barriers and Interpretation

Participants agreed that the CHR should have more interpreters and that generally there should be more community resources and supports to assist minorities. They felt interpreters should be trained in medical terms and treatments, and have an understanding of services and resources so they can be effective.

None of the participants knew that a Language Line interpretation service was available to them. One participant related that someone she knew had asked for a telephone interpretation service and was told that it was very expensive and only used in emergencies (this was in a hospital, but non-emergent setting).

Participants also said they had not been offered help with interpretation in the hospital setting. In fact, one participant recounted a story of asking for interpretation in an emergency room and was told that this was not available in any form. Participants worry about the care the elderly receive when the grown children cannot be present to interpret all of the time. They also cannot imagine how elderly people without family assistance to interpret cope in the medical setting.

The elderly participants and grown children agreed that the Language Line telephone interpretation would be helpful. They reported that interpreting for elderly parents in all settings is a great burden and it would be a relief to know that interpretation could happen without them.

Participants worried that the Language Line would be difficult to access initially. For example, if a non-English speaker went to the emergency, how would they let the staff know if they spoke Cantonese or Mandarin. This was perceived as a major barrier. In addition, they suggested that interpretation services should be available at the point of emergency contact (911 service).

Participants also saw the need for interpretation services in the community (offices of general physicians and specialists) as this is often where a medical diagnosis is made and where interpretation can be difficult.

Participants also commented that no one would access the service if they did not know about it. Elderly people may not access the care they need if they felt that interpretation would not be available to them. Participants also cautioned that the elderly might be overwhelmed if they had to initiate the telephone service themselves and were reassured when they understood that CHR staff would initiate the service.

Participants believed that CHR staff must not be aware of the Language Line service (and how it works) and that this would have to change if the service was to be successful. They also felt that CHR staff should be trained to work effectively with interpreters.

A few participants who are community support workers report that they experience misgivings in trying to interpret medical information for clients because of concerns about accuracy and client privacy. These participants also report that people tend to seek interpretation and translation help at community support agencies.

### **Translated Material**

Participants were very interested in translated material, especially those working in community support. None of the participants had seen CHR's translated material. Participants agreed that translated material should be available so people can understand the health care system and the services available.

Participants suggested the development and distribution of a survival guide (similar guides on other topics were viewed as effective) to promote translated materials and CHR services for clients. They suggested that these be distributed to clients through community agencies.

They also agreed that having a single contact person within the CHR would be helpful in terms of acquiring and distributing information, materials and resources.

A suggestion was made to develop an English/Chinese phone directory consolidating relevant services and resources. A further suggestion was made to educate non-English speakers on how to access medical services (both emergent and non-emergent care). Include information on basic communication of health problems, how to use interpreter services, strategies to use when staying in hospital and basic prevention and screening information.

Some participants were aware of translated health information being available on the Internet but acknowledged limited computer access and ability with seniors. Community support workers were interested in using the Internet to assist them in helping clients. They reported Internet use was increasing with all clients.

## **8.3 Staff and Services**

### **Staff Recruiting**

Participants identified a need to hire more Chinese professionals. Many trained professionals cannot practice due to language barriers. They would like to see the CHR offer ESL medical training to help these trained professionals practice. Some commented that it is hard to see a professional doctor work as a cook in Canada.

### **Cultural Competency**

Participants generally felt that CHR staff tried to be respectful and responsive to their needs, or to the needs of their parents/clients. Several did report that they felt that staff expected the family to provide interpreters all of the time and this created a strain on families.

## 8.4 Participation

Participants suggested that CHR involve community agencies in identifying Chinese radio, television, newspapers to use for publicity and other ways to share information with the community.

The perception is that people have no idea how they can help or become involved with diversity services. They need more information about how they can participate. It was also noted that lay people have no idea how they can effect policy, serve on a board or committee, or take on a meaningful role. More community consultation is required, as is increased education about CHR structure, services and processes.

Participants suggested that the Calgary Chinese Community Service Association (CCCSA) should/could:

- distribute information and disseminate material to clients in several ways
- host a health services information workshop for the community
- include information in a newsletter

## 8.5 Priorities

This group generally agreed with CHR priorities. They stressed the need for increased access to trained professional medical interpreters (both in-person and telephone service) including access in GP and specialist offices. In conjunction with this, awareness of interpreter services and other diversity services needs to be increased with ethno-cultural communities and agencies and with CHR staff. Recruiting more Chinese speaking CHR staff and increasing the number of Chinese physicians in the community would also help. Participants felt that the Chinese community needed access to education (including translated materials) on the health care system, CHR services, diversity programs and services, women's health, and major diseases. This group also emphasized that developing and delivering diversity services is a long-term commitment. Trust and credibility are important to effective services and participants hoped that anything started up in diversity services would be sustained.

## 8.6 Recommendations for Future Plans

### Language

This group made a number of recommendations related to language issues:

- Increase the number of trained interpreters and increase their availability.
- Increase access to interpretation services by promoting/advertising services (and how they work), making them easier to use.
- Inform CHR staff of interpretation services and encourage their use. Train CHR staff to work effectively with interpreters.
- Extend the Language Line and other interpretation services so they are available system-wide (general physician and specialist offices). Interpretation services should be available at the 911 emergency call centre because health care actually begins at that point.
- Develop strategies for non-English speakers to communicate their language needs so they can access the Language Line.
- Broadcast information about interpretation and other diversity services on Chinese radio, TV and/or newspapers.

### Translated Material

Participants' recommendations about translated material were:

- Translate material on the health care system (how it works and what is available) and disseminate through community support agencies.

- Develop a survival guide that promotes translated material and CHR services. Disseminate it through community support agencies.
- Develop a Chinese/English phone directory consolidating relevant services and resources.
- Translate material on major issues like women's health, diversity programs, and major diseases (cancer, heart).

### **Staff and Services**

Participants suggested that the CHR hire more Chinese professionals (also needed in community) and offer ESL medical training to help their practice.

### **Participation**

Participants had several ideas regarding participation in diversity planning and programming:

- Involve community agencies in identifying Chinese radio, television, newspapers to use for publicity and other ways to share information with community.
- Do more community consultation and increase education about CHR structure, services and process needed.
- Have the CHR take on a more active role in informing communities how they can participate in health care planning in a meaningful way (influencing policy, serving on boards and committees).
- Ask community agencies, like the Calgary Chinese Community Service Association, to host events and disseminate information through their activities.

### **Networking and Connecting**

This group's recommendations about networking and connecting were:

- Identify a single CHR contact so communities and agencies know how to acquire materials, identify resources and get information.
- Involve corporations and businesses (Telus, Bank of Hong Kong and others) in awareness and education efforts and other initiatives.
- Develop and deliver diversity services as a long-term sustainable commitment.

### **Education**

Several recommendations were made with respect to education:

- Develop and disseminate strategies for non-English speakers on how to access medical services, communicate about health problems, and work with an interpreter.
- Provide information on illness prevention, screening, and strategies to cope when staying in hospital.
- Distribute information and disseminate material through doctors' offices (especially those in Chinatown) as this is a good place to promote services.
- Develop and conduct community health and awareness workshops at community service agencies and with community leaders and support workers. Have health professionals involved in delivery of the workshops. Consider modeling workshops on health issues that are already established and work well (diabetes education).
- Use the Internet to educate community agencies and connect them with existing information to assist clients.

## 9.0 Themes: Iraqi Interviews

*One man talked about a verbal confrontation he had with a hospital manager over needing a female doctor for his wife who was in labour (his wife's doctor was a female but was not on call at the time). The manager threatened to call a security guard. The husband said, "You can't force us to see a man." The manager eventually found a female doctor. "I don't know why he didn't do that sooner. Other people in our community have had similar problems."*

*A participant remembered an experience he had several years ago when interpreting for a friend whose child was ill. Although the participant understood some English, he did not know what the doctor meant when he asked about "diarrhea." Eventually, through much explaining on the doctor's part, he understood.*

*One family has a disabled school-age daughter. When they attended their first appointment at the children's hospital about one year ago, an interpreter had already been arranged by the hospital and was waiting for them. This was very helpful. This family has since attended many hospital appointments, usually with an interpreter present. While the father speaks some English he has difficulty understanding and translating medical discussions. The interpreter has made it possible for the parents to be completely involved in their daughter's care.*

### 9.1 Sample

Nine interviews were conducted with a total of fifteen participants: nine males and six females. All had been in Canada for six years or less and most were young married couples. One participant had his elderly mother living with him. Some participants spoke English to varying degrees but vocabulary was often very limited. An Arabic interpreter was present for all interviews to provide assistance as necessary. Some conversations were considered so private by several participants that they asked the male interpreter to leave the room when they were interviewed and had their husbands interpret.

### 9.2 Language

#### Language Barriers and Interpretation

Only one participant knew of the Language Line because he had seen an English language sign at the children's hospital advertising the service. None of the participants had used this service or heard of anyone using this service.

When they were told about the Language Line, most participants asked whether their family physicians could use the service. They said it would be extremely helpful if they could, since husbands often need to take time off work or school to attend doctors appointments with their wives. Most families in this group have had frequent contact with the health care system through pregnancy, childbirth and caring for young children.

Iraqi people who speak some English do not always recognize the English terms for illnesses and medical conditions. Many participants said they found health history forms difficult to complete.

*Medical terms are something you don't learn at school.*

*I looked at a list of 30 [diseases and medical conditions]. I only knew a few of them.*

They were concerned that misunderstandings may cause problems with medical treatment. Participants also said they have difficulty explaining medical problems.

*The doctor said, "allergic." I didn't understand what "allergic" meant.*

*I was asked [by the doctor] about her [daughter's] birth history. I didn't know the words.*

### **Translated Material**

The literacy rate in this community is very high. Participants said, "Everybody who can speak Arabic can read Arabic." It was mentioned that literacy could be an issue with the elderly, but there are very few elderly Iraqis in Calgary.

Several participants mentioned the book "From Here to Maternity" that was given to them by their doctor or health clinic. It contained much useful information but was available only in English. One woman read the book by herself, using an Arabic/English dictionary to translate as she went along. Usually the women relied on their husbands to translate important pieces of information.

*The husband has to translate the whole book! Who has a husband that will do this?*

*I [husband] asked the doctor what is most important. He marked eight or nine pages and I translated those.*

The family with the disabled daughter found it difficult to remember the details of her physiotherapy instructions and would have found Arabic written instructions useful.

*It would be useful to have had her physiotherapy [instructions] in Arabic [written]. My wife does a lot of it [physiotherapy] at home. Now my daughter understands English more so she can help.*

Several participants had seen Arabic materials in their doctors' offices. Two people were given Arabic booklets on pregnancy and birth. One woman said she heard there were Arabic pamphlets available in the hospital (maternity) but she looked and could not find them.

It was noted by some participants that the Arabic immunization information they received at the health clinic was useful and easy to understand.

A few participants have accessed Arabic health information on the Internet. The translator and a participant estimate that 50% of people in their community have access to the Internet. Also of interest, most Iraqi people interviewed in the course of this research watch Arabic language television (many stations) through satellite television.

## **9.3 Staff and Services**

### **Recruiting Staff**

Many participants thought it would be valuable to hire staff from a wide range of cultures who spoke a variety of languages.

### **Cultural Competency**

Participants felt it was important that CHR staff learn about the values and practices of people of different cultures. Cultural traditions are important to this community and, as one man said, "We would like to keep our culture."

A few women felt they did not receive enough emotional support from the nurses in the hospital, although it's not certain whether this is a language/cultural issue or related to other barriers. For example, a young Iraqi mother felt that her nurse "gave up" when it was clear she was going to miscarry early in her first pregnancy. Although her husband was present and offered emotional support, she would have liked the nurse to hold her hand or comfort her in some other way. Another woman commented on the emotional distance of the staff who cared for her in the hospital.

## **Navigating the Health Care System**

Several participants said they wish they had more information about how the health care system works when they first arrived in Canada. For example, they would like to know how to access services and what services are covered (what if they need an ambulance but can't afford one). One person was given an Arabic language booklet in London, Ontario that explained the health care system. It was very useful. He has not seen a similar booklet here.

One participant explained the difficulty he had in accessing services for his elderly mother (wheelchair, specialist services). He said he would find it useful to have information in Arabic about the medical rights of older people, what was covered by health care and how to obtain aids to daily living.

## **Pregnancy and Childbirth Issues**

Most families interviewed had recently been through the birth of a baby or were awaiting a baby. A number of language issues around pregnancy and childbirth were identified. The interpreter and a participant speculated that 90% of Iraqi people in Calgary are "having babies."

Hospital staff do not always provide Arabic interpretation when needed. For example, the staff was having difficulty trying to teach a new Iraqi mother about caring for her baby. They brought in a nurse who spoke a different language to teach her about breastfeeding, but the nurse was Pakistani and spoke Urdu, not Arabic.

One woman commented that she didn't know what to do to take care of her baby. She eventually found an Arabic speaking nurse and asked her what to do.

Many participants had accessed the Best Beginnings program during their pregnancy. Some attended classes at an Iraqi family's house, others attended classes at a church or other location. All women who took part in Best Beginnings said they found it useful. Many had Arabic interpretation for the sessions. However, Best Beginnings was not available to all women. For one woman, there was no Best Beginnings with Arabic translation in her local health clinic (North Hill). For another woman, there was not enough space in the Best Beginnings class until she was in her ninth month of pregnancy.

*They said they were busy and did not have enough room for new pregnant ladies.*

Some women found video instruction useful, even English versions. One woman had a baby who was in a brace to treat hip dislocation. The hospital gave her a videotape explaining how to care for a baby wearing a brace. The woman found it helpful, even though she could not understand most of the English instruction. Another woman borrowed English videotapes from Best Beginnings and found them helpful, although she could not understand most of the English instruction.

While the traditional Iraqi birthing experience is different from in Canada (father not present for birth, babies often born at home, female relatives provide assistance after birth), none of the women interviewed saw these particular factors as being negative. However, some were concerned over what they saw as other differences in health care practices. For example, one woman complained that the staff "turned the baby over roughly." Another said, "They take too much blood from a tiny baby." The women said they would have felt better if the staff explained what and why something was being done. It was speculated that language was a barrier (or perceived barrier).

One woman expressed concern over not being able to obtain vegetarian meals in the hospital, although this was not a problem with others. Most families seem to favour the food brought in by their friends and family and were able to store the meals on the unit.

## **Physician Gender**

Almost all participants had major concerns about not always being able to locate a female physician for Iraqi women. For religious reasons, Muslim women cannot see a male physician, nor can Muslim men see a female physician. This is a cultural taboo—seeing a physician of the opposite gender would be extremely traumatic, not just mildly embarrassing. Two families had experiences where their situation (impending miscarriage) was made far more stressful because they had to wait many hours in hospital emergency for a female physician.

This taboo against seeing a physician of the opposite gender is so strong that two women remarked they would rather die than be examined by a man.

*Even if I die, I won't let any male doctor inside the room.*

*If I would die, I will still not make an appointment with a man doctor.*

## **9.4 Participation**

Participation in diversity planning and programming was discussed less in the Iraqi interviews than in the focus groups. One participant said she would be willing to help develop a list of health and childcare practices that were common with Iraqi people, but were considered unhealthy or unsafe by Canadians. The information could be used to educate staff on how to work with cultural differences. For example, in the “kimaat,” a young infant is bundled in a blanket and then wrapped with a long thin strip of fabric. Many Iraqi people believe this will make the baby stronger. However, there are concerns that the long thin strip of fabric may endanger a baby (strangulation) if it came undone.

## **9.5 Priorities**

All participants agreed with the list of priorities when asked. Everyone said all items were important and several identified access to telephone translation services as being the most important. Three exceptions were: one person said Best Beginnings was the most important service, another said the CHR should hire more staff that speak Arabic and another said the CHR should accept more foreign trained doctors.

## **9.6 Recommendations for Future Plans**

### **Language**

Most recommendations by this group centered on language issues:

- Produce more medical information in multiple languages. Include information specific to individual situations (physiotherapy instructions). Contact more established Iraqi communities in Canada (Toronto and Montreal) to find out what health resources are available in Arabic and could be adapted for use in Calgary.
- Promote the Language Line so staff and patients know about it. Post multilingual signs in locations throughout the health care system advertising the Language Line.
- Make the Language Line service available throughout the health care system, including the offices of family physicians, specialists and dentists.
- Ensure important signage is in multiple languages (“Tell us if you are you pregnant” sign at dentists’ offices and X-ray departments).
- Develop (or locate and reproduce) an Arabic/English list of common medical terms, diseases and disorders. While a new Canadian may seem to understand and speak English to some degree, they often do not know the medical terms, diseases and disorders.

## **Education**

The Iraqi participants offered a number of ideas related to distribution of information and educating the community.

- Provide information about accessing the health care system, diversity services and availability of translated materials to new immigrants when they first arrive in Canada. (In Calgary refugees stay at Reception House when they first arrive.). Information should be provided through a combination of presentations (with an interpreter) and Arabic written information.
- Distribute translated information on accessing the health care system, diversity services and availability of translated materials through Reception House, family doctors (especially those who have a large multicultural practice) and hospitals. Multilingual signs should be posted to say the material is available.
- Distribute health information in Arabic on the Internet. The Arabic interpreter and some community members estimate that 50% of Iraqis in Calgary have access to the Internet.
- Distribute information on health issues and diversity services (Best Beginnings, Language Line) in Arabic supermarkets and other stores, mosques (“But remember, not all Arabic people attend mosque just as not all Christians attend church.”) and places frequented by Arabic people.
- Find a representative in the community who could act as a link with the CHR. This would provide the Iraqi community with a single, visible source of information about CHR programs and resources, and would provide the CHR with a communication link.
- Publish information on health issues, diversity services and multilingual programs in Arabic publications. There is a new Arabic newspaper produced by and for the Iraqi community in Calgary whose editor (one of the interview participants) suggested a section on health questions and answers—readers submit questions and, if someone from the Calgary Health Region provided the answers in English, the editor would translate and publish both the question and answer in Arabic. (Newspaper contact info: Albayan, Box 21173, 665 – 8 St. SW, Calgary AB, T2P 4H5. Editor is Sattar, 686-3372.)

## **Staff and Services**

Several suggestions were made in relation to CHR staff and services.

- There is a critical need to recruit more female physicians due to the fact that Iraqi women cannot be examined by male doctors.
- Hire foreign trained physicians. This would help the CHR to better meet the needs of a multicultural population.
- Recruit more multicultural staff so more lay interpreters are available.
- Expand multilingual programs that are in high demand and have long waiting lists (Best Beginnings).
- Educate CHR staff about the culture and traditional health and child care practices of the Iraqi people. Encourage an understanding of traditional practices (baby care, nutrition) so they can be safely adapted. Use local people in a cultural exchange of information.

## **10.0 General Themes Across All Groups**

There were several themes that emerged as commonalities across all of the groups and with interview participants. In addition, several themes were common to most groups and some of the interview participants. These common themes are outlined below.

### **10.1 Language**

All participants felt that language was the biggest barrier to health care among ethno-cultural communities and many felt that their care (or the care family) may have been compromised due to an inability to communicate. Participants thought that increased access to and consistency of professional medical interpretation increase the quality of their health care. Some went further suggesting that this access should be a universal right. Only two participants had heard that a telephone interpretation service existed and none of the participants had used it and, most disturbingly to them, no one had been offered the service. All participants thought that the Language Line would be valuable and wanted increased access to it, and, where possible, in-person interpretation. They recommended that the Language Line be made available throughout the health care system, particularly in physicians' offices. Participants stated that the onus for interpretation falls with the family and this can be a burden in terms of time commitment, worries about accuracy and the inappropriateness of interpreting around sensitive health issues. Advertising the Language Line in ethno-cultural communities and among CHR staff was thought vital.

Representatives of immigrant serving agencies and ethno-cultural community organizations voiced serious concerns over issues of accuracy and liability when they were doing medical interpretation. Training and standards were thought to be helpful. Additionally, shrinking funding and staff time have reduced their ability to offer interpretation.

Some participants have seen a few translated health materials and found them very useful. Additional translated materials would be most welcome by all ethno-cultural communities. Participants cautioned that literacy levels vary and need to be considered. It is essential that materials be effectively distributed. Immigrant serving agencies and support organizations would eagerly distribute materials, especially those that are exact and clear and do not require a lot of explanation. In addition to the above, participants offered other distribution strategies, including doctors' offices, places of worship, shops and other places frequented by people of ethno-cultural communities. Effective distribution requires a mechanism to communicate with agencies, organizations and communities about materials and information (single CHR contact person, Internet and presentations). Participants felt that translation expertise could be found within the ethno-cultural communities.

### **10.2 Staff and Services**

All groups and most of the interview participants felt they lacked understanding about the health care system (how it works, what services are available, how to access resources). They agreed that there is a strong need for members of ethno-cultural communities to be educated about the health care system and receive printed reference materials on the topic in their first language.

Another theme voiced by all participants is the importance of CHR staff learning about the values and practices of people of different cultures. Suggested strategies included: an exchange of information at cultural awareness workshops, connecting with leaders of various ethno-cultural communities and communicating with immigrant serving agencies.

Another point stressed by all participants was the need to educate CHR staff as well as ethno-cultural community members about the Language Line (and other diversity services). They offered many ideas on dissemination of information. Many participants noted the Best Beginnings program (with and without interpretation) was extremely beneficial.

Most participants agreed it was important that the CHR hire more foreign trained health care professionals. Some recognized that standards and an accreditation procedure must be in place

for this to happen. This would help reduce some of the language barriers and would benefit the ethno-cultural communities in other ways.

The issue of physician gender came up in only two ethno-cultural groups (Hispanic and Iraqi) but the concerns of some participants regarding the need for female physicians were so strong that it is addressed here. There is a critical need to recruit more female physicians due to the fact that women in some ethno-cultural communities (Iraqi) cannot be examined by male doctors for cultural/religious reasons (to point, some participants said they would rather die than be examined by a male doctor).

### **10.3 Participation**

Participants supported diversity services in principle and were interested in the planning/participation process. Various individuals, from all of the groups and some of the interviews, offered to participate in specific ways (translate material, explain cultural traditions, help access other community members). Agency and organization representatives similarly offered their services and those of their organizations (distribute material, access community leaders and networks).

Focus group participants envisioned a range of participation, from focus group membership to serving on boards and committees. Many participants felt that in order to effectively participate and inform changes they would require education about the CHR and how to serve on decision/policy making bodies. For others time was a constraint to potential participation but they wanted to support diversity services in some way.

Many participants suggested tapping into community strengths, existing networks and identifying leaders and community volunteers. Offering honoraria shows respect for time and energy and was welcomed.

### **10.4 Priorities**

All groups and interview participants considered addressing language barriers the highest priority. Although all of the groups sanctioned increased access to professional medical interpretation, two groups (immigrant serving agencies, South Asian) felt strongly enough to lobby for the right to professional interpretation in the medical setting.

Another priority that all of the groups and many interview participants endorsed was the need to promote diversity services, especially the Language Line, with all ethno-cultural communities, organizations and immigrant serving agencies. It is absolutely essential that CHR staff know about the service because they control access to the Language Line.

Educating ethno-cultural communities and organizations and immigrant serving agencies about the health care system in general, and diversity services specifically, was considered critical by all of the groups. Education was also essential for meaningful participation. Participants felt that immigrants need to be informed about how the system works, what is available, associated costs and how to access services and resources.

Three groups and all interview participants felt that recruiting and training staff from various cultures was a priority. Some recognized that standards and an accreditation procedure must be in place for this to happen. Additionally, these groups wanted gender to play a role in recruiting, as more female physicians are desperately required for some communities. Groups stressed that these professionals were needed in the community, as well as in hospitals.

Three groups also lobbied for active ethno-cultural involvement that would include participation at all levels of planning, policy and decision making. Board and committee involvement was considered necessary for the best diversity planning. Participants also agreed that developing and delivering diversity services should be a long-term commitment.

Three groups also felt that outreach, in the form of a member of the community hired to educate and connect, was an effective way to achieve some of the priorities. Health fairs, workshops and other educational strategies were considered positive ways to connect with communities.

## **10.5 Common Recommendations for Future Plans**

The following recommendations were common to all, or almost all of the focus groups, and the interview participants where noted.

### **Language Barriers and Interpretation**

All groups and interview participants offered the following recommendations on language barriers and interpretation:

- Increase access to professional medical interpretation (Language Line and in-person interpretation).
- Offer the Language Line throughout the health care system, including general physician and specialist offices and clinics.
- Advertise diversity services, most especially the Language Line, to ethno-cultural communities and organizations, immigrant serving agencies and CHR staff.

Several groups and interview participants suggested that the CHR:

- Provide multi-language signage at hospitals and other locations where services are offered.

Several groups also recommended that the CHR:

- Consider professional training for interpreters and take into account issues of gender and culture.
- Consider using local expertise for interpretation services.
- Develop strategies for non-English speakers to access interpretation and facilitate their access.
- Encourage use of the Language Line and other interpreter services among CHR staff.

### **Translated Material**

All groups and interview participants recommended that the CHR:

- Develop, identify and disseminate translated material for ethno-cultural communities, but research literacy levels for particular audiences.
- Develop, identify and disseminate translated material to educate ethno-cultural communities about the health care system (especially diversity services), the availability of services and resources, how to access them and associated costs.
- Develop, identify and disseminate translated material on health issues; examples given included medical procedures, discharge/home care information, screening protocols, mental health, women's health, maternity information and major diseases.
- Disseminate translated material through agencies, organizations and physicians' offices frequented by ethno-cultural communities.

### **Staff and Services**

All groups and interview participants recommended the following about CHR staff:

- Recruit health professionals (especially physicians) who represent ethno-cultural communities and speak various languages (encourage and support the recruitment of foreign trained professionals).
- Educate CHR staff on cultural matters including gender sensitivities, involve local expertise within ethno-cultural communities.

Several groups and interview participants recommended that the CHR:

- Recruit female physicians (with a strong emphasis on Arabic and Spanish speakers).
- Offer training for CHR staff on working with interpreters and ESL speakers.
- Expand the Best Beginnings program as it was thought to be very successful.

## **Participation**

All groups and some interview participants recommended the CHR:

- Approach ethno-cultural community members, organization and immigrant serving agencies to participate in planning, developing and delivering diversity services.

Several groups also recommended the CHR:

- Involve ethno-cultural communities in all levels of policy and decision-making.
- Develop interactive relationships with ethno-cultural communities to exchange information, networks and connections.
- Employ community members to conduct outreach; identify and work through leaders.

## **Education**

All of the groups and the interview participants recommended that the CHR:

- Educate ethno-cultural communities about the health care system (especially diversity services), the availability of services and resources, how to access them and associated costs. Various education strategies were suggested including, awareness workshops, health fairs, translated written material, Internet/website, outreach workers, public library and ethno-cultural television, radio and newspapers.

Several groups also recommended that the CHR:

- Educate the public (especially ethno-cultural communities) about their rights within the health care system.

## **Delivering Diversity Services**

Several groups recommended that the CHR:

- Facilitate the sharing of strategies between ethno-cultural members to cope with the health care system.
- Provide a recognizable contact person within the CHR as a link for immigrant serving agencies and community organizations to provide information and resources.
- Commit, where possible, to longer term sustainable projects.

## 11.0 Conclusion

The purpose of this research was to:

- 1) give the CHR feedback on the changes they have made to services
- 2) provide input regarding future plans to address issues identified by ethno-cultural communities
- 3) identify ways that ethno-cultural communities and individuals in those communities can contribute to the CHR planning

Five focus groups and nine key contact interviews (n=71 participants) were undertaken by external consultants to assess the response of ethno-cultural communities to diversity services already offered and those planned for the future. Representatives from the following groups were recruited to participate in the focus groups: immigrant serving agencies, the Hispanic community, the South Asian community, the Vietnamese community and the Chinese community. Key informant interviews were conducted with members of the Iraqi community.

It is apparent that language is a major barrier to effective health care for many people in ethno-cultural communities. The Language Line would be of great assistance to non-English speakers but it is under-utilized—none of the participants in the focus groups and interviews had used the Language Line, only two had heard about it and none had been offered it. Those who were unaware of the Language Line included representatives of immigrant agencies, many of whom are asked by CHR staff to provide interpretation services in the hospitals. Participants recommended that the Language Line be made available throughout the health care system, particularly in physicians' offices. Some participants reported alarmingly long delays due to having to wait for interpretation. The Language Line, and other diversity services, must be promoted within the CHR, to immigrant serving agencies and to members of the non-English speaking public.

Members of ethno-cultural communities welcome translated material. Many were not aware of the translated materials currently available. Once developed, there must be a mechanism in place to distribute and promote translated materials to CHR staff and the non-English speaking public. Immigrant serving agencies can play a role in distribution.

Immigrant serving agencies are willing to help with interpretation and translation, but funding is diminishing and concerns around liability are increasing. Family and friends are often burdened by the need to provide interpretation in health care situations. There are also concerns of inaccurate interpretation when the subject is medical information. Accurate interpretation by trained medical interpreters was considered essential.

Some language and other cultural barriers would be reduced if the CHR hired more ethno-cultural staff. In particular, there is a critical need for female physicians who speak the language (Arabic, Spanish) and are culturally competent. Cultural training for all staff would be helpful, especially if it is done through a two-way exchange of information. Again, immigrant serving agencies and ethno-cultural communities are more than willing to help in this area.

There is a large information gap in ethno-cultural communities about the health care system. Information resources in multiple languages are required, along with a system for getting the information out to new immigrants and immigrant serving agencies. Some participants noted that they would like to know more about their rights as patients. (Author's Note: An extremely useful resource on patient/parent rights and responsibilities can be found in *the Alberta Children's Hospital Parent Orientation Handbook*.)

People from ethno-cultural communities are eager to participate at different levels in diversity planning and service provision, but they need to understand the system and what is required of them. Immigrant serving agencies welcome the opportunity to share their ideas and skills.

This research identified many opportunities for the CHR to enhance current diversity services to reduce cultural and language barriers for members of ethno-cultural communities.

## Appendix A: Description of Diversity Services



calgary health region

## Diversity Services

### Meeting the needs of different cultures and ethnic communities

At the Calgary Health Region (CHR) we have been changing the way we do things to better meet the needs of everyone in Calgary. To do this, we've worked with a number of immigrant serving agencies and members from different ethnocultural communities to find out what the needs are and how we can improve. We've also set up a Regional Diversity Steering Committee to guide our work, receive input from stakeholders and monitor our progress.

### What We've Done

#### Language Services

- Translated many **pamphlets** into different languages (Examples: infant/child health and safety, vaccination, family planning materials).
- Increased **over-the-phone interpretation** (Examples: 24 hr. service in emergency departments and maternity units as well as services in Oral Health, Home Care, Tuberculosis Clinic, Communicable Disease Unit, Grace Women's Health Centre, 8<sup>th</sup> & 8<sup>th</sup> Health Centre, and several Community Health Centres).
- Offered more **health services in different languages** (Examples: perinatal education is now offered in six languages, speech and language services are available in Spanish and Cantonese).

#### The People Who Provide the Services

- Trained staff on how to **work with interpreters**.
- Gave **workshops** to staff to increase their understanding of other cultures.
- Educated staff on cultural issues around **mental health**.
- Hired more **multicultural outreach workers** to provide outreach services and health education for clients who speak different languages.
- Hired more **staff** who speak more than one language.

#### Other Changes

- Educated new Canadian families by coordinating **awareness workshops and resource fairs**.
- **Organized committees** to advocate for clients and support policy development related to diversity services.
- Piloted a language and culture project for **Russian and Yiddish** speaking seniors.

### Our Priorities

- Consult and **network with staff, partners and members** of cultural and ethnic groups.
- Train staff on **cultural issues**.
- Recruit staff who **speak more than one language**.
- Provide **trained health care interpreters**.
- **Translate** health education materials.
- **Evaluate** the changes we've made.

### What We Plan to Do

#### Language Services

- Increase the number of **health services** that are offered in different languages.
- Expand the use of **over-the-phone interpretation**.
- Increase access to **trained health care interpreters**.
- Increase access to **translated materials**.

#### Other Plans

- Develop a plan to **hire and retain qualified multicultural staff** to address the health care needs of the communities we serve.
- Develop **strong partnerships** with immigrant serving agencies, ethnocultural groups and communities to reduce barriers and enhance the delivery of health services to people in ethnocultural communities.
- Provide more **cultural training** for staff.
- Develop meaningful **evaluation criteria** to assess the impact of our changes in services.
- **Communicate** with our partners and the public about the changes we've made.

### Future Involvement

- Expand the involvement of members of **ethnocultural communities** in planning activities.

## Appendix B: Focus Group Guide

### DIVERSITY FOCUS GROUP GUIDE

#### A *Stories in response to current services*

1. The Calgary Health Region has been trying to make it easier for people from ethno-cultural communities to access health care services? Can you briefly share any experiences you have had, or changes you have noticed with health care services in the last year or two? Have you heard stories from others?
2. Can we list some of the positive changes and why they are working?
3. Can we list some of the challenges that remain? Why do you think they remain?
4. Of the services/changes that are working well, which are the most important?
5. Of the issues that need more work, which are the most important?

#### B *Priorities*

6. Are your priorities similar to the CHR's priorities?
7. Where have you seen these priorities reflected in CHR services? Where are we not reflecting these priorities?
8. What priorities would you like to add?
9. What priorities would you eliminate?
10. Given these priorities, what is the best use of resources?

#### C *Future Services*

11. Keeping in mind the priorities we have just discussed, what do you think of the proposed future plans?
12. Do these future plans seem relevant/make sense to your community?
13. If you could modify this plan for services, what would it look like? What would you add? What would you delete? (Probes: **common services, attitudes, facilities, programs, supports**)
14. What additional ideas do you have for addressing the specific health needs of your community? (Probes: **selected population groups, mobile clinics, workplace, occupational health programs**)
15. How will we know when we are succeeding (evaluate/measure success)?

#### D *Future Involvement*

16. As the Calgary Health Region continues to plan and implement service changes, how can you see yourself/your community contributing to this process? (Probes: **committee or board member, volunteering to do translation, advisory role, focus group member**)
17. What help/support would you need to do this?
18. Who else should be involved in this process? (Probes: **other organizations, your community group**)
19. What strategies/services/agencies could complement what the Calgary Health Region is doing?

#### E *Close and Thank You*

20. Is there anything we haven't talked about that you feel is important?
21. Please feel free to sign up to receive a summary of this report (circulate sign up sheet).

# Appendix C: CHR Consent Form

## Interview Participant Consent Form Regional Diversity Steering Committee Project Calgary Health Region

Calgary Health Region vision states that “Respect for diversity will be fundamental and integral to the Calgary Health Region workplace and to the populations served.” The Region’s Regional Diversity Steering Committee operates on this principle and seeks to enhance the abilities of the Calgary Health Region to address issues related to diversity.

Your signature on this form is written confirmation of your willingness to participate in this interview. This form also describes the purpose of the interview and what your participation involves. A copy of this form will be given to you.

### Purpose

The purpose of holding this discussion is to provide an opportunity for you to:

- give us feedback on the changes you have seen in services to date;
- provide input regarding our future plans to address issues identified in your community; and
- identify ways that your community can contribute to Calgary Health Region planning.

### Participation and Confidentiality

Your participation in the discussion is voluntary. If you choose to participate, we will record your answers to the questions; however, we will not record your name. We would like to tape record what you have to say so that we don’t miss anything or change the words that you have used.

The information you provide is confidential. Information from the interview will only be used in a consolidated form which means that it will not be possible to identify individual people or their comments.

### Understanding of the Participant

If you sign this form, it means that you understand and agree with what we have said above. In no way, however, does it waive your legal rights or release evaluators, sponsors or involved institutions from their legal or professional responsibilities. You are also free to withdraw from the interview at any time you may wish.

Your participation in this discussion will in no way jeopardize your health care.

For further information please call Bretta Maloff, Community Development Leader, Healthy Communities at 943-8007.

\_\_\_\_\_  
**Your name printed**

\_\_\_\_\_  
**Your signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of the Interviewer**

## **Appendix D: U of C Consent Form**

### ***Research Project Title: Effective Participation at the Regional Level in Health Policy Development and Implementation***

**Investigator(s):** Wilfreda E. Thurston Associate Professor, University of Calgary (U of C)  
Judy Bader, Executive Director, Healthy Communities, Calgary Health Region  
Ann Casebeer, Adjunct Assistant Professor, U of C  
Bretta Maloff, Leader, Community Development, Healthy Communities, Calgary Health Region, and Adjunct Lecturer, U of C  
Ardene Vollman, Associate Professor, Faculty of Nursing, U of C  
Myron Weber, Associate Professor, Faculty of Management, U of C

**Sponsor(s):** Alberta Health Foundation for Medical Research  
Calgary Health Region

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The purpose of this health services research project is to examine public participation in health policy development and implementation and identify ways to ensure effectiveness. The Calgary Health Region has developed a framework to promote public participation. This research project will look at how strategies to encourage public participation work in Calgary and area, and the value of the framework.

#### **Re: interviews**

We will be looking at documents concerning the Calgary Health Region's diversity initiative, and would like to interview you about your experiences with this initiative, your opinions and observations. The interview should take no more than an hour and will be tape recorded with your permission. You are free to stop the interview at any time, or to refuse to comment or to answer any particular questions. Your participation in this project is confidential. We will not say whether you participated or not. You will never be identified in reports without your written permission to do so.

#### **Re: Focus Groups**

We will be looking at documents concerning the Calgary Health Region's diversity initiative, and will interview some people individually. In the focus group, we would like to hear your experiences, opinions and observations. The focus group will take from one to two hours, and will be tape recorded with your permission. You are free to leave at any time. You can choose when to participate and are free to decline to comment. Your participation in this project is confidential. We will not say whether you participated or not. You will never be identified in reports without your written permission to do so.

As far as we know there are no risks associated with this project. There are also no direct benefits to you but we hope to assist the Calgary Health Region and other regions to do effective public participation. Only the researchers listed above and the project research assistants will have access to the data collected. Your name will be assigned a

code and the list of study participants will be kept in a locked cabinet. The record of the interview and/or focus group will use the codes, meaning that no study participants' names will appear in the record. This record will be kept in a secure place.

In the event that you suffer injury as a result of participating in this research no compensation or treatment will be provided for you by the Alberta Heritage Foundation for Medical Research, the University, the Calgary Health Region, or the Researchers. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

**Dr. Wilfreda Thurston  
220-6940**

**If you have any questions concerning your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 220-7990.**

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Participant's Signature Date

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Investigator and/or Delegate's Signature Date

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Witness' Signature Date

A copy of this consent form has been given to you to keep for your records and reference.