

**EVALUATION OF A DIVERSITY LIAISON MODEL TO COMMUNICATE HEALTH
PROMOTION MESSAGES
TO IMMIGRANT AND REFUGEE PARENTS**

Prepared for

Reducing Disparities

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EXECUTIVE SUMMARY

This project¹ aimed to improve the overall health and wellbeing for children of immigrant and refugee parents 0-6 years of age by communicating health promotion messaging related to nutrition and oral health. The project operated between June 2009 and February 2010, and involved adding the role of outreach and health promotion education to that of diversity liaisons, Alberta Health Services (AHS) employees working in the Reducing Disparities unit who speak the language of various ethnocultural communities. Five diversity liaisons representing the languages of Mandarin/ Cantonese, French, Korean, Punjabi, and English (refugee populations only, mainly through interpreters) were identified to communicate messages in oral health and nutrition. Liaisons received training in the health content areas and in outreach and facilitation and adult learning principles, and ongoing support was provided to liaisons through regular contact with content specialists and other project staff assigned to coordinate the project.

The project was originally envisioned as one testing a “peer educator” model, and in the 2008-2009 fiscal year a pilot project was initiated to train internationally educated health professionals to communicate health promotion messages to community members in their first language. Due to funding considerations and a desire to increase alignment with Reducing Disparities, the current project instead adds the role of outreach and health promotion education to that of diversity liaisons, Alberta Health Services (AHS) employees working in the Reducing Disparities unit.

The purpose of the current evaluation was to determine the appropriateness of the current diversity liaison model, whether the model was implemented as planned, what changes were suggested for future programming based on challenges identified, and whether expected outcomes were seen. Evaluation findings will inform the development of recommendations for future program planning and service provision for immigrant and refugee families in Calgary and within Alberta.

METHODS

Interviews were conducted with 25 individuals, including liaisons, parents who had attended sessions with liaisons, content specialists who had trained and provided support to liaisons, and stakeholders from external agencies who had worked with liaisons to offer sessions. Interviews with parents and external stakeholders were conducted with interpreters where necessary. Other data sources included secondary analysis of journals written by content specialists and liaisons documenting their experience of the process, and documentation of numbers of sessions offered by liaisons and number of parents participating in sessions. Analysis and reporting was conducted by staff from an evaluation team external to the project.

¹ This project was previously referred to as the “Peer Educator Pilot Project” and much of previous documentation used this language. However, this report uses the term “diversity liaison”, in order to minimize any confusion between the model used in this project and the more pure peer educator model version, in which lay members of the community are trained in more of a “train the trainer” model.

FINDINGS

Effectiveness of Model:

- Feedback gathered from interviews suggested that the model used in this project was appropriate to promote nutrition and oral health messages to immigrant and refugee parents. Diversity liaisons were able to: 1) initiate outreach to members of the community about subjects that mattered to them; 2) begin to find adaptations to methods of providing education to suit the groups or individuals they were working with; and 3) overcome language barriers of immigrant and refugee parents.
- There was some evidence that it was valuable for liaisons to have familiarity with the ethnocultural group, but that this may not require being a member of that group.
 - However, it should also be noted that this evaluation did not compare this diversity liaison model to a 'pure' peer education model, and it is not possible to assess its level of appropriateness in different settings, populations, and topics.

Process:

- In general, the project appeared to be implemented as planned. However:
 - There were periods in which diversity liaisons may have spent more time on the project than anticipated;
 - The timing of the project presented challenges (in particular, a short time frame and overlap with the H1N1 outbreak); and
 - Having no dedicated project coordinator and a lack of clarity around mandate of other project staff compromised support for liaisons.
- Training and support for liaisons was generally sufficient, though suggestions for improvement were made (see below).
- Diversity liaisons reported that they found outreach and recruitment of parents to be more challenging than expected, and that they had not fully understood what this role looked like when the project began.
- Despite recruitment being noted as a key challenge, through trial and error liaisons eventually found successful recruitment techniques for their communities. Similarly, the liaisons developed ways of communicating the information that appeared to coincide with the needs of their communities.
- A total of 102 sessions were offered with over 100 parents attending each of the four topics.

Outcomes:

- Evaluation results suggested increases in health promotion and diversity competency for liaisons, content specialists, and other AHS staff.
- There was evidence that culturally competent material had begun to be created, but that improvements could still be made in this area (particularly for nutrition content, which is more likely to need tailoring compared to oral health content).

- Increases in knowledge of nutrition and oral health were reported by all parents interviewed who attended sessions on these topics. More than half of these parents also reported that they changed their behaviour when feeding their child, and three quarters reported changing behaviour in relation to oral health.
- More than three quarters of parents interviewed reported increased access to health and community services.
- The majority of parents reported sharing information about the sessions with other members of their community, and the Korean community in particular reported that the sessions led to a great amount of social networking and reductions in social isolation.

KEY RECOMMENDATIONS

- It is recommended that this diversity liaison model to communicate health promotion messages to immigrant and refugee parents be pursued further.
 - Further exploration should include examination of whether this particular model is applicable and transferable to other ethno-cultural communities, geographical areas within the province, and health and social topics.
 - Other models for communicating and addressing health issues should also continue to be explored, including more 'pure' peer educator models if appropriate.
- Ensure that sufficient staff resources are allocated to provide support for the diversity liaison model, including a dedicated project coordinator and clear direction for content specialists and diversity liaisons to be involved.
- Allocate funding to provide instrumental supports such as childcare, snacks, and bus tickets to support programming for immigrant and refugee parents.
- Provide further training for diversity liaisons in adult learning principles which includes hands-on facilitation and presentation experience, as well as community development and outreach strategies.
- Continue to develop culturally appropriate resources, including models or tools used in interaction with parents and materials that parents can refer to after sessions (for example, translated written materials or a website).
 - Continued interaction between content specialists and diversity liaisons while liaisons are working with parents and external stakeholders is necessary to enhance the cultural competence of resources.
- Consider implementing a regular feedback mechanism to get feedback from a larger sample of parents attending sessions (for example, forms filled out immediately after attending sessions).

GLOSSARY OF TERMS

Diversity liaison –The diversity liaison contributes to the reduction of disparities experienced by vulnerable populations and the development of Alberta Health Services as a diversity competent health care organization, to exert a positive impact on the health of these populations. The Liaison facilitates connections between staff, programs and services, and vulnerable clients/families/communities for the purposes of increasing communication, understanding, access and coordination. The Liaison works with health promotion specialists and multidisciplinary teams to plan, implement and evaluate initiatives to ensure they are accessible to vulnerable clients/families and communities. The Liaison contributes to engaging and strengthening collaborative community partnerships to collectively identify ways to increase the capacity of: 1) existing services to better meet the needs of vulnerable populations; and 2) vulnerable clients/families/communities in accessing health services and information to meet their needs.

Peer Educator –“Peer education is a broad concept and liaisons are variously referred to in the literature as community health workers, community health advisors, lay health workers/advisors, health education aides, indigenous workers, natural helpers, paraprofessionals, peer outreach workers, and, in Hispanic communities, promotoras” (Hansen et al., 2005; Taylor et al., 2001; Eng et al., 1997). Some programs offer structured one-on-one or group education, while others educate through casual conversations and the distribution of educational materials in social or public settings. Some programs are exclusively designed as educational interventions while other combine an educational component with a counseling or support component (Rhodes et al., 2007). Peer Educators often provide links between health-related services and community members. They also serve as role models for desired behaviours in health promotion and disease prevention initiatives and advocate on behalf of underserved communities (Rhodes et al., 2007).”

Outreach –providing support through trying to find and engage those who need and have barriers to accessing support or advice. In the context of the diversity liaison project, this involved individuals from various ethnocultural and language backgrounds providing supportive services to clients. This included, but was not limited to, seeking out members of the community who might otherwise be hard to reach, providing first language and culturally appropriate support and information, enhancing access to programs, and services and assisting with the provision of quality and client- focused care.

Language Community – a community of people who share a common language but can be ethnoculturally diverse (i.e. French Canada, France, Cameroon).

Cultural Community – people who have a shared, common sense of history, beliefs and values and identity.

Diversity Competence – The ability of individuals and systems to respond respectfully and effectively to individuals, families and communities of all diverse backgrounds in a manner that protects and preserves their dignity and recognizes, affirms, and values their differences, similarities and worth.

Cultural Competence – An aspect of diversity competence directly related to culture.

Health Promotion – “The Ottawa Charter for Health Promotion (1986) defines health promotion as the process of enabling individuals to increase control over, and to improve, their health. Under this definition, achieving physical, mental and social wellbeing requires individuals or groups to identify and realize aspirations, satisfy needs, and change or cope with their environment. The Charter also recognizes that health promotion policies must identify barriers to the adoption of healthy public policy in non-health sectors and contribute to the solutions that would remove these obstacles (Ottawa Charter, 1986). More recently, health promotion under the Ottawa Charter model has shifted from a focus on lifestyle and behavioural determinants toward consideration of structural change, community development and the sense of empowerment required to promote healthy living (Denton et al., 1999), leading health promotion efforts to include awareness-raising campaigns, provisions of information and advice, influencing social policy, lobbying for change, and training in combination with specific health interventions (Speller et al., 1997). Health promotion for immigrant and refugee populations under the Ottawa Charter model would seek to address many determinants of health. This would include responding to the lifestyle and behavioural elements of health promotion but would also consider health promotion at the level of the community and broader social structures.” [from health promotion in immigrant and refugee populations: literature review]

Community Development –a process of social change, which brings community members together, in an equitable fashion, to work cooperatively to identify community strengths and needs, and to address common issues that affect their health. In doing so, communities assume a greater responsibility for their own health and well being as well as that of the community, and ultimately, increasing their control over conditions that affect their lives and building a healthier community (Denetto and Wiebe, 1999).

INTRODUCTION

This project² aimed to improve the overall health and wellbeing for children of immigrant and refugee parents 0-6 years of age by providing health promotion messaging related to nutrition and oral health. The project operated between June 2009 and February 2010. It was funded by “3 Cheers for Early Years”, a granting body through the former Calgary Health Region that aimed to increase support for families with young children. The project is supported by two units from Alberta Health Services: the Reducing Disparities Unit, Health Promotion, Disease and Injury Prevention, Population and Public Health Portfolio (formerly known as Healthy Diverse Populations with the Calgary Health Region) and Nutrition Services, part of Clinical Support Services.

The project was originally envisioned as one testing a “peer educator” model, and in the 2008-2009 fiscal year a pilot project was initiated to train internationally educated health professionals to communicate health promotion messages to community members in their first language. Due to funding considerations and a desire to increase alignment with Reducing Disparities, the current project instead adds the role of outreach and health promotion education to that of diversity liaisons, Alberta Health Services (AHS) employees working in the Reducing Disparities unit who speak the language of various ethnocultural communities. The main functions of diversity liaisons are to collaborate and strengthen partnerships with health care staff and community organizations that represent vulnerable populations; to address identified needs and improve access and delivery to health programs, services and information; and provide a range of navigating, referral education and support services to vulnerable populations. While the diversity liaisons seem to be an appropriate fit given their role and ability to speak the language of the ethnocultural community they are targeting, their role is not congruent with a ‘true’ peer educator/facilitator as identified in the literature. In particular, there is a question as to whether diversity liaisons, as professionals and employees of Alberta Health Services, have “an intimate understanding of the community’s social networks, strengths, and health needs, enabling them to promote health and health outcomes within their community”. (de Peuter Chick, Jennifer. The Peer Educator Model for Health Promotion: Unpublished Literature Review completed for Reducing Disparities Unit, February, 2009).

The project involved health messages related to two specific content areas – nutrition and oral health- which were chosen based on past program planning and service delivery decisions for this project, human resources and instrumental supports available, and community interest in these particular content areas. Five language groups were chosen as targets based on languages spoken by liaisons already employed by AHS. These included: Chinese (Mandarin and Cantonese), Korean, Punjabi, Hindi and French. Within these language groups, liaisons connected with community stakeholders to determine appropriate community groups to target. A coordinator was not assigned to this project; rather, leads in both Nutrition Services

² This project was previously referred to as the “Peer Educator Pilot Project” and much of previous documentation used this language. However, this report uses the term “diversity liaison”, in order to minimize any confusion between the model used in this project and the more pure peer educator model version, in which lay members of the community are trained in more of a “train the trainer” model.

and Reducing Disparities were assigned to plan and implement the project, including organizing training and support from content specialists, working with program managers to establish support in key contact areas, and conducting regular meetings to ensure objectives were being met. The project activities included training and support of liaisons, the development of diversity competent strategies and resources, community outreach, and the communication of culturally appropriate health promotion information to parents. Project participants included immigrant and refugee parents, external stakeholders from the ethnocultural/target communities and Alberta Health Services staff (liaisons, content specialists and project leads).

Objectives of this project were: 1) to develop and strengthen partnerships within AHS, and between AHS and stakeholders, to implement a successful health promotion delivery model for immigrant and refugee parents; 2) to further develop health promotion messages in an innovative, diversity competent manner; 3) to reorient health services to facilitate access and increase uptake of health messages for immigrant and refugee parents; and 4) to enable liaisons to communicate evidence-based information in the areas of nutrition and oral health.

The purpose of the current evaluation was to determine the appropriateness of the current diversity liaison model, whether the model was implemented as planned, what changes were suggested for future programming based on challenges identified, and whether expected outcomes were seen. Evaluation findings will inform the development of recommendations for future program planning and service provision for immigrant and refugee families in Calgary and within Alberta.

EVALUATION METHODS

This section will describe how the evaluation was carried out, including several considerations with regard to carrying out evaluations with ethnically diverse populations. This evaluation was led by a member of the Evaluation Team of the Public Health Innovation and Decision Support Unit³ (hereafter referred to as “the evaluator” and “the evaluation team”) from the data collection phase onward. Additional support and direction for the evaluation was provided by the evaluation team, and staff from Reducing Disparities and Nutrition Services⁴.

This evaluation aimed to address the following key questions:

Inputs/ Infrastructure

1. Is the diversity liaison model an appropriate effective means of providing health promotion information and services to immigrant and refugee parents?

³ Formerly known as the Research and Evaluation Unit, Health Promotion and Disease Prevention Division. The evaluation design work was initiated by Shireen Suroid, Diversity Research/ Evaluation Strategist for Reducing Disparities.

⁴ Thank you to Claudia Canales for completing interviews for data collection, and Claudia Canales, Valerie Kiss, and Joan Silzer for their dedication and evaluation support.

Process/ Activities

2. Has the diversity liaison pilot project been implemented as planned (completed activities, milestones, successes and challenges)? Why or why not?
3. How has the partnership development within between AHS staff (liaisons, content specialists, etc.) and between AHS staff (liaisons) and external stakeholders helped in the implementation of the project (quality of the project; identification of the issues; construction and communication of health promotion strategies, information and resources)?
4. Did the liaisons receive appropriate training and support to communicate health promotion content to immigrant and refugee parents?

Outcomes

5. Has the diversity and health promotion competency improved among AHS staff and liaisons?
6. Are the health promotion strategies/resources diversity competent and useful for immigrants and refugee parents to enhance the health of their children?
7. Do immigrant and refugee parents adopt health behaviour changes (e.g., lift the lip; follow established feeding recommendations) as a result of receiving health promotion information?
8. Do immigrant and refugee parents have increased understanding of health promotion messages that they have received through liaisons?
9. Do parents feel supported by the liaisons? How so?
10. How have liaisons facilitated immigrant and refugee parents' access health and community services/programs/resources?

Please see Appendix A for the Evaluation Framework⁵. The main source of data was 25 semi-structured telephone interviews with four different groups:

- 14 parents of children aged 0 to 6 who had been offered educational sessions on oral health or healthy eating by liaisons. This included four interviews completed in Mandarin, three in Cantonese, four in French and three in Korean.
- All 5 diversity liaisons who were involved in this pilot project. This included one who worked with members of the Cantonese and Mandarin community, one who worked with members of the Korean community, one who worked with various French speaking ethnocultural communities (mainly from Africa), one who worked with refugee parents in English only, and one who was trained to work with the Punjabi community but offered a limited number of sessions in English only due to being trained at a later date.
- 3 content specialists who had completed training with liaisons to facilitate their work with parents. This included a nutritionist to share nutrition content, a dental hygienist to share oral health content, and a diversity educator to share adult education principles, facilitation and community outreach and engagement.

⁵ Please note that these sources used the language of "peer educator" rather than "diversity liaison".

- 4 external stakeholders, individuals from community organizations, language groups and/ or cultural groups who the liaisons worked with in some way to help offer the program. External stakeholders were chosen from Korean, Punjabi, French and Mandarin-speaking communities.

Other data sources used to address the evaluation questions included secondary analysis of journals written by content specialists and liaisons documenting their experience of the process, and documentation of numbers of sessions offered by liaisons and number of parents participating in sessions.

Parents were recruited to complete interviews through the liaison who had worked with them; liaisons contacted parents by phone and asked them if they would be willing to participate in an evaluation of the project. Liaisons were asked to use discretion in choosing parents who varied with regard to characteristics such as socio-economic status, location in the city, and the number of sessions they attended⁶. Once parents had agreed to take part in the interview, they were sent a letter with more information (see Appendix B). Liaisons, content specialists and external stakeholders were contacted directly by the interviewer.

Most interviews with parents and external stakeholders were completed by telephone, while most interviews with liaisons and content specialists were completed in person. The decision to complete interviews by telephone was based on enhancing convenience for parents, since transportation is a barrier for many immigrant and refugee parents. One pilot interview was conducted to ensure that this would be appropriate given the need for interpretation into interviewees' first language. No problems were reported with this method.

Interviews were completed by a member of the Reducing Disparities team (a diversity liaison trained and experienced with interviewing, who had not been involved with the project). Detailed notes were taken during the interview by a member of the evaluation team. Interpretation into the first language for parent and external stakeholder interviews was provided by Interpretation and Translation Services, Alberta Health Services, or through the Language Line, an externally-contracted telephone interpretation service (www.languageline.com). When an interpreter was used, they sat in the same room as the interviewer and note-taker. Though the interview guide had been translated before the interviewers, interpreters preferred to translate questions as they were being asked. The interviewer noted that both Language Line and in-person interpreters provided a richer interpretation of both the questions and responses when their proficiency in English was quite high. This was an important consideration, because analysis of interviews depends largely upon the availability of detailed responses.

All persons interviewed were given information about the evaluation and all ethical considerations, and were asked standardized questions related to consent. In addition to seeking limited background information about themselves and their role in the project, all

⁶ Though liaisons were asked to choose a variety of parents, it is acknowledged that it is likely that it was those parents who were able and willing who completed an interview. This may have led to a selection bias among the parents interviewed for the evaluation; however, language constraints made it impossible for the evaluation team to approach parents. Interview samples were not intended to be random, but simply to provide more information about whether and how the program worked for parents.

interviews involved addressed the evaluation questions seen above. See Appendices C through F for the interview guides (including consent procedures).

Only members of the evaluation team had access to full interview transcripts. All qualitative data were analysed using content analysis. A baseline coding structure was developed by two members of the evaluation team based on themes emerging from preliminary paper coding of five interviews. All remaining coding was carried out by using Microsoft Word to copy and paste instances from interviews and journals related to identified codes. Interview data was coded by the evaluation team, and staff journal data was coded by a member of the project team and a member of the evaluation team. Quantitative data related to outputs of the program (including number of sessions offered and number attending sessions) were recorded by liaisons and tabulated by Reducing Disparities staff.

EVALUATION FINDINGS

EFFECTIVENESS OF MODEL

Though this project was not able to compare this diversity liaison model to a pure peer educator model, these evaluation results did explore whether it was an appropriate model to use to communicate health promotion messages to immigrant and refugee parents. Of particular interest was that rather than selecting members of the community, the educator role in this particular project was filled by existing AHS staff members. This meant that the individuals providing the health messages were able to communicate with community members in their first language, but they: 1) may have been considered professionals rather than lay members, and 2) may not have been part of the same ethnocultural community as the individuals they were providing information to. One content specialist expressed concern that these factors may have undermined the effectiveness of the project:

“I’m happy to see AHS trying to be more community oriented, and involve new strategies for educating people about health; however the peer education model goes so against the ingrained instincts of our professionals and our system that it’s an awkward fit. By definition, [diversity liaisons] are not peer educators because they’re professionals, there’s your flaw in the beginning. It’s that fact that sets up an impossible dynamic in the community. They’re looked at as professionals and representative of professionals, but you’re asking them to behave as equals in the community which they can’t possibly be.”

- Content Specialist Interview

Despite these concerns, most of the evidence gathered in this evaluation suggested that the model was an appropriate and successful model in terms of meeting objectives of the project. Firstly, there was some evidence that diversity liaisons were able to accomplish one of the reported advantages of using a peer educator model: outreach in the community, including members of the community that might otherwise be hard to reach. More than 100 parents

attended sessions offered by liaisons in each of the topics offered (see the Process section below for more details). There was also evidence that the program offered information that was important to these immigrant and refugee parents:

“I received education about the teeth and nutrition; the two subjects were my most worried parts so I was very helped by the session.”

-Parent Interview, Korean Community

Secondly, though liaisons were AHS staff rather than members of the community, evidence suggested that liaisons were able to offer education in a way that was well-suited to the population they were working with. In some cases, this meant ensuring that sessions were less formal, in other cases, groups seemed to respond to more formal presentation styles (such as using PowerPoint).

“When I mentioned that it will be a casual environment with the children and also I will be facilitating the meeting that we will be able to share our experiences together and interact, the moms thought that it will be much better than attending an education session and was excited that this will also enable them to learn and also interact with other moms.”

-Liaison Interview

“It’s a presentation plus discussion. And facilitated discussion, all together. The slides to guide people and stay focused while we discuss.”

-Liaison Interview

Thirdly, this data suggested that language may be the most important element to providing education to immigrant and refugee parents, and that parents were not as concerned about who was providing them with this information. For example, twelve of the fourteen parents interviewed felt that receiving the information in their first language was very important. Though one parent was comfortable communicating in English, she still thought it was very important to have the sessions in first language for the benefit of the rest of the group. One parent received a one on one session and felt she would have been equally comfortable in English or French. However, though most of the parents reported that they understood some English, they were much more comfortable and confident learning in their first language.

“Very important. If I have information in English I could understand below 50 % because of the terms, but I could understand 100 % if I learn from Korean person.”

-Parent Interview, Korean Community

“Went to a home visit for young parents. They have 1 month old baby. Since they are so new to the country, and wife with no English, they were struggling to find information. I picked the first session to be 'Health Services in Calgary' just because when we were

talking over the phone before the meeting, she mentioned that she did not know any thing about healthcare in Canada, and that she was worried for her daughter.”

-Liaison Journal

In contrast, ten of the parents interviewed reported that familiarity or belonging to the same ethnocultural community was not important or was less important than other factors.

“No it wasn’t important because as long as we can understand it doesn’t matter if it was my community or someone from another community.”

-Parent Interview, French Community

Two parents reported that they would prefer to be familiar with the person communicating health promotion messages but did not specify that this required that the educator be from the same community (for example, stating that they would like multiple sessions to be offered by the same person). Several parents interviewed did specify that familiarity in terms of ethnocultural identify was important; one reported that it did not matter if liaisons were familiar, as long as they were from the same community and another reported that it was important that liaisons be familiar in some way with the community. This concept was highlighted by the French-speaking liaison, who worked with a variety of ethnocultural communities, mostly from Africa:

“About nutrition, usually just because people are coming from different countries with different products, I had the chance to live in a few African countries, so in Senegal people eat on the floor altogether, so once with the picky eating class I was asking the lady if her girl was eating well, she said yes she is good. She eats a lot better around the bowl then if we are at a table, so knowing their culture helped me to raise the right questions, and investigate.”

- Diversity liaison interview

Finally, there was evidence that this model achieved many of its intended outcomes. This will be discussed in more detail in the Outcomes section below, and included enhancing cultural and health promotion competency among liaisons and other Alberta Health Services staff, creating culturally appropriate resources, and reported changes in parents’ knowledge and behaviour and increased access to community services and resources.

Summary for Effectiveness of Model:

- Feedback gathered from interviews suggested that the model used in this project was appropriate to promote nutrition and oral health messages to immigrant and refugee parents. Diversity liaisons were able to: 1) initiate outreach to members of the community about subjects that mattered to them; 2) begin to find adaptations to methods of providing education to suit the groups or individuals they were working with; and 3) overcome language barriers of immigrant and refugee parents.
- There was some evidence that it was valuable for liaisons to have familiarity with the ethnocultural group, but that this may not require being a member of that group.
 - However, it should also be noted that this evaluation did not compare this diversity liaison model to a 'pure' peer education model, and it is not possible to assess its level of appropriateness in different settings, populations, and topics.

Recommendation:

- It is recommended that this diversity liaison model to communicate health promotion messages to immigrant and refugee parents be pursued further.
 - Further exploration should include examination of whether this particular model is applicable and transferable to other ethno-cultural communities, geographical areas within the province, and health and social topics.
 - Other models for communicating and addressing health issues should also continue to be explored, including more 'pure' peer educator models if appropriate.

PROCESS

This section will provide more detail about how this model was implemented, including descriptions of activities, data related to outputs, and identification of challenges, successes and suggestions for improvement. This will include addressing the evaluation questions related to process, including whether the model was implemented as planned, how partnerships affected the project, and whether liaisons received appropriate support and training to communicate health promotion messages to parents.

Time Spent as Part of Liaison Role

Results suggested a variation in the amount of time liaisons spent on the project, particularly depending on which stage the project was at. The liaisons trained later reported working on the project only intermittently. The three liaisons who were trained first spent the expected 0.2 FTE (about one day per week) during training, but several of them reported that they spent

half to all of their time on the project during the period they were recruiting and offering sessions. Several of the liaisons reported this as a potential disadvantage to the project.

“It takes up a lot of energy and time to do recruitment, to support. The one I just did is a pilot project, I don’t think I have given [parents] so much support after the [session] but the spirit of the peer education model is we’re supposed to give them ongoing [support], someone to contact.”

- Liaison Interview

Timing of the Project

One of the challenges that emerged in relation to the question of whether this project was implemented as planned was that of timing. For example, several liaisons and content specialists noted that it was difficult to complete the outreach required for this type of project in the short timeframe of a pilot project. Many of the parents and liaisons indicated that it was a shame not to offer sessions over a longer period or to offer more sessions. One liaison also mentioned that the timeline of the project required that she complete recruitment and education in winter, despite evidence that this might not be the best time to do this work.

Other timeline difficulties included scheduling difficulties because of the number of staff who were casual or part-time and loss of staff because the project coincided with H1N1 immunization clinics. It is also of note that the refugee and Punjabi liaisons were trained later than the other three liaisons, and therefore did not have sufficient time to fully engage in outreach. Both completed a limited number of sessions in English.

“Very late in the pilot to add new [liaison], already significant differences between training and facilitation skills within the original group, not convinced there is enough time for the new [liaisons] to get out to the community as this process takes time.”

-Content Specialist Journal

Timing appeared to have an effect on the outreach done by the liaisons who were trained later; however, despite the other timing difficulties noted, the three liaisons trained in the early stages managed to recruit over 100 parents for each of the topics presented (see the Outreach and Recruitment section below).

Training and Support for Liaisons⁷

Each of the liaisons received several sessions that were two to three hours each in the areas of nutrition, oral health, and diversity education principles (including outreach, facilitation and diversity competence). A separate round of similar training was held for the two liaisons that were trained later in the project.

⁷ Though it was not identified as an evaluation question up front, it is also of note that content specialists felt they had the support they needed and that the project team was open for feedback. One content specialist suggested it would be beneficial for the content specialists to meet more often to make the training more consistent.

All five of the liaisons felt they had adequate training in the health content areas. Liaisons were given support from program (for example, project leads), as well as content specialists. Regular update meetings were established with leads, content specialists and diversity liaisons to enhance communication and support between all of the individuals involved in the project, highlight successes, discuss resources required to enhance education, and to determine and discuss any challenges related to training, observation, recruitment of community participants and stakeholders, and communication of health promotion messages to parents.

In addition to training from content specialists, diversity liaisons also went through an 'observation period' once training was completed, whereby trainers went with the liaisons to education sessions being conducted in English for a short period of time to observe the communication of the messages, and evaluate and provide feedback on how sessions were offered. This observation period varied depending on the level of comfort by the liaison with the content, as well as the availability of the trainer and of a session being conducted in English. The content specialists communicated with the liaisons through email to answer questions and provide support. The liaisons felt that the nutritionist and oral health specialist were very supportive and quick to answer questions and get information back to them. The content specialists encouraged the liaisons to come to them with questions to ensure the parents are receiving the most accurate information possible.

"I have also let them know that in the event that they are unable to answer a question from a group participant, it is always best to let that person know that you do not have that information, but will attempt to get it and let them know or give them a contact number where they may be able to get this information. I have assured them that I will do my best to keep open communication and will always try to respond to any of their questions or concerns as soon as possible."

-Content specialist Journal

The liaisons reported that they received some support from each other by sharing their experiences on the project and talking each other through the difficult periods of outreach and recruitment. In addition, the first liaison to start offering sessions also shared her materials, which the other liaisons translated into their languages. However, there was also evidence that because of the differences between communities, liaisons may have had to resolve many challenges individually.

There were also several challenges noted with regard to support for liaisons. Firstly, there were reported difficulties achieving a balance between establishing firm guidelines and clear direction while maintaining the flexibility and openness needed to successfully recruit and communicate messages to diverse populations. For example, several liaisons reported feelings of confusion with regard to their role in carrying out the project, and/or the methods to carry it out. This included a mention that there was no direction given with regard to how many parents should be offered education as part of the program.

"That was another thing, our goal wasn't really set. When we started they said it doesn't matter how many, quality not quantity. But obviously I want to do well, see the

successes for all the time I spent on it ... [Later in the interview, when asked for recommendations for the project] I really liked that it was very open, open to the point that I thought we were almost abandoned. We're all different so we could have a lot of freedom to do it in a way that was workable for our community. If it was too set it would not have worked for every community. So that was good, but as I said some kind of target, or a better guideline, that would make more sense."

-Liaison Interview

One particular aspect that was unclear to liaisons was the method of presentation that was expected for parent information sessions. For example, the oral health and nutrition specialists reported that lecture style presentations used to present this content were not ideal for the liaison model, and expressed concern that watching the content specialists deliver formal presentations may have had the negative consequence of setting an example that they did not actually want the liaisons to follow.

"Concerned that having the [liaisons] watch mainstream classes was a disservice in that it put a certain way in their minds of how to do the sessions even though the different context was outlined and it was specifically discussed that this is not the way to use them."

-Content Specialist Journal

In contrast, the training sessions from the diversity education content specialist focused on facilitation skills and adult learning principles. This provided liaisons with chances to practice presentation skills during their health content training and receive feedback from the content specialists.

"But more importantly one by one we were able to take one item from the workshop bag and experience questioning and answering with each other and [Content Specialist] commented on what and how we were given the message out. Very useful."

-Liaison Journal

A second challenge noted with regard to training and support was ensuring that liaisons fully understood their scope of practice, and the potential limits to the information they were providing. This was noted by both the nutrition and oral health content specialist, and there was an indication that this was especially difficult in terms of ensuring that those liaisons who were parents relied on evidence-based information rather than personal experience:

"Had some concerns during the presentation that [liaisons] needed clearer scope of practice guidelines as there were times if the answer was beyond their knowledge they were guessing, providing misinformation and /or using personal experiences to answer."

- Content Specialist Journal

Another noted challenge was that of organizational challenges in terms of providing support. There was no project coordinator dedicated to the project, and there was concern expressed that this made it difficult to provide liaisons with the support they needed. A new content specialist in nutrition was assigned to the project in January as the previous individual left the organization, and the observation period often proved difficult because both liaisons and content specialists were deployed to work in H1N1 clinics. Content specialists were also fulfilling the role as part of other duties, and there was evidence that it was not always clear whether it was a part of the mandate of their position.

“They’d been told I was backing off so it was unclear who they should go to for [information about content], so that was frustrating for them. Later in September I came back on but they had to re-engage. The gals were great but it was confusing.”

- Content Specialist Interview

Finally, liaisons reported frustration that some of the instrumental parent supports (such as child care, bus tickets and snacks) were at first declined, despite the liaisons belief that they were extremely important to the success of the project.

“[Project lead told me] that ... some money can be allocated as transportation assistance for moms since transportation has been an issue for French speaking moms. [I have] been fighting for assistance resources since day one but has been told by the Project Lead that there is no budget for that. ... [I am] glad that finally people involved in the [liaison] project are all speaking the same language in terms of what assistances needed to be there to run [it]. However, it is too late for ... groups that have already started. [I believe] that it would be extremely helpful in recruiting low income participants had the assistance budget been available since day one.”

- Liaison Journal

Parents also reported that supports were important to them, though there were differences among parents in terms of what was considered important (including some differences among communities). Childcare seemed to be important for many of the parents, regardless of community. Bus tickets were seen as very important for five of the parents, including all four parents from the French community, but were of varying importance for the remainder of the parents. Many members of the Korean community reported that snacks were very important, while members of the French and Chinese communities reported snacks to be mildly important. Though this potentially may have been due to differences in income levels and level of food insecurity among the different populations, it may also have been due to differences in how sessions were offered. In particular, Korean sessions took place in the homes of different parents, and several reported that snacks were important to ease the burden of those whose homes were being used.

“If there is nothing else to eat, the owner of the house has a responsibility and should provide some snacks, but because [liaison] brought them I felt free so I didn’t have to provide them.”

-Parent Interview, Korean Community

Suggestions made by liaisons and content specialists with regard to training and support included:

- Letting the liaisons observe more sessions, both from the content specialists and from those with experience with outreach and education with vulnerable populations.
- Having the liaisons do mock presentations in front of the class and experiment with presentation and facilitation styles, having props for the different food textures discussed in the ‘feeding your baby’ session.
- Extending the training sessions into the recruitment and presentation phase so the liaisons are able to bring in questions, practice more and discuss culturally specific items such as food.
- Ensuring that sufficient staff resources are allocated to provide support for liaisons (including a dedicated project coordinator and clear mandates for content specialists).
- Ensuring that resources are allocated to provide instrumental parent supports where required, including snacks, transportation and childcare.

Issues of developing diversity competent health messages and resources were also mentioned with regard to information shared during training. These can be found in the Outcomes section.

Outreach and Recruitment

Though the liaisons received training from a diversity educator content specialist where they learned about community outreach and brainstormed ways to reach their community, many reported that they found outreach very challenging.

In many cases, immigrant serving organizations and ethnocultural and community associations helped connect the liaisons with their community by providing referrals, advertising opportunities, spaces to deliver presentations, and occasionally child minding or snacks. Community associations, immigrant and refugee serving agencies preschools, social workers, religious organizations such as churches and temples, and language specific newspapers, websites, and radio programs helped the liaisons reach their target populations.

However, several liaisons expressed frustration that their work with immigrant and refugee serving agencies was not more successful in terms of helping them reach parents and successfully recruit them to attend sessions. Interview and journal data suggested that outreach was more challenging than expected, and that they had not fully understood what this role would look like when the project began. Feedback from project staff indicated that this may have been due to the fact that though the diversity liaison role involves some outreach,

this was often working closely with agencies rather than with individuals in the community. Several liaisons reported that they would have benefited from more training and support with outreach activities.

“[O]nly 11 parents out of 35 were recruited from community, stakeholder’s contacts. I was surprised and disappointed to see the low turnout from all my contacts in the community. I spent a lot of time being in touch with key workers in the community (immigrants serving agency workers, churches, shelters, ESL schools, preschools, school nurses, community health centres, libraries, and cultural agencies). In the future if the peer education becomes part of our regular job I will probably need some extra training in outreaching.”

- Liaison Journal

Despite these reported challenges, the three liaisons who were trained early in the project reported methods of recruitment that worked for the communities they were targeting, including:

- Talking to parents directly by visiting external agencies or attending regular meetings.
- Hanging posters or leaving brochures with external agencies, or in areas that are often visited by members of the target community. For example, a Chinese supermarket or a vaccination clinic.
- Allowing parents to recruit other members of the target community through word of mouth. Many parents interviewed reported that they informed friends and family about sessions, including suggesting they attend.
- Making use of cultural newspapers, radio or television advertisements directed at different cultural/ language communities.

Tables 1 through 3 demonstrate the number of sessions offered, the number of total number of parents attending each type of session, and the number of children attending each type of session with their parents. A total of 102 sessions were offered with over 100 parents attending each of the four topics (including picky eating, feeding your baby, oral health and health services in Calgary⁸). The total number of parents attending sessions has not been given, because many of the parents attended more than one topic.

⁸ Though sessions on health services were not initially planned, these were offered in response to an identified need among parents liaisons worked with.

Table 1: Number of Sessions Offered

| | French | Cantonese | Mandarin | Korean | English | Total |
|--------------------------------|--------|-----------|----------|--------|---------|-------|
| Picky Eating | 3 | 2 | 3 | 10 | 4 | 22 |
| Feeding Your Baby | 11 | 3 | 2 | 9 | 1 | 26 |
| Oral Health | 12 | 2 | 4 | 10 | 6 | 34 |
| Health Services in Calgary | 1 | 2 | 4 | 11 | 2 | 20 |
| Total Number of Sessions = 102 | | | | | | |

Table 2: Number of Participants Attending Sessions

| | French | Cantonese | Mandarin | Korean | English | Total |
|----------------------------|--------|-----------|----------|--------|---------|-------|
| Picky Eating | 14 | 12 | 20 | 27 | 51 | 124 |
| Feeding Your Baby | 32 | 25 | 12 | 29 | 25 | 123 |
| Oral Health | 30 | 14 | 37 | 29 | 60 | 170 |
| Health Services in Calgary | 2 | 14 | 40 | 31 | 22 | 109 |

Table 3: Number of Children Attending Sessions

| | French | Cantonese ⁹ | Mandarin | Korean | English | Total |
|----------------------------|--------|------------------------|----------|--------|---------|-------|
| Picky Eating | 22 | 6 | 9 | 34 | 10 | 81 |
| Feeding Your Baby | 35 | 8 | 7 | 37 | - | 87 |
| Oral Health | 23 | 7 | 14 | 38 | 1 | 83 |
| Health Services in Calgary | 5 | 7 | 15 | 38 | - | 65 |

Partnerships and External Stakeholders

Results indicated that external stakeholders may be helpful for providing direction to work with immigrant and refugee parents, above and beyond help with reaching the target group. For example, an interview with one external stakeholder indicated that there may be existing groups or positions in the community that may be well suited to carry out the role of educating immigrant and refugee parents. This stakeholder felt that having too many people communicating health information could confuse parents, and that more streamlined delivery of health information would enhance the relationship with the community. The project team indicated that they would like to see more ongoing and formal direction and support from external stakeholders, and wanted to assess the feasibility of organizing an external stakeholder committee. In that vein, several of the external stakeholders interviewed agreed for them or someone else from their organization to be part of an external stakeholder committee if their organization allowed it.

⁹ Some of the Cantonese and Mandarin sessions were held at agencies where childcare was available, so numbers of children attending these sessions may not be accurate.

Description of Population

The liaisons were targeting immigrant and refugee caregivers of children 0 to 6 who were not being reached through formal avenues of health messaging. They understood these caregivers may have language, educational, and isolation barriers that were preventing them from accessing health information. The liaisons felt they had reached these target populations, that many of their clients had language barriers, transportation barriers and were very isolated.

“My understanding is the project really wanted to reach out to those who maybe lacking in proper health messages around raising kids, especially on the nutrition and oral health aspects. There is a chance this group is low income, low education, can’t read English, could be very isolated and [do] not know where to get that information.”

–Liaison Interview

An overview of the characteristics of the parents as reported by liaisons is provided in Table 4.

Table 4: Information about Parents as Reported by Liaisons

| | Cantonese and Mandarin | Korean | Punjabi | Refugee | French ¹⁰ |
|------------------------------|---|--|---|------------------------------|--------------------------------------|
| Area of the city | North East | South West | North and South East | North East | Not assessed |
| Social Support | Some through community agencies, some no social support available | No formal support and no relatives nearby | Immigrant Services Agency | Refugee Centre | Not assessed |
| Languages spoken in the home | Cantonese and Mandarin, often both | Korean, some English. Husbands usually speak English | Cantonese, Mandarin, Arabic, Spanish, (sessions in English) | Nepoli, some Hindi | French, most spoke a bit of English |
| Time in Canada | A few months to over 10 years, Average around 1 year | Two months to 5 years, average 2 years | Less than 3 years | Less than 1 year | Most less than 2 years |
| Number and ages of children | 4 months to 7 years | 2 groups of 12-18 months 4 groups of 3-6 years | 0 to 6 | Twins 6 years | Not assessed |
| Marital status | Married | Married | Unknown | Separated | Not assessed |
| Socio-economic status | Some professional class, some lower income | Mostly lower income | Receiving social assistance, E.I., or child health benefits | Government sponsored refugee | About half in a low income situation |

Method of Education

Results suggested that it was important to be flexible and to tailor how sessions were offered, because both communities and individuals vary in how they prefer to learn. Many parents reported that they enjoyed the social aspect of group sessions, hearing questions from other parents and the opportunity to network and build relationships. However, many also reported that one on one home visits also had the advantage of allowing for opportunities to ask more questions, speak plainly about personal issues, and get more attention to their personal situations and needs. Parents suggested having more written materials, pamphlets or booklets that they can take home with phone numbers and the key health messages, or perhaps a website they could refer to in their own languages.

¹⁰ These questions were added to the interview guide after the French liaison had been interviewed. Several of the questions were answered by email afterward.

The liaisons tailored their sessions to the community they were working with, either through larger workshop-style presentations held at agencies, or informal facilitated small group discussions or one-on-one visits. Sessions were held either at a community location such as a cultural centre or library, or in participants homes. There were some differences reported among communities in this regard, depending on liaisons' perceptions of what parents would best respond to, as well as considerations such as transportation, whether or not parents were professionals, and whether in general a cultural community placed a high value on social interaction and collectivity. For example, the Mandarin/ Cantonese speaking liaison tended to offer group sessions with a more formal power point presentation, reporting that this method helped her stay on track and helped parents learn. The Korean speaking liaison reported that she found that parents would not bring children to a community centre, so she instead grouped parents by location and offered sessions in parents' homes. This approach had the benefit of facilitating connections between the parents, who she had identified as being quite isolated.

All of the parents felt that translated materials were very important. Three parents said they were able to read English, but all were still more comfortable in their first language. Parents also mentioned that translated materials can be shown to other members of their community who did not attend the session, and be referred to for forgotten details later.

“Important, very important. If you give me English material I would lose patience with it and not read it.”

–Parent Interview, Chinese community

All of the parents felt pictures and hands on learning sessions helped them learn the health information. Parents appreciated seeing what decaying teeth look like and watching the liaisons make baby food to get a better understanding of the information.

Suggested changes to how sessions were offered included parents suggesting that having more written materials, pamphlets or booklets that they can take home with phone numbers and the key health messages, or perhaps a website they could refer to in their own languages. One liaison also suggested offering sessions in English in addition to those targeting specific communities. This may help to reach those with English as a second language and/ or individuals belonging to language or cultural communities that are not as common in Calgary so would not warrant a dedicated diversity liaison.

Recommended Health Topics

Both parents and external stakeholders said that nutrition and oral health are very important topics in their communities. However, there was evidence that the project might benefit from including education around other topics.

Other health topics suggested included:

- Child development, parenting and discipline
- Women's health, (e.g. reproductive health, breast ovarian and cervical cancers, and hormones)
- Skin health
- Diet and weight
- Senior health, including dementia and Alzheimer's
- Vision and eye health
- Heart health and diabetes
- Child and infant safety and injury prevention (e.g. childproofing the home, internet safety, and wearing helmets)
- Child first aid and common childhood illnesses
- Speech, language development, bilingual homes
- Education and the Canadian school system

Summary for Process:

- In general, the project appeared to be implemented as planned. However:
 - There were periods in which diversity liaisons may have spent more time on the project than anticipated;
 - The timing of the project presented challenges (in particular, a short time frame and overlap with the H1N1 outbreak); and
 - Having no dedicated project coordinator and a lack of clarity around mandate of other project staff compromised support for liaisons.
- Training and support for liaisons was generally sufficient, though suggestions for improvement were made (see below).
- Diversity liaisons reported that they found outreach and recruitment of parents to be more challenging than expected, and that they had not fully understood what this role looked like when the project began.
- Despite recruitment being noted as a key challenge, through trial and error liaisons eventually found successful recruitment techniques for their communities. Similarly, the liaisons developed ways of communicating the information that appeared to coincide with the needs of their communities.
- A total of 102 sessions were offered with over 100 parents attending each of the four topics.

Key Recommendations:

- Ensure that sufficient staff resources are allocated to provide support for the diversity liaison model, including a dedicated project coordinator and clear direction for content specialists and diversity liaisons to be involved.
- Allocate funding to provide instrumental supports such as childcare, snacks, and bus tickets to support programming for immigrant and refugee parents.
- Provide further training for diversity liaisons in adult learning principles which includes hands-on facilitation and presentation experience, as well as community development and outreach strategies.

OUTCOMES

Improved Staff Competency

All five diversity liaisons felt that they had improved their knowledge related to nutrition and oral health. Two said that learning this health material helped in their other roles as diversity liaisons because it increased the resources they have to offer their clients, made them more comfortable with community agencies, and gave them more tools to assess the support parents need by asking more questions about the child's meals. Liaisons shared benefits they felt to be involved with this project, including:

- Opportunities to work with professionals in other fields
- Bonding with the parents
- Improved confidence in working with their communities
- Learning new parenting skills and health information to apply in their own lives

All three of the content specialists also felt the liaisons had improved their competency related to health promotion messages in nutrition and oral health. They felt the liaisons had a good grasp on the health promotion information, how to prioritize the information and an increased understanding of their communities and how health changes happen in a community.

“Overall the lack of specific health backgrounds of the [liaisons] did not play as big of a role as anticipated.”

-Content Specialist Journal

Pre- and post-tests were administered to each diversity liaison prior to the training sessions and at the end of the project. Content specialists indicated that the pre-tests gave them a baseline upon which to plan the training sessions and to do a preliminary assessment of liaison knowledge. Pre-tests indicated a general knowledge of each of the areas, but identified a need to provide education and support in order to improve health promotion competency of the liaisons. Liaisons who had previously worked as interpreters had some information about the topic areas, but did not have the details necessary to educate and support parents in the project. Although being a parent was not a requirement for project participation, if the liaison did not have children of her own she was less likely to be familiar with the nutrition and oral health information targeted at parents with children 0-6 years prior to the training sessions.

There were a limited number of inaccurate responses on the post-tests; however, the responses were generally correct and much more detailed, representing enhanced health promotion competency of the liaisons following program training and participation. Increased familiarity with organizational standards, appropriate referral processes and strategies for working with parents was reflected in the post-test responses. Although some concerns with scope of practice remained, the majority of these issues appeared to be resolved by the end of the project.

All three content specialists also felt their own cultural competency had increased and that they had learned more about the communities the liaisons were involved with.

Cultural Competency of Material Resources

There was evidence that materials were adapted and became more culturally appropriate as the project progressed. During training of liaisons, the nutrition and oral health content specialists both adapted their resources to pare down the amount of information and focus on key messages that could be taught in a simple format. They also included props, pictures and videos, but had trouble finding translated resources and so could not have many written materials. One of the content specialists mentioned the conflict between trying to be culturally competent and not straying from rigorous, evidence-based Canadian recommendations.

While the liaisons were working with parents they made further changes to the materials. The liaison working with mostly African clients emphasized the role of Vitamin D for her clients because they are at higher risk for deficiency. Two of the liaisons felt culturally specific food traditions should also be included, such as grandparents and other family members being involved in the feeding relationship, feeding children on the floor for Eastern families or around the common bowl for African families. One mother said her child was a picky eater when eating at the table, but ate much better around the bowl with her family, and the liaison helped steer the mother back to her cultural traditions that seemed to help.

Four of the liaisons also mentioned the difference between Canadian recommendations for food items and the foods their immigrant parents were used to eating. The liaisons dealt with this discrepancy in different ways, with two of the liaisons doing some of their own research (and checking with the nutritionist) about food items from their clients culture. One liaison opened up the discussion and had parents share which foods they use, and gave the parents feedback about appropriate nutrition, and one tried to change the examples she used to be more culturally specific.

Three of the liaisons felt the materials were culturally competent by the completion of the project. One mentioned that the resources were very diverse, and that the liaisons had lots of flexibility in which resources they could use to best interact with their specific groups. Some groups responded better to professional style presentations, and some preferred informal discussions.

The other two liaisons did not feel the material was culturally competent. This was especially true for nutrition materials, because immigrants were not comfortable with the common Canadian foods the content specialists were using in their recommendations. For example, the content specialist focused on milk, which is common in Canada, but other cultures may use soy milk or goat milk. The content specialist did not feel comfortable recommending these alternatives because the evidence did not support their use. The liaisons felt oral health was culturally competent because the information is basic and less culturally specific.

One of the content specialists also felt there could be improvement in the cultural competency of the material, and suggested using translated resources that are easy to understand. The

content specialist cautioned that though incorporating 'holistic' culturally specific information can be valuable by showing clients that their practices may not be wrong or unacceptable, the liaisons need to rely on evidence-based information to support the key messages.

Increased Understanding of Nutrition and Oral Health Messages

All 12 parents who attended sessions on oral health reported learning about how to care for their child's mouth and teeth. Some pieces of information new to many parents included:

- Using a towel to clean their baby's gums before they grow teeth.
- Not to use toothpaste before the age of three.
- To brush and floss the child's teeth everyday even though they initially might not like it.
- To visit a dentist one to two times a year.

Thirteen parents who were interviewed attended sessions on nutrition. Some parents had prior information from the Best Beginning program, books, or family members, but all reported learning at least some new things from the liaisons. Common pieces of information that the parents learned include:

- Using homogenized milk while the child is young.
- When to start introducing complementary foods to breast feeding and which foods are appropriate for what ages.
- How to make baby food and freeze it for later.

Two parents also reported learning health information that was not directly related to nutrition or oral health. One parent learned how to be patient when the child is crying and the other learned how to use sun block and sunglasses to protect her child from sun exposure.

It is of note that at times parents shared inaccurate or conflicting information when reporting what they learned during sessions. Project staff felt that this suggested that more regular follow-up may be required for both liaisons and parents, and that take-home materials may be required for parents.

Adoption of Behaviour Changes Related to Nutrition and Oral Health

Parents also reported changes in behaviour after attending sessions with liaisons. Of the 12 parents who attended oral health sessions, nine reported changed behaviors. Many parents now clean their baby's gums and brush their children's teeth, and have stopped transferring objects from their own mouths to the baby's mouth. Some parents have also stopped giving their children pop and candy, and reported they are now visiting a dentist.

Eight of the 13 parents who received nutritional information reported changes in their behavior when feeding their child. Most of these changes were either in the content of the food, such as including more vegetables and meat instead of just cereals or rice, and in the way they were

feeding their children, such as picky eating techniques like sitting the child down at a regular time and place and repeatedly giving the child food they have rejected.

“I have several other children and previous I never worried about brushing the teeth, now I do. I’m more watchful about whether they do it or not.”

-Parent, Chinese Community

Parent Access to Health and Community Services

Eleven of the parents reported that they had places or people that they would ask for help after attending sessions with liaisons, though three mentioned that the language barrier presented a problem when communicating with those services. One parent said they didn’t know where to ask for help, one didn’t remember any of the services she had been referred to, and one was seeing a doctor but didn’t feel she had enough support and mentioned that she would like to see a pediatrician.

Of the parents that did feel they could find help, the sources of information mentioned were:

- Health Link
- Other telephone based services, such as 211 and the dental help line
- The internet
- Health clinics, vaccination clinics, dentists
- Community Associations, friends, family
- The diversity liaisons

Other services parents mentioned being referred to were the Blue Cross and a service from the Alberta Educational Department. Though evaluators attempted to assess any changes in parents’ confidence in attaining health information and help, only one parent answered this question directly, stating that

“Yes, I have confidence. First now I call [the liaison] for help, and second I keep in touch with the parent mothers we attended together and we share information, and [the liaison] gave me Health Link number so I can call them for the nurse.”

-Parent Interview, Korean Community

Information Sharing and Networking among Parents

Thirteen parents mentioned that they shared the health information from the peer education sessions with members of their community, and another but mentioned she had told some of her family members about the session. Specific health information was shared, involving brushing their children’s teeth, not spreading bacteria by sharing feeding implements with the baby, and feeding young children homogenized milk.

Two parents from the Korean community, the Korean liaison, and the Korean external stakeholder all mentioned that the parents in the Korean sessions had built up a network and had benefitted from the social aspect of the health sessions, sharing parenting information and breaking down the isolation some parents were experiencing.

"...[T]hey got to know each other really well after a few sessions, so they were going to keep meeting as a regular tea time thing so they had all made friends and they were going to keep it up. So they asked if they could retake my courses, and they told me if they had more sessions they wanted to keep coming."

- Liaison Interview

"[O]ne thing I want to emphasize is the parents were all stranger to each other but we are very friendly. We became friends."

-Parent Interview, Korean Community

Health Impacts

Though this evaluation did not aim to assess longer term health impacts of the project, two parents spontaneously mentioned that they had seen positive health impacts in their children since implementing the health behaviors they learned from the liaisons. Both of these parents saw improvements in their baby's mouths being cleaner. One parent said the dentist said she only has to visit once a year now because her baby's teeth are in very good condition.

One of the liaisons mentioned working first with a family to meet their basic health needs by contacting doctors and dentists and filling out health benefits paperwork before she could start her health messaging.

"They said we are struggling with this and this and that, so first I was really responsive to their needs, and in the remaining time did the topic I was there for. Some home visits, though that may be outside my real role, I really reduced those disparities I was really helping them with their reality."

-Liaison Interview

Summary for Outcomes:

- Evaluation results suggested increases in health promotion and diversity competency for liaisons, content specialists, and other AHS staff.
- There was evidence that culturally competent material had begun to be created, but that improvements could still be made in this area (particularly for nutrition content, which is more likely to need tailoring compared to oral health content).
- Increases in knowledge of nutrition and oral health were reported by all parents interviewed who attended sessions on these topics. More than half of these parents also reported that they changed their behaviour when feeding their child, and three quarters reported changing behaviour in relation to oral health.
- More than three quarters of parents interviewed reported increased access to health and community services.
- The majority of parents reported sharing information about the sessions with other members of their community, and the Korean community in particular reported that the sessions led to a great amount of social networking and reductions in social isolation.

Key Recommendations:

- Continue to develop culturally appropriate resources, including models or tools used in interaction with parents and materials that parents can refer to after sessions (for example, translated written materials or a website).
 - Continued interaction between content specialists and diversity liaisons while liaisons are working with parents and external stakeholders is necessary to enhance the cultural competence of resources.

DISCUSSION AND CONCLUSIONS

This evaluation suggests that using existing diversity liaisons employed by health services is an effective model to communicate health messages related to nutrition and oral health to immigrant and refugee parents of children 0 to 6. Despite some challenges to implementation, in particular, timing and staffing, this project was largely successful in terms of how the process was carried out and the outcomes achieved. In the relatively short timeframe of the pilot project, a large number of parents attended sessions with liaisons. Parents interviewed indicated increased understanding of health promotion messages, as well as changes in their behaviour related to those messages. Increases in health promotion and cultural competency were reported for liaisons and other Alberta Health Services staff, and culturally competent resources were beginning to be developed. The majority of those interviewed for the evaluation, including parents, content specialists, external stakeholders, and liaisons, felt that this project should continue.

Several limitations should be noted for this evaluation. First of all, because this report relies on mainly qualitative data, there is an element of subjectivity in the information presented. This limitation was mitigated by involving an external evaluation team to conduct analysis and reporting with the results. The evaluation lead is also trained in conducting qualitative research in ways that minimize bias (such as ensuring reflexivity and staying grounded in the data).

Secondly, though a strength of this evaluation was that it included detailed feedback from a relatively large number of individuals representing different perspectives, the parents interviewed for this evaluation may not be considered representative of all parents who participated in the pilot project, or of all immigrant and refugee parents in Calgary. Because of language considerations and time constraints, parents were recruited for interviews by liaisons themselves. Liaisons were asked to use discretion in choosing parents who varied with regard to characteristics such as socio-economic status, location in the city, and the number of sessions they attended. However, it is acknowledged that those interviewed were likely those parents who were able and willing who completed an interview, and this may have led to a selection bias. Evaluations of future projects may consider a regular feedback mechanism from a larger sample of parents attending sessions (for example, forms filled out immediately after attending sessions).

Thirdly, a member of the Reducing Disparities unit completed interviews with all evaluation participants, including liaisons, who were considered peers. Though this was at times reported to be "uncomfortable", no major issues were noted and interviews appeared to represent a good balance of positive aspects of the project and areas for improvement. This individual was not a direct member of the project team, but was close enough to have a good understanding of the context and major issues involved, which also added to the quality of the interview data collected.

The following are recommendations to consider for future or similar projects:

- It is recommended that this diversity liaison model to communicate health promotion messages to immigrant and refugee parents be pursued further.
 - Further exploration should include examination of whether this particular model is applicable and transferable to other ethno-cultural communities, geographical areas within the province, and health and social topics.
 - Other models for communicating and addressing health issues should also continue to be explored, including more 'pure' peer educator models if appropriate.
- Ensure that sufficient staff resources are allocated to provide support for the diversity liaison model, including a dedicated project coordinator and clear direction for content specialists and diversity liaisons to be involved.
- Allocate funding to provide instrumental supports such as childcare, snacks, and bus tickets to support programming for immigrant and refugee parents.
- Provide further training for diversity liaisons in adult learning principles which includes hands-on facilitation and presentation experience, as well as community development and outreach strategies.
- Continue to develop culturally appropriate resources, including models or tools used in interaction with parents and materials that parents can refer to after sessions (for example, translated written materials or a website).
 - Continued interaction between content specialists and diversity liaisons while liaisons are working with parents and external stakeholders is necessary to enhance the cultural competence of resources.
- Consider implementing a regular feedback mechanism to get feedback from a larger sample of parents attending sessions (for example, forms filled out immediately after attending sessions).

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APPENDIX A: EVALUATION FRAMEWORK

Project Objectives

The main objectives of Liaison Pilot Project include:

1. To develop and strengthen partnerships within AHS, and between AHS and stakeholders, to implement the liaison model for immigrant and refugee parents.
2. To further develop health promotion strategies/resources in an innovative, diversity competent manner for immigrant and refugee parents.
3. To reorient health services to facilitate access and increase uptake of health promotion messages for immigrant and refugee parents.
4. To enable liaisons to deliver evidence-based health information to immigrant and refugee parents.

Evaluation Framework

The following evaluation questions have been identified:

Inputs/ Infrastructure

11. Is the peer education model an appropriate effective means of providing health promotion information and services to immigrant and refugee parents?

Process – Activities and Outputs

12. Has the Liaison Pilot Project been implemented as planned (completed activities, milestones, successes and challenges)? Why or why not?
13. How has the partnership development within between AHS staff (liaisons, content specialists, etc.) and between AHS staff (liaisons) and external stakeholders helped in the implementation of the project (quality of the project; identification of the issues; construction and delivery of health promotion strategies, information and resources)?
14. Did the liaisons receive appropriate training and support to provide health promotion content to immigrant and refugee parents?

Outcomes

15. Has the diversity and health promotion competency improved among AHS staff and liaisons?
16. Are the health promotion strategies/resources diversity competent and useful for immigrants and refugee parents to enhance the health of their children?
17. Do immigrant and refugee parents adopt health behaviour changes (e.g., lift the lip) as a result of receiving health promotion information?
18. Do immigrant and refugee parents have increased understanding of health promotion messages that they have received through liaisons?
19. Do parents feel supported by the liaisons? How so?
20. How have liaisons facilitated immigrant and refugee parents' access health and community services/programs/resources?

Activities

The key activities in the Liaison Pilot Project include:

1. Selection and training of Liaisons
2. Providing ongoing support to Liaisons (training, regular discussion, feedback etc.)
3. Developing diversity competent strategies/resources
4. Identifying external stakeholders
5. Delivering health promotion information to immigrant and refugee parents
6. Working with external stakeholders and immigrant and refugee parents to develop and refine the project
7. Linking immigrant and refugee parents to appropriate health and social services

Outputs

Key outputs from the Liaison Pilot Project include:

1. Number and types of trainings for Liaisons
2. Number and reasons for Liaison consults
3. Number and types of strategies/resources developed
4. Number and type of stakeholders identified
5. Number and type of stakeholders participated
6. Number and types of requests for Liaison sessions
7. Number and types of Liaison sessions delivered and information given
8. Number of parents participated in each Liaison sessions
9. Number and types of referral to health and community resources
10. Number of immigrant and refugee parents linked and referred to appropriate resources
11. Number of contacts with stakeholders and immigrant and refugee parents to discuss health promotion information
12. Number and type of modifications made to strategies/resources
13. Stakeholders are satisfied with the partnership

Outcomes

The Liaison Pilot Project will have achieved its primary objectives if the following short-term outcomes have been achieved:

1. Liaisons understand the health promotion messages and methods
2. Liaisons feel supported in their role
3. Liaisons competently deliver health promotion messaging
4. Diversity appropriate training material produced
5. Immigrant and refugee parents have improved understanding of nutrition and oral health messages
6. Immigrant and refugee parents have improve understanding and access to health and community resources
7. Immigrant and refugee parents feel supported by Liaisons

8. Immigrant and refugee parents share information with their families/communities
9. Immigrant and refugee parents adopt behaviour changes for nutrition and oral health

Table 1. Activity Measures

The following will be used to measure the activities for the Liaison Pilot Project:

| Activities | Target Group | Data Source |
|--|---|--|
| Selecting and training of Liaisons | Reducing Disparities Health Promotion Specialist Liaisons | Project Documentation Reducing Disparities Team & Content specialist & Liaison Interviews |
| Providing ongoing support to Liaisons | Health Promotion Specialist Liaisons | Liaison & Content specialist Interviews & Journals |
| Developing diversity competent strategies/resources | Health Promotion Specialist Liaisons External stakeholders Parents | Liaisons & Content specialist Interviews & Journals External Stakeholder Interviews Parent Interviews/Focus Groups |
| Identifying external stakeholders | Liaisons External stakeholders | Liaison Interviews External Stakeholder Interviews |
| Delivering health promotion information to immigrant and refugee parents | Liaisons Parents | Project Documentation Liaison Interviews Parent Interviews/Focus Groups |
| Working with external stakeholders and immigrant and refugee parents to develop and refine the project | Liaisons External stakeholders Parents | Liaison Interviews External Stakeholder Interviews Parent Interviews/Focus Groups |
| Linking immigrant and refugee parents to appropriate health and social services | Liaisons Parents | Project Documentation Liaison Interviews Parent Interviews/Focus Groups |

Table 2. Output Measures

The following will be used to measure the outputs of the Liaison Pilot Project:

| Outputs | Target Group | Data Source |
|--|---|---|
| Number and types of trainings for Liaisons | Reducing Disparities Health Promotion Specialist Liaisons | Project Documentation Reducing Disparities Team & Content specialist Interviews |

| | | |
|--|---|---|
| Number and reasons for Liaison consults | Reducing Disparities Health Promotion Specialist Liaisons | Reducing Disparities Team & Liaisons & Content specialist Interviews |
| Number and types of strategies/resources developed | Health Promotion Specialist Liaisons | Content specialist & Liaison Interviews |
| Number and type of stakeholders identified | Liaisons | Liaison Interviews |
| Number and type of stakeholders participated | Liaisons External stakeholders | Liaison Interviews Project Documentation |
| Number and types of requests for Liaison sessions | Liaisons | Project documentation Liaison Interviews |
| Number and types of Liaison sessions delivered and information given | Liaisons | Project Documentation Liaison Interviews |
| Number of parents participated in each Liaison sessions | Liaisons Parents | Project Documentation Liaison Interviews Parent Interviews/Focus Groups |
| Number and types of referrals to health and community resources | Liaisons External stakeholders Parents | Project Documentation Liaison Interviews External Stakeholder Interviews Parent Interviews/Focus Groups |
| Number of immigrant and refugee parents linked and referred to appropriate resources | Liaisons Parents | Project Documentation Liaison Interviews Parent Interviews/Focus Groups |
| Number of contacts with stakeholders and immigrant and refugee parents to discuss health promotion information | Liaisons External stakeholders Parents | Project Documentation Liaison Interviews External Stakeholder Interviews Parent Interviews/Focus Groups |
| Number and type of modifications made to strategies/resources | Health Promotion Specialist Liaisons External stakeholders Parents | Liaisons & Content specialist Interviews & Journals External Stakeholder Interviews Parent Interviews/Focus Groups |
| Stakeholders are satisfied with the partnership | Health Promotion Specialist Liaisons External stakeholders | Liaisons & Content specialist Interviews & Journals External Stakeholder Interviews |

Table 3. Outcome Measures

The following will be used to measure the outcomes of the Liaison Pilot Project:

| Outcomes | Target Group | Data Source |
|---|---|--|
| Liaisons understand the health promotion messages and methods | Reducing Disparities Health Promotion Specialist Liaisons | Reducing Disparities Team & Content specialist & Liaison Interviews Liaison & Health Promotion Specialist Journals |
| Liaisons feel supported in their role | Health Promotion Specialist Liaisons | Liaison Journals Liaison & Content specialist Interviews |
| Liaisons competently deliver health promotion messaging | Liaisons Health Promotion Specialist External stakeholders Parents | Liaison & Content specialist Interviews Liaison & Health Promotion Specialist Journals External Stakeholder Interviews Parent Interviews/Focus Groups |
| Diversity appropriate training material produced | Health Promotion Specialist Liaisons Parents | Liaison & Content specialist Interviews Liaison Journals Parent Interviews/Focus Groups |
| Immigrant and refugee parents have improved understanding of nutrition and oral health messages | Parents | Parent Interviews/Focus Groups |
| Immigrant and refugee parents have improve understanding and access to health and community resources | Parents | Parent Interviews/Focus Groups |
| Immigrant and refugee parents feel supported by Liaisons | Parents | Parent Interviews/Focus Groups |
| Immigrant and refugee parents share information with their families/communities | Parents | Parent Interviews/Focus Groups |
| Immigrant and refugee parents adopt behaviour changes for nutrition and oral health | Parents | Parent Interviews/Focus Groups |

Data Sources and Methodologies

Immigrant and Refugee Parents Interviews

Immigrant and refugee parents who have received health promotion information from the liaisons will be asked to participate in a first language face-to-face interview to discuss their experience with the liaisons. The participants will also be asked to relate how these sessions

have made an impact on their understanding of the health promotion messages delivered to them by the liaisons, whether they made any modifications to their parenting behaviours, and whether or not they felt supported by the liaisons. The interviews will be conducted in the participants preferred language. The interviews will be tape-recorded and transcribed. The transcripts from the interviews will be translated into English prior to data analysis. The interviews will be semi-structured and an interview guide has been prepared for the purpose to guide the process.

5 face-to-face interviews will be conducted from each ethnic community. *However, in some communities focus groups might be a better way of collecting information. Therefore, in some instances focus groups might also be conducted. To be determined in conversation with liaisons.

Content specialist, Liaison, Reducing Disparities Team and External Stakeholder Interviews

Face-to-face interviews will be conducted with all of the content specialists (content specialists and reducing disparities team members), liaisons, and external stakeholders. These interviews will be conducted in English. The interviews will be semi-structured. Separate interview guides have been developed for the interviews. The interviews will be tape-recorded and transcribed. The transcript from the interviews will be used for the data analysis.

Content specialist Journals

Content specialists have kept journals on ongoing issues, challenges, successes, etc. throughout the project. This information will be analyzed and used in final reporting.

Liaison Journals

Liaisons have kept journals on ongoing issues, challenges, successes, etc. throughout the project. This information will be analyzed and used in final reporting.

Project Documentation

Project documentations such as the peer-liaisons self-evaluation forms, liaison resource list, and participant attendance list will be analyzed. The information will be used in final reporting.

APPENDIX B: LETTER RECRUITING PARENTS FOR EVALUATION INTERVIEW

March 30, 2010

Dear [Immigrant and Refugee Parents]:

We have asked [name of diversity liaison] to send you this letter. We are staff of Alberta Health Services who have been working with [name of diversity liaison] to provide you with services like the sessions on healthy eating for your baby or toddler and healthy teeth. We are doing an evaluation of this program to help us decide how well the program is working and to make improvements if needed. As part of this evaluation we are talking to parents like you, to learn more about your experience with the program. We would be interested in hearing all opinions, including positive comments and areas that may need improvement.

Thank you again for agreeing to participate in an interview. We will be phoning you on {insert date and time here} and the interview will be given by staff from Alberta Health Services, with help from a translator so that you can speak in your preferred language. [name of diversity liaison] will not be present. The interview will be approximately thirty to sixty minutes long. As {name of diversity liaison} mentioned, the interview is voluntary, and will not affect your involvement in sessions on healthy eating and healthy teeth, or anything else offered by Alberta Health Services. We will also offer a compensation (\$25 gift certificate to either Safeway or Superstore) to thank you for your time. We look forward to speaking with you.

If you have any questions prior to our interview, please contact [name of diversity liaison]

Thank you in advance,

Claudia Canales, Reducing Disparities
Alberta Health Services

Robyn Sachs, Evaluation Team
Alberta Health Services

APPENDIX C: PARENT INTERVIEW GUIDE

Participant name/ initials:

Assigned participant ID: _____

Community/ language:

Translator:

Date/ Time:

Thank you for agreeing to this interview with us today. We are interested in learning about your experience and what you thought of the sessions on healthy eating for your baby, healthy eating for your toddler, and healthy teeth offered by [Diversity Liaison] (Determine who - Yvonne, Sylvie.....etc.). This will help us improve health messages that will allow parents to keep their children healthy.

Anything you said here today will be kept confidential. Your name will not be associated with your comments, so please be honest in your answers because it will help us to understand what is working well and what isn't working well. There are no right or wrong answers. If you don't feel comfortable answering a question, you can just not answer it. It is your choice whether you want to do this interview with us, and you can stop the interview at any time. Doing the interview will not affect your involvement in sessions on healthy eating and healthy teeth, or anything else offered by Alberta Health Services. Do you have any questions before we start?

There are three people here to help do this interview. Claudia from Alberta Health Services will be asking the questions, I will be translating her questions and your responses. Ariel is from the evaluation team of Alberta Health Services, and will be typing notes on what I translate. The interview will take up to one hour, and you will be given a \$25 gift certificate to either Safeway or Superstore to participate.

To begin with, we want to ask you some questions to make sure we have your consent to take part in this interview. Can you tell me your understanding of why we are talking today? We just want to make sure we have explained things clearly.

[Make sure they understand it is an evaluation of the peer educator program, that they will be asked questions about their work with diversity liaison. Repeat or provide additional information if needed]

Are you comfortable doing this interview with us today?

Yes No

Are you comfortable with Ariel taking notes on what you say as I translate it? These notes will be seen by members of the evaluation team only, who will summarize them into a report.

Yes No

Do you have any questions or concerns that you would like us to address?

Yes No [If yes, address the question/ concerns before moving on]

Would you be comfortable with us including some of the translated quotes of what you say during the interview in a report about the evaluation of this program? You can say no and still agree to do the interview.

Yes No

[If participant is not comfortable with doing the interview or having notes taken, do not complete the interview unless they feel more comfortable by having questions or concerns addressed. If they are not comfortable including quotes, complete the interview and make a note so that evaluator does not include quotes for this participant.]

Questions are about your involvement with these discussion groups:

1. Did you attend a group or receive information on healthy teeth? (If no, why not?/If yes, carry on to 1.1)
 - 1.1. How did you find out about this session?
 - 1.2. What did you learn from this session? Was any of the information that you learned new to you? If so, what was new? Probe if not new: Where or from who did you learn about this topic before you came to these sessions?
 - 1.3. Do you do anything differently now because of what you learned? If so, what do you do differently and why?
 - 1.4. If you have a question that comes up in the future about healthy teeth, are you more confident that you will be able to ask for the help you need? Probe: Where would you go for answers/ help?

2. Did you attend a group or receive information on healthy eating for your baby? (If no, why not?/If yes, carry on to 2.1)
 - 2.1. How did you find out about this session?
 - 2.2. What did you learn from this session? Was any of the information that you learned new to you? If so, what was new? Probe if not new: Where or from who did you learn about this topic before you came to these sessions?
 - 2.3. Do you do anything differently now because of what you learned? If so, what do you do differently and why?
 - 2.4. If you have a question that comes up in the future about healthy teeth, are you more confident that you will be able to ask for the help you need? Probe: Where would you go for answers/ help?

3. Did you attend a group or receive information on healthy eating for your toddler? (If no, why not?/If yes, carry on to 3.1)
 - 3.1. How did you find out about this session?
 - 3.2. What did you learn from this session? Was any of the information that you learned new to you? If so, what was new? Probe if not new: Where or from who did you learn about this topic before you came to these sessions?
 - 3.3. Do you do anything differently now because of what you learned? If so, what do you do differently and why?

- 3.4. If you have a question that comes up in the future about healthy teeth, are you more confident that you will be able to ask for the help you need? Probe: Where would you go for answers/ help?

General Questions/ Outcomes

4. Was it helpful for you to receive health information from Yvonne? If yes, what was helpful and why?
- 4.1 Do you feel your contact with (DL) _____ helped you access other health and community services to improve your child's health? (Probes: finding a doctor, language line, Health Link, dental clinic, food bank, etc.). If yes, what are the services they referred you to? If no, please explain why not?
- 4.2 "Were you satisfied with the services that DL(____) helped you access, or are there any other types of services or help that you would have liked to have access to?"
- 4.3 What do you feel is the best way to get health information to you? (Probe: one-on-one, in a group with other parents, written information in your language, home visits, etc.)
5. Did you share any of the information you learned from (DL) _____ with other members of your community? Please explain.
6. We have a few questions about the way the information was provided to you. How important are each one of these factors to you (very important, important or not important)
- 6.1. Was it very important, somewhat important or not important to have information provided in your first language? Please explain.
- 6.2. Was it very important, somewhat important or not important to have the following supports provided at the group or session:
- 6.2.1. Snacks (Please explain)
- 6.2.2. Child care (Please explain)
- 6.2.3. Bus tickets (Please explain)
- 6.3. Was it very important, somewhat important or not important to have the following teaching tools:
- 6.3.1. Translated materials (Please explain)
- 6.3.2. Pictures or props (Please explain)
- 6.3.3. Hands-on sessions to show you how to do things – lifting the lip, make baby food, etc. (Please explain)
7. Would you have preferred that it was someone from your ethnocultural community providing you with health information (for example, someone that you were familiar with or knew beforehand?)
8. If these groups were to continue in the future would you be interested in attending? Why or why not?

- 8.1. What are the most important health issues in your community? Probe: What other topics do you think you and other parents in your cultural community would be interested in learning more about?
- 8.2. What is the best way to reach out to people in your community to address these health issues? Do you have any suggestions for other ways to address health issues, aside from educational sessions?
- 8.3. How could we inform people about sessions like the one offered by DL(____)?

9. Will you recommend these groups to a friend? Why or why not?

Any additional comments _____

APPENDIX D: DIVERSITY LIAISON INTERVIEW GUIDE

Community/ language:
Assigned participant ID:

Date/ Time:

We are doing this interview today to evaluate the Peer Educator Pilot Project. We would like to ask you a few questions about what you think of the project. Please provide your answers as accurately as possible. Your answers will help us understand what is working well and what isn't working well.

Anything you say here today will be kept confidential. Your name will not be associated with your comments, so please be honest in your answers because it will help us to understand what is working well and what isn't working well. There are no right or wrong answers. Our understanding is that taking part in this interview and the evaluation is considered to be part of your role as a diversity liaison/ peer educator. However, if you don't feel comfortable answering a question, you can just not answer it. Do you have any questions or concerns about this?

Yes No

Ariel will be taking notes during the interview. She has identified you as a peer educator in the ____ community, but has not included your name. Any feedback you give about the program will remain confidential. For example, we will report feedback about the program as a summary of what the group says, so that you will not be personally identifiable. We may include quotes from the interview in our report, but would not include any names. However, your suggestions about specific cultural strategies for your community may be included in the evaluation report. This entire interview will take approximately 1 hour.

Are you comfortable doing this interview with us today?

Yes No

Are you comfortable with Ariel taking notes on what you say? These notes will be seen by members of the evaluation team only, who will summarize them into a report.

Yes No

Do you have any questions or concerns that you would like us to address?

Yes No [If yes, address the question/ concerns before moving on]

Would you be comfortable with us including quotes of what you say during the interview in a report about the evaluation of this program? You can say no and still agree to do the interview.

Yes No

[If participant is not comfortable with doing the interview or having notes taken, do not complete the interview unless they feel more comfortable by having questions or concerns addressed. If they are not comfortable including quotes, complete the interview and make a note so that evaluator does not include quotes for this participant.]

Questions are about your involvement with these peer educator health promotion sessions:

Background

1. Describe your understanding of the peer educator model?
2. What was your role in this project?
3. Do you feel that this role was clear to you?

4. How would you describe the intended target group for the peer educator program?
5. Do you feel that you reached this target population? Please explain.

6. Please describe the target population that you worked with on this pilot project.
 - a. Probes: Please describe the parents you worked with in terms of:
 1. What area of the city they lived in?
 2. Number and ages of children
 3. Your sense of the support that was available to them – either from their own family or more formal social supports.
 4. Languages spoken in the home?
 5. Number of months/years in Canada?
 6. Marital status?
 7. Their socio-economic status?

7. Based on your FTE, how much time do you think you spent on this project when you were actively involved in training, recruitment, program delivery and administrative duties?

Training and Support to Deliver Health Promotion Messages

8. To what extent do you feel that you received adequate training to deliver health promotion information to parents? Why, Why not? What changes would you suggest?
 - a. Were the messages provided to you in a way that you could effectively use the information to teach parents? Please explain.
 - b. Was the material culturally appropriate? Why or why not? Can you comment specifically on Nutrition materials? Specifically on Oral Health materials?
 - c. Please describe any changes made to the training [to the material during training?] that helped you better use the information to teach parents.
9. Based on the contents of the current kits, were they appropriate to use or are further modifications necessary? Please explain. Can you comment specifically on Nutrition materials? Specifically on Oral Health materials?

Activities and Outputs

10. Please describe what educational strategies and format you used to work with your groups (lecture, facilitated discussion, informal one-on-one discussion)?
 - a. Why did you choose this/ these format(s)?
 - b. Which did you feel worked the best? Why?
11. Please describe any cultural modifications made to the presentations to meet the needs of parents with children 0-6 years.
12. What other types of health promotion information do you feel parents in the cultural group you were assigned to work with need to raise healthy children? What gaps, if any, exist?
13. How did you work with other agencies to implement this project (probe: recruitment, child care, space generating interest)?
 - a. Did this help you achieve the goals of the project? Why or why not?
 - b. What were the challenges?
14. How important was it to provide the following to the parents you connected with:
 - i. Snacks (Please explain)
 - ii. Child care (Please explain)
 - iii. Bus tickets (Please explain)
15. The following questions involve the collaboration amongst AHS staff in conducting this project.
 - a. Did you improve your role as a diversity liaison by working with other AHS staff? Please explain.
 - b. Did working with other AHS staff help to achieve the goals of the project? Why or Why not?
 - c. Can you describe any challenges in working with other AHS staff?
 - d. Did this project increase the cultural competence of other AHS staff involved with this project? Please explain.
16. We would like your general impressions on the support provided to you throughout this project, and the best ways we could provide support in the future if the project were to continue. Please explain how you felt supported by the following:
 - a. Supported by trainers?
 - b. Supported by other diversity liaisons/ peer educators?
 - c. Supported by project coordinators?
 - d. If yes, how? If no, explain what improvements could be made?

Outcomes and General Comments

17. What were the specific successes that you had with your target groups?
18. What were the challenges in working with your target groups?
19. What were the overall challenges with the project?
20. Do you feel your competency in health promotion knowledge in the content areas of nutrition and oral health has increased? Why? Why not?

21. Do you feel that the peer educator role should continue as a part of the diversity liaison role?
 - a. What are the advantages, if any, to including this as a part of your role?
 - b. What are the disadvantages, if any, to including this as a part of your role?
22. Do you feel that this model is an appropriate way to get health promotion information out to parents with children 0-6 years in your community? Please explain.
 - a. Is the health promotion information diversity competent? Please explain.
 - b. Have parents improved their understanding of health promotion messages in nutrition and oral health? Please explain.
 - c. Have parents changed their health behaviour related to nutrition and oral health? Please explain.
 - d. Have parents accessed to other services increased? Please explain.
23. What advice/recommendations would you give for the future implementation of this project?
24. Are there any other comments that you have about this project?

Thank you. These are all the questions that I have. Here is my contact information if you think of something else later please contact me.

APPENDIX E: CONTENT SPECIALIST INTERVIEW GUIDE

Participant name/ initials:

Assigned participant ID: _____

Community/ language:

Date/ Time:

We are doing this interview today to evaluate the Peer Educator Pilot Project. We would like to ask you a few questions about what you think of the project. Please provide your answers as accurately as possible. Your answers will help us understand what is working well and what isn't working well. Your participation is voluntary. If you do not feel comfortable answering a question, you can just not answer it. You are also free to refuse participation altogether or withdraw at any time.

Anything you said here today will be kept confidential. Your name will not be associated with your comments, so please be honest in your answers because it will help us to understand what is working well and what isn't working well. There are no right or wrong answers. Our understanding is that taking part in this interview and the evaluation is considered to be part of your role as a Health Promotion Strategist in the area of _____. However, if you don't feel comfortable answering a question, you can just not answer it.

Do you have any questions or concerns about this?

Yes No

Ariel is from the Evaluation Team of Alberta Health Services. She will be taking notes during the interview. She has identified you as a peer educator in the ____ community, but has not included your name. Any feedback you give about the program will remain confidential. For example, we will report feedback about the program as a summary of what the group says, so that you will not be personally identifiable. We may include quotes from the interview in our report, but would not include any names. This entire interview will take approximately 1 hour.

Are you comfortable doing this interview with us today?

Yes No

Are you comfortable with Ariel taking notes on what you say? These notes will be seen by members of the evaluation team only, who will summarize them into a report.

Yes No

Do you have any questions or concerns that you would like us to address?

Yes No [If yes, address the question/ concerns before moving on]

Would you be comfortable with us including quotes of what you say during the interview in a report about the evaluation of this program? You can say no and still agree to do the interview.

Yes No

[If participant is not comfortable with doing the interview or having notes taken, do not complete the interview unless they feel more comfortable by having questions or concerns addressed. If they are not comfortable including quotes, complete the interview and make a note so that evaluator does not include quotes for this participant.]

Background

1. What was your understanding of the peer educator model?
2. What was your role in this project?
3. How much time did you spend in:
 - a. Training the peer educators?
 - b. Supporting the peer educators?
 - c. Administrative role (evaluation, reporting)?

Process: Outputs and Activities

4. Were there any modifications made to the training materials, resources and strategies to meet the needs of immigrant and refugee parents with children 0-6 years. If yes, what were they and how was this done?
 - a. Probe: What changes were made to the materials, if any, during training?
 - b. Probe: Did any of the peer educators approach you to make changes to the material once they had started using them with parents? Please describe this process.
5. Please describe your relationship with the peer educators in this project.
 - a. How well did you feel you were able to provide ongoing support to peer educators? Please explain.
 - b. How important do you feel your relationship with the peer educators was to the success of the project? Please explain.
6. Please describe your relationship with the other Alberta Health Services staff in this project.
 - a. Did you get the support you feel you needed to carry out your role? Please explain.
 - b. How important do you feel your relationship with AHS staff was to the success of the project? Please explain.
7. Do you have any suggestions for future training in your content area?
8. Do you have any suggestions for training in other content areas or educational techniques in the future?
9. To what extent do you feel that your diversity competency improved over the course of this project?

Outcomes

10. In general, do you feel that the peer educators understand the health promotion messages and methods after receiving training? Do you feel they are competent in the delivery of health promotion messaging at the end of the project?

- a. What improvements would you suggest, if any?
11. Do you feel that diversity appropriate training material was created? Please explain.
12. How effective was it to work with the diversity liaisons to relay health promotion messages to at risk populations. Please explain.
13. What were the specific successes of this project?
14. What were the overall challenges with the project?
 - a. Probe: Do you feel that these challenges got in the way of the success of the project? Please explain.
15. Do you feel that this model is an appropriate way to get health promotion information out to parents with children 0-6 years in immigrant and refugee communities? Please explain.
16. What advice/recommendations would you give for the future implementation of this project?
17. Are there any other comments that you have about this project?

Thank you. These are all the questions that I have. Here is my contact information if you think of something else later please contact me.

APPENDIX F: EXTERNAL STAKEHOLDER INTERVIEW GUIDE

Participant name/ initials:

Assigned participant ID: _____

Community/ language:

Translator:

Date/ Time:

Hello, I am (name of the interviewer) from Alberta Health Services – Calgary. We are evaluating the Peer Educator Pilot Project which began last fall. It involved training diversity liaisons who spoke the language of the communities we wished to work with about child nutrition and oral health. Diversity liaisons then connected with individual communities to share this health promotion information with parents with children 0 to 6 years of age. We would like to ask you a few questions about what you think of the project. This will help us in improving the design and delivery of health messaging, making them more culturally appropriate and accessible for other parents.

Please provide your answers as accurately as possible. Your answers will help us understand what is working well and what isn't working well. Your participation is voluntary. If you do not feel comfortable answering a question, you can just not answer it. You are also free to refuse participation altogether or withdraw at any time. Your or your organization's name or other identifying information will not be reported and will be removed to protect your identity. This entire interview will take approximately 20-30 minutes.

There are three people here to help do this interview. Claudia from Alberta Health Services will be asking the questions, I will be translating her questions and your responses. Ariel is from the evaluation team of Alberta Health Services, and will be typing notes on what I translate. The interview will take up to one hour.

Are you comfortable doing this interview with us today?

Yes No

Are you comfortable with Ariel taking notes on what you say as I translate it? These notes will be seen by members of the evaluation team only, who will summarize them into a report.

Yes No

Do you have any questions or concerns that you would like us to address?

Yes No [If yes, address the question/ concerns before moving on]

Would you be comfortable with us including some of the translated quotes of what you say during the interview in a report about the evaluation of this program? You can say no and still agree to do the interview.

Yes No

[If participant is not comfortable with doing the interview or having notes taken, do not complete the interview unless they feel more comfortable by having questions or concerns

addressed. If they are not comfortable including quotes, complete the interview and make a note so that evaluator does not include quotes for this participant.]

Questions about your involvement with these peer educator health promotion sessions:

Background

1. What is your understanding of the Peer Educator Pilot Project?
 - a. Who was the diversity liaison that you were in contact with for the project?
2. What was your role in this project?

Outcomes

3. Tell us about the health needs of parents with children 0-6 in your cultural community.
4. Do you feel that a project like the peer educator project will assist in meeting those needs if it were to continue in the future? Yes?/No?, Why?/Why not?
5. Do you think the model of having a diversity liaison from Alberta Health Services that speaks the language of your cultural community and provides health promotion information to parents is/would be effective?
 - a. If yes, what types of impacts have you seen/do you foresee for immigrant and refugee parents?
 - i. Probe: health behaviour changes?; Access to services?; Social isolation?
 - b. If no, what suggestions do you have for us to make this better?
6. Do you feel that this project has been helpful for parents with children aged 0-6 in your community? Please explain.
7. What were the challenges of this project, if any?
8. Do you feel that your organization could work with staff of this project to meet the needs of parents with children 0-6 in your community?
 - a. What should AHS be providing?
 - b. What could your organization provide?
9. Are you satisfied with the input you were able to provide regarding delivering health promotion information for parents with children 0-6 years in your community through this project? If no, how could we get your input?
10. Are there other strategies you would suggest to increase access to health promotion information for families from this cultural group? If yes, what are they?
11. Would you be willing to participate in a committee to further direct this project should it continue? If no, why not?
 - a. Probe: [If they need to check with someone (ie. Manager)]: If you had the permission to, would you be willing to participate? Is it important?
 - b. Probe: Is there a different member of your organization who we might be able to connect with to see if they might be interested in participating on a committee to direct this project if it continues?
12. Do you think this project should continue in the future? Why/Why not?
13. Do you have any other comments about anything we spoke about today?

Thank you. These are all the questions that I have. Here is my contact information if you think of something else later please contact me.