A Message from the Research Team

There has been tacit acknowledgement of the value of a "learning health system" in British Columbia, championed primarily through non- or arms-length government agencies such as Health Research BC (Health Research BC, 2024). The concept itself has been the topic of discussion across disparate health systems internationally, seen by most as part of the solution to address challenges of healthcare supply, demand, access, and equity that we are currently facing. At its core, a learning health system aims to facilitate learning for the purposes of adjustment and improvement based on patient encounters and those working in the system "at the coal face" in an iterative cycle of continuous learning. These cycles, or "feedback loops," are rooted in authentic patient or community engagement so that an understanding of the lived and living experiences of receiving healthcare inform health system improvement. The output taps into system change through collaboration and partnerships among the "pentagram partners" in healthcare, including healthcare providers, administrators, decision-makers, researchers, and patients/communities (Boelen C, 2000). Ultimately, however, productive output from a learning health system requires policy support to implement evidence-based changes.

In addition to being informed by the move towards a learning health system, healthcare planning and delivery in Canada has also witnessed an increasing focus on meeting the needs of vulnerable populations or those who do not have equitable access to care. Lack of appropriate access may be due to geography or social conditions including historical experiences of non-inclusion or contemporary experiences of barriers precipitated by influences such as language, race, sexual orientation, or income status. Beyond Canada's commitment to accessibility expressed in the Canada Health Act ("… that a province or territory provide reasonable access to insured health services on uniform terms and conditions and without financial or other barriers" [Health Research BC, 2024]), British Columbia has committed to reducing health disparities across all populations (Provincial Health Services Authority, 2011). Although this reflects an ethical commitment to justice and inclusivity which, in and of itself is intrinsically valuable, there are also pragmatic incentives to promote health equity across a diverse population, including improving population health (Bhatt, 2018), enhancing community well-being (Morten et al., 2023) and optimizing resource allocation (Bhatt, 2018). This leads to the contention that planning healthcare based on the needs of the most vulnerable communities will lead to a robust healthcare system for all (Rod et al., 2023). Given this, prioritizing data and evidence that supports well-functioning healthcare innovations to meet the needs of diverse communities is essential.

We know that innovation often arises in low resource settings in response to limited infrastructure, financial constraints, and healthcare provider scarcity. Recognizing the potential to shift conventional thinking and see such settings not through a deficit lens but as sites for best practices, provides productive opportunities when thinking about healthcare optimization.

Such is the case with Umbrella Multicultural Health Co-op (UMHC), through their commitment to immigrant, refugee, and newcomers' health and well-being. The Cross Cultural Health Broker model employed at UMHC not only improves care for patients but also takes advantage of the skills, training, and experiences of healthcare professionals trained in different jurisdictions. Training and empowering the latter increases the overall health of the community of newcomers to Canada.

As alluded to above, learning health systems are data driven, where data must be understood expansively to included not only peer-reviewed scientific data, but also individual and community experience of care. When this is overlooked, it not only exacerbates the conceptual and experiential distance between those organizing and those receiving care, but it also misses the opportunity for *grounded* quality improvement. This project sought to bring together the strands of our larger social commitment to healthcare equity, optimal use of health human resources, and the focus on scaling up innovation. The resounding positive experiences by both patients and Cross Cultural Health Brokers that we documented, however, will only lead to change if there is a larger political commitment to the values of the Learning Health System, promoting equity and scaling up innovation. We believe that the potential for system alignment of these values is high and present these findings to effect evidence-based solutions.

Sincerely,

The Umbrella – CCHB Research Team

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Project Overview

This project was borne out of the recognition of the productive intersection between solutions for optimizing the healthcare training, experience, and abilities of newcomers to Canada, the current constricted health human resource environment in British Columbia, and our social commitment to provide appropriate access to healthcare for all residents, including those who have immigrated or arrived as refugees.

We set out to better understand and document an innovative model of employing Internationally Trained Health Professionals as Cross Cultural Health Brokers (CCHBs) to provide culturally competent and appropriate care to immigrants, refugees, and newcomers to Canada at the Umbrella Multicultural Health Co-op (UMHC). At UMHC, Cross Cultural Health Brokers (CCHBs) are defined as bilingual/bicultural health workers who bridge language and cultural barriers to support the care of immigrants, refugees, and newcomers to Canada (Umbrella Multicultural Health Co-op, 2017). CCHBs assist patients and participants from their communities in accessing medical services, social services, and health promotion activities while supporting the relationship between patients and family doctors. Currently, UMHC supports care in five service languages: Spanish, Arabic, Tigrinya, Farsi/Dari, and English.

Initial contact with the Umbrella Multicultural Health Co-op by the principal investigator (JK) in the summer of 2023 ignited a curiosity about the productive use of newcomer professional healthcare experience and harnessing this resource to meet population level need, juxtaposed with the relative anonymity of the model of cross cultural health brokerage, from a health systems perspective. That is, the outcomes, provider and patient experience, and system integration of the use of healthcare professionals trained in other jurisdictions is not widely known about or discussed. Given the human resource challenges that currently besiege healthcare in Canada, there is a social responsibility to scale up models that appear to be effective, which requires a close examination of the model itself. As leaders at the UMHC expressed in an initial meeting that they are drastically under-resourced to meet community need, it was concluded that advocacy for additional resources required, as a starting place, data on its efficacy in both serving the target population and using to capacity the resources of healthcare professionals trained in other jurisdictions.

To this end, the goal of this project is to describe and document the role of Cross Cultural Health Brokers in increasing access to culturally appropriate healthcare for immigrants, refugees, and newcomers to Canada. Specific objectives include understanding and documenting:

1) The role internally trained healthcare provider (ITHP)-based CCHBs play in facilitating access to healthcare for new Canadians by documenting activities and approaches;

2) The impact of this facilitation from a patient perspective, including likely courses of action if the CCHB was not available;
3) The motivation and satisfaction of ITHPs who undertake role; and,
4) Investigating a systematic approach to better utilize the untapped resource of internationally trained healthcare providers.

Anecdotal and observational evidence through UMHC already attest to the efficacy of this model. By rigorously documenting impact and satisfaction for both care providers and patients, we can contribute to an emerging evidence base that can lead to better use of existing resources (ITHPs) to meet the needs of a vulnerable population in a cost-effective way. Aiming to improve healthcare access, this fills a knowledge gap in the community social service sector. The goal is to provide local evidence for health system decision-makers to guide and shape regional and/or provincial decisions. Utilizing the unique insights of ITHP Cross Cultural Healthcare Brokers and immigrant/refugee populations seeking healthcare will enhance the current comprehension of how the social services sector can effectively address increasingly diverse and complex needs.

Alignment with SPARC's Goals and Objectives

This work is based on actualizing our social commitment to reducing health disparities and promoting equity for vulnerable populations, which aligns with SPARC's values of promoting social justice through a lens of inclusion. Creating a feedback loop between those providing and receiving services through the CCHB model and policy and decision-makers through prioritizing the voices of those with lived and living experiences moves us further towards the system capacity to iteratively adjust based on emerging information, leading to a more robust approach to health equity. This process reflects SPARC's core process framework, starting with gathering community data to inform planning and leading to building partnerships to ensure the ongoing capture of relevant data for quality improvement.

Meeting Project Goals and Objectives: How did we do?

We met all project goals for Phase I, starting with further developing the collaboration between the Centre for Rural Health Research and the Umbrella Multicultural Health Co-op. As all meaningful work with communities – particularly communities at a social disadvantage due to power and resource imbalances – rests on authentic relationships, developing and nurturing these relationships was the starting point for our work. This allowed productive partnerships that worked to strengths, with those from UMHC providing the history and context of the work and facilitating recruitment of participants and with CRHR offering methodological expertise in gathering, analyzing, and reporting relevant data. We also experienced some challenges that provided valuable learning.

There are always challenges in cross-cultural/multi-linguistic research that exceed the capacity of language translators to solve. There are cultural attributions of meaning to common words that may be different from the semantic or literal meaning that can be glossed over during the translation process. Although we had good translation for interviews with participants when required, our experience with translators reinforced the value of the work of CCHBs who go beyond language interpretation to identify and describe key concepts through a cultural lens, both to patients and clients, and then reciprocally back to healthcare providers. Our micro-experience of the differences in literal versus cultural translation reinforced the value of cultural interpretation alongside language interpretation and solidified for us the importance of this distinction in clinical encounters.

As we prepared for this work through conversations with Umbrella leadership and a thorough review of the literature, we had a solid background understanding of the challenges in access to health and social care for the target population and the context that informed their need for care. That is, some members of the target population arrive in Canada after facing trauma or discrimination in their country of origin and bring with them an array of healthcare beliefs and practices which may be at odds with the normative healthcare culture in British Columbia. Understanding this prior to the interviews contributed to creating the conditions for successfully learning from the participants about their experiences.

Background and Context

The Need for Culturally Appropriate Care for Newcomers to Canada

British Columbia (BC) is the landing site for diverse communities of immigrants, refugees, and newcomers to Canada due to its temperate climate and the opportunity the province offers for improved quality of life (Welcome BC & Province of British Columbia, 2023). Although the Lower Mainland in particular offers an array of social services to aid in the settlement process, cultural, language, and access challenges to healthcare still exist. Such barriers stem from lack of familiarity with the healthcare system, lack of understanding of normative behaviour around healthcare, and in many instances, a lack of trust due to the episodic nature of healthcare interactions (Ahmed et al., 2016). For many, the lack of adequate access is compounded by poor social determinants of health once they arrive in Canada, such as inadequate housing, unemployment, and a lack of education and broader social support. Some individuals also may arrive in Canada with pre-existing health conditions or trauma, which can affect their overall health and well-being (Zivot et al., 2022). This can subsequently lead to increased rates of post-traumatic stress disorders (PTSD), depression, and anxiety (Henkelmann et al., 2020).

Additionally, higher prevalence of certain chronic disease conditions may be present in certain populations due to genetics, but also lifestyle changes and limited access to preventative care upon arrival in Canada (Wang & Kwak, 2015). This is known as the “healthy immigrant effect”,

referring to the deterioration in health status over time for most immigrants despite arriving in Canada with a higher-than-average health status compared to the average Canadian (McDonald & Kennedy, 2004). More than just impacting health status and quality of life for this population, health inequities in British Columbia cost the province an estimated $2.6 billion annually (Health Officers Council of BC, 2008).

To address the health needs of immigrants, refugees, and newcomers to Canada, it is essential for healthcare providers to be sensitive and aware of potential cultural differences in healthcare beliefs and practices (Ahmed et al., 2016) and to better tailor services to the needs of specific communities accordingly. Although not impossible, this is exceedingly difficult for many Canadian-trained physicians, due to the diversity of the population; even when achieved, building trust with this patient cohort is difficult due to the cultural divides and the inherent power imbalance that can lead to caution and a subsequent lack of disclosure of true healthcare needs (Ahmed et al., 2017; Donnelly, 2008; Kalich et al., 2016).

The Role of Cultural Community Health Brokers

While the Canadian healthcare system mandates equitable healthcare for immigrants and refugees, there remains a large gap in reality between stating this as a values proposition and fulfilling it. Challenges such as language and cultural barriers and the discrete needs of the settlement population have been difficult to address. One emerging solution, however, is the role of cultural brokers or community health workers (CHWs). Cultural brokers are most commonly described as staff engaged in generic community outreach programs, offering linguistic and culturally appropriate assistance to members of the community they serve (Torres et al., 2013). In some cases, they are specifically front-line health workers trained in their country of origin not able to register for practice in Canada. Their role extends beyond caring for an individual and includes attention to upstream public health initiatives. The impact they have on clients' lives and their role in bridging the gaps in immigrant and refugee healthcare is explored in more detail below.

In Canada, the most widely known cultural health broker program is the Multicultural Health Brokers Cooperative in Edmonton, Alberta. This program has provided the framework for developing other cultural broker programs around the country such as the BC Multicultural Health Services Society (Bever & Hogg, n.d.). There is not a uniform national or provincial curriculum for health brokers, and most organizations develop training and curriculum independently. Recently, the formation of the Community Health Worker Network of Canada (CHWNC) has enabled more communication between each independent organization. Several concerns or actionable items have been raised such as precise definitions of the scope of work (which would make adjusting to the needs of local communities difficult), the need to organize the workforce at the local, regional, provincial, and national levels, adopting standardized training, the lack of recognition, and unregulated status of CHWs. This is underscored with the recognized need to conduct research on the workforce composition and competencies (Torres et al., 2014). With the formation of CHWNC, the relationships between organizations will likely strength the profession and enable more efficient advocacy for CHWs.

The Multicultural Health Brokers Co-op is an independent health workers organization but is funded by health and social service ministries; this status enables cultural brokers to provide an expansive range of support services reflective of the needs of the clients it serves. The organization seeks intersectoral, cross-governmental collaboration to create, implement, and evaluate their programs. Maintaining their independent status enables them to continue providing care that negotiates between multiple systems and communities and looks to address many different social determinants of health for individuals and their families. Some of the services they help their clients access include extended healthcare (diagnostics, access to specialists), family violence programs, supportive housing initiatives, childcare services, and connecting women to community groups, for example.

The overall role of cultural brokers as bridging the gap between immigrants and refugees and accessing healthcare can be summarized as follows:

> "Brokers interpret meaning, mediate in conflict and facilitate the cocreation of contextually meaningful solutions for care. Brokers build trust between community members and providers through their high level of cultural competence, relational capital, skill and dedication" (Luig et al., 2023).

In a study examining the role of cultural brokering on enhancing care for patients with diabetes and obesity, it was observed that they develop a holistic, contextual overview of the client's life before developing models of what causes can contribute to weight gain or illness. Through their cultural competency, they interpreted and responded to concepts of the etiology and management of obesity and diabetes and facilitated conversations about root causes and spoke to addressing those. Root causes could be food insecurity, poor sleep, or drastic migratory changes to diet/activity; bidirectional cultural interpretation enables culturally safe communication of both the diagnosis and an understanding of the management within a cultural context (Luig et al., 2023).

An additional area explored in-depth in the literature is facilitating access to mental health support for immigrants and refugees. This is done through informal/preventative support to youth and families by facilitating cultural integration and a sense of belonging in the community. Again, highlighting their role in address the social determinants of health for families, cultural brokers may see that a family is financially restricted to choosing government housing where youth are more likely to be exposed to drugs, alcohol, and violence, and counter this by assisting with employment, housing, and post-secondary registration support for the family (Brar-Josan & Yohani, 2019).

A large part of their role is addressing the barriers to accessing mental health services that clients themselves have constructed. Some clients fear stigma or negative repercussions such as losing custody of children, imprisonment of spouses (family violence), or even deportation (Salami et al., 2018). By addressing these concerns, they can enhance the family's sense of

safety and stability and help them to understand the role or benefit mental health services can provide for them (Yohani et al., 2019).

As the brokers themselves may have faced similar challenges or trauma pre- or post-migration, they are trusted intermediaries that are able to provide supportive counselling while helping families understand mental health services available, their purpose, and screening for appropriate healthcare referrals. In addition to this, they may also provide contextual information to the mental healthcare provider to enhance the care for the individual. Cultural interpretation may also be needed as generally, psychological services brokers noted that mental health services are representative of western culture/values (Brar-Josan & Yohani, 2019). Cultural brokers may be able to recognize when treatment/therapy is not culturally appropriate and ensure that the client is able to pursue therapy that better meets their needs. Language interpretation may also be provided during sessions.

MCHB encourages this level of engagement between the organization and clients by operating at five different levels: 1) one-to-one holistic support to promote health literacy and introduce the healthcare system; 2) connecting families and building social networks through activities; 3) mobilizing communities by having culturally-relevant strategies to deliver information; 4) acting as a bridge between clients and healthcare providers or institutions, and 5) improving at the level of health systems through policies, programs, and practice.

The service provided by cultural brokers is not only appreciated by clients, but also healthcare providers, who acknowledge that they enable health units to meet their mandate to serve immigrant and refugee clients. As one care provider noted,

> "… I don't think we could do our work without them … I think that they're hugely influential in the outcomes … I mean certainly there's a role for both of us [public health] within helping that family with health outcomes, but … the brokers … we really depend on them" (Torres et al., 2014).

CHWs are able to illustrate the vital importance of considering cultural needs when serving immigrant and refugee populations, which as precipitated a paradigm shift. As Torres et al. noted,

> "One health care professional from the AHS [Alberta Health Services] stated that because the Health Broker model was culturally and linguistically appropriate, it had been successful in making a "paradigm shift" within some parts of the health system. According to this health care professional, because of this shift, most health service providers in the city now understood the need to look at 'culture' when serving immigrants and refugees" (Torres et al., 2013).

The Alberta Health Services (AHS) health professionals acknowledged that MCHB's cultural brokers wages are not at the same level as other staff doing similar jobs (Torres et al., 2014).

A consistent challenge is funding, as funding priorities typically favour service delivery rather than community development (Torres et al., 2013). Due to this, cultural brokers end up adapting modalities of their work such as time, place, or mode of communication, to ensure clients are supported, as need for services do not necessarily occur between 9am to 5pm (Luig et al., 2023). As a result of the poor wages, most health brokers end up working part-time hours and work multiple jobs to support their cost of living. At MCHB, as of 2013, the hourly rate was not changed in accordance with inflation since 1998.

As alluded to above, while the work of cultural brokers has a large impact within communities, they face several different challenges. With increasing awareness as well as populations immigrating to Canada, health brokers are required to manage a higher caseload. This in turn can cause an increase in stress levels, especially as they must keep themselves updated on subject-specific information and available local resources, which are often shifting. Furthermore, if more health brokers are hired, they will require more mentors to monitor their work as well as identify more support systems for health brokers and their clients. This challenge is more specific to MCHB as their model consists of mentors assigned to monitor the work of each CHW.

Canada's existing challenge with recruitment and retention of healthcare workers raises concerns for the management of the growing population. However, the sustainability and effectiveness of the system can be enhanced through the contributions made by immigrant healthcare workers. For example, the media constantly reports on the physician shortage across Canada; one of the solutions is the employment of immigrant, internationally trained healthcare providers. As per Statistics Canada's 2016 Census, 36% of physicians identified as immigrants (Government of Canada, 2022). Furthermore, Internationally Trained Healthcare Professionals (ITHPs) often serve underserviced areas or rural regions (Gutman et al., 2021), enabling them to provide care to those that may not otherwise have locally accessible care. Therefore, understanding the opportunities and challenges that ITHPs face can allow the system to better support these individuals that provide care for Canada's population and help to mediate the physician shortage.

Challenges of Canadian Licensure for Internationally Trained Healthcare Providers

There are several barriers or challenges that Internationally Trained Healthcare Professionals face when attempting to begin practicing medicine in Canada. These challenges can begin prior to immigrating to Canada or even prior to leaving Canada for international medical schools. One-third of ITHPs reported that they had not heard of licensing exams and details of the residency application process prior to immigrating, and a majority reported that the available information does not match the reality of the situation that they face when they arrive (Wang et al., 2023).

One example cited was the reality of the competitiveness of residency matching in Canada. In 2021, there were 325 ITHP positions available for 1,822 ITHP applicants, resulting in a 22.6%

match rate. Of the positions that are available, they limit the offered specialities – such as family medicine, internal medicine, psychiatry, and some pediatric positions, relative to what is offered to a Canadian Medical Graduate resident (MacFarlane, 2021).

While the Canadian Medical Association recently released a policy on equity and diversity in medicine, the current CaRMs and matching process for ITHPs has structural barriers and systemic discrimination which reflects the type of marginalization that the policy was meant to address (MacFarlane, 2021). ITHPs are expected to pass 2 exams – the MCCQE1 and the NAC OSCE before applying to the residency program, whereas CMGs can write these exams after getting matched and can still proceed to residency even if unsuccessful. There is perceived individual discrimination as well from peers, faculty members, and the overall educational system (Najeeb et al., 2019). One Canadian International Medical Graduate noted, "It's hard enough, without having to think that someone else thinks you're incompetent just because you went to medical school outside of Canada." For this reason, Canadian ITHPs report feeling like they need to work extra hard to prove their competence when compared to peers graduating from a Canadian medical school. For many immigrant ITHPs, they find it even more challenging to adjust to the culture shock of contextualizing their skills to the North American population and culture (Najeeb et al., 2019). One immigrant ITHP described their experience as: "Illnesses are the same but patient expectations and how you manage them may be different."

When investigating ITHP's feelings on being prepared for the exams and the residency application, they reported feeling like they do not have enough support. Identified supports needed included more structured, affordable educational resources and financial support (Wang et al., 2023).

ITHPs have described having the desire to help others and being willing to be involved in various different initiatives to help newer ITHPs (Najeeb et al., 2019). This may stem from recognition that they themselves wish to have faculty and peer mentors to help them adapt and progress successfully in their residencies. It is important to note that it was specified that mentors should not be involved in formal evaluations to enable an open mentoring relationship. Beyond just helping ITHPs, immigrant ITHPs utilize a large proportion of their charity efforts to care for individuals of their country of origin (Nwadiuko et al., 2018). African born and educated physicians practicing in Canada or the US donated an average of $6500 in remittances towards family members, friends, and organizations annually (Clemens, 2011).

However, the majority of ITHPs have described attempting to get residency for between 1 to 10 years and spending over $10, 000 over this period (Wang et al., 2023). The barriers that exist are enough to encourage many to abandon Canadian licensure. The top three reasons for stopping pursuing residency include frustration, financial strain, and family responsibilities. This leads ITHPs to pursue alternative career paths or consider returning to their country of origin. One Canadian survey found 33% of immigrant ITHPs were considering leaving Canada to go back to their country of origin (Wang et al., 2023).

Choosing an alternatively career path is described to be largely influenced by factors related to the internationally educated physician's personal interests and goals (Chowdhury et al., 2023). Typically, participants that graduated a number of years ago (3-5 at least, or >15), had a long stay in Canada and were male had a high rate of being employed in an alternative career, relative to women, younger, and more recently graduated individuals (Turin et al., 2022). This is possibly due to their focus on achieving a residency spot or studying for their licensing exams. ITHPs report considering what qualifications and experience are required for the career and whether more school is required. In some cases, despite their extensive skills, Canadian experience is required. As one ITHP described;

> "You actually have the skills, you have the certification, but they still want you to have had the Canadian experience, which still makes it tedious. Even with this medical office administration. The fact that I even went to school here, they still want me to have had two years' experience" (Chowdhury et al., 2023).

Personal resource requirements for achieving the criteria for registration is also considered and weighed against the potential financial outcome or job. The standard employment-related factors such as wages, working hour flexibility (especially given some work part time to study for the licensing exam), and networking opportunities were also considered important factors when deciding whether or not to pursue an alternative career. Jobs with possibility of transferable skills were considered favourable as they required less effort and resources. One study examining labour market integration of highly-skilled immigrants in Canada found that 50% of ITHPs are employed in health-related nonregulated jobs (Turin et al., 2022). This also likely meant that these jobs could align with the goals of the ITHP (Chowdhury et al., 2023).

Summary

Providing structural supports and culturally valuing the role of cultural brokers or community health workers in facilitating healthcare for newcomers to Canada is an essential intervention to optimize both immigrant and refugee health and well-being, but also to optimize healthcare resources. CCHBs who fill these roles may choose to remain as cultural brokers; for those who see it as a stepping-stone for full licensure in Canada, recognition of its value in introducing the Canadian healthcare system should be accounted for in the licensure process. This can complement additional strategies currently being developed to increase the efficiency, effectiveness, and fairness of healthcare licensing in Canada while still maintaining a firm commitment to ensuring that quality care is available to all patients.

Research Approach and Methods:

Qualitative interviews were conducted to better understand the role of Cross Cultural Health Brokers in facilitating access to care for immigrants, refugees, and newcomers to Canada at Umbrella Multicultural Health Co-op. This study was conducted in accordance with the guidelines and regulations of the University of British Columbia's Behavioural Research Ethics Board (Ethics ID: H23-03759).

Setting and Participants

We interviewed two groups of participants: clinic patients with experiences of care facilitated by a CCHB, and CCHBs themselves, who spoke to their experiences of the role. Participants in both groups were recruited through UMHC, passively by posters (see Appendix 1), word of mouth, and through the assistance of Co-op coordinators.

Data Collection

Interviews were conducted between January 15th and February 2nd, 2024. Participants were given the option of an in-person interview or a virtual interview. In person interviews (n= 2) were held in a private room at the Umbrella clinic and virtual interviews (n=13) were conducted over Zoom videoconferencing program. Interviews were led by the Principal Investigator (JK) or the Research Coordinator (AC), with the other designated as a diligent notetaker. Participants received a consent form prior to their interview and time was set aside before beginning each interview to answer any participant questions. Verbal or written informed consent was then requested and received from all participants, including permission for audio recording. Interviews ranged from 29 minutes to 1 hour in duration. When necessary, interviews were supported by a translator (n=5) to allow for communication across different languages between participants and the research team. In cases where a participant spoke a language other than English, oral consent was obtained through the translator.

Data Analysis

Given the short timeline of this project, data will be analyzed in two phases. This report details the analysis of Phase I. Each phase is described below.

Phase I:

January 10th, 2024 – February 23rd, 2024

Interviews were attended by both researchers (JK and AC). Immediately following interviews, the two researchers discussed what they identified as the most salient elements of the interview. These ideas were used to iteratively inform and improve the interview guide for future interviews.

A process of rapid qualitative analysis was then undertaken, informed by literature on rapid qualitative research methodologies (Nevedal et al., 2021; Taylor et al., 2017). From interview

notes and notes taken during discussions of the most important emerging finding from the aggregated interviews, a framework of initial themes was developed. The primary coder (AC) then revisited notes from each of the transcripts and pulled out thematic quotes to augment the analysis. The themes collaboratively identified by the research team have been written up into the findings of this preliminary report, outlined below. This initial thematic framework will be used for the more rigorous coding of the transcripts after February 23rd.

This preliminary report aims to be a rigorous, pragmatic analysis, shaped by rapid methodologies that have been found to be effective in achieving evaluation objectives and establishing rigour (Nevedal et al., 2021; Taylor et al., 2017). At the same time, this rapid analysis allowed us to reduce the time and financial costs incurred through more traditional methodological approaches, resulting in a rigorous report within a truncated timeline.

A Note on Translation in Qualitative Data Collection and Thematic Analysis:

Given that the research participant population is necessarily one of newcomers to Canada, we utilized translation services to support conversations with participants who prefer to speak in their native language, which in some cases, was not English (the language of the research team). As suggested by Abalkhail (2018), we acknowledge that translating qualitative data can be challenging, as "language constructs different ways of understanding the social world." To successfully communicate across languages, cultural understanding must be integrated into the translation process. To this end, we commit to transparency in the process of reporting how translation is performed through the course of this project, and to ensuring that participant feel their experiences are accurately understood, both through the use of cultural brokers and translators at Umbrella, as well as through the member checking process.

Though translation in research requires additional steps be taken to establish methodological rigour and a sound analysis, literature also suggest some advantages to the "continuous act of translation" (Helmich et al., 2017). In some instances, the process of decoding and recoding in two languages can offer the research team additional opportunities to make sense of the data and encourage data engagement at multiple levels (Helmich et al., 2017).

Phase II:

February 23-June 31

All transcripts will be reviewed to ensure quality of transcription, and ongoing analysis will be supported by partners from Umbrella who will advise on interpretation of the data and findings. Partners will also provide an interpretive lens on the culture of origin in cases where interviews were performed in different languages, increasing the validity of the analysis. Following the analysis of the transcripts in Phase I, where emerging themes, interpretations, and recommendations were made (see below), we will move into coordinating a focus group with representatives from Umbrella to receive feedback, this time, on the interpretation of our data and findings. This round of member checking provides an extra layer of validity to ensure that our researcher interpretation is congruent with participants' experience, thus providing more credibility and trustworthiness to the analysis and final report (Birt et al., 2016). We felt

this to be particularly relevant given the cross-cultural reach of this work. Once coding and member checking is completed, the research team will meet again to discuss and revise final themes, as needed, improving the validity of our findings.

While we are committed to taking lead from participants in the member checking process, we observed a high level of continuity across interviews, and anticipate than re-analysis will not be required. As such, rather than recursing and performing a detailed, formal thematic analysis of the same dataset as analyzed in Phase I, we aim to adjust and focus on adding additional interviews with more participants in Phase II, to bolster and diversify the perspectives represented in our report recommendations. We will further focus on augmenting our dataset through interviews with partners at other social service agencies that have established linkages with UMHC, to learn more about productive overlap of services as well as any potential gaps. We are interested in learning from other NGOs working in the newcomer settlement sector about their involvement in supporting newcomers' healthcare needs and about how the social services sector can effectively address the diverse and complex needs of newcomer populations. Additionally, we will add interviews with a broader cross-section of staff at Umbrella, including individuals involved in leadership and members of the clinical healthcare teams.

Revised Phase II Focus: Impact of Research on Community Social Services Sector

Much of the work done by Community Health Centres involves outreach to and creating linkages with other, more expansive, community resources. These productive relationships underscore the focus on social determinants of health and honours the commitment to "going upstream" to pursue a model of wellness, not of illness. This commitment is likewise centred at UMHC, through the hiring of ITHPs that have the cultural competency to engage with other social service sectors that can support individual clients seeking care. Furthermore, through documenting the outreach to and role of players in the community social service sector (food banks, programs for street-entrenched/underhoused, domestic violence shelters, MOSAIC, etc.), we will be able to uncover and document more clearly not only the role of this sector in promoting health and health equity, but also uncover the value-added of bringing disparate agencies together to benefit from the combined expertise of agencies that are, to some degree, inter-woven. One of the strategic approaches of many Community Health Centres is leveraging scant resources through outreach to create synergy of purpose. Understanding the way in which community social service agencies work synergistically is crucial as we move towards health service delivery networks. This is underscored by recognizing that very few services can meet all of their constituents' needs independently, especially when coming from an expansive, biopsychosocial/social determinants of health perspective.

In summary, Phase II will extend our existing data set through additional interviews with UMHC patients, CCHBs, and UMHC leadership and clinicians. As we heard clearly through the initial data gathering process about the importance of networks of care with other settlement agencies, we will consider this interface in more detail through primary data gathering (through interviews) with representatives from agencies UMHC commonly refer to. On completion of

data gathering, we will move on to creating the conditions for effective knowledge translations with policy and decision-makers including creating policy-directed outputs and socializing findings with partners in relevant decision-making positions. The knowledge translation plan will be pragmatically adjusted, depending on whether we are successful in the UBC CUES grant competition. Further details are included below.

Findings

We interviewed nine patients (two of whom were also UMHC volunteers) and seven Cross Cultural Health Brokers. Themes from interviews with the patient cohort revealed the context of settlement, importance of access to healthcare, experiences of care at UMHC, attributes and qualities of CCHBs and barriers to accessing care. Themes from interviews with CCHBs included the context of the immigration to Canada, challenges faced by newcomers, the CCHB model of care, experiences of CCHBs and opportunities for growth. Each are described in detail, below.

Umbrella Patients

Context and Settlement Experiences

In discussing their experiences of settlement, almost all participants shared that coming to Canada had been an overwhelmed process. It was mitigated in some instances by having pre-existing social connections in Canada, such as family or a religious community that supported the transition and was conversely compounded for individuals who had less English language comprehension. One participant explained of the process, “It’s like [climbing] a big mountain when we’re newcomers here.”

Other unknowns, such as the relatively cold winter climate, understanding of public transit and other social systems, and overall cultural adjustments were also cited as challenges. For example, some participants discussed the difficulties of being far away from familial support while raising their children in a different and unfamiliar country and cultural context.

Participants also noted the need to find housing and a source of income as newcomers to Canada. After that, access to appropriate healthcare was cited as a priority for all the participants. One participant, while on the waitlist at UMHC, was connected to a midwife for perinatal care. She immediately faced language barriers, meliorated by the intervention of the participants’ landlady who was able to support her through her pregnancy by providing language interpretation between the participant and the midwife, until the participant was connected to a CCHB at UMHC in the post-partum period.

Experiences of UMHC attachment were influenced by when participants first learned about the clinic. Participants who came to Canada several years ago, before there was a waitlist, became attached to the clinic quite quickly, while those who were newer to UMHC discussed their

experiences with an ever growing and often closed waitlist, indicative in part of the growing population of newcomers to Canada but also of the growing positive reputation of UMHC.

Importance of Access to Healthcare

Before being attached to UMHC, participants discussed experiences of accessing care through walk-in clinics and emergency departments. For many, these experiences were challenging, with some participants describing feeling rushed and unheard. As one noted, "With the language barrier, sometimes I feel that they don't have patience with me or with my family. They don't understand [me]… and I don't understand them." In some instances, this led to avoidance of care, due to the sense that accessing care through walk-in clinics was futile. One participant commented, "Before Umbrella, I had migraine headaches…I was very upset – the doctor did not understand. So, I gave up and was no longer with that family doctor."

Participants lamented long wait times in urgent care and emergency departments, which were new experiences of healthcare for them. Overall, while care through walk-in clinics and emergency departments were seen as the first line of healthcare access for newcomers unattached to a family doctor, this did not meet participant needs.

Even after attachment to UMHC, and connection with a Cross Cultural Health Broker, participants were still concerned for family and friends who were accessing non-brokered services. As one participant noted,

> *"[My friends] are still struggling with the walk-in clinics and with translation. They prefer not to go to the doctor because sometimes they don't understand anything, or they don't find the help they need."*

Participants contrasted their current care at UMHC with instances where they had not had any language or cultural support. In some cases, family members, such as children, were able to support their parents with translation, but this was often difficult due to the need to translate unfamiliar medical terminology.

Experience of Care through UMHC

Given the challenges of accessing care in Canada, participants voiced the importance of comprehensive care, specifically for newcomer populations, underscored by ongoing relationships with providers and well supported by language and cultural interpretation. Conversations with patients revealed that in most cases, these needs were met by the involvement of UMHC's Cross Cultural Health Brokers.

Beyond language interpretation in clinical encounters, participants discussed the support of CCHBs in translating government documents, filling out applications for WorkSafe BC, housing, and extended healthcare (physiotherapy, dental). Beyond these services, participants also touched on UMHC as a community gathering place, where for example, Mum and Tots and

senior community groups meet. Some participants also noted the value of having social workers and counsellors available, to further support the transition for newcomers to Canada.

Participants viewed UMHC's scope of care overall as holistic, encompassing not only basic health needs, but also the social determinants that shape health, such as secure housing, employment, childcare, and education. As one participant noted,

> *"Umbrella helped me with everything: it was so much easier when I started with the clinic. There was a lot of information - not just about health, but also housing and other things I needed in that moment."*

Ultimately, participants reported that beyond the culture at UMHC and the experience of being welcomed and listened to in the clinic, having the support of a Cross Cultural Heath Broker was the most meaningful element of their care, and something that set UMHC apart from other healthcare settings.

Attributes and Qualities of CCHBs

Most participants cited the CCHB's role as interpreters (both in terms of language and cultural translation) as their most valuable contribution to their care, yet few stopped there. Participants were sure to specify that the role of CCHBs went far beyond just providing a communication link.

In many cases, CCHB language interpretation support was set in contrast not only to healthcare experiences where language support was not offered, but also in contrast to participants' experiences with Provincial Language Support, the interpretation service provided by the government at healthcare centres. Having interpretation support was seen as critical to supportive and effective care, and yet even with provincially provided translation services, participants often found that their appointments were not as effective as they'd hoped. Working with a CCHB was seen as infinitely more valuable due to the longitudinal relationship developed with CCHBs over time. Having an advocate that was familiar with participants' life circumstances, health statuses, and their families, rather than a stranger providing language interpretation over the phone, set the CCHBs apart. As one participant shared, "The interpreter just interprets. The CCHB knows my situation, my history, it's more comfortable. It's really different."

Others explained that where medical translators are only allowed to directly translate physicians' orders, the CCHBs are able to provide further context to a treatment plan if the participant was unsure of what the physician was suggesting. Even in cases where participants spoke some English, they explained, "There are medical words that maybe I don't know…the translator knows that word, they can explain it...This is the good thing that I always appreciate…that we are with Umbrella."

Participants valued the strength of relationships they were able to develop with their CCHBs over time, appreciated the flexibility and availability of their CCHBs, and acknowledged their significant value as health navigators and advocates, who could support setting up appointments and facilitating referrals to other domains of care. These facets of the partnership between CCHBs and their clients were not present or supported by a strictly medical interpreter in appointments with a physician and patient.

Strength of Relationships

The capacity to build trust between CCHBs and patients was a crucial enabler of a positive and beneficial relationship between the two. Some participants described their relationships with their CCHB as almost an extended family member. One expressed, "If one day I don't speak to my CCHB, it's like I lost something. I become lost."

Participants also shared that communicating in the same language, even outside of appointments, laid the groundwork for clear comprehension and trust. As one said, "It's comfortable when you're speaking in your language, especially about health issues…we can explain better how we feel, not only health [wise], but [emotionally]." In this case, the shared understanding that comes from a shared language and cultural understanding enabled deeper communication about emotional and mental wellness, on top of physical wellbeing.

Availability of CCHBS

Participants placed high value on CCHBs flexibility in terms of mechanism of contact, as well as availability. One participant shared that being able to text her CCHB, in her first language, when she had a concern, was reassuring, especially as she was learning to navigate the healthcare system. She shared, "Even when I'm at my house and have some situation with my kid or my family, I can text my CCHB in [my first language], 'Here's why I'm worried, what do I need to do?'"

Participants explained that their CCHBs were consistently available to answer questions and address concerns and quick to respond when contacted: "We aren't having issues getting hold of [our CCHB]. We're always communicating with the doctors through [our CCHB]. Even if she is not available, she always gets back to us, to get us the help we need." Another shared, "Monday to Friday, even when we don't have an appointment, we can text [our CCHB] and ask something. She's awesome."

This flexibility contributed to a sense of familiarity between participants and their CCHBs, enhancing the trust between the two.

Cultural Safety and Respect

Across the board, participants also shared their appreciation for the respect shown to them by all UMHC staff, but especially in their relationships with CCHBs: "I feel very supported…my culture, my thoughts and ideas, my questions -- everyone has been really respectful."

In a few instances, participants reported a cultural preference for having a family member translate when conversations about personal body parts were necessary, but for the most part, having established a relationship with their CCHBs helped to mitigate any social discomfort.

Overall, participants shared that UMHC staff work hard to ensure that, when possible, clients received care from someone who shared a language and cultural background with them. For example, regarding care through UMHC's mobile clinic, which serves farmworkers in the Fraser Valley, one participant noted, "Most of the farmers are from Central America and Mexico; it was very good to see how they brought a physician from Mexico to make sure people feel like they are in their home, even though they are not in their home. It's amazing."

Navigation Expertise

Participants also acknowledge and appreciated CCHBs capacity to provide support in setting up referral appointments to specialists, assisting with healthcare system navigation, and answering questions within their scopes as health brokers. For example, while participants had different levels of understanding about their CCHB's professional or healthcare backgrounds, each clearly expressed understanding that provision of medical advice or care was outside of their CCHB's scope. Despite this, participants shared that CCHBs were diligent about facilitating referrals and acting as a link between patients and their physicians at UMHC. As one participant shared, "[My CCHB] will explain, 'I can't help you, but I will ask the doctor.'" In cases where the physician was unavailable, CCHBs provided referrals to other resources, or would suggest that clients go to urgent care or the emergency room, depending on the situation.

In other cases, where participants had needed to access specialist supports, participants shared that their CCHBs would do whatever they could to speed up specialist appointments. One participant gave the example of support her CCHB had provided to her family in setting her child up with diagnostic assessment services for complex developmental needs. She shared, "[My CCHB] helped us find an organization to support us. I have no knowledge of the issue at all and she helped with the paperwork."

Participants also shared that working with a CCHB had improved their understanding of the Canadian healthcare system, which was usually very different than the one they were used to. This was seen as a unique strength of working with a CCHB, and not something that necessarily occurred when working exclusively with a physician. As one participant said:

> *"I have now an understanding about the health system in Canada that I haven't had before. Umbrella has been helping me a lot to understand that. And I'm sure that so many patients like me are beginning to understand better. Doctors don't have the time to explain the system, they're just attending [to] you for the symptoms you have. But the CCHB has been doing that and answering my questions about the health system."*

Feeling Seen and Respected

A notable difference for participants in this study between experiences of care outside of UMHC and within UMHC was a feeling of being "seen" and understood. Participants had overwhelmingly positive comments about their engagement with UMHC staff across the board, from physicians to CCHBs to front office staff. These positive experiences were at times contrasted with negative experiences of care at other health centres. One participant shared that her explanations of her chronic pain had fallen on deaf ears in her interactions with her previous physician. She was relieved to explain that her experience at UMHC had been very different:

> *"When I told [my doctor at Umbrella] that the other doctor did not listen and said 'my heart is crying,' [the doctor] gave me a very big hug. She is a very good lady. She really helped me. I like her and she is good at medicine. For a long time, I was in a very bad situation. I went through depression for three years, but she very much helped me. Umbrella really helped me."*

Others shared that through their engagement with UMHC, and specifically, through working with a CCHB, their own confidence in their capacity to navigate the health system had grown. As their language skills improved, so did their comfortability in attending and making appointments alone. Having a safety net and available advocates resulted in enhanced feelings of self-efficacy and confidence in accessing healthcare services:

> *"The [CCHBs] have taught me a lot, they have taught me that I have value, and that I can understand more and have a good service… And that sometimes I don't need to go [to appointments] with someone because I know how to translate some things. This might sound like the minimum, but at the end, for me, they are very important."*

Other participants agreed, sharing that their reliance on UMHC CCHBs decreased as their understanding of the health system increased.

Barriers to Accessing Care and Potential Improvements

Beyond language and cultural barriers to accessing care, which could in many cases be mitigated by the involvement of a Cross Cultural Health Broker, participant experiences of barriers fell into four main categories including work precarity and challenges with taking time off to access care, distance to the UMHC clinic, the limited capacity of UMHC given the large and growing patient population, and slow wait times to see specialists.

Certain patient populations served by the clinic, including farmworkers, who mainly utilized UMHC's mobile clinic, had particular challenges with work arrangements which made attending healthcare appointments difficult. Often these participants were only able to schedule appointments around their work schedules, and voiced concerns about repercussions from taking time off. One participant, currently on a health leave, explained that they didn't know if

they would be allowed to take any further time off, even if that was recommended by a physician:

> *"I really don't know the answer. I'm assuming no, but it's hard for me to tell. I feel a lot of pressure from [my employer], so I think that maybe they would ask me to go back [to my home country]."*

In these cases, having options such as the UMHC mobile clinic, which operates on a pop-up bases and specifically targets the needs of temporary foreign farm workers, was very helpful. A few participants shared that if the mobile clinic didn't come out to their region to provide care, they were not sure how else they would access care.

Other patients appreciated the option of having phone appointments with their, though noted that there were cases where an in-person appointment was necessary. One patient, living outside of metro Vancouver, suggested longer clinic hours would be helpful, such that they would have time to travel into the city after work to see a healthcare provider.

Overall, participants were incredible positive about their feedback regarding care at UMHC facilitated by CCHBs. For the most part, participants only wished the clinic had a higher capacity to see more patients and to reduce their waitlist. They suggested this could be achieved through hiring more physicians or expanding service languages to support more diverse clients. Even so, participants didn't attribute blame to UMHC for these limitations, only noted that they wished for the care to be available to a wider audience.

Despite recognition of limited capacity, participants also noted that they could see that UMHC has been striving to expand care in response to the high needs of the population: "Umbrella has been improving a lot. They've been working a lot to find more resources to help more people." One participant shared that many of her friends were having challenges finding family doctors and that she wished all her friends had the kind of service she received at UMHC: "I feel sorry for [my friends]. Because I feel so lucky to be here, to have this kind of doctor, this kind of service for my family."

Regarding CCHB coverage, participants shared that even with the stretched capacity of UMHC, they felt their CCHBs were consistently available and reliable. In instances where a CCHB was away or traveling, another was available to cover their cases. "They don't leave you alone," shared one interview participant.

Volunteering

Two patients that were interviewed also spoke to their experience as UMHC volunteers. Both found volunteering to be a meaningful way to give back to the organization that had helped them so significantly, with the desire to contribute both to their communities of origin as well as to the clinic. Having had very positive experiences at the clinic, both participants expressed a motivation to further enable that support for other members of their community. For one,

volunteering instilled a sense of purpose, and allowed her to demonstrate to others in her cultural community the potential for a radical improvement in mental and physical health. They explained, “It’s not about money or gifts, I like people…they are very kind.”

Some volunteers supported social programs, such as a senior program, which focuses on handmade crafts and cooking. Other volunteers support UMHC staff in clinical settings. One participant, with healthcare training herself, shared, “Health is my passion. I really want to be of service to my community.” This participant provided translation and organization support at pop-up clinics for farmworkers, where coffee and flu shots were provided, along with refreshments. She shared, “I am very happy to be a part of this; it is amazing to help our community.”

Volunteers discussed the value of expanding the training offered to new volunteers. The requirements to begin in a volunteer role were seen as low barrier, which was a strength of the program, yet some suggested a bit more structure would be valuable. Participants were interested in further training that could be conducted both virtually (for potential volunteers that do not live close to the clinic) as well as in-person.

Cultural Community Health Brokers

CCHB interview participants focused on several elements of their practice, including the general context of their work in the Canadian healthcare system, the utility of UMHC as a unique clinic, the function of their roles as CCHBs, their experiences of their role, and system challenges and areas for improvement.

In setting the context for their work, several CCHB participants, like the patient participants, discussed the challenges faced by newcomers to Canada in accessing the healthcare system. Participants noted several barriers to care, including the complexity of the Canadian healthcare system and cultural and linguistic barriers newcomers face in setting up a new life in a foreign country.

Context of the Cross Cultural Health Brokerage Model: Complexity of the Canadian Healthcare System

CCHBs reported that that the reality of settling into Canada and the disillusionment that accompanied experiencing barriers to care often lead to shock and frustration for their newcomer patients. Challenges referenced included difficulty attaching to a family doctor, the need for referrals to access specialist care, and frequently long wait times to access specialist services. This was especially affronting for newcomers who had left countries where they did not need a referral to see a specialist, or where they were accustomed to seeing a general practitioner “within a half hour” if needed. In contrast, some patients may have waited up to 2 years on the UMHC waiting list, only to become attached to a family physician and learn that to see a specialist they may have to wait another 6-9 months.

"They will be in shock… 'what's going to happen…?' This person is in pain, not able to walk, not able to sit. So, it's hard, but we try to explain to the patients that things are different here and it takes time to be seen by a specialist."

As one CCHB emphasized, even BC citizens and permanent residents face challenges with accessing family doctors, "…so imagine how hard it is for someone who is a newcomer, who is new to the system…"

In other cases, CCHB participants explained the limitations of the healthcare system in supporting immigrants who don't speak English. Even if a patient was able to access care at a walk-in clinic, CCHBs identified the challenges they face once they are in front of a healthcare provider. Though clinics are supposed to be able to provide language interpretation for patients, those systems were not always available, and often depended on provider willingness to engage. CCHBs identified that even where resources exist to support newcomers (such as the Provincial Language Service), they are often not easy to access.

In response, one CCHB participant explained that the role of UMHC staff is to make the Canadian healthcare system as "accessible" as possible. It was important to CCHBs to provide "realistic information and realistic hope" to their patients, to set expectations, and assist them in navigating a new system while mitigating the surprise of obstacles frequently encountered along the way.

Challenges Faced by Newcomers

The discrepancy in expectation versus reality in newcomers' experiences of Canada was seen by CCHBs as additionally fraught by other social challenges including general language barriers, cultural variance, a history of trauma, and the need to address other social determinants of health, such as housing and employment.

The context spurring newcomers' immigration to Canada was seen as a contributing factor to the challenges faced in Canada. One CCHB compared their own experience of immigration to that of many of their patients:

"For me as an immigrant, I was planning to come here. But although I was planning, it was very tough...But our clients, they came here without any planning… [Many] found themselves here to escape from war and bad situations in their countries. Their pain and their suffer[ing] was much more than mine."

CCHBs also touched on population specific challenges, such as those faced by immigrants working as temporary foreign farmworkers, a specific demographic targeted by UMHC. CCHB participants identified these clients' primary concern as getting and keeping a job – even at the expense of their health. Participants shared that many of their clients work up to 10 hours a day and at the end of their workday, don't have the time, energy, or means to seek out healthcare. Rather, "…they just want to go home and forget the day."

Again, CCHBs noted the idealization of working conditions in Canada, sharing, "'People think they will have good opportunities, a secured job, be well-paid…what I've seen is that these people don't get support from their employers…they come with so much hope." Frequently, CCHBs reported that employers are unsupportive of their employees taking time off to meet their healthcare needs. Many of UMHC's clients experience precarious employment with very little flexibility and allowance for illness. One shared, "We have to educate them, that they are allowed to get sick."

CCHBs Model of Care

In explaining their work, CCHBs, like patient participants, discussed the difference between their roles as CCHBs and the role of medical interpreters. While interpreters can only interpret, CCHBs discussed the importance of their role as advocates, who can ask follow-up questions, clarify important values with the physician, and add context if they see their client lacks understanding. One CCHB explained,

> *"Here it is beyond translation. There is a barrier for people who are newcomers. They don't understand the system, they don't know what to ask...so they become confused, totally confused…The culture is totally different, the system is totally different, there is a language barrier. So CCHBs act as a bridge to fill these gaps…"*

CCHBs also addressed the importance of having long-term relationships with their clients. Where the PLS interpreter could be a new person every time the patient visits a doctor, CCHBs follow the care of their patient throughout their health journey, providing continuity in support and further enabling the development of trust and security in their own relationship with their patients, and consequently the trust between the patient and the healthcare provider.

CCHBs participants shared that frequently, their work fills existing gaps in the healthcare system, where provincially provided interpretation services fall short. One explained,

> *"I think all the governmental places or health facilities, they are supposed to have [interpretation]. But some people are calling me. I was in a meeting yesterday training, [and a client] called me, 'Please, please I need help to communicate with a specialist.' So, I cut my meeting and go."*

Additionally, CCHBs discussed their role as cultural translators, not just language interpreters, for example, explaining symptoms to patients in a culturally respectful manner, helping patients navigate instances where they have a gender preference for their provider, or sensitively interpreting culturally inappropriate questions. One participant explained,

> *"If something is not culturally accepted, we inform the physician, 'This is not good, or cannot be said.' For example, a form can ask, 'Are you sexually active?' I can't directly*

ask this to the patient I support, especially one that is a married woman...So, we try to clarify in other words to [prevent patients] from being offended."

This culturally sensitive translation allowed for the facilitation of care without compromising the integrity of the interaction between patients, CCHBs, and providers.

Trust Building with Patients to Enabling Care

In addressing the services provided by UMHC, CCHBs touched on the importance of their involvement in patient care, and their partnerships with healthcare workers at the clinic. A positive "three-way" connection between health brokers, healthcare workers, and patients was seen as essential to good health outcomes. Trust, primarily facilitated by the involvement of CCHBs, was the cornerstone of this relationship. One CCHB shared, "We trust the patients and the patients trust us, and also we trust the physicians and the physicians trust us." This enabled the development of successful therapeutic alliances between the clients and the physicians, and successful CCHB interpretation between "patient talk" and "doctor talk". Witnessing positive relationships between CCHBs and healthcare workers was important to patients in building their own trust with their healthcare worker. This was developed through open communication, but also through the non-verbal relationships between the CCHB and physicians.

Several CCHB participants focused on the importance of trust between CCHBs and patients, for care to be effective. As one shared,

"If [patients] don't know with whom they are talking, there cannot be trust. Here, we have face to face communication. We know each other. We support them [at Umbrella] from the day they are admitted."

The trust described by CCHBs was important on numerous levels. Patients had to feel safe enough to share honestly about their health concerns, as well as have sufficient trust in their CCHB and provider to adhere to their recommendations. "If they don't feel the trust" one CCHB explained, "they don't feel open to share…you have to know your people, with whom you are working."

Another discussed their experience with creating a manual for a patient who had recently been diagnosed with diabetes, but who the CCHB described as having trouble accepting the condition. In this case, the CCHB developed an educational manual for them, in collaboration with their doctor, so that the patient could come to better understand their diagnoses. "It was so much work, yes," the participant explained, "but the patient has to understand in order for the physician's management to 'hit the target.'"

In terms of building trust, CCHBs noted that consistency, openness, and patience were key. "Listening is very important," one shared, "If [patients] feel you understand them, you can create a good relationship, based on trust. This is important for newcomers who have had a

stressful life. Everything is new for them. You need to listen…then you will have a good understanding of each other."

Additionally, CCHBs described the seriousness with which they took their jobs, and their intentionality in following up with patients they hadn't heard from in a while. One shared, "When they see we are actively following up, they feel valued." This also contributed to the development of a trusting partnership between the CCHB and the patient.

The Value of CCHB Healthcare training

CCHB participants also discussed the influence their healthcare training had on their work. Across the board, a healthcare background was seen as an enabler of their position and contributed to their success. In facilitating conversations between physicians and patients, one participant explained that given their healthcare training, "I know what the doctor is trying to understand, so I ask in a way that is culturally appropriate…I will also translate back [to the doctor] in a way the doctor will understand." In these cases, the involvement of a CCHB was seen to not only improve the process and outcome for patients but also for the physicians involved. Furthermore, the healthcare background of the CCHBs often took some burden off of providers. One participant shared,

> *"When the patients get medications, they need a kind of explanation with it. It makes it easier for the family doctors to kind of explain it once, just mention it to us, and I as a CCHB, as a cross-culture health worker, will explain it in the language of that patient… [We have patients] who cannot even read and write their own language, their first language. It makes it really hard. So as a CCHB, we will send them voice messages. We try our best to make our patient understand what's happening, what he or she has to do."*

Having knowledge of medical terminology was also an enabling factor for CCHB participants in brokering conversations between patients and providers. In cases where CCHBs determined the language literacy of their clients was not high, having a sound understanding of medical terms and disease processes enabled the CCHBs to communicate complex concepts in simple and understandable language for their clients.

Participants were sure to clarify the importance of clearly communicating to the physician everything they share with the patient to ensure they are not overstepping their scope as CCHBs, despite their international medical training.

> *"We can explain about the diseases a bit more in our conversation if [patients] want to know more about the conditions they have. We can explain more, but all things that we have already talked with the physician about."*

Participants shared that if asked a clinical question, they are sure to consistently refer their clients to the healthcare provider rather than provide clinical advice, even if they know the answer. In some specific instances, CCHBs reported these limitations caused a sense of

powerlessness, but each understood the scope of their role and had a keen awareness of maintaining professional boundaries. Wishing they could contribute more was often mitigated by positive professional relationships between healthcare providers at UMHC and the CCHBs. Participants reported that health professionals at UMHC held them in high esteem and valued their input.

CCHB participants had different approaches when it came to sharing their educational backgrounds with their clients. Some avoided disclosing their training, to avoid having to decline answering clinical questions, while others preferred to share their educational background, to build their clients' confidence in their position and interpretation.

Emphasis on Social Determinants of Health

The scope of UMHC, as well as the CCHBs, spanned beyond the clinical care. Several CCHB participants emphasized their role in supporting patients with the social determinants of health, with one suggesting that their involvement in this area was the "most important part of the CCHB role." Another described care at UMHC as a "package" rather than an exclusively healthcare service. "We are not just about the healthcare system," noted one participant, "we are a community."

CCHB comments revealed a consistent desire to tackle any problem brought their way. Beyond having a "checklist" of things they support clients with as a part of their role, participants noted that they have a great deal of flexibility to "tailer care to patient need." Assistance included scheduling appointments, providing health system navigation advice, teaching clients about public transportation, and assisting with social support services such as employment assistance or disability and low-income housing applications, and connecting clients with external resources, for example, low-income legal aid clinics.

Relating to the temporary farmworker population, one CCHB noted that in many cases, connections to UMHC are the only contact that workers have with the "outside world," beyond their employers. This makes them a key connection and a crucial advocate for this population.

Experiences of CCHBs: Rewards

In discussing their work facilitating care for immigrants and newcomers, CCHBs also discussed their personal experiences with the role, including both rewards and challenges.

Overall, many CCHB participants voiced an altruistic desire to give back and to facilitate access to care for members of their cultural community. Frequently, participants described their roles as "rewarding," and enjoyed the many opportunities they had to make a difference in the lives of new immigrants. Some drew on their own experiences of immigrating to Canada, and a consequential desire to make the process easier for others, sharing, "I know about the struggles and obstacles they deal with. I know that other side of the story." Another participant echoed this value:

> *"I migrated here. Serving people from [my] own country is so rewarding for me. When we are able to fulfill the needs of our patients and our people from our own community and other communities, it makes a feeling of satisfaction for me. It's so important."*

For many, their role as a CCHB was more meaningful to them than just a regular job, and they discussed their work as an opportunity to "give back". Despite the difficulties of working with high needs populations, each CCHB found meaning in the successes of their clients:

> *"When you start with a new family with a lot of challenges and a lot of struggles and at the end are able to solve problems and put them on the right way, and they start working, they start achieving their goals -- it's a big success for us."*

Opportunities to Work in Healthcare

Given the healthcare backgrounds of the CCHB interview participants, several shared that it was professionally rewarding to be connected to the health sector in Canada. Even though they were not able to practice as independent healthcare workers, being involved in the field of health was a priority and seen as a beneficial way to continue to be involved in healthcare while pursuing licensure options.

Participants interested in becoming licenced in Canada described the path as long, expensive, and complicated. Some CCHBs identified a sense of frustration within the internationally trained healthcare provider community, citing a mismatch between the dire need for more healthcare workers in Canada, and not seeing this need reflected in more streamlined pathways for skilled immigrants. Working as a CCHB provided meaningful opportunities to learn about the Canadian health system from within, honour one's professional inclinations, and offer their skillset to their community while seeking licensure.

Despite not providing clinical care, participants shared that their work as CCHBs gave them the opportunity to refresh their clinical skills by "seeing new cases, patients, and health conditions every day" and participating in the "circle of management of sickness." Along with clinical skill refreshment, participants shared that their work in health navigation was helpful in integrating them into the Canadian health system and providing the opportunity to learn more about new system processes every day.

Positive Work Culture at UMHC

Participants also discussed the rewards of an overwhelmingly positive work culture at UMHC, marked by meaningful and productive collegial relationships between all members of the team. This was true within the CCHBs staff team, as well as between CCHBs and other healthcare professionals, such as the nurse practitioners and physicians providing care. One CCHB compared their experience at UMHC to their experience working as a nurse in their country of origin, explaining that back home, it is difficult for a nurse to speak with a physician, whereas at UMHC, the "physician is a friend and a colleague."

Others shared that working alongside the physicians at UMHC led to meaningful learning opportunities, and that they felt valued and appreciated for their work. Members of the team felt aligned in their desire to see UMHC continue to grow: "We dream of how big we want Umbrella to be." Another participant shared,

> *"Self-care is our positive teamwork. It's all of us working towards one goal. To provide great and exceptional service to our clients…everyone is very supportive, helpful. It's a great work spirit. I'm really happy to have this kind of chance to work with our team here, honestly."*

Participants described the value of a close-knit team of CCHBs, where team members were diligent in sharing helpful resources they discovered with the whole team, such as low income dental or physio clinics, for the benefit of the entire UMHC community.

Again, participants noted that the positive team atmosphere cultivated between employees at UMHC was important for patients as well, and that witnessing the positive regard between CCHBs and physicians assisted in building patient confidence in their care.

Experiences of CCHBs: Challenges

CCHBs reported an overall highly positive perception of their work and their role, though did note that in some cases, boundaries were difficult to define and protect, leading to consequential moral distress when drawing a line between work and personal life. Additionally, participants noted the at times overwhelming emotional cost of their work and some difficulties with defining their role to patients and professional partners.

Importance of Boundaries

Given the professional and personal sense of responsibility CCHB participants identified in their roles, and the criticality of their work in enabling effective patient care, participants shared some challenges in setting boundaries in their work and with patients. As one CCHB described, "being a CCHB is more than a job". Participants reported that they were willing to work beyond their standard work hours to prevent delays in care, in some cases at their own expense. CCHBs shared that while it was not mandatory to be consistently available to clients, due to the substantial language and systems barriers their clients face, they sometimes took on responsibilities to support above and beyond their "normal" job duties. "If we can support, to take pain from that patient in some situations…we should," noted one CCHB participant.

In one example, a participant described a time where a patient called them from a bank and requested support with translation. This kind of activity fell beyond their "scope" as an UMHC cross cultural health broker, but time and again, participants reported that they would help wherever they could.

Participants did note that it was important that they set "healthy boundaries" with their patients and lay out clear expectations for their partnership. One participant shared that while

she was very accessible via text, most of her patients know not to contact her on the weekend unless it is very urgent. “We have this really great connection, but at the same time, with healthy boundaries.” It was helpful for CCHBs to lay out clear expectations for clients early in their relationship, and to outline exactly what they could and could not support clients with. Participants noted the importance of not doing everything for patients and working hard to support them in taking on more and more of their own care as they come to know the system. As one participant noted, “‘We need to empower patients to navigate the system by themselves.” This not only contributed to patients’ autonomy but reduced the burden on CCHBs. Boundaries were important to the wellbeing of CCHBs, as well as other patients, who may receive less support if a handful of patients are taking the majority of a CCHB’s time.

Given the desire of each employee at UMHC to help patients, some CCHBs noted the importance of limiting the workplace “culture” of going extra “above and beyond. This was thought to have the potential to encourage protective boundaries around CCHBs’ time, while still acknowledging the significant needs of the clientele served at UMHC. This was still held in the context of appreciation for the supportive nature of the UMHC team, and recognition that the “above and beyond” nature of many members of the team was not a workplace requirement, rather frequently an outcome of the intrinsic desire of staff to support their clients.

Emotional Toll

Participants also discussed the heavy emotional toll that supporting patients could take, especially in instances where patients were in very difficult positions. One shared:

> *“I feel really emotional dealing with [clients]…I feel like a lot of sympathy. I put myself in their place. They are vulnerable, they don't have language, they don't have money, they [are] alone here. I think a lot about them after my work …it’s really exhausting. But it’s also rewarding at the end…it touches my feelings and my daily life.”*

The emotional burdens of working with a highly vulnerable population was held in tension with the personal values and sense of responsibility and professional satisfaction CCHBs received through the successes of their job.

Patient Frustration

Finally, participants reported that challenges at times arose when their patients did not have a clear understanding of their role or what a CCHBs could control. For example, one participant shared that early on, patients may think CCHBs are just “secretaries” who follow up and schedule their appointments, while other clients may blame CCHBs for long wait times to see the doctor. In a minority of instances, CCHBs noted that this frustration could appear as rudeness and impatience directed toward the CCHB, but overall, participants expressed empathy for their clients and compassion towards these frustrations. One CCHB explained, “I can understand it. I can wait for my appointment, but for my kids, I have no patience for it. And they [the patients] are the same…”

Participants further explained their strategies for setting clear expectations and explaining realistic timelines to patients:

> *"When patients are coming in, they have health issues, housing issues, disability issues and more. Helping them is going to take a lot of time – forms and processes take a lot of time. So, I need to explain that…If you explain this, they will be happy. If you don't explain, they are not happy because they don't understand."*

Participants noted that when patients have a clear understanding of their CCHB's limitations and abilities, their connection is much stronger, and patients are very kind and appreciative.

Opportunities for Growth

Expanding UMHC's Capacity

In discussing areas for improvement, the most salient theme was a desire to build up the capacity of UMHC to take on more patients. The availability of physicians was discussed as the main limiting factor, and participants expressed a desire to see more clinicians hired, and importantly, ones who possess cultural sensitivity, with experiences in working with newcomer populations. One participant elaborated on these systemic challenges: "The Canadian health system is totally mismatched with immigrants here."

Participants were interested in taking more patients off the waitlist, yet balanced this desire with the acknowledgement that they didn't want to diminish the standard of care currently provided at UMHC. Given the high level of need of the patient population served at UMHC, and the importance of investing in the patient-provider relationship, some CCHBs explained that they book longer doctor appointments for certain patients, at times up to 1 hour, versus the standard 30 minutes, both of which are substantially longer than the 5–10-minute appointment that is typical for most family doctor appointments. But as one participant noted, "We need to keep our standard [of care] and [also] accept more people. So, it's really challenging."

Participants suggested that funding for hiring other team members, such as a full time Medical Office Assistant and more CCHBs and social workers, may also assist with alleviating the caseload burden for existing physicians and nurse practitioners, allowing more patients to come off the waitlist. CCHBs shared that the UMHC waitlist was monitored for urgency, with clients becoming attached based partially on the priority of their needs. In some instances, CCHBs explained that they may offer some support to individuals on the waitlist even before they are attached to the clinic. Others noted it would be valuable for UMHC to offer longer service hours, beyond 10am-5:30pm.

In the case of the mobile UMHC clinic, CCHBs described the waitlist as less formal. Workers served by the mobile clinic were often in Canada on a seasonal basis, rendering the concept of a

waitlist impractical. CCHBs explained they do their best to accept and work with anyone that comes to the mobile clinic.

Adding Service Languages

As well as attaching more clients, participants were also interested in expanding the number of cultural communities supported by CCHBs at UMHC, beyond the current five service languages. More service languages would be enabled by funding to expand the CCBH model of care, and to hire more brokers of diverse cultural backgrounds. CCHBs also discussed their desire for more funding for "community health centres like Umbrella" where clients can access diverse primary care and social services in one unified location.

Desire for Professional Legitimization

In discussing opportunities for growth and improvement in their roles, almost all CCHBs discussed the desire for further legitimization of their professional role, such that specialists, other physicians, patients, and referral organizations understand what the role of "cross cultural health broker" entails. One noted, "We are trying to have recognition. When you say 'I'm a social worker' [people] know what that is. When you say, 'I'm a CCHB,' what is it? We want to have this kind of recognition."

Participants shared that widespread recognition of their role may allow for more productive relationships with other resource organizations within the health sector and reduce their need to repeatedly explain their role to others working outside of UMHC when advocating on behalf of their clients.

Participants also suggested that professional recognition would better allow for the creation of a uniform training program for CCHBs and consolidate advocacy work for the professional group: "We need to have collaboration together to have one training for anyone as a CCHB joining the field in the future…" The role was held in high esteem, and participants were invested in seeing the professional position develop and expand across Canada and beyond.

Enhanced Referral Relationships

Several participants also discussed desires for enhanced and more formalized referral relationships between UMHC and other institutions, such as BC Housing, WorkSafe BC, and other settlement organizations. While many CCHBs described having developed personal relationships with individuals at these organizations, having more formalized linkages was identified as a potential area for improvement. Informal relationships were described as currently productive, given the small team of CCHBs at UMHC, but participants worried about planning for the future, and the growth of the UMHC team. As one participant expressed, "What happens if I change my job? If there is a new CCHB? She won't know about these informal relationships…" Having established connections at other organizations was immensely valuable in speeding up care for patients, yet these relationships were frequently personal, developed by CCHBs over time working with specific contacts at referral organizations, and not always transferrable to other team members.

Increased Physical Resources

Finally, physical resources and infrastructure, such as a larger clinic space, a more reliable mobile clinic van equipped with a consultation room, and medical supplies available for clients to take home were also cited as factors which could augment UMHC's capacity.

Discussion and Recommendations

The lack of healthcare resources available for newcomers to Canada has been well documented (Beiser, 2005) and is part of the larger challenge of providing settlement resources to match our immigration targets. These challenges are set within the larger context of physician shortages in Canada and the potential for increased healthcare needs of those coming from traumatic situations, such as in the case of refugees. As we learned from participants in this study, this is compounded for some in the focal population by limited proficiency in English and exposure to healthcare providers who may not have the cultural competence needed to understand and address the diverse needs of newcomers. In this context, fear of stigma and discrimination, even passively without intent, can deter newcomers from seeking healthcare or disclosing sensitive information. Challenges with system navigation was also noted by participants in this study prior to their access to CCHBs, with the lack of understanding leading to difficulties accessing primary care, specialist services, and preventative care.

Addressing these barriers requires a comprehensive and culturally competent system-level approach supported by provincial policies and resources. Although this is intrinsically of value from within a healthcare system that prioritizes universal access to care and recognizes the importance of meeting the needs of diverse populations, a focus on appropriate primary care and attention to social determinants of health for newcomers will also reduce overall system costs through preventative and up-stream care. To this end, we recommend the following:

(1) Examining the potential to scale the model of CCHBs across health system domains, geographies, and settings in response to the characteristics of the population;
(2) Additional funding to support the current work on CCHBs at UMHC but also to expand across the province; and,
(3) Additional infrastructure funding for UMHC to build resources as a Centre of Excellence in supporting the spread of the CCHB model.

Internationally Trained Health Professionals face significant challenges in obtaining Canadian licensure. Although efforts are currently being made to streamline the assessment and licensing process and provide more support to ITHPs in their journey to practice, significant barriers still

exist. Such barriers start with Canada's rigorous licensing and certification standards, residency training, and learning the contextual nuances of how healthcare in provided in Canada. This culminates in a large proportion of foreign-trained physicians being unable to secure licensure to practice in Canada and resorting to other entry-level jobs (Chowdhury et al., 2023) which both diminishes the potential for the newcomer to work to their professional scope and reflects a missed opportunity for addressing essential health human resource gaps. This provides an opportunity for ITHPs to play a significant role in health promotion, decreasing health disparities, and increasing equity for the populations they serve. This is a benefit to both the communities and the healthcare system. To this end, we recommend the following:

(4) A collaboration between the Ministry of Health, the Ministry of Advanced Education and Training, the Ministry of Post-Secondary Education and Future Skills and the Ministry of Jobs, Economic Development and Innovation to create a provincial pathway for the integration of CCHBs into our healthcare system, with the nuances of the regulatory structure and scope of practice reflecting the needs and priorities of CCHBs and those communities in which they work;
(5) Consider the role of CCHBs as a valued stepping-stone to full Canadian licensure due to the knowledge of and experience with the Canadian healthcare system the position demands; and,
(6) Augment the Provincial Language Services to offer not only language interpretations within clinical settings, but also cultural interpretation.

As Phase II of this project will focus on the interface between UMHC and other settlement agencies in British Columbia, we anticipate further recommendations to improve referral pathways between agencies to optimize the strength and capacity of all.

What's Next?

1) Member checking with UMCH staff and leadership

To augment the validity of our findings, which were derived from a thorough, rapid thematic analysis, we will sit down with staff and leaders from UMHC to discuss questions or comments that may arise around the cultural interpretation of the dataset. This member checking process will improve the quality of our analysis and the reliability of our recommendations, as well as act as a checkpoint to inform us if a more fulsome, formal analysis of the initial dataset is required.

2) Expanded data collection, integrating diverse voices from the social services sector involved in newcomer settlement support

As noted above, the next phase of our project will include further interview with Umbrella leadership as well as clinicians at UMHC, such as physicians, nurse practitioners, social workers, and mental health counsellors. We will also expand data collection in include interviews with participants from other relevant social service agencies working in the newcomer settlement and healthcare sector, including organizations such as MOSAIC (settlement and employment services for newcomers), Immigrant Services Society of BC, and NewtoBC.

3) Extended literature review

Phase II of the project will also include an expanded literature review. The initial review that has informed this report, conducted over the past month, has revealed new and interesting directions in the literature that may be of value to us in expanding our project findings to other social services organizations. We have thoroughly examined the literature on the benefits of community health workers to immigrant, refugee, and newcomers to Canada, as well as licensing challenges for internationally trained health professionals in Canada. We will augment this literature with a thorough review of immigrant, refugee, and newcomers' experiences of healthcare in Canada. This expanded literature review will further ground our findings and advocacy in the rigorous context of evidence-based research.

4) Knowledge translation

Finally, given the practical importance of this data, and our evidence-based findings on the value of the UMHC model of utilizing ITHC to facilitate access to care for immigrants, refugees, and newcomers to Canada, knowledge translation will be an essential output of our project. In accordance with our commitment to the principles of community-based research, we will provide community-facing summaries to participants, UMHC, and partner organizations that use plain language to communicate findings. More formal strategies for knowledge translation, including the validation of findings through peer-review publications and presentations at relevant conferences, will be enacted through macro, meso, and micro perspectives.

Micro-level knowledge translation strategies (those targeting implementation of findings in day-to-day practice) will involve applying the findings of patient/client experiences to quality improvement initiatives within Umbrella.

At a meso level, knowledge translation strategies will be focused on working with social service sector agencies to share the results of the innovative model adapted by UMHC. These relationships, many of which already exist through Umbrella, will allow the efficient scale and spread of the output of this work to organizations who could adapt the model to their clients.

At the broadest level, next steps will include networking with the Ministries of Health and the Advanced Education to report on the provincial implications for repurposing the training, experience, and capacity of IMGs to participate in BC's healthcare system as non-clinical cultural

health brokers.[1] These conversations will be focus on developing and enacting policy and funding frameworks that support Cross Cultural Health Brokerage at a provincial level. If findings from further interviews with participants from a broader range of organizations continue to demonstrate the success of the model, our finalized findings will form the basis of advocacy for system recognition and support of internationally trained health professionals as cross cultural health brokers.

[1] If we are not successful with a secondary CUES grant, we will not engage in person with the Ministry of Advanced Education and Training, but instead submit a written report, including recommendations, to them.

References

Abalkhail, J. M. (2018). Challenges of translating qualitative management data. Gender in Management: An International Journal, 33(1), 66–79. https://doi.org/10.1108/gm-03-2016-0029

Ahmed, S., Shommu, N. S., Rumana, N., Barron, G. R. S., Wicklum, S., & Turin, T. C. (2016). Barriers to Access of Primary Healthcare by Immigrant Populations in Canada: A Literature Review. Journal of Immigrant and Minority Health, 18(6), 1522– 1540. https://doi.org/10.1007/S10903-015-0276-Z

Anahideh, H., Kang, L., & Nezami, N. (2022). Fair and diverse allocation of scarce resources. Socio-economic planning sciences, 80, 101193. https://doi.org/10.1016/j.seps.2021.101193

Beiser M. (2005). The health of immigrants and refugees in Canada. Canadian journal of public health = Revue canadienne de sante publique, 96 Suppl 2(Suppl 2), S30–S44. https://doi.org/10.1007/BF03403701

Bever, A., & Hogg, R. (n.d.). Cultural Brokers: A strategy for promoting health equity among newcomer women A quality improvement study for BC Women's Hospital and Health Centre.

Bhatt, J., & Bathija, P. (2018). Ensuring Access to Quality Health Care in Vulnerable Communities. Acad Med, 93(9):1271-1275. doi: 10.1097/ACM.0000000000002254.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation?. Qualitative health research, 26(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Boelen C. (2000). Towards Unity for Health. Challenges and Opportunities for Partnership in Health Development. Geneva: World Health Organization

Brar-Josan, N., & Yohani, S. C. (2019). Cultural brokers' role in facilitating informal and formal mental health supports for refugee youth in school and community context: a Canadian case study. British Journal of Guidance & Counselling, 47(4), 512–523. https://doi.org/10.1080/03069885.2017.1403010

Canada Health Act: RSC 1985, C C-6. CanLII. (n.d.). https://canlii.ca/t/532qv

Chowdhury, N., Lake, D., & Turin, T. C. (2023). Choosing Alternative Career Pathways after Immigration: Aspects Internationally Educated Physicians Consider when Narrowing down

Non-Physician Career Choices. Healthcare 2023, 11(5), 657. https://doi.org/10.3390/HEALTHCARE11050657

Clemens, M. A. (2011). The Financial Consequences of High-Skill Emigration: Lessons from African Doctors Abroad (S. Plaza & D. Ratha, Eds.). Diasporas for Development. https://www.proquest.com/books/financial-consequences-high-skill-emigration/docview/1030492045/se-2

Government of Canada. (2022). Immigration Matters in Health Care. Benefits of Immigration on Canadian Sectors. https://www.canada.ca/en/immigration-refugees-citizenship/campaigns/immigration-matters/growing-canada-future/health.html

Gutman, A., Tellios, N., Sless, R. T., & Najeeb, U. (2021). Journey into the unknown: considering the international medical graduate perspective on the road to Canadian residency during the COVID-19 pandemic. Canadian Medical Education Journal, 12(1), e89. https://doi.org/10.36834/CMEJ.70503

Health Research BC. FAQ for Health Authorities on Learning Health Systems. (2024). https://healthresearchbc.ca/bc-support-unit/info-and-resources/patient-oriented-learning-health-systems/faq-for-health-authorities-on-learning-health-systems/

Health Officers Council of BC. (2008). Health Inequities in British Columbia. www.phabc.org

Helmich, E., Cristancho, S., Diachun, L., & Lingard, L. (2017). 'How would you call this in English?': Being reflective about translations in international, cross-cultural qualitative research. Perspectives on medical education, 6(2), 127–132. https://doi.org/10.1007/s40037-017-0329-1

Henkelmann, J.-R., De Best, S., Deckers, C., Jensen, K., Shahab, M., Elzinga, B., & Molendijk, M. (2020). Anxiety, depression and post-traumatic stress disorder in refugees resettling in high-income countries: systematic review and meta-analysis. The British Journal of Psychiatry, 6(4). https://doi.org/10.1192/bjo.2020.54

Luig, T., Ofosu, N. N., Chiu, Y., Wang, N., Omar, N., Yip, L., Aleba, S., Maragang, K., Ali, M., Dormitorio, I., Lee, K. K., Yeung, R. O., & Campbell-Scherer, D. (2023). Role of cultural brokering in advancing holistic primary care for diabetes and obesity: a participatory qualitative study. BMJ Open, 13(9), e073318. https://doi.org/10.1136/BMJOPEN-2023-073318

MacFarlane, M. M. (2021). When a Canadian is not a Canadian: marginalization of IMGs in the CaRMS match. Canadian Medical Education Journal, 12(4), 132. https://doi.org/10.36834/CMEJ.71790

McDonald, J. T., & Kennedy, S. (2004). Insights into the 'healthy immigrant effect': Health status and Health Service use of immigrants to Canada. Soc. Sci. Med., 59(8), 1613–1627. https://doi.org/10.1016/j.socscimed.2004.02.004

Najeeb, U., Wong, B., Hollenberg, E., Stroud, · Lynfa, Edwards, S., & Kuper, · Ayelet. (2019). Moving beyond orientations: a multiple case study of the residency experiences of Canadian-born and immigrant international medical graduates. Advances in Health Sciences Education, 24, 103–123. https://doi.org/10.1007/s10459-018-9852-z

Nevedal, A. L., Reardon, C. M., Opra Widerquist, M. A., Jackson, G. L., Cutrona, S. L., White, B. S., & Damschroder, L. J. (2021). Rapid versus traditional qualitative analysis using the Consolidated Framework for Implementation Research (CFIR). Implementation science: IS, 16(1), 67. https://doi.org/10.1186/s13012-021-01111-5

Nwadiuko, J., Varadaraj, V., & Ranjit, A. (2018). International Medical Graduates—A Critical Component of the Global Health Workforce. JAMA, 319(8), 765–766. https://doi.org/10.1001/JAMA.2017.17961

Provincial Health Services Authority. (2011). Towards reducing Health inequities: A Health system Approach to chronic Disease Prevention. A Discussion Paper. Vancouver, BC: Population & Public Health, Provincial Health Services Authority.

Rod, MH., Rod, NH., Russo, F., Klinker, CD., Reis, R., & Stronks, K. (2023). Promoting the health of vulnerable populations: Three steps towards a systems-based re-orientation of public health intervention research. Health & Place. 80. doi: 10.1016/j.healthplace.2023.102984

Salami, B., Salma, J., & Hegadoren, K. (2018). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. https://doi.org/10.1111/inm.12512

Taylor, B., Henshall, C., Kenyon, S., Litchfield, I., & Greenfield, S. (2018). Can rapid approaches to qualitative analysis deliver timely, valid findings to clinical leaders? A mixed methods study comparing rapid and thematic analysis. BMJ open, 8(10), e019993. https://doi.org/10.1136/bmjopen-2017-019993

Torres, S., Labonté, R., Spitzer, D. L., Andrew, C., & Amaratunga, C. (2014). Improving Health Equity: The Promising Role of Community Health Workers in Canada. Healthcare Policy, 10(1), 73. https://doi.org/10.12927/hcpol.2014.23983

Torres, S., Spitzer, D. L., Labonté, R., Amaratunga, C., & Andrew, C. (2013). Community health workers in Canada: Innovative approaches to health promotion outreach and community development among immigrant and refugee populations. Journal of Ambulatory Care Management, 36(4), 305–318. https://doi.org/10.1097/JAC.0B013E3182A5480F

Turin, T. C., Chowdhury, N., Lake, D., & Chowdhury, M. Z. I. (2022). Labor Market Integration of High-Skilled Immigrants in Canada: Employment Patterns of International Medical Graduates in Alternative Jobs. Healthcare (Switzerland), 10(9), 1705. https://doi.org/10.3390/HEALTHCARE10091705/S1

Umbrella Multicultural Health Co-op: Providing practical access to affordable health care services. Umbrella Multicultural Health Coop. (2017). https://umbrellacoop.ca/

Wang, L., Kwak, MJ. (2015). Immigration, barriers to healthcare and transnational ties: A case study of South Korean immigrants in Toronto, Canada. Social Science & Medicine, 133, 340–348. https://doi.org/10.1016/J.SOCSCIMED.2014.11.039

Wang, Y., Das, R. L. V., Lapa, T., Marosan, P., Pawliuk, R., Chable, H. D., Lake, D., & Lofters, A. (2023). Career development of international medical graduates in Canada: status of the unmatched. Humanities and Social Sciences Communications 2023 10:1, 10(1), 1–7. https://doi.org/10.1057/s41599-023-01534-z

Wang, Y., Luke, R., & Marosan, P. (2018). Training International Medical Graduates Through an International Physician Organization. Medical Science Educator, 28(2), 273–274. https://doi.org/10.1007/S40670-018-0559-9/METRICS

WelcomeBC, & Province of British Columbia. (2023). WHY CHOOSE BRITISH COLUMBIA, CANADA. https://www.welcomebc.ca/Choose-B-C/Why-Choose-British- Columbia-Canada

Yohani, S., Kirova, A., Georgis, R., Gokiert, R., Mejia, T., & Chiu, Y. (2019). Cultural Brokering with Syrian Refugee Families with Young Children: An Exploration of Challenges and Best Practices in Psychosocial Adaptation. Journal of International Migration and Integration, 20(4), 1181–1202. https://doi.org/10.1007/S12134-019-00651-6/FIGURES/6

Zivot, C., Dewey, C., Heasley, C., Srinivasan, S., & Little, M. (2020). Exploring the state of gender-centered health research in the context of refugee resettlement in Canada: A scoping review. *International Journal of Environmental Research and Public Health*, *17*(20), 7511. https://doi.org/10.3390/ijerph17207511

Appendix

Appendix 1: Participant Recruitment Poster

Are you interested in sharing your experiences about accessing health care through the Umbrella Multicultural Health Cooperative?

Umbrella Multicultural Health Co-op

You are invited to take part in a 30-60 minute interview at Umbrella, a location convenient to you or virtually through Zoom.

Your input will be used to understand the role of Cross Cultural Health Brokers in helping immigrants, refugees, farm workers and newcomers to Canada access health care.

You will receive a $40 Superstore gift card for participating.

Want to participate or learn more about the study? Please contact the project coordinator, Audrey Cameron, at audrey.cameron@ubc.ca. or 778 386 3212

Dr. Jude Kornelsen, from the Centre for Rural Health Research at the University of British Columbia is leading this study.

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