



AMSSA

Cultures West

Affiliation of Multicultural Societies and Service Agencies of BC

Vol. 20, No. 2: Fall 2002

La diversité dans les soins de santé; un pont entre les cultures

Diversity in Healthcare...Bridging Cultures

Diversidad en los servicios de salud...conectando culturas



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COVER ART BY TONY SAMSON

Diversity in health care ... bridging cultures

Diversity in health care ... bridging cultures



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**Affiliation of Multicultural
Societies and Service Agencies
of British Columbia**

205 - 2929 Commercial Drive
Vancouver, BC V5N 4C8
Tel: (604) 718-2777
1-888-355-5560
Fax: (604) 298-0747
Email: amssa@amssa.org
Website: www.amssa.org

AMSSA is an affiliation of 85 Member Agencies providing multicultural programs and immigrant settlement services throughout BC.

VISION:

AMSSA believes in a just and equitable society which values Canada's cultural diversity.

MISSION:

AMSSA provides leadership in advocacy and education in British Columbia for anti-racism, human rights, and social justice. AMSSA supports its members in serving immigrants, refugees and culturally diverse communities.

GOALS:

1. To build Member Agencies' capacity through effective communication, facilitation, and collaboration
2. To advocate for social justice and equity in immigration, multiculturalism, anti-racism, and human rights
3. To increase AMSSA's profile as a provincial organization

AMSSA STAFF:

| | |
|------------------------|---------------------|
| Executive Director | Lynn Moran |
| Program Director | Timothy Welsh |
| Administrative Assist. | Valentina Rodriguez |
| Calendar Coordinator | Bernard Bouska |
| Accountant | Brita Fransvaag |

EDITORIAL COMMITTEE:

| | |
|----------------------------|----------------|
| Editor – Leslyn V. Johnson | |
| Suzanne Barclay | Brenda Gentles |
| Lynn Moran | Timothy Welsh |
| Valentina Rodriguez | |

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AMSSA: 25 Years of Leadership



Dr. Carole P. Christensen, Keynote Speaker

“1983:

*The main purpose of
the new Affiliation
is to act as a resource
centre and conduit
of information for
multicultural-related
activities and concerns
around BC ...”*

1977

The Affiliation of Multicultural Societies of BC (AMS) is born in Vernon. Several multicultural societies from the interior indicate a desire better communications, a common voice in dealing with governments and the public at large, and to hear from each other about ways to promote multiculturalism in BC. Hodson Manor, a heritage home in the False Creek area of Vancouver, is the headquarters of the Affiliation of Multicultural Societies with Josepha Allan Herfst as the first President.

1979

A major conference, “Toward a Multicultural Policy for BC”, is sponsored in Vancouver by the provincial government and the Affiliation. Some of the recommendations from that conference are implemented, but BC is still without a Multicultural Policy.

Lynn Moran,
AMSSA’s Executive
Director

1980

A Human Rights Workshop is held in Victoria co-sponsored by the AMS and the Intercultural Association of Victoria. “They Built BC”, a display held in conjunction with the workshop, is produced by summer students of AMS.

1981

AMS adopts its logo designed by Okanagan artist Jack Davis composed within a stylized dogwood blossom representing the province. The five sides represent five regions: Vancouver Island, the Lower Mainland, Okanagan, Kootenay and Northern BC. The five figures represent the five main groupings of the human race; their circle holding hands represents harmony and their feet coming together symbolize unity with the total representing the name and aims of multiculturalism.

1982

Cultures West is revamped as the main vehicle for carrying out the information and networking functions of AMS. As a newsletter for multicultural interests, news and issues in BC, it seeks to reflect not only the activities of the AMS membership, but also the current issues relating

to multiculturalism in the broadest sense.

1983

Under the name of “Affiliation of Multicultural Societies and Service Agencies of BC”, a reborn affiliation is formed at a meeting of representatives from various multicultural societies and immigrant service agencies around the province. The main purpose of the new Affiliation is to act as a resource centre and conduit of information for multicultural-related activities and concerns around BC on as broad a basis as possible.

With an expanded membership base, including emerging immigrant and refugee serving agencies, the organization adopts constitutional changes and alters its mandate to reflect the new reality in BC, and to be more compatible with funding criteria of the time. At AMSSA’s first Assembly, held on October 1983, Dr. Joseph Katz is elected President, and there is a membership of 12 multicultural societies and service agencies.

1986

AMSSA first proclaims Multiculturalism Week as an annual event throughout BC, in order to increase cross-cultural





Raj Pagely, Past President, and wife.

understanding and appreciation. Multiculturalism Week continues on throughout the years as an established tradition in BC.

AMSSA Multicultural Health Committee is established with a mandate to actively advocate for fair and equitable policies and standards in health care, as well as to achieve culturally sensitive and responsive health care in BC.

1987

AMSSA Advocacy Committee is formed. One of its first important tasks is to look at multicultural and minority rights issues at both the federal and provincial levels of government. The committee meets to discuss a provincial multicultural policy. In November, AMSSA Executive Officers meet with the BC Cabinet Committee on Cultural Heritage to present a proposed Multicultural Policy for the province of BC. The final draft reflects the participation of more than thirty organizations.

1990

AMSSA is instrumental in establishing a provincial Multiculturalism Policy that emphasizes that "multicultural" applies to all Canadians. This policy is, in part,

an outcome of the proactive efforts of the Anti-Racism and Advocacy Committee.

1992

AMSSA undertakes to market and distribute *The Multifaith Calendar* as its major fundraising activity for the year. The Multifaith Calendar, produced by the *Multifaith Action Society*, an AMSSA member organization, is intended to be an important reference for those interested in learning how followers of different religions celebrate life's meaning and purpose.

The Immigrant Integration Coordinating Committee (IICC) is established as an AMSSA standing committee. Its mission is to further strengthen the provincial immigrant service sector and improve immigrant integration services; to lobby for adequate funding and programs and to develop professional standards in service delivery.

1994

AMSSA membership increased from 49 to 75 agencies in the past three years.

1996

The Board formally adopts a new vision, mission, core values and goals for the organization.

The Collaborative Committee on Multiculturalism (CCM) is formed, with a mission to provide a supportive network and a collaborative voice on multiculturalism.

AMSSA Community Education Society of BC is incorporated.

1997

Through the IICC, AMSSA collaborates with the Vancouver Refugee Council and the Social Planning and Research Council of BC, to organize a province-wide community forum on the legislative review of the Immigration Act. 180 people attend.

1999

The IICC responds to the arrival of 600 Chinese Migrant Boat People by developing on-line resource information on events, news articles, myths vs. facts information and related correspondence. The committee initiates an on-going dialogue between federal and provincial government representatives and service providers to address the impact of changes to the Employment Insurance Act.

2001

AMSSA-IICC joins with ELSA Net and other interested organizations to form the BC Coalition for Immigrant Integration (BC-CII). The BCCII is a broad-based coalition of over 70 agencies providing immigrant settlement and integration services and English Language Services for Adults (ELSA) in communities throughout the province.

AMSSA sponsors "Finding a Home: The Refugee Experience in Vancouver", an interactive exhibit designed to increase awareness of the difficulties and experiences of refugees when coming to Canada. It also challenged misconceptions about refugee life.

2002

AMSSA is presented with the Distinguished Services to Families Award by the BC Council of Families.

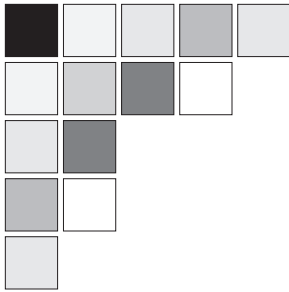
AMSSA now has 86 member organizations.

Note: This compilation does not represent all of AMSSA's achievements over its 25 years of existence.

The volume of achievements are so great that we would need to write an entire book!



AMSSA Past Presidents Jo Herfst, Raj Pagely and Ed Eduljee cut the anniversary cake.



mind buster quiz

case studies

The following are some common dilemmas that take place in Acute Care between health care professionals and patients/clients/family members who speak little or no English. Imagine being an interpreter in these sessions:

1. A man with limited English proficiency who is married and the father of 2 young children is diagnosed with cancer and transferred to the Palliative Care Unit. The Health care team calls for a family meeting to discuss the patient's medical condition and plans. Two issues that arise relate to problems with pain control and discharge. The wife spends most of the day at her husband's bedside and discourages nurses from giving him extra morphine to control the pain. She also does not want him to be transferred to their home or a hospice.

How would you reconcile the following issues:

- The beliefs and expectations of the family?
- The clinical values and practices of Palliative Care?
- The health care policies according to the Ministry of Health and hospital institutions?

Consider how the wife's cultural values influence her decision not to let him have morphine.

2. At the end of an interview session a patient and his wife discuss with each other in Urdu if they should ask the nurse about how his diabetes could affect their sexual life. The nurse and interpreter are still in the room. They hear the husband say: "Perhaps not".

What should the interpreter do, given:

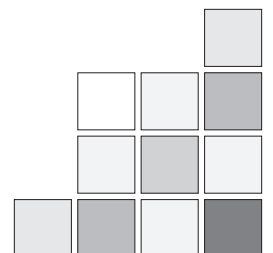
- The sensitivity, yet importance of the topic to the couple?
- The fact that the session was over?

(submitted by Pat Semeniuk and Sandra Wilking)

quiz

1. Canada's Multilingual Education Network is a multi-language resource of high-quality translated information, for professional health-care providers and their clients in 12 languages. Which of the following languages is not offered?
 - a) Tagalog
 - b) Italian
 - c) Darshan
 - d) English
2. On average, how many clients visit the Bridge Clinic in Vancouver each month?
 - a) 100
 - b) 200
 - c) 300
 - d) 400
3. What is the estimate of people with profound deafness in B.C?
 - a) 2,500
 - b) 4,000
 - c) 5,000
 - d) 5,500
4. The Canadian Health Network has produced a number of documents on issues that relate to ethnic groups in Canada. Which of the following topics/studies was not published by CHN?
 - a) Multiculturalism and AIDS
 - b) Language Barriers in Accessing Health Care
 - c) Tobacco use in British Columbia
 - d) Tips to help new immigrants adjust to life in Canada
5. Clients of the Bridge Clinic speak English, French and how many other languages?
 - a) 40
 - b) 32
 - c) 26
 - d) 18
6. Health Care organizations in BC still often rely on non-professional interpreters to assist them with interpreting for their clients. Which of the following can sometimes be asked to render interpreting services.
 - a) Other patients
 - b) Volunteers
 - c) Children
 - d) All of the above

For answers to Mind Buster Quiz, see page 21.



A Day in the Life of an Interpreter

by Teresa Ching and Irene Lee

It is a glorious morning, one of those days that you wish you could spend in the park instead of having to work, but work is slow these days. It is always slow in summer. Yesterday I had only one appointment right in the middle of the afternoon, and for only one hour. It was hardly worthwhile but you never know how your day is going to shape up.

Today I have a relatively full day; 4 one-hour appointments. But with running from one location to another, it will take the whole day.

The phone rings. Someone is at Surgical Day Care for day surgery and the nurse has difficulty communicating with him. It is almost 8:00 am and my first appointment starts at 9:00 am. There is no point rushing to the hospital, so it will have to be by telephone. It turns out that the patient has some vague idea which part of his body is to be operated on, but has no clue what kind of surgery he is having. It must be scary not knowing what is being done to you or why.

My first appointment is at the Women's Clinic at the VGH. I have two patients. Everything is fairly straightforward; the patients are there for colposcopy. The appointment takes an hour, which leaves me some time before my next appointment at the Women's Hospital. I always like to allow plenty of time for traveling and finding parking. Parking on hospital grounds is so expensive; if you work for one hour, you will end up paying for 2 hours. If you factor in time spent in traffic and the cost of gas, it works out to be just slightly above minimum wage. Sometimes I wonder why I bother. But being a medical interpreter has its rewards. You learn so much on the job. It is always fulfilling to know that your work makes a difference when patients get a better understanding of their medical problems and how to manage them.

It is 10:50 am when I arrive at the Women's Clinic. My client is there for amnio-centesis. After checking in at reception, I am asked to interpret the instruction sheets to the client while we are waiting. Things are running a little late today. We are called in at about 11:15 when the nurse outlines the procedure and the risk factors to the patient. My client is a lady in her mid-thirties. She has heard all kinds of weird stories about how amnio-centesis is done, and can't believe when the nurse tells her those stories are not true. *Does the doctor put a needle through my belly button? Does the needle go through the fetus?* At one point the nurse almost cancels the procedure; it appears that the patient has no idea what the procedure is for. As a patient, she believes that it is the doctor's order and you do not question the doctor. She has no idea that she can decide whether or not to have the test. By the time we finish all the explaining and she has signed the consent form, we are already behind schedule.

I am really uncomfortable about her going through with this since she is obviously a little concerned about the potential risks. And, given her education level, I do not think she fully understands the situation. I mention my concerns to the nurse who asks her repeatedly to think it over but she declines. Ultimately it is her decision. I hope things turn out well for her.

We are really behind schedule. By the time we finish, it is already 12:30 pm, half an hour over time. Luckily my next appointment is not until 2:00 pm. Not enough time to go home for lunch as planned, but I still have time to grab a bite somewhere nearby. Just as I am turning onto Cambie Street, my pager beeps. There is a patient at Mt. St. Joseph Emergency and he speaks no English. It will only take 30 minutes. Mt. St. Joseph is not that far away. If I spend 30 minutes at Emergency, I could still grab a sandwich at the cafeteria on my way out. What wishful thinking!



I arrive at the hospital shortly before 1:00 pm. The patient is an elderly gentleman who is taken by ambulance to Emergency because he feels dizzy and weak and cannot get out of bed. He is too weak to talk so we have to find out about him from his wife.

"Does your husband have any medical condition like high blood pressure, diabetes, hepatitis, kidney disease etc?"

"He doesn't have diabetes, but I do. My doctor says it is very mild and I do not require medication."

"Does your husband have any medical condition at all?"

"He doesn't, but I do. You see, I have..."

"Is your husband on any medication?"

"He doesn't like pills, but I am on lots of medication. There is this white pill which I take 3 times a day, then there is a pink one which..."

"Is HE on any medication at all?"

"Not really."

"What do you mean not really? Is he taking anything or not?"

"Only when he has a cold or a cough."

"Who is your husband's family doctor?"

"We used to see the same doctor but now I see a different one."

"Which doctor does your husband see?"

"Well, he used to see Dr. so and so, but then our son got married and the house is too small..."

"Who is your husband's family doctor?"

"I was coming to that. You see, after our son got married, we had to move out and the doctor we were seeing was too far away. We have to take Bus No. X and then change to Bus No. Y and..."

How do nurses do it? How do they remain calm in the face of such obfuscation? I am so tempted to say "Lady, we are not interested in your medical condition or your family history, just answer the questions." But of course I can't. It would be unprofessional to show your frustration although you feel like swearing.

My half-hour appointment turns into 50 minutes. By 1:45pm. I really have to go. My 2:00 pm appointment is at the Children's Hospital. I don't even have time to look for free parking and have to drive into the hospital parking lot. I am starving and stressed out. I arrive at Outpatient Psychiatry at exactly 2:00 pm. Thank goodness the patient is not there yet. There is time for me to catch my breath. My client is 5 minutes late. He has with him a magazine in English. Does he speak English? As I am about to ask him that question, we are called in. It takes only a few minutes to establish that he speaks fluent English and my services are not required. All that rush for nothing! But at least I get paid for the hour, and maybe I can get some lunch after all.

After checking with the Interpreter coordinator to make sure I am not required somewhere else, I head for the cafeteria. Whoops, my pager goes off again. It's the Elizabeth Bagshaw Clinic asking if I could do a telephone interpretation. The client is already on the phone, so I might as well. There goes my lunch! Well, I have a fruit bar in my car, and a bottle of water. They will have to do.

My last appointment for the day is at 3:30 pm at the BC Cancer Agency. My patient is in for a follow up. The doctor has some good news for her. Her cancer is in remission and she does not need to be seen again for quite some time. At least my day ends in a positive note. It is now 4:30pm. I don't care if anybody else calls, I am turning off my pager. I've had enough for one day!

Teresa Ching and Irene Lee are Freelance Medical Interpreters who provide interpreting services to hospitals and health care facilities in the Lower Mainland.

Interpretation Services in Health Care: A Provincial Approach

by Suzanne Barclay, MBA



In January 2000 AMSSA's Multicultural Health Committee initiated the Interpreter Services in Health Care Project. The report identified that limited and non-English-speaking health care consumers are not always guaranteed the universal access to health care that many people take for granted. And, while some areas of the province, such as the Lower Mainland and the Fraser Valley now have systems to overcome these language barriers, other health care providers make do without proper systems or resources. The report showed that there is no province-wide, coordinated approach to interpretation services, but rather a patchwork of systems, services and standards. As a result of the report AMSSA called upon the Ministry of Health to establish province-wide interpreter standards and services.

In support of AMSSA's recommendation, Children's & Women's Health Centre of BC (C&W) and the former Vancouver Richmond Health Board supported a feasibility study for a Regional Language Centre.

At its core, a centrally coordinated Regional Language Centre would ensure standards of care across the province, and consistent equitable access to these services. A provincially funded and managed language service would:

1. Allow better use and management of the interpreter resources. E.g. the article "A Day in the Life of an Interpreter" shows that due to improper coordination among service providers, interpreters spend too much time travelling rather than assisting in the delivery of care.
2. Ensure consistent application of standards for Professional Health Care Interpreting. A central service can better evaluate how health care professionals work with interpreters as well as the interpreters' work itself. Greater accountability for performance and service delivery is also available from a single agency.
3. Provide equitable access to services – access not denied due to geographical limitations or uneven budget allocation.
4. Allow better control and management of financial resources by reducing costs and duplication of services.
5. Allow better analysis of interpretation services statistics. E.g. C&W has developed *FITS – The Friendly Interpretation Tracking System* – a database and software program that allows lower mainland hospitals to better manage the dispatch of their Interpretation Services and to analyze those services.

Many of the benefits described above have been clearly demonstrated by the provincial Medical Interpreting Services, which provides Sign Language services for deaf and deaf-blind persons. And, while some may indeed benefit from the patchwork of services, a centralized system would remove barriers to the majority of patients with limited English proficiency (LEP, and prove to be more cost-effective.

Significant amounts of money are being spent for language services in the Lower Mainland (this year approximately \$1,000,000 for interpretation in four hospitals). Yet huge gaps still exist throughout the continuum of care and throughout the province.

It is imperative that the Health Authorities and the Ministry of Health recognize the benefits of establishing both a Regional Language Centre, and a standardized province-wide Language Service. These two agencies would:

- ensure access for all British Columbians to health services by removing language barriers
- apply professional interpreting standards consistently throughout the province
- dedicate human and financial resources to this sector and apply them more effectively and efficiently.

Suzanne Barclay is the manager of the Office for Cross-Cultural Care & Diversity at Children's & Women's Health Centre of BC. She is committed to removing language barriers for all persons with LEP accessing health care in BC.

Bridge Community Health Clinic (BCHC)

by Dr. Rolando Barrios

Bridge Community Health Clinic (Bridge) was established in 1994 in response to the unmet health care needs of refugees and new immigrants. Bridge is a partnership between Providence Health Care, Vancouver Coastal Health Authority, Immigrant Services Society, BC Multicultural Health Services Society and other refugee and immigrant serving organizations.

The purpose of the clinic is to improve immediate access to primary and preventative health services for refugees and new immigrants, and to provide a bridge for them to access available health services within the community.

The Bridge has developed partnerships with other health organizations such as The Children's Centre at Mount Saint Joseph Hospital, BC Women's Health Centre, TB Control Program, STD's outreach program, and the Provincial Laboratory. The clinic has a dedicated team of doctors, nurses, interpreters, a health settlement worker and an office assistant who all have expertise in working with diverse populations.

The clinic provides health screening, immunization, prenatal care and referrals to other health services. Clinical services are provided Monday through Friday afternoons. Bridge also has dedicated clinics for mental health problems (Wednesday afternoons), HIV/AIDS and addictions (Thursday afternoons), and provides immigration medical exams on Wednesday mornings or as needed.

Bridge clients are usually refugees, refugee claimants and new immigrants. Over 80% of them have been in the country for less than one year. Only about 15% of clients at Bridge are able to speak either English or French. To address this, Bridge has on-site interpreters for the most common language groups and has access to the telephone interpretation services. In addition, most of the staff speaks a second language.

Some barriers in accessing services are systemic (i.e. lack of/ or limited health coverage, lack of immigration status). Barriers can also be individual in nature (i.e. culture, language, poverty, lack of knowledge/understanding of the health system.) Although clients are not required to have health care coverage, staff at the clinic do help them to get registered either through immigration or the BC Medical Services Plan.

The health settlement worker provides clients with an orientation of available services and an overview of the Canadian Health Care system. She also assists new comers to get health coverage, to register with a family doctor in the community, and refers them to other immigrant and settlement organizations for housing, legal assistance, financial assistance, support groups or language training.

The Bridge Clinic will soon move to a new location. The clinic expects to continue meeting the needs of refugees and new immigrants at its new location, the Raven Song Community Health Centre, at #200-2450 Ontario Street. This move is a positive step that will lead to opportunities for enhancing Bridge services by integrating with the community health services and primary care now available at Raven Song

Dr. Barrios is a Family and Community Medicine Specialist who came to Canada as a refugee in 1991. He is a founding member of the Bridge Clinic and is currently the physician leader there.



Culturally Competent Health Care

by Beth Stanger

“My son has heart disease. Today he has had his fourth heart surgery. I am thankful to God that I am in this country. Here the doctors and nurses are very nice. Because of them I have never felt alone and because of them my son is alive. Thank you!”

This letter was written on one of our hospital's patient comment cards - in Urdu, a language of Pakistan. It was written by the mother of a young boy who was in the hospital intensive care unit repeatedly due to a heart condition. Her comments demonstrate the benefits for patients when staff are able to respond to patients' linguistic and cultural backgrounds as well as their medical needs.

Going to the hospital is an experience that can be fraught with anxiety and concern. Families come to health care providers wanting the very best for their loved ones. And health care staff and volunteers are fully dedicated to providing the best care available. Given the diversity of BC's population (especially in Vancouver and Richmond where over half the school aged children speak a language other than English at home) we can safely assume that everybody brings into the hospital setting their own values, traditions, beliefs and ways of communicating. Thus, despite all the best intentions, misunderstandings, gaps in service and raised anxieties may occur. However, being culturally competent – i.e. being open and responsive to the range of patients' diversity in these areas – can enhance understanding, fill service gaps and bring about greater satisfaction for staff, patients and their families.

Many hospitals across Canada are now fully involved in cultural competency initiatives. One example is the Ketogenic Diet Program. This is a successful initiative designed to manage a variety of seizure conditions (epilepsy) in young children through a special, and strictly controlled, diet. One of the benefits of the diet is that it often reduces the need for anti-seizure medications, which often have undesirable side effects. The original menu items of the Ketogenic Diet were based on foods common in the 'mainstream' North American diet. In recognizing the need for a more diverse program, staff at BC's Children's Hospital expanded the menu items to allow families from diverse ethnic backgrounds to follow the diet.

Here's another example. The Vancouver Coastal Health Authority has determined that residents of their service area speak more than a hundred languages. It is impossible to translate health education materials into all these languages. Safe Start, a health education program to promote home safety for infants, babies and children, created user-friendly brochures and pamphlets in easily understood English. The material also includes a variety of diagrams, illustrations and photographs. As a result, new mothers who are not fully fluent in English can still get information on how to "accident proof" their home and keep their babies and children safe.

Sometimes being culturally competent means doing things differently to meet specific cultural needs, as in adding items to the Ketogenic Diet menu plans. At other times, it requires a more universal and therefore more inclusive approach, as the case of the Safe Start program.

Modifying individual programs to meet patients' needs is essential, but it is not enough. Ultimately cultural competency requires systemic change across the continuum of care, and not only in program and service delivery, but also in staffing, fund development and allocation, and in health research and curriculum design. To achieve the larger goal of systemic change, Canada formed a National Network for Cultural Competency in Paediatric Health Care that is steered by a

Being culturally competent – that is, being open and responsive to the range of patients' diversity in these areas – can enhance understanding, fill in service gaps and bring about greater satisfaction for staff, patients and their families

consortium of paediatric hospitals. The Network's goal is to develop national cultural competency standards and to build these standards into Canada's health services accreditation program.

The Network is well on its way to achieving this purpose. Its first conference took place in Ottawa and was highly successful. Two years later Vancouver hosted a second conference that attracted paediatric hospitals, executives of Canada's paediatric, nursing and physician associations and the Canadian Council on Health Services Accreditation (CCHSA). The CCHSA accredits all hospitals and health services in Canada. When hospitals achieve accreditation it means that they meet nationally-approved standards for providing quality health care services. At the Second National Forum, participants developed and endorsed a position statement with draft national standards. Furthermore, CCHSA made a commitment to work with the Network to include the proposed cultural competency standards in their 2005 accreditation guidelines.

We are working hard for 2005 to make cultural competency standards mandatory for Canadian health care organizations. And we are looking forward to the time when all health services will be culturally competent to meet the needs of *all* Canadians - in all their diversity!

If you want to know more about the National Network on Cultural Competency in Paediatric Health Care, visit www.capch.org/partnerships_cultural.html.

Beth Stanger is the Coordinator of Diversity & Equity Children's and Women's Health Centre of BC.



Cultural standards established at the Second National Forum on Cultural Competency in Paediatric Health Care

Standard 1

The organisation develops, implements and regularly evaluates organisational policies and practices to ensure cultural competence.

Standard 2

The organisation ensures effective cross-cultural communication with its diverse patients/clients.

Standard 3

The organisation provides regular professional development opportunities in order to build cultural competence skills and evaluates staff behaviours and attitudes towards diverse staff and clientele.

Standard 4

The organisation develops, implements and evaluates strategies to recruit, retain and promote qualified, diverse and culturally competent staff at all levels of the organisation.

Standard 5

The organisation designs, implements and evaluates services to meet the health and health care needs of their evolving patient population in all its diversity.

Standard 6

The organisation identifies and implements innovative strategies for meaningful participation of diverse community members in organisational processes – including governance.

Standard 7

The organisation regularly evaluates the results of its efforts and monitors progress towards cultural competency.

Standard 8

The organisation establishes mechanisms to develop meaningful research and evaluation methodologies, knowledge and data that meet the health and health care needs of the evolving diversity of its clientele.

Integrative Health Care Promotes Respect for Diversity

by Barbara Findlay

Research shows that over the past decade nearly half of all Canadians are choosing an integrative approach to their health and healing. British Columbians are more likely than other Canadians to combine complementary/alternative therapies, practices or products with conventional western medicine to manage illness and promote wellness. This is perhaps a result because of our location on the Pacific Rim and the open-mindedness that evolves within a multicultural population. Yet despite this growing phenomenon, we live in a society where health care delivery is still based on a biomedical worldview and true respect for diversity remains the exception rather than the norm.

People cite many reasons for seeking an integrative approach to healing. From their families of origin or ethno-cultural communities, they hold onto trusted health beliefs and practices. People across cultures, living with chronic illness, are often disappointed by the limitations of Western medicine. In seeking to manage their symptoms (such as pain or fatigue) and improve their quality of life, they expand their 'toolbox of options' to include other systems of healing. Others are

*Working with clients,
the Tzu Chi Institute
borrows philosophies,
practices and therapies from
across a number of health
belief systems, including
Western medicine.*

discouraged by the rising cost of high-tech health care and seek lower-cost lifestyle changes that are rooted in ancient healing traditions. And still others are caught up in the possibilities for a global community that acknowledges the strengths and weakness of every health belief system.

As Canada's leading advocate for integrative healing, the Tzu Chi Institute for Complementary and Alternative Medicine is committed to expanding possibilities for wellness and improved quality of life. Despite its 'mainstream' location on campus at the Vancouver Hospital and Health Sciences Centre, one of the Institute's founding principles was to foster respect for diversity in health care. It is a non-profit society, governed by an independent Board of Directors and remains an unprecedented health care initiative in Canada. Its original mission was to research complementary and alternative health care (CAHC) for the purpose of integrating those approaches that were proven to be safe, effective and cost-effective with mainstream western medicine. Today, the Institute's Integrated Care Program is gaining international fame as a 'living laboratory' for developing and evaluating a feasible model of integrated health care delivery.

The practitioner team at the Tzu Chi Institute includes chiropractors, mind-body counselors, a massage therapist, naturopath, medical doctor, registered nurse, acupuncturist, nutritionist and a doctor of traditional Chinese medicine. Working with clients, they borrow philosophies, practices and therapies from across a number of health belief systems, including Western medicine.

Barbara Findlay is the Executive Director at Tzu Chi Institute for Complementary and Alternative Medicine. As Canada's leading advocate for integrative healing, Tzu Chi is committed to expanding possibilities for wellness and improved quality of life in our society



*... we live in a society where
health care delivery is still based
on a biomedical worldview
and true respect for diversity
remains the exception rather
than the norm.*

The staff and practitioners at the Tzu Chi Institute experience many of the same barriers as do their clients who seek an integrated approach to their health care. The most visible barrier to clients is the attitude of health care providers. United States and Canadian studies confirm that 60% of clients don't discuss their CAHC use with their family doctors for fear of jeopardizing the relationship or being criticized for their choices. Regardless of which health belief system they subscribe to, practitioners who are ethnocentric in their thinking believe that their brand of medicine is superior to all others, thereby hindering an integrative approach. Ethnocentric thinking usually stems from fear of losing position or power within the existing system or just plain ignorance. The Tzu Chi Institute continues to provide many students, across professional disciplines, the opportunity for a learning experience in the clinic. This strategy is very effective in promoting respect for differences while demonstrating that the client can and

should be the common ground between all practitioners.

Another barrier is the question of 'evidence'. Western medicine bases its practice on the results of scientific studies. It often rejects practices or theories from other health belief systems that are not backed up by similar methods. Lack of funding for research, methodology challenges and failure to acknowledge the merit of literature published in non-English journals, all contribute to this situation. As part of its research mandate, the Tzu Chi Institute works with other related academic organizations to find solutions.

In Canada, the question of evidence is also complicated by the fact that complementary and alternative therapies, practices and products are part of a 2-billion dollar growth industry. Living in the information age, people are exposed to copious amounts of literature, especially via the internet, and may not have the necessary skills to discern quality information from marketing scams.

The 'readiness' of our social systems to accept integrative health care as an option remains the greatest barrier for all of us. Many indicators of respect for diversity on a systems-level are still lacking. Some examples include:

- Regulation of natural health products and CAHC practices is in its infancy in Canada

- Institutional policies allowing CAHC to be provided in conventional health care settings such as hospitals or long term care facilities are rare
- Responsive curriculum for new health professionals is just beginning to be offered, usually as an elective and rarely as core content
- Physicians remain the gatekeepers of our publicly funded health care system preventing other regulated professionals, such as naturopaths, to practice primary health care
- Equitable reimbursement strategies for CAHC practitioners are not supported by governments and differ from province to province

With much optimism, the Tzu Chi Institute continues to work at the forefront of all of these issues. And while change feels slow at times, there is much evidence to support the fact that Canadians value an integrated approach to their health care *and* that respect for diversity is at the core of this movement towards integration. It is important, therefore, that integrative health care remains on all of our agendas as a 'diversity issue'.

For more information about the Tzu Chi Institute or to inquire about enrollment in the Integrated Care Program, call 604-875-4769 or visit our website at www.tzu-chi.bc.ca

Initiatives to break down the barriers to integrative health care

- Accepting students and interested professionals for observational placements in the TCI clinic
- Serving in advisory capacity to Health Canada and other government offices around role of integrative health care in health reform
- Consulting with conventional health care agencies re: policy development and helping to design pilot projects which improve patient access to CAHC
- Providing TCI speakers bureau for public and academic educational events
- Sharing our experiences through publications and presentations
- Making TCI information resources available more widely to conventional practitioners and agencies



Key differences between complementary and alternative health care (CAHC) and Western medicine:

| <i>CAHC</i> | <i>Western Medicine</i> |
|------------------------------------------------------------------------------|-------------------------------------------------------------|
| Focus on the whole person – mind, body and spirit | Focus on the affected part – head, neck, heart, blood, etc. |
| Encourages client to be an active participant – relationship is facilitative | Care is usually prescriptive in nature |
| Supports quest for well-being and improved quality of life | Focuses on cure |
| Aims at the 'roots' of a health problem rather than treating symptoms | Tends to treat symptoms |
| Treats individuals versus conditions | Treatment usually dictated by condition |
| Validates subjective experiences | Relies mainly on objective measures |



BC Regional Roundup

Agency: LEGAL SERVICES SOCIETY
Program: Public Legal Education,
“Benefits and Services for Seniors”

This is an adaptation of the Popular Legal Services Society’s booklet “When I’m 64: A guide to Benefits and Services for People Aged 60 and Over”, for seniors whose first language is not English. “Benefits and Services for Seniors” tells seniors about their rights, including what benefits they might be entitled to receive when they retire or if they get sick; where they can get information about benefits; how their rights to safety are protected; and who can help them appeal an unfavorable decision. The booklets are available in Chinese, English, Japanese, Korean, Punjabi, and Spanish, and coming soon in Farsi.

For more information fax 604-682-0965 or e-mail: ho.distribution@lss.bc.ca

Agency: GAY AND LESBIAN EDUCATORS OF BC (GALE-BC)
Program: Gay Straight Alliance Bursary Fund

Gay and Lesbian Educators of BC (GALE-BC) have established a bursary program to encourage secondary schools to start GSA clubs, and for existing clubs to pursue initiatives to reduce homophobia and heterosexism in schools. Students can apply for funds through a sponsor teacher in their school. Deadlines for bursary applications are in November and April. Complete details about the fund are available by visiting their website at www.galebc.org.

Agency: COLLINGWOOD / SOUTH VANCOUVER
NEIGHBOURHOOD HOUSES
Program: On-Site Settlement Services

Collingwood Neighbourhood House is adding on-site Settlement Workers to the community of Collingwood / Renfrew.

CNH and South Vancouver Neighbourhood Houses are joining forces to hire a Mandarin and Cantonese-speaking Settlement Worker for both of their communities. Collingwood Neighbourhood House will also be providing on-site settlement services for the large Spanish speaking population in their service area. This is a new approach for CNH, who in the past focused on delivering information and referral services, often having to refer outside of their community. Now newcomers who speak Mandarin, Cantonese or Spanish can receive many important adaptation supports close to home, at their child’s school or in their ESL class. The Settlement Workers will also provide support to their multilingual information and referral volunteers.

Anyone interested in volunteering in this program should contact Sara Yuen or Val Cavers at 604-435-0323.

Agency: IMMIGRANT SERVICES SOCIETY OF BC /
SURREY DELTA IMMIGRANT SERVICES SOCIETY / MOSAIC
Program: BC Network of Associations for Internationally
Trained Professionals

Immigrant Services Society of BC, MOSAIC and Surrey Delta Immigrant Services Society are participating in a joint two-year project funded by the Department of Canadian Heritage. The project represents a new approach in British Columbia in responding to the



labour market integration of immigrants with foreign credentials. The project focuses on developing the capacity of ethno-cultural communities; creating networks and/or associations of internationally trained professionals; providing linkages between the key stakeholders and involving them in developing policy.

Fundamental to the project is the involvement of immigrants from diverse ethno-cultural backgrounds, from a wide geographic area of BC, who face barriers in accessing their specific professions and/or trades. The project will ensure that immigrants and organizations supporting immigrants are involved in all stages of the process.

In fall 2002 the project will begin community consultations in the following 5 communities: the Lower Mainland, Fraser Valley, Vancouver Island, Okanagan and Northern BC.

For more information, or to be included in the consultation process, please contact one of the members of the Project Management Committee.

| | | |
|-------------------------------------------|------------------------------------------------|------------------------------------------------------------|
| Kelly Pollack MOSAIC | Clifford Bell Immigrant Services Society | Anisa Kassam Surrey Delta Immigrant Services Society |
| 604-254-0244 kpollack@ mosaicbc.com | 604-684-2561 cbell@issbc.org | 604-597-0205 akassam@sdiss.org |



Anisa Kassam from Surrey Delta Immigrant Services Society, with the Honourable Jean Augustine, Secretary of State for Multiculturalism, Department of Canadian Heritage and Leela Viswanathan from the Council of Agencies Serving South Asians (CASSA) at the announcement of the BC Internationally Trained Professionals Network project (BCITP Net) in Halifax.

Agency: IMMIGRANT SERVICES SOCIETY OF BC
Program: Multicultural Youth Peer Support Group

The Immigrant Services Society of BC is launching an exciting youth initiative - the Multicultural Youth Peer Support Group Program. This program is designed to assist young immigrants and refugees between the ages of 13 and 25 who are facing challenges adjusting to their new life in Canada.



Participants of the Multicultural Youth Peer Support Group.

As of October 2002, the Multicultural Youth Peer Support Group Program will train 15 Youth volunteers to become Peer Support Group Facilitators. The training will run over 11 weeks and cover topics focusing on group dynamics, assertiveness training, facilitation skills, self-esteem building and various cross-cultural issues. Once the training is completed, the volunteers will themselves facilitate peer support groups for immigrant and refugee youth.

For more information, please contact Carmen or Sherry at 604-684-7498 or email them at cmunoz@issbc.org and sherrys@issbc.org.

ANNOUNCEMENT

AMSSA is looking for Board members. We are looking for people with skills in communication, marketing and fundraising and who are willing to give six to eight hours a month to the organization. If you are interested, please put your name forward to Lynn Moran at lmoran@amssa.org, listing your skills and experience.



The Components of Health Care Interpreting Programs

by Kiran Malli

In the Lower Mainland, many organizations struggle to provide linguistically appropriate services to a culturally diverse population. Health care staff use family and friends, bilingual staff members, and volunteers as well as other patients to communicate to limited and non-English speaking patients/clients. This presents a variety of problems including bias, language proficiency and confidentiality. However, all organizations realize that providing linguistically appropriate care is a little more complex than paging overhead for any bilingual person who may be available at the time.

A successful health care interpreter program should include the following six key components¹

1. Policy Development

- A formal approach to establish linguistically appropriate health care which provides access for minorities

2. Data Development

- Infrastructure to collect data on ethnic and linguistic groups and use in program planning
- Develop, identify and implement models of community needs assessments that are culturally and linguistically relevant and applicable to large and small communities

3. Collaborations/Coordination of Services

- Improve coordination among all health systems and with related agencies (education, social services, etc.) to comprehensively address health needs of limited English proficiency (LEP) populations

4. Interpreter Standards/Testing/Training and Services Models

- Define the role of interpreters and situations where they should be used
- Develop models for training interpreters and ensure training for all
- Develop standards and qualifications for medical interpreters, ensuring assessments for language and interpreting skills
- Develop guidelines for using bilingual staff as interpreters and ensure that minimal standards, qualification and training needs are met

5. Translation of Materials

- Develop protocols for accurate and appropriate translation of patient materials such as consent forms and health promotion materials
- Develop standards for translated materials
- Develop clearing houses or other mechanisms to promote sharing of bilingual written materials

6. Funding

- Encourage government and public institutions to allot resources to ensure equitable access

Kiran Malli is a Language Services Coordinator with Richmond Health Services Delivery Area - Vancouver Coastal Health Authority. She believes in the universality of the Canadian Health Care system and desires to make this true for all Canadians.

¹ Adapted from *Improving Access for Limited English-Speaking Consumers*

A Working Model: Medical Interpreting Service For The Deaf And Hard Of Hearing

by Susan Masters



In October, 1997, the Supreme Court of Canada ruled that in British Columbia, the Medical Services Commission and hospitals must provide interpretation services for people who are Deaf or Deaf-Blind when they are accessing health care services or receiving medical care. One year later, the Medical Interpreting Service of the Western Institute for the Deaf and Hard of Hearing (MIS) began operating with funding from the Provincial Services Health Authority.

STRUCTURE OF THE MIS

- The service operates twenty-four hours, seven days a week with access through dedicated toll free voice and TTY lines, electronic mail and facsimile. Services are centralized in Vancouver with the exception of those on Vancouver Island.
- A full time Multicultural Community Coordinator (MCC) is responsible for educating health care professionals and consumers about the MIS. The MCC is also a liaison who resolves any complaints about service.
- There is a full time Medical Interpreter, with the dual duties of interpreting for appointments and interpreting at meetings for the MCC, who is Deaf.
- A roster of freelance interpreters is available across the province. Wherever possible outside the Lower Mainland, a local interpreter is contracted. If no local interpreter is available, there is an option to fly one in for appointments.
- Advanced training for ASL (American Sign Language) interpreters was developed and implemented, through a community college. Besides the educational component, the department also had to create an infrastructure. This involved building a database to handle interpreter bookings, patient profiles, statistical data, as well as developing publicity materials

There has been considerable consumer involvement and on-going monitoring of the service model, primarily through the MIS Advisory Committee. The committee is comprised of representatives from the Deaf, Deaf-Blind and interpreter communities. The committee meets with the MIS staff four times a year to provide feedback and identify any concerns from their respective communities.

Susan Masters the Coordinator of Interpreting Services at the Western Institute of the Deaf and Hard of Hearing and the Administrator for MIS. She has been involved with the interpreting profession for 25 years.

Advanced Medical Interpreters Program: Why We Need Advanced Training In Acute Care For Health Interpreters

by Pat Semeniuk & Sandra Wilking

“As clinicians, we really need to know where the person (patient/client/family member) is coming from in such a complex situation (end of life discussion) in order to find the best solution for the patient. The interpreter becomes critical in unlocking the subtleties”.

This statement is only one of many from various clinical practices that eventually became the driving force behind the pilot program entitled Advanced Interpreter Training in Acute Care. Another equally important issue was how interpreters could assist staff in meeting the challenges of providing culturally responsive patient centred care and treatment.



What were the training assumptions for the pilot program?

- Patient Centred Care Values form the basis of the care and treatment of patient/client/family. Care and treatment is “customized” to the individual’s needs and circumstances rather than asking the individual to respond to care.
- Clinical experience and the literature strongly indicate that language and culture are inseparable and impact the communication process. Chinese speaking patients bring to the session their own language and cultural references. Health Care professionals also bring to the encounter their own language (medical/health and everyday North American expressions) and practices (medical protocols, institutional policies, legal and professional accountabilities). Neither party is usually aware of the other’s differences or similarities.
- The goal of interpretation in acute care is to establish direct communication between the patient/client/family and health care professionals. An integral part of this process is the interpreter as an added resource to the health care team on linguistic and cultural issues. The interpreter is not a mere “communications tool”.

How were the training assumptions translated into a pilot training program?

- Vancouver Hospital and Simon Fraser University together with Providence Health Care and Children’s & Women’s Health Centre of BC developed and implemented a 12 week, 144 hour Advanced Medical Interpreter’s Program in Acute Care.
- The program was built on key clinical areas or issues where Cantonese and Mandarin-speaking interpreters were frequently required and on the role and issues interpreters face in an acute care environment.
- Students were guided through an experiential based program. They were challenged to increase and refine their interpretation skills and acquire knowledge related to the key treatment and care issues facing patients/families and health care professionals.
- Students had to interpret clinical presentations, participate in role play case scenarios, engage in class discussions, participate in an audited interpretation sessions and complete self-evaluation questionnaires.

What were some immediate findings?

- Health care professionals at the unit level need to be briefed on both the role and responsibilities of an interpreter and on their own role and responsibilities in the interpretation process, including briefing the interpreter on the clinical goals of the session. They need to recognize interpreters as professionals who can be an asset to the health care team by assisting them through the linguistic and cultural issues that may emerge during a session.
- Patients/clients and families need to be aware of what an interpreter can or cannot do.
- Interpreting in an acute care setting is complex and challenging. It can involve many individuals with different perspectives and opinions. The challenge for an interpreter in this environment is being accurate and faithful to both content and 'spirit' of the messages. These messages may contain many English or Chinese language euphemisms and are complex in nature.

- Interpreters need to be assertive yet respectful in their practice, to engage in continual professional development and to keep abreast of new clinical terms and concepts

What Next?

- The pilot program is currently under rigorous evaluation in order to determine what areas of the program need strengthening, and what should be eliminated or introduced. Evaluation results are expected in 2003.

Pat Semeniuk is the Professional Practice Leader at Vancouver Coastal Health Authority. Sandra Wilking is a Cultural Consultant with Vancouver Hospital.

A View from the North

by Sharon Pannu

Immigrant and Multicultural Services Society (IMSS) has been serving immigrants and refugees in BC's Northern Region for the past 25 years. We have always felt a gap in the interpretation services we provide for our clients. Whenever the need for interpretation arises, we always try our best to connect a suitable person to interpret for our clients. Our interpreters accompany them to doctor's office, Health Unit, Hospital, Lawyer's office and Court, etc. There is no compensation for them.

However when it comes to medical interpretation, the interpreters have very limited knowledge of the medical terminology and it becomes hard to fully justify their role in this capacity. Sometimes a child or family member will accompany the patient to provide the interpretation. With family members present, most patients are not comfortable sharing their health history and hold back information. Therefore, the interpreter is unable to transfer the information to the doctor. It is even worse when a child is involved. Children have

their own limitations in understanding medical problems and as adults are also shy, it is hard for a child to fully grasp the situation and then interpret it.

Prince George is a fairly big city and we have IMSS to provide the necessary services to the immigrants and refugees, but we cannot fully cope with the need. Most other northern communities have very limited resources available to them and we often receive enquiries and phone calls. We also have limited funds, resources and time, so it becomes quite hard to service other agencies on a regular basis.

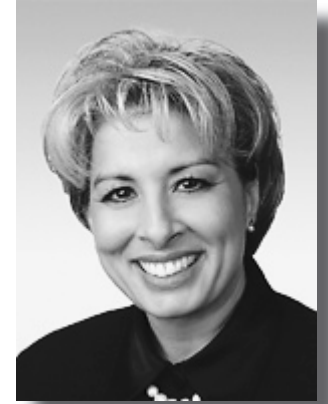
Most of the resources and upgrading of these services are available in the Lower Mainland. However, northern communities are left to deal with their issues on their own. Therefore having an on-line language service available would be one step closer to connecting us with larger communities in the Lower Mainland. The resulting services will be a lot more professional and accurate.

Sharon Pannu is a Settlement Counsellor with Immigrant and Multicultural Services Society in Prince George

Putting Patients First: Caring for Diversity

by the Honourable Sindi Hawkins, Minister of Health Planning

In keeping with this issue's focus on language barriers in accessing health care services, Cultures West invited the Minister of Health Planning to submit an article addressing this issue and some of the other ways the provincial government is responding to the needs of our diverse population. Following are the Minister's comments:



In British Columbia, we participate in a society of many cultures, languages, traditions and heritages. Every day, our health system and health professionals serve patients with diverse needs. To provide quality, appropriate care for all British Columbians, our government is committed to building a more effective, modern and sustainable health care system.

[...]To focus resources on patient care, we have reduced the number of health authorities from 52 to six. This reduces health administration costs, increases efficiency, and results in savings, which will be used to provide better patient care. We have also introduced three-year health funding and performance agreements with health authorities so they can plan, deliver and evaluate health services based on the needs of their multicultural communities.

To ensure equitable, quality services for patients across BC, we have established provincial standards for emergency, acute care and specialty services. To meet the needs of diverse patients, we are also developing new care options and delivery models for primary care, long-term and home care, chronic disease management, and injury prevention.

Our government is working with our health care partners to plan and deliver culturally appropriate care. This year, health authorities developed strategic plans to address the health care needs and improve access to health services for Aboriginal peoples. As part of our Aboriginal Health Services Strategy, we are also strengthening relationships with Aboriginal communities and their involvement in health planning and the delivery of services.

To support British Columbians in taking care of their health, we are providing information and tools for

living longer, healthier lives. We have made health information and advice available 24 hours, seven days a week with the BC HealthGuide Program. It consists of the BC HealthGuide Handbook, OnLine and BC NurseLine. A confidential service, BC NurseLine is available in over 130 languages by calling 604 215-4700 or 1-866-215-4700 toll-free in BC.

In partnership with the First Nation Chief's Health Committee, we have also produced a BC First Nations Handbook – a companion to the BC HealthGuide Handbook. This handbook provides reliable information on many health topics and services, prevention and management of chronic conditions, home treatment options, and healthy lifestyle choices. The new handbook will be available in November 2002.

I commend the leadership and dedication of BC's health authorities, health professionals and other service providers in delivering quality, culturally responsive care. In BC, medical interpretation and translation services are available in multiple languages, including Cantonese, Mandarin, Vietnamese, Japanese, Farsi, Spanish and Punjabi. In addition, health information and education materials are available in plain English and other languages that patients speak. And, to help health professionals provide the best care, educational sessions on cross-cultural communication and interpretation are also being offered for clinical staff in BC's health care facilities.

In building a more effective and sustainable health care system, our government is committed to providing quality, appropriate care that British Columbians need. We are working to build a health system that addresses the diverse needs of British Columbians and supports their efforts in living healthier lives.

Kudos

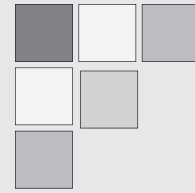
CAMPBELL RIVER MULTICULTURAL AND IMMIGRANT SERVICES ASSOCIATION

The Campbell River Multicultural and Immigrant Services Association (MISA) acknowledges the extraordinary work and commitment of its Programs Manager, Kathie Landry. MISA is celebrating its 10th Anniversary this year, and Katie has definitely been a big part of their achievements during this time. Her role with the organization evolved from a volunteer to practicum student, to outreach and settlement and finally to become Programs Coordinator/Manager. Kathie puts 200% into everything that she does.

Collaboration is one of the key principles of MISA's work. And, Kathie has worked tirelessly with funders, community and regional partners to realize MISA's mission. She also worked with many board members to make sure that our organization is functioning at its highest standard and in the most ethical and transparent manner. She will tell you that she has grown much and made life long friends through MISA. Those who are associated with MISA thank her for her commitment, competency and most of all her compassion and friendship.

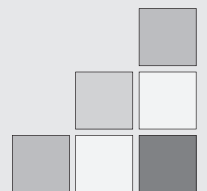


Kathie Landry, Executive Director of Campbell River & Area Multicultural and Immigrant Services



mind buster answers

1. a) Tagalog
2. d) 400
3. c) 5,000
4. b) Language barriers in accessing Health Care
5. a) 40
6. d) All of the above



multicultural health bibliography

Collated by Ivan Tsui & Valentina Rodriguez

AMSSA Resources

Case Studies in Health Care: A Discussion on the Linguistically Appropriate Services - June 1999

Interpreter Services in Health Care - January 2000

Print Resources

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Ivan surfs the web looking for multicultural health resources.



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National Aboriginal Health Organization: <http://www.naho.ca>

Transcultural and Multicultural Health Links: <http://www.iun.edu/~libemb/trannurs/trannurs.htm>

UMHS – Multicultural Health: <http://www.med.umich.edu/1libr/multicul/multi00.htm>

World Health Organization: <http://www.who.int/home-page/>

Online Resources

Canadian Health Network Health Centre: http://www.canadian-health-network.ca/1ethnic_groups.html

Canadian Mental Health Association: <http://www.cmha.ca>

Canadian Nurses Association: http://www.cna-nurses.ca/_in_progress/_search/_frames/issuestrends/issuestrendsframe.htm

Cultural Medicine: <http://www.geocities.com/SoHo/Study/8276/CulturalMed.html>

Health Canada: <http://www.hc-sc.gc.ca>

Multicultural Resources: BC Cancer Agency: <http://www.bccancer.bc.ca/PPI/RecommendedLinks/CancerRelatedwebsites/MulticulturalResources.htm>

Multilingual Health Education: <http://www.multilingual-health-education.net/resourcesandlinks.asp>

Videos

Abortion: Stories from North and South

A Small Spark Has Become a Flame – Promptvision Productions of Canada Ltd.

Ann Ross: Rebel with a Cause – National Film Board of Canada

Between the Lines: Issues in Refugee Mental Health – Mount Allison Productions (CD Rom)

Healing Spirit – National Film Board of Canada

Nurse Care Series – National Film Board of Canada

Poundmaker's Lodge: A Healing Place – National Film Board of Canada

Surviving Death: Stories of Grief – National Film Board of Canada

The Long Walk – National Film Board of Canada

AMSSA Member Organizations

| | | | |
|-------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| Abbotsford Community Services (ACS) | City of Richmond - Advisory Committee on Intercultural Relations | Legal Services Society of BC (LSS) | Terrace & District Multicultural Association (TDMA) |
| Adult Learning Development Association (ALDA) | Collingwood Neighbourhood House (CNH) | Little Mountain Neighbourhood House Society (LMNHS) | Trail & District Multicultural Society (TDMS) |
| Association of BC TEAL (Teachers of English as an Additional Language) | Comox Valley Family Services Association (CVFSA) | Mennonite Central Committee of BC - Refugee Assistance Program (MCC- RAP) | Vancouver Association for the Survivors of Torture (VAST) |
| Association of Neighbourhood Houses of Greater Vancouver (ANH) | Community Legal Assistance Society (CLAS) | Mission Community Services Society (MCSS) | Vancouver Citizenship Council (VCC) |
| Big Sisters of BC - Lower Mainland | Cowichan Valley Intercultural & Immigrant Aid Society (CVIIAS) | Multicultural Heritage Society (MHS) - Prince George | Vancouver Cross-Cultural Seniors Network Society |
| BC Association of Social Workers (BSASW) - Multiculturalism & Anti-Racism Committee | Crisis Centre - Vancouver | Multicultural Society of Kelowna (MSK) – Immigrant & Community Serving Agency | Vancouver & Lower Mainland Multicultural Family Support Services (VLMMFSS) |
| BC Heritage Language Association (BCHLA) | ELSA Net | Multifaith Action Society (MAS) | Vancouver Multicultural Society (VMS) |
| BC Human Rights Coalition (BCHRC) | Families as Support Teams (FAST) | Nisha Family and Children's Services Society | Vancouver Society of Immigrant & Visible Minority Women (VSIVMW) |
| BC Settlement and Integration Workers Association (BCSIWA) | Family Education and Support Centre | North Shore Multicultural Society (NSMS) | Vancouver Women's Health Collective |
| BC Teachers Federation – Social Justice Program (BCTF - SJP) | Family Services of Greater Vancouver (FSGV) | OPTIONS: Services to Communities Society - Surrey | Vernon & District Immigrant Services Society (VDISS) |
| Boundary Multicultural Society (BMS) | Fraserside Community Services Society (FCSS) | Pacific Immigrant Resources Society (PIRS) | Vernon Multicultural Association |
| Burnaby Multicultural Society (BMS) | Gay & Lesbian Educators of BC (GALE BC) | Penticton & District Multicultural Society (PDMS) | Volunteer Vancouver |
| Campbell River & Area Multicultural & Immigrant Services Association (CRMISA) | Immigrant & Multicultural Services Society (IMSS) | Progressive Inter-Cultural Community Services Society (PICS) | WATARI |
| Canadian Hispanic Congress (CHC) - BC Chapter | Immigrant Services Society of BC (ISS) | Public Legal Education Society (People's Law School) | West Coast Domestic Workers' Association (WCDWA) |
| Canadian Jewish Congress (CJC) - Pacific Region | Immigrant & Visible Minority Women of BC (IVMW) | Quesnel Multicultural Society | Westcoast Child Care Resource Centre – Multicultural & Diversity Services (WMDS) |
| Canadian Mental Health Association (CMHA) - BC Division | Inland Refugee Society of BC (IRS) | Richmond Multicultural Concerns Society (RMCS) | Westcoast Coalition for Human Dignity (WCHD) |
| Canadian Red Cross – Lower Mainland Region – Abuse Prevention Services (APS) | Institute for Media, Policy & Civil Society (IMPACS) | Scouts Canada - Provincial | YMCA Vancouver International |
| Central Okanagan Society of Immigrant & Visible Minority Women (COSIVMW) | Inter-Cultural Association of Greater Victoria (ICA) | SUCCESS (United Chinese Community Enrichment Services) | YWCA Vancouver International |
| Central Vancouver Island Multicultural Society (CVIMS) | Jewish Family Service Agency (JFSA) | Social Planning Council - North Okanagan | |
| Chilliwack Community Services | Kamloops Cariboo Regional Immigrant Society (KIS) | Social Planning & Research Council of BC (SPARC) | |
| Chimo Crisis Services - Richmond | Kamloops Multicultural Society | Society for Community Development | |
| | Kiwassa Neighbourhood Services Association | Surrey-Delta Immigrant Services Society (SDISS) | |
| | Langley Family Services Association (LFS) | Taiwanese Canadian Cultural Society (TCCS) | |
| | Law Courts Education Society (LCES) | | |

