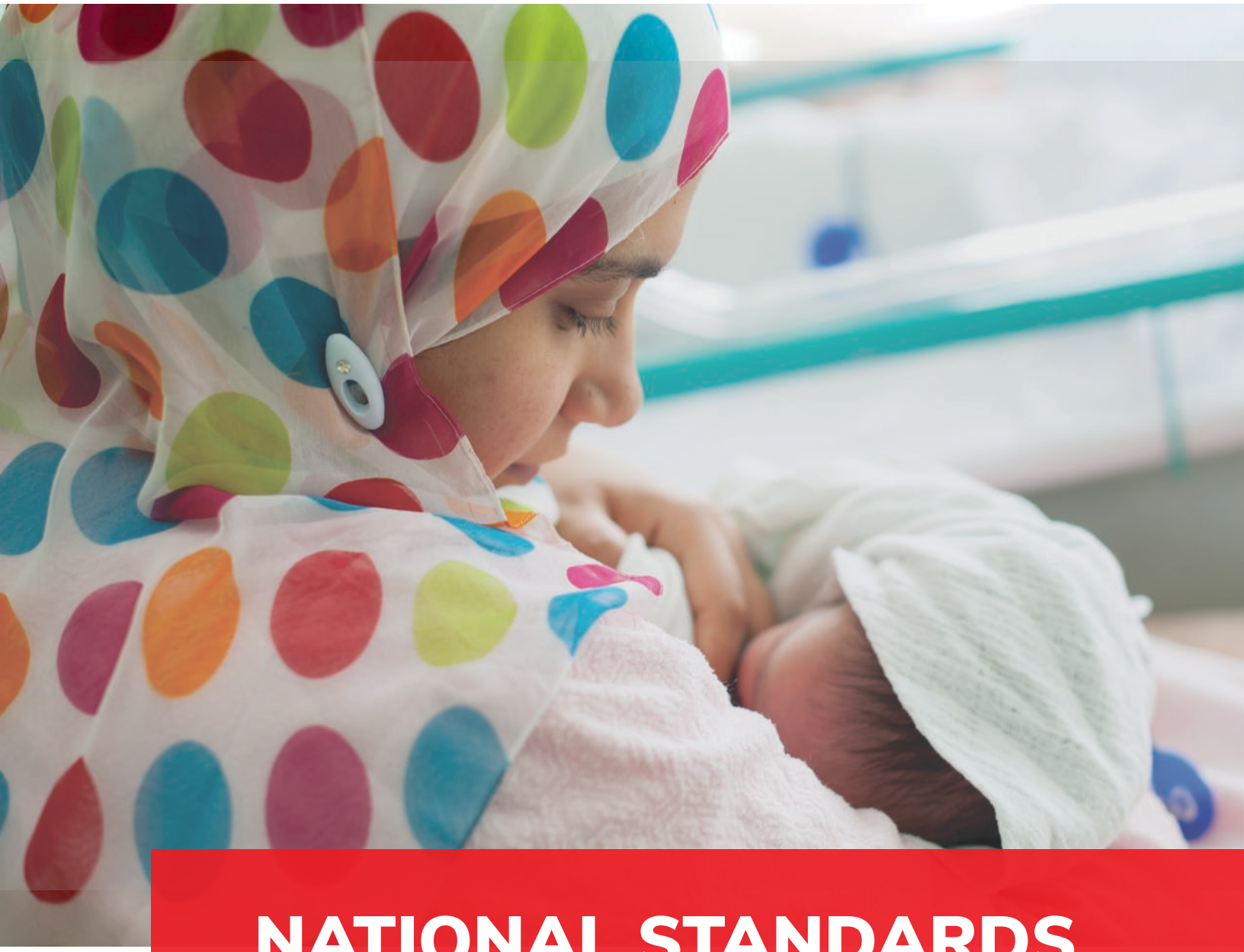
NATIONAL NEWCOMER NAVIGATION NETWORK

RÉSEAU NATIONAL DE NAVIGATION POUR NOS NOUVEAUX ARRIVANTS



NATIONAL STANDARDS FOR HEALTHCARE EQUITY

The Case for Provincial Interpretation Services

Hosted at: / Situé à: CHEO

Funded by: Immigration, Refugees and Citizenship Canada

Financé par: Immigration, Réfugiés et Citoyenneté Canada

Educational partner: / Partenaire pédagogique Université Saint-Paul University

Cat Goodfellow and Christine Kouri. “National Standards for Healthcare Equity: The Case for Provincial Interpretation Services. National Newcomer Navigation Network, 2022.

A LETTER FROM THE NATIONAL NEWCOMER NAVIGATION NETWORK (N4)

The National Newcomer Navigation Network (N4) is a national network for the diversity of providers who assist newcomers in navigating the complex Canadian healthcare and social service systems. N4's pan-Canadian intersectoral network brings together professionals from the healthcare sector, social service sector, settlement sector, academia and other sectors to connect, learn, and collaborate. N4 provides opportunities for professional development, continuing education, networking, and the sharing of data and resources, with the aim to promote best practices in the field of newcomer navigation.

Beginning in 2019, N4 conducted a needs assessment to better understand the current strengths and gaps in newcomer navigation across Canada.[1] [2] One gap that was identified was the ability for newcomer-serving professionals to collaborate across sectors on time sensitive projects, which led to the founding of N4's Community of Practice (CoP). The needs assessment also identified inadequate access to interpretation services as a significant barrier to providing equitable health and social services to newcomers. N4's CoP formed a working group solely focused on improving access to interpretation services through the drafting of this position paper, leveraging the expertise of working group members as well as the wider N4 CoP, and supported by N4 infrastructure.

The dual pandemics of the racial justice movement and the global COVID-19 pandemic raised a global consciousness of inequities. Many organizations and governments made commitments to change, yet have struggled on how to address key barriers to equity. On behalf the N4 CoP, it is our pleasure to provide an evidence-based and actionable position paper to support Canada in creating equity for newcomers to Canada.

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[1] Julia Kurzawa and others, 'Newcomer Navigation from Coast to Coast: Report on N4 Outreach and Site Visits' (National Newcomer Navigation Network, 2019).
[2] Mariah Maddock and others, 'Newcomer Navigation from Coast to Coast during a Dual Pandemic' (National Newcomer Navigation Network, 2022).

CONTENT

1. ACKNOWLEDGEMENTS

N4 would like to thank the Access to Interpretation Working Group members and the Community of Practice Steering Committee for their participation in this work. Their tireless commitment to ensuring this position paper was evidence-based, and outcome-focused, during a global pandemic, was instrumental and greatly appreciated. A full list of these champions of equity can be found at the end of this document. N4's infrastructure, which supported this work, would not be possible without the support of our funder, Immigration, Refugees and Citizenship Canada (IRCC).

2. EXECUTIVE SUMMARY

Immigration is a key economic strategy for Canada. In addition, our country is committed to welcoming refugees in its global humanitarian role. Ensuring the successful integration of the diversity of newcomers to Canada requires attention to system inequities which arise in publicly funded services. Healthcare is seen as key to overall wellbeing and is therefore publicly funded by the provinces. Those systems, however, have systemic barriers for newcomers which result in inequitable access and experiences.

In consultation with healthcare and settlement providers across Canada, the National Newcomer Navigation Network (N4) has developed a proposed national standard and an accompanying set of recommendations to address language barriers for newcomers. By implementing this standard, we can promote safe, equitable and positive healthcare access and experiences for newcomers. This position paper provides a roadmap towards access to healthcare interpretation as well as reflections on the points of intersection between the healthcare and settlement sectors, which work closely together but are rarely considered in tandem in policy.

A review of the literature as well as anecdotal evidence indicate that access to professional healthcare interpretation is a serious health equity issue. Without the ability to communicate with a care provider in their preferred language, patients cannot engage with healthcare services, and the legislative obligations under which healthcare providers function cannot be met. A wealth of data shows that when a professional interpreter is not present, family members, friends and staff are often called upon as ad hoc interpreters. This can lead to medical errors, parentification of children and a lack of understanding of, and therefore adherence to, treatment plans. In some cases, settlement workers attempt to support equitable care by booking and attending healthcare appointments, a task which they caution is outside of their skillset and can compromise professional boundaries. Professionals struggle to respect confidentiality limits of the Circle of Care.

Patient safety and quality of care are compromised in other ways when healthcare interpreters are not available. Evidence shows that patients are not offered timely referrals to specialists because their health conditions are not fully understood by the provider. Patients do not feel heard, and consequently rate their experience poorly. Missed appointments lead to delayed and increased level of care, lead to worse outcomes, and increased use of emergency services.

At the organization level, lack of healthcare interpretation creates administrative and financial challenges. Rebookings, repeat visits and the use of healthcare personnel decrease system efficiency. Healthcare staff acting as ad hoc interpreters incurs additional risks to accuracy and therefore patient safety.

While there are standards that have been created to promote the use of interpreters at the point of care, there are system barriers towards their implementation. Large organizations can create and promote systems of booking interpreters however struggle with consistency and cost concerns within their already stretched budgets. Individual practitioners struggle to understand how to access trained interpreters, and at times refuse newcomers to avoid incurring the additional cost.

To reduce these organizational and individual barriers to quality care, N4 recommends that a national standard be set whereby provincial health ministries fund a centralized interpretation service that incorporates both remote and face-to-face interpretation options. This step, already in practice in Manitoba, has been shown to improve the interpreter booking process, increase system efficiencies by reducing repeat or follow-up visits, increase patient safety and provide a better and more equitable experience for newcomers to Canada.

3. INTRODUCTION

"Language is a literal and figurative vessel for familiarity, trust and understanding — the underpinnings of a sturdy therapeutic alliance."

Yue Bo Yang, Trust in Translation [2]

This position paper builds on and supports efforts made across Canada to increase access to professional interpretation services in healthcare and settlement. The purpose of the paper is to provide a brief overview of key issues surrounding healthcare interpretation in order to support concrete, evidence-based recommendations for increasing access to interpretation at the provincial and systems levels. A review of the literature indicates that access to healthcare interpretation is a serious health equity issue. Patient safety and quality of care are negatively impacted when patients cannot freely and clearly communicate with their healthcare providers in their preferred language. As a result, evidence shows that patients with limited official language proficiency experience worse outcomes than fluent English or French speakers: this includes more follow-up visits, more cancelled or missed appointments, less adherence to treatment, and a limited understanding of interventions, tests and medications. Removing these barriers to quality healthcare also reduces costs.

Work by N4 over the past three years has indicated that health and settlement providers are intensely worried about this inequitable access to interpretation available to their clients. Between July 2019 and January 2021, N4 staff met with 572 stakeholders from 166 organizations, including children's hospitals and rehabilitation centres, general hospitals, newcomer clinics, community clinics, and settlement organizations. The goal of these meetings was to perform a national needs assessment for healthcare and settlement professionals who work with newcomers to Canada and assist them in navigating the complex Canadian health and social services systems.

This work took place within the context of what some call the dual pandemics of COVID-19 and the racial justice movement raised the awareness of inequities experienced by newcomers to Canada. Indeed, Public Health Ontario found newcomers were twice as likely to test positive for COVID-19 in the first wave of the pandemic. Providers reported enduring challenges with accessing and using interpretation services and expressed frustration about how this impacted their clients and patients. The use of personal protective equipment (PPE) and virtual visits added complexity to the communicative relationship between provider and client. By contrast, it was heartening to hear providers in British Columbia and Manitoba and their patients benefitting from access to funded provincial remote or face-to-face interpretation services. Time and time again, we heard that centralized, funded access to interpretation reduced or eliminated many of the barriers to accessing professional interpretation. Despite some policy advances, systemic barriers remain across health, settlement and social services for newcomers.

Inspired by the more positive directions in healthcare interpretation, N4 worked with the N4 Community of Practice Steering Committee to develop a working group which would support providers and organizations in reducing barriers to interpretation services. This paper is the key deliverable from that working group. It is our hope that implementing provincially funded, centralized interpretation services will move Canada towards more equitable access to interpretation, and therefore a more equitable healthcare experience.

[2] Yue Bo Yang, 'Trust in Translation', CMAJ, 192.39 (2020) <https://doi.org/10.1503/cmaj.201499>.

4. SCOPE

This paper focuses on issues of concern to provincial and regional policymakers and argues for the inclusion of interpretation services in provincial healthcare budgets. Although we offer a brief look at the provider-level realities of working with interpreters, this is intended as a backgrounder. Our working group were also generous in providing their anonymized stories to offer powerful insights into the human cost of communication challenges in healthcare. Providers and organizations seeking best practices and guidance can find excellent research and analysis in *Caitlin Murphy's Speaking Freely: A Case for Professional Health Interpretation in London, Ontario, the KW4 Ontario Health Team's Environmental Scan of Interpretation Services in Kitchener, Waterloo, Wellesley, Wilmot, Woolwich* and *Sarah Bowen's The Changing Face of Manitoba: Considerations for Provincial Interpreter Services: Leading Practices, Building on Success.* A fulsome cost-benefit analysis is also out of scope for this paper. We direct interested readers to *Ilene Hyman's Literature Review: Costs of Not Providing Interpretation in Healthcare.*

Unlike previous work in this area, the field of enquiry for this position paper has been expanded to include some material on the settlement sector. Health and settlement frequently work closely together, although they are frequently siloed in broader immigrant policy initiatives. It was observed during N4's needs assessment that settlement professionals were often deployed as ad hoc interpreters, cultural brokers and health system navigators.

Although this position paper focuses on the interpretation needs of newcomer communities, Canada is also home to more than 70 distinct Indigenous languages, including the signed languages of Atgangmuurngniq (Inuit Sign Language) and Plains Sign Talk. Work on writing this position paper began in 2022, the first year of the UNESCO Indigenous Languages Decade which aims to preserve, revitalize, and support indigenous languages worldwide.[3] N4 acknowledges the narrow scope of this position paper and encourages readers to think broadly about the many intersecting language needs and opportunities in Canada. Indigenous-led organization Native Land Digital has developed an interactive map, located at **Native-Land.ca**, which shows Indigenous languages spoken in your area.

[3] UNESCO, 'Los Pinos Declaration [Chapoltepek] – Making a Decade of Action for Indigenous Languages: Outcome Document of the High-Level Event "Making a Decade of Action for Indigenous Languages" on the Occasion of the Closing of the 2019 International Year of Indigenous Languages, 27-28 February 2020 Mexico City, Mexico - UNESCO Digital Library' <https://unesdoc.unesco.org/ark:/48223/pf0000374030> [accessed 26 January 2022].

5. RESEARCH

5.1. *Policy review*

The integration of language interpretation during healthcare encounters is a human right bound in legal and healthcare systems.[4] However, for people with limited/non-English or French language proficiency, this right is frequently not upheld when accessing healthcare services. The burden of responsibility is placed upon the individual newcomer families and groups. This stands in contrast to the justice system, where it is understood that effective communication is a core requirement for any legal process.

Evidence shows that people facing language barriers receive poor quality care with a greater risk for medical errors, unnecessary tests, and adverse reactions to treatment.[5] Laura Simich's 2009 report on health literacy and immigrant populations in Canada suggests that health literacy is the strongest predictor of health status and important to maintain health.[6] Simich defines health literacy as "a multidimensional communication process. It also involves healthcare providers competencies, the 'legibility' of the healthcare system for diverse groups and appropriate policy and programs to achieve effective communication."[7]

Special attention must be paid to ensure that policies across sectors are coordinated to advance healthcare access, the social determinants of health and quality of care for language interpretation and translation as a human right. Relevant sectors shaping health beyond health systems include education, social protection, housing, labour and legal services.[8] Health and communication messages must be tailored for specific contexts and language needs using culturally accepted on- and offline modes of information transfer and exchange.[9] A rights-based analysis of the issue demonstrated that interpreters must be accurate and unbiased in order to facilitate informed consent in healthcare settings, highlighting the legal and ethical risks in working with untrained interpreters.[10] Obligations of healthcare systems must coordinate language resources and interpretation. Per Canada's Charter of Rights and Freedoms, "every individual... has the right to the equal protection and equal benefit of the law without discrimination."[11] Similarly, Ontario's Human Rights Code prohibits discrimination on the grounds of ancestry, race, colour, ethnic origin, and place of origin.[12] Because language is tied to race and ethnic origin, it has been identified by the Ontario Human Rights Commission that languages barriers exert a disproportionate burden on racialized Canadians.[13]

[4] Government of Canada, 'The Canadian Charter of Rights and Freedoms' (Government of Canada, 2006) <https://www.justice.gc.ca/eng/csj-sjc/rfc-dlc/ccrf-ccdl/check/art14.html>.
[5] Nishi Kumar and others, 'The Right to Language Accessibility in Ontario's Healthcare System' <https://www.wellesleyinstitute.com/health/the-right-to-language-accessibility-in-ontarios-health-care-system/>.
[6] Laura Simich, 'Health Literacy and Immigrant Populations' (Public Health Agency of Canada, 2009).
[7] Laura Simich, p. 3.
[8] Olena Hankivsky and Anuj Kapilashrami, Beyond Sex and Gender Analysis: An Intersectional View of the COVID-19 Pandemic Outbreak and Response (National Collaborating Centre for Determinants of Health) <https://nccdh.ca/resources/entry/beyond-sex-and-gender-analysis-an-intersectional-view-of-the-covid-19-> [accessed 8 March 2022].
[9] Olena Hankivsky and Anuj Kapilashrami.
[10] Anjum Sultana and others, 'Language Interpretation Services in Healthcare Settings in the GTA'.
[11] Government of Canada.
[12] Government of Ontario, 'Human Rights Code, R.S.O. 1990, c. H.19', Ontario.Ca, 2014 <https://www.ontario.ca/laws/statute/90h19> [accessed 28 February 2022].
[13] Sultana and others.

Studies reveal that women tend to provide family 'healthcare' roles and this creates additional barriers in accessing healthcare for many newcomer women and families who are primarily responsible for family health.[14] In addition to proficiency in one of Canada's two official languages, English and French, some refugee women and their families arrive with lack of reading and writing skills in their own language.[15] An emerging body of literature suggests that basic literacy and health literacy also impact refugee women's access to healthcare and settlement.[16] [17] [18] [19]

Simich's findings also suggest that low health literacy has been linked with poorer mental health outcomes for Southeast Asian women and interlinked with depression and [un]employment.[20] Consistent with the findings of Seterah Rouhani, Simich concludes that immigrant women were found to have lower literacy than immigrant men.[21]

Language and basic literacy and health literacy are important social determinants of mental health and well-being of refugee women, and these factors need to be integrated when planning healthcare services and settlement supports. Including multiple community resources beyond and including healthcare services can assist in the processes of building health literacy as well as cultural brokering. Language resources vis-à-vis interpreter services have been linked with geography and prevalence of ethnic groups that speak minority languages.[22] [23] However, the availability of interpreter services and built-in linguistic support for newcomer groups and groups who speak minority languages are not well integrated across health systems in Canada. Simich recommends that health literacy should be a part of mainstream language classes and that policy and program recommendations for enhancing health literacy include a focus on the needs of immigrant and refugee women, working across services and sectors such as employment agencies, public health services and cultural brokering services; all to support the development of health literacy skills and better therapeutic relationships between healthcare providers and people with limited English or French proficiency.[24] [25]

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[14] Nancy Clark and Bilkis Vissandjée, 'Exploring Intersectionality as a Policy Tool for Gender Based Policy Analysis: Implications for Language and Health Literacy as Key Determinants of Integration', in Palgrave Handbook of Intersectionality in Public Policy (Palgrave Macmillan, 2019), pp. 603–23.
[15] Nancy Clark, 'Exploring Community Capacity: Karen Refugee Women's Mental Health', International Journal of Human Rights in Healthcare, 11.4 (2018), 244–56 <https://doi.org/10.1108/IJHRH-02-2018-0025>.
[16] I. S. Kickbusch, 'Health Literacy: Addressing the Health and Education Divide', Health Promotion International, 16.3 (2001), 289–97 <https://doi.org/10.1093/heapro/16.3.289>.
[17] Diane B. Mitschke, Regina T. P. Aguirre, and Bonita Sharma, 'Common Threads: Improving the Mental Health of Bhutanese Refugee Women through Shared Learning', Social Work in Mental Health, 11.3 (2013), 249–66 <https://doi.org/10.1080/15332985.2013.769926>.
[18] Setareh Rouhani, 'Refugee Healthcare in British Columbia : Health Status and Barriers for Gorvernment Asssised Refugees in Accessing Healthcare' (University of British Columbia, 2011) <https://doi.org/10.14288/1.0072326>.
[19] Margareth Santos Zanchetta and others, 'Construction of Francophone Families' Health Literacy in a Linguistic-Minority Situation', Alterstice - Revue Internationale de La Recherche Interculturelle, 2.2 (2012), 47–62.
[20] Laura Simich.
[21] Laura Simich.
[22] Setareh Rouhani.
[23] Zanchetta and others.
[24] Laura Simich.
[25] Melinda McPherson, Refugee Women, Representation and Education: Creating a Discourse of s (Routledge, 2015) <https://www.routledge.com/Refugee-Women-Representation-and-Education-Creating-a-discourse-of-self-authorship/McPherson/p/book/9781138703339> [accessed 22 March 2022].
[13] Sultana and others.

5.2. *The key role professional interpreters play in healthcare*

We have established that there are strong legal and policy imperatives for funding healthcare interpretation. The body of research on interpretation in healthcare highlights at the individual level the many vital reasons for funding interpreters as a key part of a person's healthcare journey. Over the past twenty years, there has been increasing interest in this area of health equity. In 2001, Sara Bowen wrote that "little research has focused on the effects of language barriers on health outcomes, service utilization, patient satisfaction, or overall costs to the health system or to society."[26] By 2009, Ilene Hyman was able to characterize the body of Canadian research on the issue as "small but growing."[27]

Many studies have focused on the experiences of patients with limited English proficiency in healthcare systems.[28] Ilene Hyman describes interpretation as "central to providing 'high quality' healthcare that is accessible, equitable, timely, safe, and patient centered," a list of requirements which clearly shows that common language is foundational to every part of the healthcare experience.[29] Challenges stemming from the lack of healthcare interpretation include lack of patient understanding, lack of provider understanding of health or cultural contexts, compromised quality of care including the risk of medical errors, the ethical problems of family members (particularly children) acting as interpreters, inefficiencies through staff members not involved in the patient's care acting as interpreters, and the inability to access and utilize care due to language barriers (including missed appointments and lack of access to specialists).

During the N4 needs assessment, chief among the challenges raised by the network was the issue of access to and use of interpretation services.[30] Stakeholders described these services as underutilized, cumbersome, costly, and not adequately integrated with health systems. Challenges with interpretation were later compounded by COVID-19, with providers reporting struggles communicating through PPE, difficulties bringing in interpreters when restrictions prevented additional people in treatment rooms, lack of literacy surrounding virtual care and apps, and a resurgence in relying on family members to interpret. For Francophone newcomers, an additional barrier was accessing telephone interpretation services which often require listening to or reading an English-language introduction or voice prompts.

In the context of the global SARS-CoV-2 pandemic, refugee patients experienced exacerbation of mental health issues, inequities in social determinants of health and decreased access to integrated primary care and community migrant services.[31] The two most frequently noted challenges with managing refugee mental health during COVID-19 included access to healthcare services and challenges with virtual care technologies.[32] Within the theme of access to care, clinicians reported that previous war-time traumas and public health restrictions have increased isolation, fear and anxiety for refugees in Canada. Simultaneously, social determinants such as the economic downturn have led to increased social exclusion, unemployment, precarious housing, and limited access to language and integration classes; maintaining pre-existing refugee disparities.[33]

[26] Sara Bowen, 'Language Barriers in Access to Healthcare' (Health Canada, 2001), p. 5.
[27] Ilene Hyman, 'Literature Review: Costs of Not Providing Interpretation in Healthcare' (Access Alliance Multicultural Health and Community Services, 2009).
[28] Ariel Yeheskel and Shail Rawal, 'Exploring the "Patient Experience" of Individuals with Limited English Proficiency: A Scoping Review', Journal of Immigrant and Minority Health, 21.4 (2019), 853–78 <https://doi.org/10.1007/s10903-018-0816-4>.
[29] Ilene Hyman, 'Literature Review: Costs of Not Providing Interpretation in Healthcare' (Access Alliance Multicultural Health and Community Services, 2009), p. 1.
[30] Mariah Maddock and others, 'Newcomer Navigation from Coast to Coast: A Pan-Canadian Needs Assessment. Final Technical Report' (National Newcomer Navigation Network, 2022).
[31] Joseph Benjamen and others, 'Access to Refugee and Migrant Mental Healthcare Services during the First Six Months of the COVID-19 Pandemic: A Canadian Refugee Clinician Survey', International Journal of Environmental Research and Public Health, 18.10 (2021) <https://doi.org/10.3390/ijerph18105266>.
[32] Benjamen and others.
[33] Benjamen and others.

5.2.1. *An ethical imperative for quality healthcare*

Strong provider-patient communication is the foundation of a positive, safe and effective healthcare experience. Interpretation has been framed as an ethical imperative based on the rights of Canadians to healthcare, in line with the principle of universal access to care stipulated in The Canada Health Act.[34] All Canadians are entitled to a uniform experience in the healthcare system—an experience which is fundamentally dependent on the ability to communicate clearly with their provider with full understanding and consent. Where this is not possible, individuals are denied an equitable experience and quality of care can all too easily be compromised.

Additionally, providers may feel required to fall back on ad hoc interpreters such as friends and family members in order to proceed with appointments. These ad hoc interpreters are generally not skilled in healthcare terminology and may lack the cultural context to interpret accurately. In some cases, research has shown that an ad hoc interpreter can even introduce more error into an interaction than those done entirely without an interpreter.[35] In particular, working group members in the pediatric field highlighted the additional ethical considerations when relying on children to act as interpreters. Children should not be put in a position to receive confidential medical information about their adult relatives, nor should they be exposed to the complexities of discussing diagnosis and treatment. In such cases there is an additional urgent need to provide timely access to trained healthcare interpreters. When professional interpreters are not available, providers are more likely to fall back on a family member to interpret.

5.2.2. *Patient safety*

Medical errors occur in cases where the provider cannot freely and fluently communicate with their patient. Doctors, nurses and pharmacists have all reported challenges stemming from a lack of interpretation which have negatively impacted their ability to provide quality care.[36] A patient without a professional interpreter is less likely to understand their diagnosis, less likely to be able to give fully informed consent for treatment, and ultimately less likely to adhere to their treatment protocol.[37] Hyman's meta-review of studies of patient safety showed that "language barriers limit the process of informed consent and contribute to preventable morbidity and mortality".[38] Flores et al found that working with trained medical interpreters was an important factor in ensuring patient safety, because "errors made by ad hoc interpreters are significantly more likely to have potential clinical consequences."[39] Their suggestion at the policy level was to reimburse interpretation costs to ensure patients and providers could communicate accurately.[40]

[34] Caitlin Murphy, 'Speaking Freely: A Case for Professional Health Interpretation in London, Ontario' (London and Middlesex Local Immigration Partnership, 2015), p. 2.
[35] Glenn Flores and others, 'Errors of Medical Interpretation and Their Potential Clinical Consequences: A Comparison of Professional versus Ad Hoc versus No Interpreters', Journal of the American College of Emergency Physicians, 60.5 (2012), 545–53 <https://doi.org/10.1016/j.annemergmed.2012.01.025>.
[36] Caitlin Murphy, 'Speaking Freely: Position Paper' (London and Middlesex Local Immigration Partnership, 2017).
[37] Caitlin Murphy, 'Speaking Freely: Position Paper'.
[38] Ilene Hyman, p. 14.
[39] Glenn Flores, 'The Impact of Medical Interpreter Services on the Quality of Healthcare: A Systematic Review', Medical Care Research and Review, 62.3 (2005), 255–99 <https://doi.org/10.1177/1077558705275416>, p. 13.
[40] Glenn Flores.

Cultural safety for patients is another area that intersects with interpretation in healthcare. The term was coined by Maori nurses in New Zealand, and the concept aims to improve quality healthcare and outcomes for Maori people, and more broadly to health disparities and quality of care for Indigenous communities globally. It has also been used and applied in broader cultural contexts, for example when patients differ from their providers in terms of language, age, gender, sex orientation, socioeconomic status, ethnic background, religion/spirituality and/or disabilities. At the core, cultural safety is an ethical approach to redress inequitable power relations through partnership, participation and protection. Attending to patient quality of care must include uptake of cultural safety as a tool for improving language interpretation services and supports.

5.2.3. *Quality of care*

> ***An interpreter reported to his supervisor, an N4 working group member, that he was scheduled with a patient seeing a cardiologist. The patient informed the cardiologist and interpreter that he was amazed by the accessibility of the interpretation for his appointment. He had been to his family doctor who had called for a lot of unnecessary tests. His care had been delayed because as a result of communication challenges he couldn't be quickly connected to the right specialist.***

Diamond et al state that patients who have limited English proficiency receive a lower quality of care across several different domains than their English-speaking counterparts.[41] They cite challenges with "decreased access to acute care and preventive services, decreased satisfaction with care, poor understanding of instructions or medications, longer hospital stays, and an increased risk of medical errors and misdiagnoses."[42] These quality of care limitations have been widely supported in the literature, with Wilson et al adding that patients who cannot freely communicate with their providers can additionally struggle with bad reactions to medication that they cannot discuss or have rectified.[43]

Furthermore, measuring quality of care is complicated when patients cannot accurately communicate with their providers. This is because patient satisfaction is also negatively impacted by language barriers. Patients who do not speak the same language as their provider and are not offered an interpreter consistently rate their healthcare provider lower for measures including friendliness and respectfulness.[44]

[41] Lisa C. Diamond and others, 'Getting By: Underuse of Interpreters by Resident Physicians', Journal of General Internal Medicine, 24.2 (2009), 256–62 <https://doi.org/10.1007/s11606-008-0875-7>.
[42] Diamond and others.
[43] Elisabeth Wilson and others, 'Effects of Limited English Proficiency and Physician Language on Healthcare Comprehension', Journal of General Internal Medicine, 20.9 (2005), 800–806 <https://doi.org/10.1111/j.1525-1497.2005.0174.x>.
[44] Caitlin Murphy, 'Speaking Freely: Position Paper'.

5.2.4. Summary

Overall, working with a professional healthcare interpreter reduces the instance of all the above challenges.[45] For a truly patient-centred care experience, communication, emotional support, cultural brokering and a full understanding of both diagnosis and treatment are vital. As Hyman and Bowen both suggest, the availability of, and funding for, professional interpretation should be considered part of an overall strategy to assure patient safety, patient outcomes and quality of care.[46] [47] The upfront costs of providing interpretation can later be recouped through improvements to patient compliance, decreased hospital admission and/or readmission to hospital, and/or length of stay, saved costs of staff and physician time, staff turnover and a reduction in the use of emergency departments.[48] Furthermore, Hyman indicates that "language access services appear to be most efficient and cost effective when organized at a regional (rather than facility) level."[49]

5.3. Ensuring uptake of professional interpretation

Even when professional interpreters are available, their services are not always utilized. Both the literature and N4 research show three main reasons for this under-use: prohibitive cost, difficulty with booking timely services, and lack of provider training. Dowber et al report from multiple sources that "the most commonly cited reasons for low uptake of these services include cost issues - such as lack of reimbursement mechanisms - and timeliness of access."[50] In this section, we give an overview of these issues and present recommendations for reducing barriers to the use of interpretation services.

5.3.1. Cost

> ***One hospital uses an automated system to inform patients about pre-operative fasting guidelines. This system is presented in English and French. Patients who cannot understand either language sometimes arrive to their surgery without having followed the guidelines. When this is caught, the surgery must be rebooked which wastes time and resources and creates additional stress on the patient.***

Through the N4 needs assessment, it was found that even the perception of increased costs could prevent providers from calling on healthcare interpretation. In some cases, providers having to pay interpretation costs out-of-pocket could be a deterrent from taking on patients who had limited English or French language proficiency.[51]

Telephone interpretation can be a cost-effective secondary option when face-to-face interpretation is unavailable quickly enough, or in the needed language.[52] Evaluating the Toronto Central Local Health Integration Network's Language Services Toronto program, Dowber et al found conclusively that when providers were given access to low-cost, high-quality professional telephone interpretation, there was "a marked decrease in the use of ad-hoc, non-professional strategies."[53]

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[45] Leah S. Karliner and others, 'Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature', Health Services Research, 42.2 (2007), 727–54 <https://doi.org/10.1111/j.1475-6773.2006.00629.x>.
[46] Ilene Hyman.
[47] Sara Bowen and others, 'From "Multicultural Health" to "Knowledge Translation"—Rethinking Strategies to Promote Language Access within a Risk Management Framework', The Journal of Specialised Translation, 14, 2010.
[48] Ilene Hyman.
[49] Ilene Hyman.
[50] Tatiana Dowbor and others, 'Shrinking the Language Accessibility Gap: A Mixed Methods Evaluation of Telephone Interpretation Services in a Large, Diverse Urban Healthcare System', p. 2.
[51] Mariah Maddock and others.
[52] One working group member identified that cost-effective choices can vary based on appointment length. There is a tipping point where the appointment is long enough that an in-person interpreter becomes the most cost-effective choice.
[53] Tatiana Dowbor and others.

5.3.2. *Administrative challenges*

> ***An RN at a hospital reported seeing that a patient was stuck at the registration booth because he could not find a language he understood on the check-in screen. The RN was able to show him how to scan his card, direct him to the right clinic, and ensure that an interpreter could meet him there in person. She expressed concern that had she not noticed him at the booth, he would have missed his appointment. The combination of insufficient language options and self-service registration created a barrier for the patient to even enter the hospital without difficulty.***

A common reflection by participants in N4's needs assessment was that medical professionals were often demotivated to use interpretation services even when they were available. The follow-up survey administered by the working group echoed this concern, with one respondent writing, "we are currently putting our struggles into trying to get the family practitioners to start using the interpretation line which is available to them. [...] This is a basic right, and the resource is there to be used."[54] In the literature, we see that there are barriers for physicians and other medical providers in accessing those interpretation services that are available.

Generally, survey participants agreed that the process to book an interpreter could be hard to navigate. Working group members reported the issue of multiple interpretation vendors used by a single organization, each with their own booking process. Centralizing the booking process reduces this administrative challenge, saving providers time.

In some cases, providers are concerned that working with an interpreter could add additional time to an individual's appointment.[55] However, some evidence from the US suggests that providers can perceive an appointment with interpretation as longer, so there may be bias at play.[56] An additional consideration here is that the reduced likelihood of repeat and follow-up appointments due to poor adherence to treatment may offset those cases in which individual appointments take longer.

5.3.3. *Provider training*

> ***A health equity specialist shared that COVID-19 created additional challenges around accessing interpretation. She explained that her organization had to train and support providers through a steep learning curve to use remote interpretation technology. Scheduling, internet connection instability, rebooking and understanding how to guide patients through the process were all barriers to a positive interpretation experience. Multiple vendors each had their own booking process, policies, phone numbers and language availability. The specialist suggested that a centralized service would streamline access, simplify the training process for providers, and offer access to more languages.***

[54] N4 survey.
[55] N4 survey.
[56] Thornton et al., 2009

Studies from Canada, the US, Switzerland and Australia have all identified that provider training is key to increasing uptake of professional interpretation.[57] [58] [59] Providers should be educated on how and when to book an interpreter; additionally, Jaeger et al point to the importance of training administrative staff to work effectively with patients who need interpretation.[60] However, Sarah Bowen cautions that quality, effective provider training must be more profound than "simply information sharing and educational interventions".[61]

Providers should be approached as allies in this work, and their requirements as service users considered. One evaluation of Toronto's program suggested that equipment for phone interpretation could be a barrier to use. Additionally, providers were "at times unsure about the preparation interpreters have received for the role, their knowledge of medical terminology and their ability to maintain confidentiality." We can see here that providers wanted to facilitate communication between themselves and patients, but did not always have enough knowledge about, or confidence in, the available telephone interpretation service.[62] Letting providers choose the best interpretation modality based on timeliness, patient preference, availability of the needed languages, technology and training would be an important consideration in establishing centralized provincial services.

6. SETTLEMENT EXPERIENCES WITH HEALTHCARE INTERPRETATION

During the environmental scan preceding this position paper, little formal work was found on interpretation in a settlement context. Overall, based on N4 needs assessments and networking in the sector, it is understood that speaking a language frequently spoken by people seeking settlement services is a strong asset for a settlement worker. Workers are called upon to engage not only their linguistic competences but also their cultural knowledge, often acting as ad hoc interpreters and cultural brokers for their clients. Indeed, Ontario Council of Agencies Serving Immigrants state that a key activity for settlement staff is to "provide interpretation and translation to clients as required".[63] A provincial government survey of settlement workers across Ontario in 2000 found that 68.7% of settlement workers were immigrants and the majority were bi- or multi-lingual, and while reporting this data Koltermann and Scott add that "we know that the majority of settlement counsellors speak the languages of their clients."[64] The evaluation report for WeSpeak, an interpretation app launched across southwestern Ontario 2020, makes an explicit link between their clients' needs in settlement, and the need for interpretation in healthcare. They state, "interpretation services are often only provided through immigrant and newcomer serving agencies and have not been integrated with health services, and do not receive health funding. Moreover, these interpreters are largely untrained in the realm of medical interpretation. In this regard, language access has remained a settlement issue and not a health issue, even though many patients require assistance communicating with their providers for most, if not all, of their lives."[65]

[57] Christine B. Phillips and others, 'Low Levels of Uptake of Free Interpreters by Australian Doctors in Private Practice: Secondary Analysis of National Data', Australian Health Review, 35.4 (2011), 475–79 <https://doi.org/10.1071/AH10900>.
[58] Fabienne N. Jaeger and others, 'Barriers to and Solutions for Addressing Insufficient Professional Interpreter Use in Primary Healthcare', BMC Health Services Research, 19.1 (2019), 753 <https://doi.org/10.1186/s12913-019-4628-6>.
[59] CRICH Survey Research Units, 'Reducing the Language Accessibility Gap: Language Service Toronto Program Evaluation Report' (St. Michael's Hospitals, 2014).
[60] Jaeger and others.
[61] Sara Bowen, 'The Changing Face of Manitoba: Considerations For Provincial Interpreter Services: Leading Practices, Building on Success', 2010.
[62] CRICH Survey Research Units.
[63] Iren Koltermann and Daniel Scott, 'The Competencies of Frontline Settlement Practitioners in Canada' (eCaliber Group, 2018), p13.
[64] Iren Koltermann and Daniel Scott, 'The Competencies of Frontline Settlement Practitioners in Canada' (eCaliber Group, 2018), p. 39.
[65] WeSpeak, 'Language Access Initiative: Utilization Report April 1, 2020 - March 31, 2021', 2021, p. 1.

Models of interpretation in settlement do vary somewhat across the country. One method of providing service by an N4 partner organization was a collaboration between a settlement organization and a hospital "which provided both access to the hospital's internal booking system so that the settlement workers could ensure interpreters were scheduled as needed for clients' medical appointments, to mitigate this challenge."[66] Some settlement organizations train their translators and interpreters in-house but do not certify them. Access Alliance Multicultural Health and Community Services run the social enterprise Access Alliance Language Service. Other organizations draw in community members with interpretation and translation experience to meet the need for languages required by settlement clients.

Members of the N4 working group who worked in settlement tended to agree that additional interpretation needs were often filled through links to other community organizations. Members reported working with other community agencies to find staff who spoke a needed language, before reaching out to a professional interpretation service which may be costly. Some additional services like telephone interpretation or RIO (in Ontario) are available to settlement organizations. There is a recognition by settlement providers that settlement workers and ad hoc interpreters are not always able to facilitate professional interpretation where specialist language or knowledge is required, such as in complex healthcare or legal matters.

However, healthcare professionals do not seem to be as informed about the different types of interpretation required by newcomers and the specialized training required to be a professional healthcare interpreter. This was brought up in the N4 needs assessment report, in which Maddock writes, "There was sometimes a lack of understanding in healthcare between a settlement worker language proficiency versus a trained medical interpreter leading to inappropriate requests during visit accompaniment by settlement staff within healthcare."[67] Working group members confirmed that patient confidentiality was also complicated by these situations.

Education was considered a core recommendation for improving how healthcare interpretation services intersect with settlement. Providers have reported through the N4 needs assessment that "Participants reported a lack of established partnerships among the health and settlement sector was a barrier to providing equitable healthcare to newcomers. When these partnerships were pre-established, newcomers experienced a more seamless transition between services."[68] In Winnipeg, one working group member reported that annual training surrounding interpretation in both healthcare and settlement has led to a reduced incidence rate of healthcare providers asking settlement workers to interpret. One key element of this training is assisting settlement workers in identifying the boundaries of their expertise and appropriate support. It would be appropriate for a settlement worker to interpret in settings such as opening a bank account or filling out government paperwork. It would not be appropriate for a settlement worker to interpret during a private and confidential medical appointment.

[66] Julia Kurzawa, p11.
[67] Julia Kurzawa, p. 10.
[68] Mariah Maddock and others, 'Newcomer Navigation from Coast to Coast: A Pan-Canadian Needs Assessment. Final Technical Report' (National Newcomer Navigation Network, 2022), p 17.

Indeed, discussions on this topic with working group members from healthcare, settlement and education concurred that many clients are reluctant to have their settlement worker involved in their healthcare or their children's schooling. Consequently, in a justice or healthcare situation, the settlement worker should know to request external, professional interpretation for their client.

A second important element of training is educating medical service providers about how to work effectively with interpreters. In Manitoba, this is becoming part of the curriculum for medical and nursing students and physicians' assistants; trainees have early exposure to the concept of interpretation, as well as regular orientations and examples in clinical settings. By working intersectorally with settlement organizations and other community organizations, healthcare providers can develop a richer understanding of when and how to use interpretation services. Settlement and education workers can work productively with healthcare providers to identify cases where specialized healthcare interpretation is required. Professional boundaries for settlement workers can be upheld with the assistance of healthcare workers, leading to better and more empowering experiences for newcomers.

7. RECOMMENDATIONS

In response to the challenges outlined in this paper, the following recommendations have been collated from existing sources and validated by the N4 Access to Interpretation Working Group.

7.1.1. Federal level

Develop and implement national standards for professional interpreters.[69]

7.1.2. Provincial level

Establish funding models for professional interpretation to support all healthcare organizations, from health promotion to tertiary care.[70]

Create legislation amendments and policies which ensure the use of professional interpretation in healthcare.[71]

Establish access to professional interpretation on a cost-recovery basis for non-health-related sites, programs, and services, e.g. social services, justice, education.[72]

7.1.3. Regional or systems level

Establish formal policies, procedures, and practices regarding access to interpretation as a key component of health equity for newcomers, including professional development and communication strategies to support its implementation.[73]

Promote equitable hiring by seeing non-official languages as an asset.[74]

Create policies that recognize health interpretation as a "medically necessary" service, respecting minority language rights for residents not proficient in an official language.[75]

Consider training International Medical Graduates living in Canada, but not working in their fields of study, to qualify them as medical interpreters and health educators.[76]

[69] Caitlin Murphy, 'Speaking Freely: A Case for Professional Health Interpretation in London, Ontario'.
[70] Caitlin Murphy, 'Speaking Freely: A Case for Professional Health Interpretation in London, Ontario'.
[71] Caitlin Murphy, 'Speaking Freely: A Case for Professional Health Interpretation in London, Ontario'.
[72] Sara Bowen and others.
[73] Caitlin Murphy, 'Speaking Freely: A Case for Professional Health Interpretation in London, Ontario'.
[74] Caitlin Murphy, 'Speaking Freely: A Case for Professional Health Interpretation in London, Ontario'.
[75] Caitlin Murphy, 'Speaking Freely: A Case for Professional Health Interpretation in London, Ontario'.
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ACCESS TO INTERPRETATION POSITION PAPER WORKING GROUP

This working group met monthly from November 2021 to March 2022 and drafted a position paper on interpretation, in order to call for an interpretation approach which can be implemented nationally to ensure equitable access and experiences with health and social services.

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