



Bridging the Cultural Divide in Health Care Settings

The
Essential
Role of
Cultural
Broker
Programs



DEVELOPED FOR:
National Health Service Corps
Bureau of Health Professions
Health Resources and Services Administration
U.S. Department of Health and Human Services

DEVELOPED BY:
National Center for Cultural Competence
Georgetown University Center
for Child and Human Development
Georgetown University Medical Center

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Definition of Terms

■ **acculturation:** Cultural modification of an individual, group, or people by adapting to, or borrowing traits from, another culture; a merging of cultures as a result of prolonged contact. It should be noted that individuals from culturally diverse groups may desire varying degrees of acculturation into the dominant culture.

■ **assimilation:** Assuming the cultural traditions of a given people or group.

■ **culture:** An integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious or social group; the ability to transmit the above to succeeding generations; is dynamic in nature.

■ **cultural brokering:** This term has multiple definitions. Cultural brokering is defined as the act of bridging, linking, or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change (Jezewski, 1990). A cultural broker acts as a go-between, one who advocates on behalf of another individual or group (Jezewski & Sotnik, 2001). A health care intervention through which the professional increasingly uses cultural and health science knowledge and skills to negotiate with the client and the health care system for an effective, beneficial health care plan (Wenger, 1995).

■ **cultural awareness:** Being cognizant, observant, and conscious of similarities and differences among cultural groups.

■ **cultural competence:** The NCCC embraces a conceptual framework and definition of cultural competence that requires organizations to:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) institutionalization of cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the requirements above in all aspects of policy development, administration, and practice/service delivery and involve consumers systematically (modified from Cross, Bazron, Dennis, & Isaacs, 1989).

■ **cultural sensitivity:** Understanding the needs and emotions of your own culture and the culture of others.

Definition of Terms

- **ethnic:** Of or relating to large groups of people classed according to common racial, national, tribal, religious, linguistic, or cultural origin or background.
- **ethnicity:** The Institute on Medicine (IOM), in a 1999 report edited by Haynes and Smedley, defines ethnicity as how one sees oneself and how one is “seen by others as part of a group on the basis of presumed ancestry and sharing a common destiny...” Common threads that may tie one to an ethnic group include skin color, religion, language, customs, ancestry, and occupational or regional features. In addition, persons belonging to the same ethnic group share a unique history different from that of other ethnic groups. Usually a combination of these features identifies an ethnic group. For example, physical appearance alone does not consistently identify one as belonging to a particular ethnic group.
- **linguistic competence:** Linguistic competence is the capacity of an organization and its personnel to communicate effectively and to convey information in a manner that is easily understood by diverse audiences. Such audiences include persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity (Goode & Jones, 2003).
- **race:** There is an array of different beliefs about the definition of race and what race means within social, political, and biological contexts. The following definitions are representative of these perspectives:
 - Race is a tribe, people, or nation belonging to the same stock; a division of humankind possessing traits that are transmissible by descent and sufficient to characterize it as a distinctive human type;
 - Race is a social construct used to separate the world’s peoples. There is only one race, the human race, comprising individuals with characteristics that are more or less similar to others.
 - Evidence from the Human Genome project indicates that the genetic code for all human beings is 99.9% identical; more differences exist within groups (or races) than across groups.
 - The IOM report (Haynes & Smedley, Eds., 1999) states that in all instances race is a social and cultural construct. Specifically a “construct of human variability based on perceived differences in biology, physical appearance, and behavior.” The IOM adds that the traditional conception of race rests on the false premise that natural distinctions grounded in significant biological and behavioral differences can be drawn between groups.

I. Overview and Purpose of the Guide

■ Through a Cooperative Agreement, the National Health Service Corps (NHSC), Bureau of Health Professions (BHP), funded the National Center for Cultural Competence (NCCC) to conduct an exciting new effort, the *Cultural Broker Project*. The goal of this collaborative project was to encourage the use of cultural brokering as a key approach to increasing access to, and enhancing the delivery of, culturally competent care. Cultural brokering can be defined in many ways. Cultural brokering has been defined as “...bridging, linking or mediating between groups or persons of different cultural backgrounds to effect change” (Jezewski, 1990). The NHSC is embracing and promoting this concept as a viable and much-needed approach in the effective delivery of health care to culturally diverse populations, particularly those who are underserved and vulnerable.

The goal of the *Cultural Broker Project* is in keeping with the NCCC’s overall mission to “increase the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems.” Cultural and linguistic competence have emerged as fundamental approaches to the goal of eliminating racial and ethnic disparities in health. A major principle of cultural competence involves working in conjunction with natural, informal supports and helping networks within diverse communities (Cross et al., 1989). The concept of cultural brokering exemplifies this principle and can bridge the gap between health care providers and the communities they serve. One aspect of the project is to develop a guide to implement cultural broker programs in health care settings, particularly those that employ or serve as placement sites for NHSC scholars and clinicians in service.

This guide is designed to assist health care organizations in planning, implementing, and sustaining cultural broker programs in ways including the following:

- Introduce the legitimacy of cultural brokering in health care delivery to underserved populations.
- Promote cultural brokering as an essential approach to increase access to care and eliminate racial and ethnic disparities in health.
- Define the values, characteristics, areas of awareness, knowledge, and skills required of a cultural broker.
- Provide guidance on establishing and sustaining a cultural broker program for health care settings that is tailored to the needs and preferences of the communities served.

This guide can serve as a resource to organizations and agencies that are interested in partnering with health care organizations to enhance the health and well-being of communities.

II. What Is the Role of Cultural Brokers in Health Care Delivery?

■ The Concept of Cultural Brokers: A Historical Overview

The concept of cultural brokering is an ancient one that can be traced to the earliest recorded encounters between cultures. The term *cultural broker* was first coined by anthropologists who observed that certain individuals acted as middlemen, negotiators, or brokers between colonial governments and the societies they ruled. Different definitions of cultural brokering have evolved over time. One definition states that cultural brokering is the act of bridging, linking, or mediating between groups or persons of different cultural backgrounds for the purpose of reducing conflict or producing change (Jezewski, 1990). A cultural broker is defined as a go-between, one who advocates on behalf of another individual or group (Jezewski & Sotnik, 2001).

■ Rationales for Cultural Brokering in Health Care

The concept of cultural brokering has evolved and permeated many aspects of the U.S. society, including health care. A review of literature reveals that during the 1960s, researchers began to use the concept of cultural brokers within the context of health care delivery to diverse communities. Wenger (1995) defined cultural brokering as “a health care intervention through which the professional increasingly uses cultural and health science knowledge and skills to negotiate with the client and the health care system for an effective, beneficial health care plan.” Numerous rationales exist for the use of cultural brokers in the delivery of health care. They include, but are not limited to:

- emergent and projected demographic trends documented in the 2000 Census in which the diversity in the United States is more complex than ever measured;
- diverse belief systems related to health, healing, and wellness;
- cultural variations in the perception of illness and disease and their causes;
- cultural influences on help-seeking behaviors and attitudes toward health care providers; and
- the use of indigenous and traditional health practices among many cultural groups.

In addition, formal education may not have provided many health care practitioners with the knowledge and skills needed to address effectively cultural differences in their practice. Last, the need for cultural and linguistic competence in health care delivery systems is emerging as a fundamental approach in the goal to eliminate racial and ethnic disparities in health. The concept of cultural brokering is integral to such a system of care.

■ Who Is the Cultural Broker?

The characteristics, roles, and skills of cultural brokers are highly variable. Currently, the term *cultural broker* is used to denote a range of individuals from immigrant children who negotiate two or more cultures daily (Phillips & Crowell, 1994) to leaders in organizations who serve as catalysts for change (Heifetz & Laurie, 1997). The range and complexity of roles are equally varied. Cultural brokers may serve as intermediaries at the most basic level—bridging the cultural gap by communicating differences and similarities between cultures. They may also serve in more sophisticated roles—mediating and negotiating complex processes within organizations, government, communities, and between interest groups or countries.

One cultural broker may have extensive training and experience; another may have just been appointed to this role—for example, a parent in the community, or a support person in the organization—and wish to learn what is involved. In a broader sense, many staff working in health care settings or health education programs span the boundaries of the *culture of health care* and the *cultures of the people they serve*.

1. Cultural broker as a liaison

Cultural brokers are knowledgeable in two realms: (1) the health values, beliefs, and practices within their cultural group or community and (2) the health care system that they have learned to navigate effectively for themselves and their families. They serve as communicators and liaisons between the patients/consumers and the providers in the health care agency.

These personnel can play a critical and beneficial role—on a personal level, in the community in which they live, and on a professional level, in their respective agencies or practices. These personnel effectively bridge the two worlds. Similarly, NHSC scholars and clinicians in service, who come from diverse cultural backgrounds, also may be effective in assuming this role and function—particularly when housed in service areas where they have an understanding of the values, beliefs, and practices of the community.

2. Cultural broker as a cultural guide

Cultural brokers may serve as guides for health care settings that are in the process of incorporating culturally and linguistically competent principles, values, and practices. They not only understand the strengths and needs of the community, but also are cognizant of the structures and functions of the health care setting. These cultural brokers can assist in developing educational materials that will help patients/consumers to learn more about the health care setting and its functions. They also can provide guidance on implementing workforce diversity initiatives.

Some organizations that are well connected to the communities they serve use a community member as a cultural broker because of the member's insight and experiences. A critical requisite for the cultural broker is having the respect and trust of the community. Using a community member as a cultural broker is acknowledgment that this expertise resides within the community. This approach also allows the health care setting to provide support for community development.

3. Cultural broker as a mediator

Cultural brokers can help to ease the historical and inherent distrust that many racially, ethnically, and culturally diverse communities have toward health care organizations. Two elements are essential to the delivery of effective services: (1) the ability to establish and maintain trust and (2) the capacity to devote sufficient time to build a meaningful relationship between the provider and the patient/consumer. Cultural brokers employ these skills and promote increased use of health care services within their respective communities. For instance, cancer researchers have had to find ways to ease the concerns of the African American community about participating in clinical trials. For many African Americans, the Tuskegee study is a painful reminder of medical research gone wrong. In that study, conducted from 1932 to 1972, poor Black men were not fully informed about their participation in medical research on syphilis. They also were not given treatment for their disease, despite the eventual availability of drug treatment. Cultural brokers often can bridge this chasm of distrust that many cultural communities have toward researchers. Cultural brokers can be instrumental in reestablishing trust and reinforcing the importance of participating in research, particularly related to the elimination of racial and ethnic disparities in health.

4. Cultural broker as a catalyst for change

In many ways, cultural brokers are change agents because they can initiate the transformation of a health care setting by creating an inclusive and collaborative environment for providers and patients/consumers alike. They model and mentor behavioral change, which can break down bias, prejudice, and other institutional barriers that exist in health care settings. They work toward changing intergroup and interpersonal relationships, so that the organization can build capacity from within to adapt to the changing needs (Heifetz & Laurie, 1997) of the communities they serve.

Whatever their position or roles, cultural brokers must have the capacity to:

- assess and understand their own cultural identities and value systems;
- recognize the values that guide and mold attitudes and behaviors;
- understand a community's traditional health beliefs, values, and practices and changes that occur through acculturation;
- understand and practice the tenets of effective cross-cultural communication, including the cultural nuances of both verbal and non-verbal communication; and
- advocate for the patient, to ensure the delivery of effective health services.

■ Who can fulfill the role of cultural brokers in health care settings?

Almost anyone can fulfill the role of a cultural broker. Most cultural brokers assume multiple roles within health care and other settings and their respective communities. Although cultural brokers serve the same function, they come with different expectations and have divergent experiences, yet aim to create a cultural connection.

Cultural brokers may be any of the following:

- outreach and lay health worker
- peer mentor
- community member (family member, patient)
- administrative leader
- nurse, physician, physical therapist, or health care provider
- social worker
- interpreter
- program manager
- health educator
- board member
- program support personnel

Cultural brokers may work in these settings:

- community health centers
- community-based organizations
- government offices
- churches, mosque, kivas, plazas, temples, and other places of worship
- schools
- universities
- hospitals
- faith-based organizations
- migrant communities

Whatever their position, cultural brokers aim to build an awareness and understanding of the cultural factors of the diverse communities they serve and of the ways in which such factors influence communities. Cultural brokers may not necessarily be members of a particular cultural group or community. However, they must have a history and experience with cultural groups for which they serve as broker including:

- the trust and respect of the community;
- knowledge of values, beliefs, and health practices of cultural groups;
- an understanding of traditional and indigenous wellness and healing networks within diverse communities; and
- experience navigating health care delivery and supportive systems within communities.

III. Cultural Brokering: Benefits to Health Care Delivery Systems

The vast network of federally qualified health centers and agencies serving in designated health professional shortage areas will greatly benefit from a cultural broker program. A cultural broker program has the potential to enhance the capacity of individuals and organizations to deliver health care services to culturally and linguistically diverse populations, specifically those that are underserved, living in poverty, and vulnerable. The *Health Care Growth* initiative was launched in 2001 with the goal of adding 1,200 new and expanded health center sites to the current network and increasing the number of people served annually to 16 million by 2006. In support of the *Health Care Growth* initiative, a complementary initiative is being implemented for the National Health Service Corps (NHSC). This initiative is designed to reform and expand the NHSC by placing more of its clinicians in areas of greatest need. The NHSC initiative can greatly benefit from a cultural brokering program by supporting system expansion to meet the needs of larger proportions of populations that are underserved and uninsured.

DC PHYSICIAN CREATES AN ENVIRONMENT OF TRUST FOR HIS PATIENTS

Kyu Rhee, M.D., an NHSC clinician and associate medical director with Unity Health Care, Inc., Upper Cardozo Clinic, in Washington, DC, cares for a diverse patient population—from Spanish-speaking persons to Asians, Ethiopians, and individuals who are homeless—in a busy urban setting. “Cultural brokering is not a recipe approach,” he says, rather, it is the process where listening is the essential component, one that cuts across all cultures. By carefully listening to his patients, Rhee says, he benefits by understanding his patients holistically, and thus is able to better treat their health care problems. This benefit became starkly evident when he saw a woman from Zimbabwe who had suffered from headaches for 4 years and from back and chest pain for months. After talking with her, Rhee discovered she had been a rape victim, had witnessed death as a child in her war-torn country, had left her native home, and had just been divorced. Hearing these tragedies of life is an entrée into people’s lives, he says, that can benefit the provider by helping him or her to recognize cultural factors affecting patients’ health and behaviors. Dr. Rhee, in his role as associate medical director, is able to use the information he elicits from patients to enhance and improve care. Additionally, as a cultural broker, he is able to use this knowledge as a vehicle to support other providers through mentoring and inservice training.



■ Benefits to the NHSC

Most of the health care settings that sponsor NHSC scholars and clinicians in service are ideal locations for housing cultural broker programs. These settings include, but are not limited to, rural clinics; health departments that provide comprehensive primary care; hospital-based programs that have ambulatory care; such specialty programs as mobile clinics, homeless shelters, school-based health programs, and HIV/AIDS clinics; community mental health programs; academic programs that have a primary care community-based system of services; tribal and migrant health programs; and those health care settings in U.S. territories. A cultural broker program in these health care settings can:

1. assess the values, beliefs, and practices related to health in the community being served;
2. enhance communication between patients/consumers and other providers;
3. advocate for the use of culturally and linguistically competent practices in the delivery of services; and
4. assist with efforts to increase access to care and eliminate racial and ethnic disparities in health.

NHSC PROVIDERS LINK APPALACHIAN COMMUNITIES AND CARE

The Southern Ohio Health Services Network, also called the Network, instituted policy and practices to increase access to health care and mental health services and to recruit and retain a cadre of NHSC clinicians committed to rural Appalachian communities. The Network required physicians to live in the communities they serve, which fostered closer ties, mutual respect, and trust between providers and families. The Network also created an array of supportive services including school-based health clinics, multidisciplinary teams, integrated mental health services, and community-based social work services. All were responsive to the needs and preferences of the families and communities. Such policy and practices promoted cultural brokering as an essential component in the delivery of health care and mental health services within this Network. Kim Patton, the Network's executive director, states that the physicians are more attuned to their patients' life—from the foods they eat to their values, beliefs, and perceptions about health and illness. Of the 43 physicians in the Network's system, 15 are NHSC providers, and many stay on with the Network after their service period expires. Providing health care using a community-focused, culturally competent approach has helped create this continuum and improve access to services within these Appalachian communities.

Another important benefit of cultural brokering is the potential to increase retention of NHSC providers. They make a career commitment to serve vulnerable populations because it is a positive experience that gives them a sense of fulfillment.

■ Benefits to the Patient/Consumer

1. Patients/consumers who have positive experiences with cultural brokers will be more likely to continue to access services, which potentially improves health outcomes and reduces health disparities.
2. Patients/consumers will recognize the health care setting's commitment to deliver services in a manner that respects and incorporates their cultural perspectives.
3. Patients/consumers may be motivated to seek care sooner when they know that providers understand and respect their cultural values and health beliefs and practices.
4. Patients/consumers may be able to communicate their health care needs more effectively and better understand their diagnoses and treatment.
5. Patients/consumers who benefit from this approach may also encourage others within their community to access and use services. This approach has the potential to positively impact the health of the entire community.

BREAST HEALTH AWARENESS BAG BENEFITS GENERATIONS OF WOMEN

In Washington, DC, the Howard University Cancer Center offers a Breast Health Awareness bag to teen girls who participate in the "Project Early Awareness" breast health education program.

Cultural brokering is an essential aspect and adds to the success of this program. The health education model uses a young cancer survivor, Kimberly Marks, as a cultural broker who is credible with, and leaves a lasting impression on, young women participating in this program. "They know I'm only a little bit older than them," Marks says. "It makes my experience more real to them." Participants receive a bag after they have learned breast cancer detection skills. This bag includes a breast self-exam shower card, a plastic breast model, and other educational information. It also contains a card that their mothers, grandmothers, or other female relatives can complete and send back for a free gift. The materials found in the bag serve as useful health education information for the girls and for other women in their families.



PHOTO BY GARY LANDSMAN

COMMUNITY HEALTH CENTER'S OUTREACH PROGRAM TO HOMELESS POPULATION

Providing health care services to individuals who are homeless is a significant challenge for many localities, including Washington, DC, where the homeless population exceeds 15,000. Many among this population have special health care needs due to HIV/AIDS, mental illness, substance abuse, and serious physical health problems. Additionally, other barriers to care exist because of the transient nature of homelessness, lack of shelter, and no effective system for communication. To address the complex needs of this population, Unity Health Care, Inc., a federally qualified community health center in Washington, DC, operates Project Orion. Through mobile clinics, Unity Health Care uses highly skilled clinicians and outreach workers to deliver comprehensive services to vulnerable and hard-to-reach populations living on city streets. Project Orion focuses on individuals who abuse substances and those who are most at risk for HIV. It has effectively provided services in familiar settings that engender safety and trust among this segment of the homeless population. This outreach program exemplifies some of the many benefits of cultural brokering for the patient/consumer.

■ Benefits to the Health Care Provider

1. Health care providers will be able to elicit more in-depth information that will assist with accurate assessment, diagnosis, and treatment.
2. Health care providers will be able to communicate diagnosis and interpret risks associated with different treatment options more effectively.
3. Health care providers may be more effective in serving patients/consumers who have chronic diseases and conditions that may require a higher degree of self-management.
4. Health care providers who communicate effectively with patients and consumers may experience a greater degree of satisfaction in their work, particularly when they see improved health status and outcomes.
5. Health care providers can become more knowledgeable of and connected to the communities they serve.

PHYSICIANS GAIN INSIGHT INTO HMONG HEALTH BELIEFS AND PRACTICES

Physicians in Merced County, CA, are learning more about the healing practices of local Hmong shaman, to whom the



community looks first for its health care needs. Shaman function as cultural brokers by increasing physicians' understanding of Hmong health practices and healing ceremonies used for specific illnesses or conditions. Physicians are conducting interviews with practicing shaman to create a historical account of traditional practices. Through this program, coordinated by the Healthy House within a MATCH (Multidisciplinary Approach to Cross-Cultural Health) Coalition, a non-profit community health organization, physicians have become more aware and

understanding of the kinds of healing interventions their Hmong patients have sought before seeking the help of Western medicine.

■ Benefits to the Health Care Setting

1. Health care settings can create a reputation for being committed and inclusive community partners, which improves access and use.
2. Health care settings can increase the use of preventive services to minimize the use of cost-prohibitive emergency care.
3. Health care settings can increase cost effectiveness in service delivery by decreasing return visits from patients/consumers who did not clearly understand treatment protocols.
4. Health care settings may be able to reduce potential liability through improved communication (Physicians Risk Management Update, 1995; American Medical News, 1966; Virshup, Oppenberg, & Coleman, 1999; Meryn, 1998; American Family Physician, 1997; Hospital Topics, 1997; JAMA, The Journal of the American Medical Association, 1997).
5. Health care settings can engender mutual respect and trust within the communities they serve, which assures sustainability.

RURAL CLINIC'S COMMUNITY BOARD ENHANCES PROGRAM INCLUSIVENESS AND SUSTAINABILITY

Dianne Smith, executive director of Dove Creek Community Health Clinic in rural Colorado, used her knowledge of the community to seek respected community members to sit on the volunteer board of trustees. Smith, who grew up in the remote town of Dove, where the closest hospital is 26 miles away, knew many of these individuals were from farming families like hers and clearly understood the health care needs of the community. She chose individuals from banking, retail, schools, local government, and health care to identify ways (1) to raise funds for the clinic to expand its services and (2) to help create programs that would improve access for the community, which in recent years, suffered economically from years of drought. The board organized a telethon that raised \$37,000 for clinic equipment and for room expansion. "Their work gave them a sense of pride," Smith notes. "Because the board represents the community, the community feels strongly this is their clinic, and that they all are part owners in it." The benefit to Dove Creek Community Health Clinic is a sustained effort that strengthens the clinic's capacity to continue to serve the health needs of the community. Smith exemplifies the role of cultural broker by knowing both community needs and community members and their quest to improve community health.

NATIVE AMERICAN WOMEN BRING DATE RAPE PREVENTION TO THE CLASSROOM

Date rape and unhealthy relationships that lead to violence against teens and young women are significant problems on the Yankton Sioux reservation and in nearby areas in South Dakota. The Native American Women's Health Education Resource Center identified these as serious problems and decided to create a program that would increase awareness and educate girls, starting at an early age. The Health Education Resource Center relied on its youth advisory council for expertise and for guidance on developing curricula and programs. The youth advisory council served as cultural brokers by sharing experiences about real-life situations involving dating and unhealthy relationships, a perspective the adult staff could not possibly have. The center developed a curriculum, complete with a guide for facilitators and teachers, and a workbook for young women that has been widely disseminated to schools, tribal youth programs, shelters in South Dakota, and across the country.

IV. Guiding Principles for Cultural Broker Programs in Health Care Settings

■ Health care organizations should carefully consider the values and principles that frame their approach to the provision of services and supports and that govern their participation in community engagement. A major value of cultural and linguistic competence involves extending the concept of self-determination beyond the individual to the community (Cross et al, 1989; Goode, 2001). Communities have the inherent ability to recognize their own problems, including the health of their members, and to intervene appropriately on their own behalf (Goode, 2001). The NCCC adopted the following principles for community engagement (Brown, Perry, & Goode, 2003) based on this value:

- Communities determine their own needs.
- Community members are full partners in decision-making.
- Communities should economically benefit from collaboration.
- Communities should benefit from the transfer of knowledge and skills.

CULTURAL AND LINGUISTIC COMPETENCE GUIDE CONNECTIONS WITH COMMUNITY

When patients at La Clinica Latina at the Ohio State University Medical Center first see clinic co-director Cregg Ashcraft, M.D., they see a non-Hispanic male physician and assume he doesn't speak Spanish. Ashcraft, who grew up in Mexico, and later practiced there and in many Latin American countries, says his bilingual skills are essential to providing primary and preventive health care to a Latino population that is mostly undocumented and low income. He requires that Spanish-speaking clinicians provide the array of services offered by this clinic. Many of the providers and staff represent the

patients' diverse countries of origin. This diversity acknowledges group differences among the Latino population. Ashcraft says his language skills and experience guide his effort to "understand as best as I can the situation that

people are in." Ashcraft has assumed the role of cultural broker, both as a physician in his clinical practice and as an administrator influencing policy supporting the use of cultural brokers.



The values that govern community engagement are commensurate with those of cultural brokering. Similarly, the following principles are essential to developing and sustaining effective cultural broker programs.

1 Cultural brokering honors and respects cultural differences within communities.

There is a high degree of diversity within any given community. This diversity may not be readily apparent to individuals and organizations that seek to provide services to these communities. Cultural broker programs must be attentive to how community members identify themselves. Self-identity is influenced by historical, social, economic, generational, and other cultural factors.

It is essential that health care organizations:

1. recognize and respond to cultural differences within communities, including those whose members speak the same language;
2. acknowledge the strengths of bicultural and multicultural practitioners and staff; and

A COMMUNITY'S SELF-IDENTITY INFLUENCES COMMUNICATION AND OUTREACH

Having grown up in East Los Angeles and being only the second child in her extended family to go to college, long-time community health advocate Sandy Bonilla always considered herself a “*Chicana** from the barrio.” A former youth violence and drug prevention consultant to the U.S. Department of Health and Human Services in Washington, DC, who spent years doing outreach in Latino communities, Bonilla returned to California to work at Casa de San Bernardino, Inc., a non-profit, county-funded health center in a low-income neighborhood. About 60% of the Latino population in the community is second- and third-generation Mexican and call themselves *Chicano*,* a term that has social and national significance for Mexican Americans, particularly in the West and Southwestern United States.

Bonilla felt her childhood experiences and years spent working with Latino non-profit community groups easily prepared her for grassroots work with youth at high risk in this neighborhood. She quickly realized, however, that, unlike her work in Washington, DC, communities, she had to be careful not to use the terms *Latinos* and *Hispanics* interchangeably in this particular neighborhood, as Chicanos perceived *Latino* as someone from Latin America and *Hispanic* as someone with Spanish blood. Her colleagues also told her not to use the term *Mexican American*, because Chicanos associated *Mexican* with the growing number of Mexican immigrants in the community with whom they say they compete for low-wage jobs. Terminology used to self-identify was also important for other individuals of color in the community. Bonilla says, “You don’t say African American here. It has an academic connotation. You say Black.” Understanding and using the terms that the community uses to identify itself was an important factor in taking the first steps to communicate successfully with teens and other project participants in the community.

**Chicano/a*: This term has a myriad meanings for Mexican Americans in the Southwestern United States. For some, it is a political identity for social empowerment that arose from the farm workers’ effort to unionize under activist César Chavez. For others, it is a distinction that symbolizes pride in their Mexican Indian ancestry.

3. be knowledgeable of group differences including how individuals self-identify. Honoring and respecting diverse characteristics and the complexity of these dynamics are inherent in providing culturally and linguistically competent service delivery.

2 Cultural brokering is community driven.

A major principle of cultural competence and community engagement is the recognition that communities determine their own needs. Health care settings that have structures and personnel to gauge the strengths, perceived needs, and preferences of diverse communities are well positioned to integrate a cultural brokering program. This process, commonly referred to as asset mapping, assists the health care setting in identifying community members who have a natural instinct for listening to, leading, and organizing their peers and who can function more effectively as cultural brokers at multiple levels.

COMMUNITY MEMBERS HELP DIRECT HEALTH INTERVENTIONS IN DIVERSE COMMUNITY

Ray Michael Bridgewater, executive director of the Assemblies of Petworth in Washington, DC, looks to community members to lead the charge for partnerships that constitute the work of this community empowerment organization. The Assemblies’ projects take place in the most ethnically diverse wards in the city, and they require an understanding and knowledge of the cultures of Caribbean and West Indian, Latino, African immigrant, African American, and growing Eastern European communities. “My board of directors very much resembles the community,” Bridgewater notes.

Two such projects are a telemedicine health program for Latino immigrants that involves partnerships with local libraries and a “Mama and Baby Bus,” which provides screening and checkups. The Mama and Baby Bus program involves partnerships with the local March of Dimes; Mary’s Center for Maternal and Child Care, Inc.; and Capital Community Health Plan. Family outreach workers serve as cultural brokers and help spread the word among the community about the dates and times the bus will arrive.

3 Cultural brokering is provided in a safe, non-judgmental, and confidential manner.

Health care settings must ensure that cultural brokering programs are conducted in a safe, non-judgmental, and confidential manner. This requirement means that each aspect of this principle is incorporated into the organizational philosophy, infrastructure, and practice model. This includes, but is not limited to, articulating values and principles and establishing procedures to ensure that providers, staff, cultural brokers, and patients/consumers understand and accept this approach to service delivery.

NAVAJO HEALTH EDUCATOR MONITORS TRIBAL HEALTH THROUGH HOME VISITS

Katie Tree, community advocate and diabetes health educator for the Dineh (Navajo) tribe in Chilchibeto, AZ, makes home visits once a week to assess community members at high risk on the Navajo reservation, such as the elderly, new mothers, and individuals with chronic illness. Tree checks community members' vital signs and medication and refers them to the local public health nurses who visit the reservation monthly. The home visits are a convenient and comfortable setting for patients to receive basic checkups because the closest health care facility, grocery store, or any other major retail outlet is 25 miles away from this small Northeastern Arizona town. Tree serves multiple roles within this tribal community. As a healer, she occasionally performs such indigenous ceremonies for community members as blessing, crushing, and boiling corn pollen to clear a person's sinuses. As a cultural broker, she also helps physicians follow up with patients by educating them about how Dineh tribal members seek out different medicine men for various illnesses, "much in the way the White man sees a cardiologist for heart problems and a dentist for dental problems."

CULTURAL EXCHANGES FOSTER RECIPROCITY BETWEEN SHAMAN AND PHYSICIANS

Using hand-held tape recorders, Hmong community outreach liaisons interview shaman healers to obtain their training history and life story. This telling of stories is in a comfortable, folklore style and is familiar to shaman and the Hmong community alike. "The voice recorders allow shaman who are not literate to transmit information about their patients," says program director Marilyn Mochel. The tape recorders also allow shaman to describe specific ceremonies performed for certain illnesses or conditions for their current patients. Story telling provides a safe format for the exchange of cultural information. Moreover, Mochel states, "A deeper understanding of the regional variations of shaman ceremonial styles is emerging." These stories also chronicle the shaman's accounts of their traumatic journey from Laos to settlement camps in Thailand, and to their final destination in the United States as refugees. At the same time, the histories help local physicians to understand the shaman's healing heritage. This knowledge allows local physicians to accept the traditional ceremonial practices of the shaman without judging them by Western medical standards.



4 Cultural brokering involves delivering services in settings that are accessible and tailored to the unique needs of the communities served.

To meet the unique needs of communities, health care settings must have the capacity to provide services through non-traditional approaches, particularly in relationship to where, when, and how such services are provided. It is essential that cultural brokering programs have the resources and flexibility to adapt to the community context and the lifestyles of individuals served.

5 Cultural brokering acknowledges the reciprocity and transfer of assets between the community and health care settings.

The interchange of skills and knowledge between health care organizations and communities is a dynamic occurrence. Culturally competent health care settings recognize and acknowledge that inherent in any community are resources and assets to support service delivery. Collaborative relationships between health care settings and communities have many benefits. Selected examples of knowledge exchange and transfer of assets follow.

- **Building a community network of cultural brokers/medical interpreters.**

The MATCH program conducts medical interpreter training for individuals speaking South Asian languages who work with the Hmong refugees. An interpreter training curriculum, “Bridging the Gap,” developed by the Cross Cultural Health Program in Seattle, WA, has been adapted for the Laotian languages of Hmong, Lao, and Mien. This curriculum, “Connecting Worlds,” has sections that are taught in these Laotian languages.

- **Leadership and workforce development.**

Campeños sin Fronteras hires women trained as promotoras into leadership and administrative positions for the migrant health program in Yuma, AZ. Grant writing and development skills are taught to women who are interested in the administrative aspect of health education. They learn professional skills in communicating with health care foundations, government health agencies, and other collaborators, such as the Yuma County Division of Health and Human Services and the University of Arizona College of Public Health.

REST BREAKS PROVIDE HEALTH EDUCATION MOMENTS FOR FARM WORKERS

Promotoras (lay health educators) in the Campeños sin Fronteras program distribute their health care material and talk with migrant farm workers at times when the farm hands are not working—at 4 a.m. when they are waiting at local sites to be picked up for work and at lunch breaks in the fields.

“They go to the pick-up sites, find out who the foreman is, and tell them who they are, and ask permission to talk with the workers,” says project director Emma Torres. Farm workers invite the promotoras to join them for lunch, sharing their burritos as they sit on the ground and talk. They discuss health-related issues on HIV/AIDS and high-blood pressure using Spanish-language flip cards. “Latinos have a love of food, and sharing with others signals a bond among those who eat together,” she adds. As a result, the farm workers benefit from this transfer of knowledge in a setting that is accessible and convenient.



V Knowledge, Skills and Awareness for Cultural Brokers

■ Cultural brokers require a set of competencies that enable them to work cross-culturally and that include, but are not limited to, awareness, knowledge, and skills as described below.

Awareness. Cultural brokers are aware of (1) their own cultural identity, (2) the cultural identity of the members of diverse communities, and (3) the social, political and economic factors affecting diverse communities within a cultural context.

Knowledge. Cultural brokers innately understand (1) values, beliefs and practices associated with illness, health, wellness, and well-being of cultural groups; (2) traditional or indigenous health care networks within diverse communities; and (3) medical, health care, and mental health care systems (e.g., health history and assessment, diagnostic protocols, and treatment and interventions).

COMMUNITY CHARACTERISTICS

Effective cultural brokers are cognizant of the multiple factors impacting community diversity. These factors include, but are not limited to the following: geographic location, population density, population stability, age distribution of population, social history, intergroup relationships, and the social, political, and economic climates of communities served (Goode, 2001).

INDIVIDUAL AND GROUP CHARACTERISTICS

Other factors influencing diversity among individuals and groups are race and ethnicity, language, nationality, clan or tribal affiliation, acculturation, assimilation, age, gender, sexual orientation, educational literacy, social economic status, political affiliation, and religious and spiritual beliefs (modified from James Mason, Ph.D., NCCC senior consultant).

Skills. Cultural brokers have a range of skills that enable them to (1) communicate in a cross-cultural context, (2) communicate in two or more languages, (3) interpret and/or translate information from one language to another, (4) advocate with and on behalf of patients/consumers, (5) negotiate health care and other service delivery systems, and (6) mediate and manage conflict. Commensurate with the conceptual framework of cultural competence, the knowledge and skill levels of cultural brokers are also along a continuum. Knowledge acquisition is not a discrete process; instead, it evolves over time leading to levels of proficiency.

VI. Implementing and Sustaining a Cultural Broker Program

■ Organizational Capacity to Support Cultural Broker Programs

A systematic approach is necessary to fully implement and sustain a cultural brokering program in health care settings. This approach will require vision and commitment of leadership, buy-in or acceptance of both the community and health care setting personnel, development of a logic model or framework for the cultural broker program, and identification and allocation of resources. Health care settings that have these key elements are most likely to support and sustain cultural broker programs.

The following checklist may be used as a guide to implement and sustain a cultural brokering program:

Vision and Commitment of Leadership

- Conduct a process for creating a shared vision and commitment for implementing and sustaining a cultural broker program.
- Identify and include key community constituencies in this process who represent interests of the diverse communities served. Ensure that both formal and informal leadership is represented.
- Ensure that personnel at all levels of the organization are represented and are encouraged to assume leadership roles.

Buy-in and Acceptance

- Collaborate with key community constituencies to promote cultural brokering as an approach to enhance access to, use of, and satisfaction with services delivered.
- Engage personnel in a series of interactive discussions to help them understand how a cultural broker program benefits them, the patients/consumers they serve, the health care setting and diverse communities.
- Provide information including benefits and outcomes, to health care personnel and the community about organizations that are implementing cultural broker programs.

Implementing and Sustaining a Cultural Broker Program

Logic Model or Framework for a Cultural Broker Program

- Convene a work group to guide the development of the framework that defines the parameters of a cultural broker program within the health care setting and the community it serves.
- Clarify values and philosophy that support cultural brokering within the practice model.
- Create, review, and amend policies that ensure the implementation of a cultural broker program.
- Establish an infrastructure to support cultural brokering that may include, but is not limited to the following: staff recruitment and retention, professional development and staff training, adaptation of practice to incorporate the roles and functions of cultural brokers, location and scheduling of services, memoranda of agreement with collaborating agencies or programs, management of data systems, information dissemination approaches, patient confidentiality and related state and federal statutes, and formative evaluation processes for continuous improvement.
- Establish objectives and timelines for implementing the program.

Identification and Allocation of Resources

- Identify or reallocate fiscal resources to support the program.
- Identify personnel who are interested and have the capacity to function as cultural brokers from both the health care setting and the community.
- Identify personnel responsible for managing or coordinating the program.
- Collaborate with key community constituencies to identify and access non-fiscal resources to support the program (e.g., location and physical settings, information dissemination, and cultural and community informants).

VIII.

Summary

■ Cultural brokering clearly has an essential role within health care settings. Such programs benefit health care providers and the overall health care delivery system. Patients/consumers may reap the greatest benefit because cultural brokering creates an environment of mutual understanding and respect for cultural values and health beliefs and practices. Cultural broker programs can facilitate clinical encounters with more favorable outcomes, can enhance the potential for more rewarding interpersonal experiences, and can increase the satisfaction with services received.

Implementing and sustaining cultural broker programs benefit the National Health Service Corps (NHSC) and the national safety net that provides primary health care to the most vulnerable and underserved populations in the United States. Cultural broker programs have the potential to increase retention of NHSC providers by bridging the cultural divide in health care settings. Cultural brokering is a viable approach to both increasing access to health care in support of the effort to eliminate racial and ethnic disparities in health and improving the health and well-being of this nation's communities.

VIII.

Appendix A: Impact of the Cultural Broker Program

The following programs illustrate the diverse settings and linguistic approaches in which cultural brokers positively impacted the community's health.

Empowering Girls to Take Control of Their Bodies Through Breast Cancer Detection Skills

The health concern: Washington, DC, has the second highest breast cancer death rate for women in the United States, particularly African American women. Many of those deaths are due to late diagnosis, and could have possibly been avoided through early detection and an understanding of risk factors. Rosemary Williams, M.Ed., CTR, cancer program manager at the Howard University Cancer Center, notes that the cancer center is seeing an increase in the number of African American women in their 20s and 30s with lumps.

The strategy: In 2001, the Howard University Cancer Center, with funding from the Cancer Research and Prevention Foundation, entered into a partnership with five area high schools to create a long-term initiative to reduce the death rate. Howard health officials realized that talking with women while they were still young would be a critical time to create an awareness and understanding about their bodies and for them to learn breast cancer detection skills.

The action: Working with five DC high schools to create an open class period, the cancer center launched “Project Early Awareness: a Breast Health Education Program for High School Girls,” which takes breast health education to 11th- and 12th-grade girls, most of whom are African American. Program coordinator Kimberly Marks, a 27-year-old African American breast cancer survivor, shares her story with the girls. A nurse or health educator from the Howard University Medical Center then teaches breast self-examination (BSE) using a video and plastic model. Students also are encouraged to talk with the school nurse or guidance counselor about any concerns they have. The girls receive a Breast Health Awareness bag, which contains information about the Howard University Cancer Center, a BSE shower card and plastic breast model, and a brochure on BSE. They are asked to share the information with their mothers, grandmothers, and other female relatives. A gift incentive has been found to lead many of these women to follow up on a checkup of suspicious lumps in their breast.

Why it works: The success of the program was due to the use of cultural brokers as a liaison at both the administrative and community levels. At the administrative level, Williams worked diligently with principals from the high schools to schedule the educational session around the girls' class schedules. At the community level, Kimberly's participation as a real-life example of the impact of breast cancer was an immediate draw. Like the girls she spoke to, she was a young African American woman from the community. “The girls know

Kimberly is not that much older than them, and that makes breast cancer prevention very real,” Williams notes. “When Kimberly starts to tell her story of breast cancer, that really gets their attention.”

Low Rider Bike Club: The Teen Alternative to Drugs and Violence

The health concern: In recent years, gangs, violence, and substance abuse have been among the greatest health concerns in a low-income Westside neighborhood of San Bernardino, CA. The Casa de San Bernardino’s Westside Prevention Project, a county-funded drug and youth violence prevention program, provided on-site counseling sessions to youth at high risk. Few students in this largely Chicano and Black community came for counseling because of the stigma associated with being in an “anti-drug and anti-violence” program, because program participation was perceived as not “cool”. “We knew what we had wasn’t working,” says Sandra M. Bonilla, Westside Prevention Project manager.

The strategy: Casa looked to the community to help it identify ways to attract youth at high risk to the center. It held community potlucks to meet community members. Interaction from those potlucks led Casa to observe who the community’s trusted authorities were, among them: Basilio, a father-like figure who rebuilt bikes; Bobby, a 40-plus-year-old youth advocate with over 15 years of experience working with gang youth members in the Westside barrio; and Jesse, a 22-year-old who was skilled in organizing baseball games and other activities for youth. Those individuals were, in turn, recruited to lead an advisory group, which eventually identified a symbol of the street culture that would attract youth at high risk and that crossed ethnic boundaries—low rider bikes, the two-wheel equivalents of the well-known cars, with gleaming handle bars and velvet seats. Together with Casa health professionals, the community advisory group created the Westside Prevention Project Low Rider Bike Club, a program that gives free low rider bike parts to youth for each weekly counseling session they attend, and requires regular attendance to keep club membership.

The action: Membership in the club, with the motto, “We don’t need to get high to ride low,” begins as a 20-week program. In this program on the basis of their individual assessments, youth attend sessions on any number of areas, for example, adolescent drug treatment, aggression replacement training, and life and leadership skills development. Participants must also attend special workshops. In November 2002, the project brought Low Rider Bike Club members to meet with college students at Cal State San Bernardino to discuss how youth programs help them. More than 200 youth have participated in the program since it was launched 2 years ago, and more continue to enroll in the program. Program officials find that as the young people’s self-esteem, attitudes and schoolwork improve, they direct their energy toward more mainstream activities, such as playing on a baseball team and volunteering to become youth leaders, endeavors that youth at high risk rarely seek out.

Why it works: As a cultural broker, Bonilla became a liaison between the mental health providers and the community. She immersed herself in the community, talking with parents, teens, community leaders, and others and gained their trust to identify a strategy for attracting youth at high risk to counseling services. These community members—who became the project’s community advisory group—in turn, acted as cultural brokers themselves, serving as cultural guides. They identified the low rider bike subculture as one to which teens in the neighborhood could readily relate. It was this effort—getting to know the community and choosing respected individuals in the neighborhood—that led to a community-driven initiative.

Shaman and Physicians Partner for Improving Health for Hmong Refugees

The health concern: Merced County, CA, is home to some 8,000 Hmong refugees with limited English proficiency. Many of this community's immigrant population have disabilities, or may not be literate, and are unfamiliar with the U.S. medical system. These individuals also are at risk for tuberculosis, hepatitis infection, depression, uncontrolled hypertension, diabetes, and many other illnesses and conditions. Following Hmong tradition, residents, who also are often fearful of Western providers, seek the help of a healer or shaman, before they see a Western medical provider. The shaman perform different ceremonies to treat a person's illness, which caused concern among the local medical community. Western health care providers also felt that Hmong patients' health was compromised because they delayed seeking their help. Shaman often were not well received when they accompanied families to the hospital when a patient was admitted.

The strategy: Healthy House within a MATCH* Coalition strives to improve access to health care services that are linguistically and culturally competent for the diverse ethnic communities in Merced County. It has established a number of programs, including the Partners in Healing Program, which facilitates understanding between the Merced health care providers and the Hmong shaman. "It was important especially for the medical professionals to become knowledgeable about the Hmong culture and the role of the shaman in order to deliver culturally sensitive care to this community," says Marilyn Mochel, R.N., certified diabetes educator, who helped to cofound Healthy House.

The action: Healthy House, which is funded by The California Endowment Foundation, began offering a 7-week certificate program in which shaman and physicians from the local hospital exchange health care experience and information. The shaman attend health education sessions on Western style medicine that local physicians conduct. They also take a tour of the hospital emergency and operating rooms and other units. Upon graduation, they receive a jacket with special embroidery that they can wear during hospital visits. "They're much more well received because it identifies them as a partner with the Merced medical community," Mochel notes. The shaman reciprocated by offering opportunities for health care providers to observe ceremonies in their homes. In December 2002, Healthy House staff traveled to several communities in Laos and Thailand for 3 weeks to visit medical care facilities and to view and document current living and health conditions of Hmong in those countries. "A view of the Thamphrabad settlement camp north of Bangkok, where more than 20,000 Hmong refugees survive within the grounds of a Buddhist temple on some 300 acres, was worth the trip," Mochel says.

Why it works: As cultural brokers, Mochel and her staff served as mediators, speaking with community members to identify the most respected members of the community—the shaman—to help improve health care and access to health care services for the Hmong. The cultural broker process involved creating opportunities for physicians and shaman to share their cultural beliefs about healing practices and illness. Mochel and the Healthy House staff facilitate all the efforts to ensure that both parties are brought to the table as teachers and learners. The road to improved access is a slow one, says Mochel. "But what we're hearing from people is that they are less fearful to seek care from a physician."

*MATCH—Multidisciplinary Approach to Cross-Cultural Health

Community Health Center's Outreach Program to Homeless Population

The health concern: Over the course of a year, approximately 15,000 people are homeless in Washington, DC. Among single adults who are homeless, approximately two-thirds have special health care needs due to HIV/AIDS, mental illness, substance abuse, and serious physical health problems. Individuals who are homeless lack permanent shelter, transportation, and telephone services, which makes health care access and use a significant barrier. The challenge for health care providers is to ensure that these patients make their doctor appointments and adhere to medication regimens.

The strategy: Unity Health Care, Inc., a federally qualified community health center in DC, knew that in order to provide primary care services to the homeless community, it would need to bring services to the locations where individuals who are homeless gather. As cultural brokers, providers and outreach workers at Unity built on their expertise in providing health care to the homeless: Before becoming a federally qualified health center, Unity was known as Health Care for the Homeless. Many of the staff who work at Unity—which also provides health care to other underserved communities—knew that in order to respond to the culture of persons without shelter, services would need to be delivered in a safe and familiar environment.

The action: Unity Health Care provides services to the homeless population in several ways. Clinicians travel weekly in vans, to certain areas throughout the city, to provide primary care services to the most hard-to-reach individuals who are homeless. Project Orion targets only those individuals who are drug users and are most at risk of HIV/AIDS. Individuals who are homeless receive free, confidential services including education, counseling, and testing for HIV/AIDS, sexually transmitted diseases, hepatitis B and C and tuberculosis, and medical and case management services. Project Orion staff also return to sites to distribute test results.

Project Orion outreach workers function as cultural brokers and work diligently to get to know individuals who are at highest risk. Over time the outreach workers have become familiar with needle usage patterns among these individuals and the “street” jargon they use. As cultural brokers, the outreach workers have created a regular source of health for the individuals who are homeless and most at risk.

Why it works: According to Sister Eileen Reid, R.N., a shelter-based health center manager, the outreach workers serve as cultural brokers for individuals who are homeless receiving services through the mobile clinics. Cultural brokering involves the outreach workers' knowledge and expertise in the delivery of a complex array of health care and mental health services and supports to the homeless population. It also involves the creation of a comfortable and safe environment.

NHSC Providers Link Appalachian Communities and Care

The health concern: Southern Ohio Health Services Network, is also called the Network, a National Health Service Corps (NHSC) site with 11 primary care health care centers. It serves many poor residents in the Appalachian counties of Adams, Brown, Clermont, Fayette and Highland. Kim Patton, the Network's executive director, indicates that lack of access to health care services, particularly mental health care for children, has been one of the major issues facing these communities. For example, the Network has seen an increase in the number of children with attention deficit disorder. However, parents often felt a stigma associated with having their children being seen by a mental health provider and were reluctant to make appointments for their child to see one. Additionally, Network administrators found recruiting and retaining qualified physicians to its community health centers in this Appalachian region to be a challenge. Difficulty recruiting and retaining physicians has had an impact on access to care for the area's more than 240,000 residents, all widely geographically dispersed.

The strategy: Network administrators considered ways to integrate mental health services into the medical practices. This approach would enable residents to become more comfortable about seeing mental health care providers and to become more familiar with the need for regular medical care. They also aimed to create a setting so that physicians could also learn more about their patients' environment.

The action: Network administrators implemented a multifaceted approach. Approach 1: The administrators contracted with three licensed independent social workers, who were in the community, in schools, and in neighborhoods, linking parents with medical and social services. These social workers already functioned as cultural brokers by bridging the cultural divide between health and human service providers and the local communities. Approach 2: The Network hired a psychiatrist, to whom any of the 11 primary health care centers can refer patients. The primary care physicians, social workers, and psychiatrist formed a multidisciplinary team to increase access to services and provide a more comprehensive approach to service delivery. Approach 3: The Network administrators also worked with officials of two elementary schools to create school-based health centers offering primary care for children and their families. Services included those aimed at parents, such as parenting skills-building classes. Approach 4: The Network included a stipulation in physician contracts that they live in the communities they serve. This approach encouraged the physicians to actually be part of and accepted into community life.

Why it works: The Network clearly saw the benefit of cultural brokering as (1) a means to increase access and use of health and mental health services, (2) a recruitment and retention strategy that enabled NHSC clinicians to be woven into the fabric of the community, and (3) an effective approach to engender trust within these Appalachian communities.

Native American Women Bring Date Rape Prevention to the Classroom

The health concern: In the late 1990s, date rape had become an increasing concern among teens living on or near the Yankton Sioux Reservation in South Dakota, a rural, mostly farming community in the south central part of the state. Teens involved in the Youth Leadership Program at the non-profit Native American Women's Health Education Resource Center felt that the issues surrounding date rape would be an important outreach effort around which the center could develop a program. The center had expertise in programs focusing on violence against women. Since 1991, the center's Domestic Violence Program had offered services and safe residence in its four-bedroom shelter for battered women and their children. Center staff knew it was important to target teen girls in order to prevent the cycle of violence against adult women. "Many of our young women get involved in unhealthy relationships," says center director Charon Asetoyer. "We want to be able to prevent the traumatization before it occurs."

The strategy: Health Education Resource Center staff realized that creating a dialogue and education about this issue with young girls should begin in the classroom, shelter, or community groups, or all of them combined. They also knew their best opportunity for creating a realistic teen dating violence prevention curriculum should start with the voices of the teens themselves. The teens had either experienced or seen many of their friends in unhealthy relationships that led to violence against young girls.

The action: The Health Education Resource Center held focus groups with members of the youth advisory council on issues the teens felt were of most concern including date rape and issues surrounding teen dating and healthy relationships. Youth advisory council members continued to meet on their own in the offices of the center and also provided feedback on the curriculum. For example, they noted that teen girls need information on how to date safely, how to identify a potentially dangerous dating situation, how to be assertive, and how to cope with an assault should it occur. "The need for prevention education was clear," Asetoyer says. Date rape and other violence against young women was and continues to be swept under the rug. Moreover, many young girls are unsure about or unaware of what an unhealthy relationship is and are afraid to talk about it, especially if it results in an assault. This situation resulted in the development of the Teen Dating Violence Prevention Curriculum, complete with a guide for facilitators and teachers and a workbook for young women. The curriculum includes discussions on what a healthy relationship is, how an abusive relationship can lead to teen violence, and 15 warning signs. The Health Education Resource Center has received 300 orders for the curriculum since it was released in 2001. Schools, tribal youth programs, and shelters in South Dakota and across the country have placed orders, and interest continues to build.

Why it works: As cultural brokers, the youth advisory council drove the content of the curriculum. The teens provided a perspective on real-life dating issues that Health Education Resource Center staff, as adults, could not. As a result, the center initiated a program that provides girls with the skills to identify and prevent dating violence. The program also allows young women who have been assaulted an opportunity to express their feelings and start the healing process.

IX. Appendix B: Mission of the National Center for Cultural Competence

■ The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance, and consultation; (2) networking, linkages, and information exchange; and (3) knowledge and product development and dissemination. Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments, and strategic approaches to incorporating systematically culturally competent values, policy, structures, and practices within organizations.

The NCCC is a component of the Georgetown University Center for Child and Human Development (GUCCHD) and is housed within the Department of Pediatrics of the Georgetown University Medical Center. It is funded and operates under the auspices of Cooperative Agreement #U93-MC-00145-09 and is supported in part from the Maternal and Child Health program (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services (DHHS). Since its inception, the NCCC has shared partnerships with two Federal departments, two Federal administrations, one Federal agency, and nine of their respective bureaus, divisions, branches, offices, foundations, and programs. The NCCC conducts a collaborative project under the auspices of another Cooperative Agreement with the GUCCHD and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, DHHS. The NCCC also has partnerships with foundations, universities, and other non-governmental organizations (NGOs).



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X Appendix C: Cultural Broker Contacts

■ Listed below is contact information for the cultural broker examples highlighted in this guide.

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XIII.

Additional Resources

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