Community health workers and culturally competent home care in Belgium: A realist evaluation

--- ACCEPTED FOR PUBLICATION ---

Abstract

This qualitative study investigates through a realist evaluation how the work training programme of 10 community health workers (CHWs) contributed to culturally competent home care services. A European Social Fund project trained 10 jobseekers with migration backgrounds to become CHWs in Brussels (Belgium). Three research questions were formulated: (1) What increase in the cultural competence of the home care organisations can be identified at the end of the project? (2) How did the training contribute to this increase? (3) Which factors and preconditions made the positive outcomes of the training more likely? This study analysed 10 mid-term interviews with individual CHWs in training and four focus groups at the end of the project with CHWs, care employees, trainers and project coordinators (N=25). First, the results showed that the increase in cultural competence was located mostly on the surface structure of the organisation (e.g. adapting communication materials) and not in its deeper structure. Second, the principles of strengths-based education proved to be important during the training (e.g. getting to know, recognise and address the competences and skills of the CHWs). Third, contextual factors at the micro-level (e.g. interest in care and cultures), the exo-level (e.g. management culture) and the macro-level (e.g. policy regulations) could foster or hinder the process of increasing cultural competence. This paper concludes that although the project contributed to a shift in organisational culture towards cultural competence, it remains challenging to effect a similar shift in the deep structure of care organisations.
Keywords
Community health workers, culturally competent care, older adults with migration background, home care services, work training programme, accessibility to care

What is known about this topic?
- Culturally competent care services are needed to improve the accessibility of care services for older adults with a migration background.
- Previous research has focused on community health workers to improve (the accessibility of) care.
- Strengths-based education has proved to be useful in education for students with diverse socio-cultural backgrounds.

What does this paper add?
- The findings indicate that cultural proficiency determines the extent to which culturally competent care can be reflected in the care organisation.
- This paper demonstrates the ability of strengths-based education to empower individuals who are often perceived as underskilled.
- This study shows the importance of the active involvement, engagement and commitment of home care organisations in creating cultural competence.
1. Introduction

The number of older adults with a migration background in Brussels (Belgium) is rising sharply. By 2020, this group will make up more than one-third of the Brussels population of over-65s. Although researchers predict that the demand for formal care will increase among this group, as a supplement or replacement for informal care (Fokkema et al., 2016), at this time, older people with a migration background make almost no use of home care services and remain very difficult for professional home care providers to reach (Suurmond et al., 2016). Barriers are constituted by language, low health literacy and knowledge of the healthcare system, lack of social networks facilitating access to timely care, and insecurities related to intercultural encounters, in which inadequacy on the part of care organisations in addressing migrants’ needs plays a role (Ahaddour et al., 2016; Kristiansen et al., 2016).

To improve accessibility, research has called for more culturally competent care services. Cultural competence is a complex concept (Gebru & Willman, 2010; Hemberg, 2019; Henderson et al., 2018; Long, 2012) and is commonly understood as “the dynamic and evolutionary process of acquiring the ability to provide effective, safe, and quality care to individuals from different cultures, along with considering the different aspects of their cultures” (Sharifi et al., 2019, p6). Conceptualising cultural competence in greater detail, Sharifi et al. (2019) developed a model based on the six most common attributes of cultural competence: (1) cultural awareness (understanding, identifying and reflecting on the similarities and differences of cultures and one’s own prejudices), (2) cultural knowledge (continuously acquiring information about different cultures), (3) cultural sensitivity (valuing, respecting and admiring cultural diversity), (4) cultural skills (facilitating effective communication between individuals from different cultures) (5) cultural proficiency (seeking knowledge about cultural competence and developing new therapeutic approaches based on culture, reflecting a commitment to change), and (6) dynamicity (becoming culturally competent through frequent encounters with different older adults).
The introduction of community health workers (CHWs) is often studied as a means to improve care and the accessibility of care services. The most widely accepted definition of CHWs is provided by the American Public Health Association (2020):

CHWs are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Research has shown that CHWs improve the health knowledge of community members and increase care utilisation (Andrews et al., 2004; Swider, 2002). However, little is known about the broader impact of CHWs in making the home care organisation culturally competent, and research is needed to establish which components make the training of CHWs effective (Verhagen et al., 2013). In addition, Sharifi et al. (2019) have identified a need for more research on education for culturally competent care and the role of healthcare organisations therein.

Education for culturally competent care can be organised according to the principles of strengths-based education. Strengths-based education identifies, recognises and affirms the strengths of students as a means of motivating them and allowing them to excel. It is guided by five educational principles: (1) measuring strengths, achievements and determinants of positive outcomes to enhance these strengths; (2) individualising learning experiences by tailoring training to student needs and interests, highlighting their qualities and providing feedback; (3) networking for praise and recognition, so that students discover their strengths and share this new information, and that in building strengths the best talents can be brought together; (4) deliberately applying strengths within and outside the classroom, giving students opportunities to explore/practice their strengths; and (5) intentionally developing strengths through novel experiences to expose students to information, resources and opportunities for heightening their skills and knowledge (Lopez & Louis, 2009).

To respond to the need of home care organisations to provide culturally competent care in a super-diverse neighbourhood, a work training programme with CHWs was developed. Jobseekers with
a migration background were trained to become CHWs in order to increase the accessibility of home care services and improve their cultural competence.

This qualitative study uses a realist evaluation to address the questions of what works, how, for whom and under which circumstances (Dalkin et al., 2015). It explores the perceptions of key stakeholders in a European Social Fund (ESF) project within which a work training programme for CHWs was developed to create culturally competent home care organisations. The realist evaluation uses a context-mechanisms-outcomes (CMO) configuration to include the outcomes, mechanisms and context of the project (Dalkin et al., 2015). Three research questions were posed to create this configuration:

- **Outcomes:** What increase in the cultural competence of the home care organisations can be identified at the end of the project?
- **Mechanisms:** How did the training contribute to the increased cultural competence of home care organisations?
- **Context:** Which factors and preconditions made the positive outcomes of the training more likely?

2. **Methods**

2.1 **The setting**

Within a ESF’s call, the ‘Innovative neighbourhood care model tailored to a vulnerable neighbourhood’ project (2016–2017) was developed. The project was designed to address three challenges in deprived urban areas of Brussels: (1) migrant families living in the neighbourhood are excluded from care services; (2) home care services operating in the neighbourhood lack culturally competent care and outreach programmes; and (3) the neighbourhood residents with a migration background face high unemployment. To adapt to these challenges, 10 people with a migration background and experience or great interest in care were recruited as CHWs to a work training programme. The nine-month programme consisted of courses on culturally competent care and the Dutch language, an internship in a home care organisation, and formal exchange moments between CHWs and care employees. In
addition, a five-day training course on culturally competent care was organised specifically for care employees. Five home care organisations participated by sending employees to the five-day training course and offering internships to CHWs.

2.2 Data collection
To understand the multiple perspectives of stakeholders of the project, purposeful sampling was used. All stakeholders were given a chance to participate, however not all could be present. Four participant groups were included: (1) CHWs who followed the full training programme, (2) care employees who followed the five-day training course on culturally competent care, (3) trainers from both training events, and (4) project coordinators of the participating home care organisations. Qualitative data were collected in April 2017 and October 2017. Ten individual interviews with CHWs were conducted halfway through the project, and four focus groups with the four participant groups (N = 25) were conducted at the end of the project. The individual interviews lasted between 30 minutes and 120 minutes. The focus groups lasted between 116 minutes and 140 minutes. Both the interviews and focus groups were conducted in Dutch, French or English at the premises of a local NGO. Some participants who could not attend the focus groups were engaged in an email interview (Burns, 2010).

2.3 Data analysis
All the interviews and focus groups were audio-recorded and transcribed verbatim. In the first step, the CMO configuration (Pawson & Tilley, 1997) was developed deductively based on a review of the literature (Marchal et al., 2010) and establishes an overview of the outcomes, mechanisms and context. First, the outcomes (Pawson & Tilley, 1997), i.e. the effects triggered by the mechanisms and context, were categorised by applying the six attributes of Sharifi et al. (2019) model of cultural competence as main labels. Second, the mechanisms (Pawson & Tilley, 1997), i.e. the different components of the project, were categorised using the five principles of strengths-based education formulated by Lopez and Louis (2009). Third, the three main labels for the context (Pawson & Tilley, 1997), i.e. the setting in which the project was put into practice and which determined whether the
project worked, were developed in accordance with Bronfenbrenner’s (1979) ecological model. This model clarifies the interaction of an individual with the environment and describes different levels that affect individual behaviour: (1) micro-contextual factors (i.e. the capacities of individual CHWs), (2) exo-contextual factors (i.e. the role of organisations in affecting behaviour) and (3) macro-contextual factors (i.e. the broader impact of culture, values, norms and policy) (Bronfenbrenner, 1979).

In the second step, the data were analysed in line with the thematic analysis techniques of Braun and Clarke (2006), using MaxQDA software. This consisted of: 1) becoming familiar with the data; 2) coding interesting features of the data (This process was mainly done deductively, building on the insights of the literature of the CMO configuration as described in the first step. However, other codes came out inductively); 3) searching for themes; 4) reviewing themes; 5) defining and naming themes (such as surface and deep structure in outcomes); and 6) writing up the report (Braun & Clarke, 2006).

In the third step, the new information derived from the collected data (as found in step 2) was further integrated into the final CMO configuration (building further on the figure of step 1), resulting in table 2.

The first author led this process, while the co-authors provided feedback and discussed discrepancies. Throughout the project, regular meetings were held with the ESF project steering group to discuss the progress and research design, review the preliminary results, and make adjustments. The objective was to shape the research in a participatory way and to include reflections and new questions in the course of the research. The inclusion of different researchers and project members also contributed to this research’s objectivity, thereby ensuring credibility and confirmability of the findings (Guba & Lincoln, 1982).

### 2.4 Ethical aspects

The study was conducted according to the ethical guidelines of the Declaration of Helsinki (World Medical Association, 2013). A team of researchers, including the authors, reflected on research process and potential harm and discomfort. Participants were informed about the details of the study through
3. Findings

The participants of this study were CHWs, care employees, trainers and project coordinators (Table 1). Twenty women and five men participated. The CHWs had diverse national backgrounds (e.g. Syria, Cameroon, Pakistan and Rwanda). Their ages ranged from 25 to 56.

The findings (Table 2) are presented under the following headings: Outcomes, Mechanisms, Context, and What works in which context.

3.1 Outcomes

The participants indicate different aspects that are categorised in the results under the following outcomes, inspired by Sharifi et al. (2019) model of cultural competence: (1) cultural awareness, (2) cultural knowledge, (3) cultural sensitivity, (4) cultural skill, (5) cultural proficiency and (6) dynamicity.

First, in terms of cultural awareness employees reported that during and because of the project they reflected on their own identity by sharing and discussing with the other trainees their own and community’s values, vision, perceptions on lifestyle (e.g. their own way of living, familial relationships)
or own perceptions of care and ageing (e.g. can a woman be washed by a man). They also learned to reflect on the culture and values of their own care service (f.e. through exercises as ‘If you were the manager, what would you change in terms of cultural competence?’ and reflecting on ‘How do we approach people as an organisation?’). In the words of one project coordinator:

Exploring different truths. We have our ways of doing things, but the awareness that there are different truths is created. (PC4)

Second, regarding cultural knowledge participants mentioned that they learned the importance of getting to know customs, traditions and beliefs of various cultures. A project coordinator explained what this cultural knowledge entailed:

We have to teach our employees how to cook Halal, how to give intercultural care. And other things too, how to enter people’s home, like taking off their shoes, how to deal with men and women patterns. These are all things that have to be taken into account. (PC2)

However, the participants were aware that it was impossible and undesirable to know all specificities of all cultures. It was more important to be open and willing to get to know a culture, as a project coordinator explained:

You cannot learn all the languages that exist, that is a bit difficult. Also cooking, you cannot endlessly learn about all types of cuisines. It is about an attitude of how are we going to try to meet your demand together and how are we going to solve it together. (PC5)

By getting more insights into various cultures, they also learned the shortcomings and barriers towards their care services, f.e. the need for outreaching to the community.

Third, in terms of cultural sensitivity care employees spoke of gaining greater understanding, a more open attitude and respectful curiosity in dealing with older people with a migration background.

One participant described being more alert to culturally sensitive elements:

It’s a reflex that you ask everyone, how’s that within your community? How do you do that? Or how was that with you? There’s a history in it, too. How did they get here? How did this evolve? (PC5)

Fourth, regarding cultural skills employees mentioned that they were able to address and inform clients in more qualitatively (by having an informal talk on the street), to develop a capacity to care for older people with a migration background (by respecting individual preferences) and to work
on a relationship of trust (by being close and accessible to make people feel comfortable). As a CHW explained:

In the first contact with the person, it’s important to make them feel comfortable, to give them some confidence, because it’s all new. Like the person yesterday, I gave her my phone number if she wanted to phone to see if her husband was okay. It’s little things like that to put the person at ease. It’s normal, she doesn’t know me, she doesn’t know how I’m going to manage with her husband. Afterwards, she gave me a big hug. (CHW 3)

Fifth, different examples of cultural proficiency were found inductively. The examples given by the participants can be divided into two levels: surface structure and deep structure. Surface structure is about adapting practice to immediately observable behavioural and social characteristics of the target group (Resnicow et al., 1999). Examples given by the participants included adapting leaflets, using representative images, and including Halal cooking. However, across the focus groups, it was clear that outcomes at the level of deep structure were more difficult to accomplish. Deep structure concerns the inclusion of social, cultural, environmental, psychological and historical characteristics that influence the behaviour of the target group in the development and adjustment of the care offer and organisation (Mier et al., 2010; Resnicow et al., 1999); in changes to deep structure, the care provision and how it is organised would be adapted to the target group, not the other way around. A CHW explained the importance of considering customs and traditions within providing care and understanding where these were coming from:

When you go to a Moroccan family, you know: "I have to wait a bit before I go in." Or you have to ask, "How does that happen with you?" "What do I have to do?" "What don’t you like?" "What do you like?" Because we Moroccan families don’t open up immediately, the women first put on a headscarf. But in the place of the physiotherapist, I would think: "Oh, they’re not at home.” (CHW7)

Some ideas raised by the participants to implement in the future were employing go-to persons for cultural competent care and working in culturally diverse teams.

Last, dynamicity took place mostly with the direct participants of the training events. Participants indicated they felt more confident after taking part in the training. During the internships
and field visits, the CHWs interacted with older adults and got to know them, their living environment, struggles and enjoyments. A CHW explained how the activities in the field taught her more than only the theory could:

There's the theory, but we've really been in the field. We've met older people, we've done interviews, we've made visits and all that, so we've really seen the obstacles and the problems, in fact, there's the culture, the traditions, in the field we learn a lot. (CHW7)

Overall the respondents noted little overspill to the home care organisations in terms of cultural competences. However one case was seen where overspill to the whole home care workforce was realised. This CHW testified she felt included in the particular home care organisation as a ‘full’ colleague from the outset. In that case, the scope of the outcomes was broader, as colleagues at the management level were taking concrete steps toward culturally competent care (i.e. adapting leaflets and offering culturally sensitive training). In other home care organisations the CHW was often only seen by colleagues as an intern and therefore not completely integrated into the team. These home care organisations noted fewer changes in the cultural competences of their employees. This showed the importance of having the whole team on board in order to be able to take concrete steps.

3.2 Mechanisms

The analyses of the mechanisms demonstrated the importance of strengths-based education (Lopez & Louis, 2009), consisting of five principles: (1) measuring students’ strengths, (2) individualising the learning experience, (3) networking for praise and recognition, (4) deliberately applying strengths within and outside classroom and (5) intentionally developing strengths through novel experiences.

**Measuring students’ strengths**

The strengths of the CHWs were explicitly measured at the start of the training programme. Two strengths in particular were engaged actively in the initial interview and classes: (1) migration background and (2) previous experience or interest in care.

First, the CHWs had diverse migration backgrounds, and the trainers explicitly asked for their perspectives as input in their classes. The mix of cultures among the CHWs was perceived as essential for achieving cultural competence:
It’s a nice mix, there’s all countries, each with its own tradition, each with its own culture, each with its own philosophy, I personally like the mix. (CHW5).

Second, previous experience or interest in care were seen as assets in following the training. Participants were able to appeal to their existing knowledge and previous experiences during the training and draw on that experience in reflecting on norms and values.

**Individualising the learning experience**

To individualise the learning experience, the training was tailored to the students’ experiences and strengths in four ways: (1) engaging their knowledge and experiences and highlighting strengths, (2) sharing practical examples about care among different cultures, (3) taking into account their life stories and motivation and (4) the project coordinator providing learning support.

First, trainers actively engaged the knowledge and experiences of the CHWs and highlighted their strengths to encourage an open attitude and look for solutions together. Second, in class the participants were able to give practical examples of care among different cultures from their own experience. Third, trainers found that using digital stories in class was a way of ensuring that the life stories and motivations of the participants were taken into consideration. Digital stories are often used in training for health or social work to work on emancipation by giving people a voice in telling their personal story (Vacchelli & Peyrefitte, 2018). Fourth, monthly meetings between the participants and the project coordinator were organised; the CHWs explained how this strengthened the group process and provided learning support (e.g. discussion of the learning path, work experiences and homework assignments). Support throughout the training was crucial, according to project coordinators:

So that the participants are not sent out onto the streets at random to do their assignments. No, there’s the training, that those people are formed step by step in that direction. (PC1)

**Networking for praise and recognition**

Networking among CHWs was encouraged in order to share information and bring talents together through three activities: (1) discovering one’s own network, (2) learning methods to broaden the network and (3) sharing knowledge and experiences with care employees.
First, participants discovered their own network during the courses, after which they learned methods for broadening that network. Because of the knowledge they had acquired of the care system, some CHWs occupied a stronger position in their social network:

It’s true that we learnt a lot [...], there are a lot of things that I passed on to those around me and they were very happy that they got to know it. And I was so happy because I knew something good, so I passed it on every time there was someone in need, I said, “This is what I learned today.” (CHW7)

Then, the CHWs identified the importance of sharing knowledge and experiences with care employees during the formally organised exchange moments. These were organised twice and brought together the CHWs and care employees to share their experience and reflect on how to work in more culturally competent ways. One care employee explained how she learned from the CHW in her organisation:

The CHWs in our organisation have followed a class and they will come to you. You talk about certain things [...] and then they already have a certain opinion. At that moment it is also a learning moment for me. It really is a win–win situation because of the visits they have made as part of their training. They also got to know different organisations that they didn’t know about before, and through them I learned that too. (CE3)

**Deliberately applying strengths within and outside the classroom**

Participants were encouraged to gain more knowledge by applying their strengths outside the classroom in two ways: (1) take-home assignments and (2) spontaneous work as CHWs.

First, the CHWs noted that their take-home assignments helped them to understand the needs of older people better:

Because I start to understand, I go to the interview [as part of the assignment] and look up about residential care centres and some organisations and talk with them about the culture, listening to them. (CHW3)

Second, some participants gained enough confidence to work spontaneously as CHWs in their community, informing older people and their families about the care offer:

It went so far that the CHWs themselves spoke to the older people about “I see you’re having a hard time, but you know there’s a service centre around here, don’t you?” And they themselves were very happy that they could communicate that. (T1)

**Intentionally developing strengths through novel experiences**

Novel experiences developed the CHWs’ skills and knowledge through (1) field visits and (2) internships.
First, participants valued the field visits, which allowed them to get to know the care services and broaden their views on care. After all, in the beginning of the training CHWs had some prejudices towards care services. During the training many encounters allowed the CHWs to talk with clients and care employees, discussing with them the needs, which made them have a more positive attitude towards healthcare services:

They have started to look at differently and they have started to realise that it is okay to have care provided by professionals. (T1)

Second, by being involved as interns in the home care organisations, CHWs gained extensive knowledge and developed self-confidence in their work. In this role, care employees observed that the participants were loyal to the home care organisations and proud to be part of them:

She was also very proud to be involved in this project, to represent our organisation in this way. I feel an enormous loyalty with her. (CE6)

Similarly, the project coordinators were convinced that the CHWs had brought new perspectives to the home care organisation:

I think that we were subconsciously already doing something about culturally competent care, but maybe not enough, and now it lives on different levels and within different services. (PC1)

3.3 Context

The context that defined the achievement of culturally competent home care organisations by influencing the mechanisms was structured according to Bronfenbrenner’s ecological model (1979). In this study, the (1) micro-, (2) exo- and (3) macro-levels will be described.

First, at the micro-level respondents found that their interest in care and its cultural aspects shaped their attitude during the training, as did the fact that they had relevant competences in care and unique cultural experiences:

Because, when I was a child I wanted to be a nurse, to care for the people. Different cultures, different ages, that is not a problem. So it is something inside me. You cannot ask anyone to do that job, you have to be really motivated. (CHW3)

Second, at the exo-level the specific job of CHWs, as developed in this project, was not yet a recognised profession. Consequently, having no tangible workplaces after the internships for CHWs
limited the home care organisations to include the participants in their organisation afterwards and with that limited the transfer of cultural competences from the CHWs to other employees. Additionally, the extent to which the home care organisation was able to be flexible in offering opportunities for the CHWs during the internship to participate actively in the organisation also determined the context. A project coordinator noted that home care organisations could offer even more opportunities in the future:

[...] bring the CHWs on board, all in the positive sense, that they would bring that expertise into the operation of the home care organisation. (PC5)

Last, at the macro-level the political support defined the actions that could be taken:

If we can’t adjust our own offer, we’ll have to tell our minister. He sees that this target group will not be reached, but then we have to learn a number of lessons from this study: to show what is wrong with the offer in Brussels to approach this target group and with our staff training package. (PC2)

The support of the management of the home care organisation was also a factor, as this reflected the capacity of the project and determined which options could be put into practice:

That’s a classic thing, expectations around interculturalism. So, diversity experts are always recruited all over the organisation to increase income, but yes, there is something in return. Namely, interculturalising processes in which the policy also has to be implemented by the organisation itself. (T2)

### 3.4 What works in which context? Bringing together contexts, mechanisms and outcomes

Although the contextual factors outlined above defined important preconditions for the mechanisms described, one of these turned out to have a particularly important impact on the outcomes: high participation of CHWs in home care organisations. The degree to which the home care organisations offered opportunities for the CHWs to participate actively in the organisation could differ. This high participation was especially important because of three reasons. First, in the exchange between the CHWs and the home care organisations, mutual learning took place; this was very strong in some organisations, but not strong enough in others. As a result, what the CHW had learned could not be put fully into practice in the workplace, limiting the extent of the transfer to the entire organisation.

Second, to encourage this mutual learning, the CHW had first to be in a position to acquire ideas and knowledge about how home care organisations work; that is, the CHW had to have access to the
everyday functioning of the organisation and sufficient support to make use of that access. One participant was especially strengthened in her role as CHW through opportunities to participate actively in meetings at the home care organisation:

I had twice a week the meeting with her for how the work is, how the area is, how the training is, what it requires, the difficulties with the client, so I was well supported in fact. (R1)

Third, CHWs were able to strengthen and stimulate the whole team by pointing out shortcomings in the services of the home care organisations:

The highlight for me was when the two CHWs introduced themselves in a team meeting and then I heard afterwards from my colleagues that they knew what they were talking about, that they really learned things in the trainings and that it was actually very interesting for the colleagues. (CE1)

4. Discussion

This study has investigated the outcomes, mechanisms and context of a work training programme for CHWs with the aim of creating culturally competent home care organisations.

Although the outcomes can be categorised according to different principles (Sharifi et al., 2019), the biggest impact of the project was the shift in mindset towards working in ways that are culturally competent. In this respect, the home care organisations involved in the project were encouraged to take specific steps for the future. However, it appears that, in most of the organisations, cultural competence was achieved only by the employees who were directly involved in the project through training. There was little overspill into the organisation more broadly. Previous research has highlighted the importance of providing cultural competence training to all employees and at different levels of care organisations (Kaihlanen et al., 2019; McCalman et al., 2017). Furthermore, only the surface structure of the organisations was addressed. The challenge remains of reorganising the deep structure to meet the needs of older adults with a migration background. As discussed in previous studies (Gebru & Willman, 2010; Kardong-Edgren & Campinha-Bacote, 2008), cultural competence is a process that develops in practice over time, and this helps to explain why changes to deep structure take longer than changes to surface structure.
Regarding the mechanisms, strengths-based education (Lopez & Louis, 2009) proved capable of engaging and empowering the participants. Three further principles crucial for education were identified in the data. (1) Experience-based education (Kolb, 1984) puts the experiences of participants at the centre of training while also providing opportunities for reflection; here, this took place in the classroom, as well as in the field visits and internships. (2) Culture-based education (Singh & Espinoza-Herold, 2014) respects diverse knowledge systems and skills; here, the training was able to draw on the diverse backgrounds of the participants to create openness and respect for different cultures. (3) Group-based education (Roy & Lin, 1993) values group interaction; here, it was particularly useful in creating a safe learning space and increasing the motivation of the participants.

In terms of context, a key finding was the importance of the exo-level in creating opportunities for CHWs to participate actively in the home care organisation. This is in line with the findings of previous research (van der Hem-Stokroos et al. (2003). Therefore, strong commitment is required from home care organisations for mutual learning to take place and for cultural competence to be achieved in the organisation more broadly.

In the course of conducting this research, some limitations became apparent. First, the attribution paradox (Marchal et al., 2010) was in play, as might be expected in a realist evaluation of a complex project. The behaviour of participants and organisations is determined by many interlinked factors, and it may be impossible to assess the exact contributions of certain mechanisms or contexts to particular outcomes. Nevertheless, the value of a realist evaluation in providing a detailed picture of multiple determinants, and in categorising them as mechanisms or context, remains.

Second, the CMO configuration dilemma (Marchal et al., 2010) should be taken into account. In particular, the generative causal relationships between the outcomes, mechanisms and context need to be assessed, questioning whether the outcomes are the result of the mechanisms or whether the outcomes are better explained by contextual factors. Similarly, contextual factors may moderate the relation between mechanisms and outcomes, or an outcome may influence its context. Moreover, some
contextual factors are essential for the outcomes, leading to confusion as to whether those factors form part of the mechanisms.

Third, it should be noted that the research design and time constraints in this study permitted only short-term outcomes to be measured. (It was necessary for the funding agency to receive an evaluation in a short time.) It is anticipated that additional outcomes would have emerged if the interviews had been conducted over a longer period. Nevertheless, the relatively short time frame for this study made it possible to draw rapid conclusions that can inform future projects.

However, some strengths could also be mentioned about this research. First, the research takes into account the different stakeholders at play in the project. Including this broad range of participants such as, CHWs, care employees, trainers and project coordinators, enabled the researchers to understand the multiple perspectives on the project.

Second, this research provides an overview of the context, mechanisms and outcomes. Not all research applying the CMO-framework gives an overview of all three (e.g. Mitchell, 2015), however we found it essential to give an overview of the context, mechanisms and outcomes to get a clear insight into the project.

On the basis of the findings of this study, a number of recommendations can be made for policy and practice regarding outcomes, mechanisms and context. First, in terms of outcomes, the focus on culturally competent care should be reflected upon in light of increasing attention to the question of person-centred care versus culturally competent care (Campinha-Bacote, 2011). Kaihlanen et al. (2019) have already probed whether this focus will lead to stereotyping and to individual differences between people of similar backgrounds being ignored. However, these concerns apply mostly to the early literature on cultural competence, which typically used a categorical approach; more recent work has focused on communication skills, awareness of cross-cutting cultural and social issues, and health beliefs present in all cultures (Epner & Baile, 2012). Culturally competent care has thus moved beyond assumptions about older people based on their cultural backgrounds and now aims to implement principles of patient-centred care (Teal & Street, 2009). In the work training programme in the present
study, extra attention was paid to the diverse backgrounds of the participants themselves and their communication skills. As these aspects turned out to be a crucial element in culturally competent care, it is recommended that a patient-centred approach be included in programmes that aim to create culturally competent care.

Second, in relation to mechanisms, strengths-based education proved to be the basic principle of the work training programme. This ensured an approach based on the competences of the jobseekers with a migration background. All too often, such competences go unrecognised and underutilised (Schuster et al., 2013), despite their potential high value. Therefore, more training should apply the strengths-based approach to recognise and develop the strengths of individuals who might otherwise be perceived as underskilled.

Third, in terms of context, the active involvement, engagement and commitment of home care organisations is crucial to the creation of cultural competence. In order for the organisation to be able to benefit from their knowledge, CHWs should be actively involved (van der Hem-Stokroos et al., 2003). The creation of a fully supportive context requires investment in cultural competence for a whole organisation, not only some of its employees. Different levels of the care organisation should be addressed (Kaihlanen et al., 2019; McCalman et al., 2017) by developing a culturally competent strategy towards attitudes in the workplace.

Acknowledgements

The authors acknowledge the practice partners EVA bxl vzw, Kenniscentrum Wonen Welzijn Zorg vzw and Groep Intro vzw and thank all the participants who took part in the study. We also thank European Social Fund for their support throughout the project. We are grateful to all researchers who contributed to the data collection, including Sarah Dury. The drawn conclusions, however, remain the authors' responsibility.
References


<table>
<thead>
<tr>
<th>Participants</th>
<th>Men</th>
<th>Women</th>
<th>Job description</th>
<th>Individual interview</th>
<th>Focus group</th>
<th>Email interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health workers (CHW)</td>
<td>2</td>
<td>8</td>
<td>Community health worker</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Care employees (CE)</td>
<td>1</td>
<td>5</td>
<td>Staff member, diversity, Work contracts, Carer, Coordinator local service centre</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trainers (T)</td>
<td>0</td>
<td>2</td>
<td>Teacher</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project coordinators (PC)</td>
<td>2</td>
<td>5</td>
<td>Management, Policy officer</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
TABLE 2 Summary of the CMO configuration for the training of CHWs on culturally competent home care organisations

<table>
<thead>
<tr>
<th>CONTEXT</th>
<th>MECHANISM</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micro-level</td>
<td>Measuring student characteristics</td>
<td>Cultural awareness</td>
</tr>
<tr>
<td>• Interest in a caring profession and its cultural aspects</td>
<td>• Diverse migration backgrounds among participants</td>
<td>• Reflecting on own cultural values and beliefs</td>
</tr>
<tr>
<td>• Previous experience with care and diverse cultures</td>
<td>• Previous experience or interest in care</td>
<td>• Learning to reflect on own care services</td>
</tr>
<tr>
<td>Exo-level</td>
<td>Individualising the learning experience</td>
<td>Cultural knowledge</td>
</tr>
<tr>
<td>• Workplace prospects after training</td>
<td>• Engaging the knowledge and experiences of the participants and highlighting their strengths</td>
<td>• Being open to acquire more knowledge about various cultures</td>
</tr>
<tr>
<td>• Extent of opportunity for active participation</td>
<td>• Sharing practical examples of care among different cultures</td>
<td>• Learning about shortcomings in care services and barriers for older people with a migration background</td>
</tr>
<tr>
<td>Macro-level</td>
<td>Networking for praise and recognition</td>
<td>Cultural sensitivity</td>
</tr>
<tr>
<td>• Support of the government</td>
<td>• Discovering own network</td>
<td>• Greater understanding, more open attitude and respectful curiosity in dealing with older adults with a migration background</td>
</tr>
<tr>
<td>• Support of the home care organisation</td>
<td>• Learning methods to broaden the network</td>
<td>• Being alert to culturally sensitive elements and barriers</td>
</tr>
<tr>
<td></td>
<td>Deliberately applying strengths within and outside the classroom</td>
<td>Cultural skills</td>
</tr>
<tr>
<td></td>
<td>• Take-home assignments</td>
<td>• Being able to address and inform individuals from other cultures</td>
</tr>
<tr>
<td></td>
<td>• Spontaneous work as CHW</td>
<td>• Developing the capacity to care for older people with a migration background</td>
</tr>
<tr>
<td></td>
<td>Intentionally developing strengths through novel experiences</td>
<td>• Working on a trust relationship</td>
</tr>
<tr>
<td></td>
<td>• Field visits</td>
<td>Cultural proficiency</td>
</tr>
<tr>
<td></td>
<td>• Internship</td>
<td>• Working on surface structure: adapting practice to behavioural and social characteristics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Working on deep structure: developing and adjusting the care offer to the target group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dynamicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Developing cultural competences through encounters with older adults</td>
</tr>
</tbody>
</table>