



**HEALTH PROMOTION
IN IMMIGRANT AND REFUGEE POPULATIONS:
CULTURALLY APPROPRIATE STRATEGIES
FOR HEALTH PROMOTION**

LITERATURE REVIEW

***3 Cheers for the Early Years*
ALBERTA HEALTH SERVICES - CALGARY**

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EXECUTIVE SUMMARY

Introduction

The purpose of this literature review is to identify evidence-based practices that would inform the development of culturally and linguistically appropriate and effective health promotion strategies for improving pre- and post-natal health outcomes for refugee and immigrant women. While the majority of Calgary's female immigrant and refugee population is of child-bearing age, pregnant immigrant and refugee women are less likely to access prenatal education classes provided by Alberta Health Services - Calgary (Wallace et al., 2002). This is of particular concern as lack of prenatal care, poverty and language barriers, all of which are present in the immigrant and refugee community, have been shown to contribute to poor birth outcomes. In response, this report situates the need for effective health promotion for refugee and immigrant women in the context of recent population and health statistics and known barriers to health care. It then examines a number of health promotion models considered exemplary for immigrant and refugee populations as well as specific principles and practices recommended for culturally and linguistically appropriate health promotion strategies. The report concludes with recommendations for developing and implementing pre- and post-natal health promotion programs for Calgary's refugee and immigrant women.

Population and Health Statistics

About one-fifth of the female population served by Alberta Health Services – Calgary is comprised of immigrants and refugees (Statistics Canada, 2007). Of female immigrants and refugees served, 22.6% are newcomers (having arrived between 2001 and 2006; *Ibid.*). Nearly one-half of female newcomers to Calgary are of childbearing age (between the ages of 18 and 35; City of Calgary, 2007).

Newcomer immigrant and refugee populations face significant challenges upon arrival in the Calgary area. Of female immigrants and refugees arriving in 2005, 62.2% knew neither English nor French (City of Calgary, 2007). Securing appropriate employment and adequate income have been found to be critical challenges for new immigrants (CRSEO, 2005), and the average income of recent immigrants is one-half of that of Canadian-born individuals (Informetrica Limited, 2000).

While newly-arrived non-refugee immigrants exhibit better health than their Canadian-born counterparts, with time their health status converges with that of the general population (Stampino, 2007). Refugees are at particularly high risk for poor physical and mental health, including nutritional deficiencies, anaemia, upper respiratory tract infections, and post-traumatic stress disorder (Gagnon et al., 2006).

Prenatal Health and Access to Health Care

Refugee and immigrant women are at increased risk for low birth weight infants, perinatal morbidity, and perinatal and neonatal mortality (van Eijsden et al., 2006), are more likely to have birth by caesarean section (Small et al., 1999), and are more likely to experience postpartum depression (Stewart et al., 2008). There are also significant disparities in access to and uptake of prenatal care among immigrant and refugee populations (Grewal et al., 2008). Disparities in pre- and post-natal health and health care are attributed to cultural differences (Oxman-Martinez and Hanley, 2006), socioeconomic status (Count, 2005), language barriers (Reitmanova and

Gustafson, 2008), and pre-migration stress as well as present life stresses and lack of social support (Zarate-Abbott et al., 2008).

Health Promotion Models

Models considered appropriate for refugee and immigrant health promotion include:

- The Ottawa Charter for health promotion (emphasizing the importance of enabling people to increase control over, and to improve their health; Ottawa Charter, 1986);
- The determinants of health approach (addressing non-medical determinants of health including migration trajectory and migration experience (Vissandjee et al., 2004), poverty (Oxman-Martinez and Hanley, 2006), limited access to resources (Maritime Centre of Excellence for Women's Health, 2000), and lack of social support (Stewart et al., 2008));
- The population health promotion model (addressing a broad range of risk factors affecting refugees and immigrants; Hamilton and Bhatti, 1996);
- Planning and Evaluation of People-Led Endeavours (focusing on empowerment, social support, democracy, equity, trust and fun; Raeburn, 1996); and
- The ecological model (programs that are community-based, holistic, utilizing 'local experts,' and contextually appropriate, including peer educators and cultural brokers/liaisons; Ida, 2007).

Health Promotion for Refugees and Immigrants

Health promotion strategies designed for majority populations are generally not effective for diverse populations (Zarate-Abbott et al., 2008). The literature recommends the following principles and practices for developing health promotion programs for refugee and immigrant populations:

Cultural and Linguistic Congruence: Health promotion is most effective when congruent with the population's values, beliefs and practices (Torres et al., 2008) and when provided in the first language and dialect of and at an appropriate literacy and health literacy level for the target population (Zarate-Abbott et al., 2008). The literature recommends making 'deep structure' modifications (e.g., re-writing materials, in the target language, such that the content becomes appealing and relevant to the cultural codes and norms of the population; Reese and Vera, 2007) or developing new programs specifically designed for the target population (Goldstein and Noguera, 2006) to achieve cultural and linguistic congruence. The literature also recommends using emotional and tonal qualities and visual images that are normative for the target community (Zarate-Abbott et al., 2008).

Community-driven: Health promotion initiatives are optimally effective when they are community-driven, or developed in collaboration with stakeholders of the target community; when they are tested for cultural relevance with a sample of the target community; when they incorporate community members as role models; when they are delivered within the community and with the help of community members; and when they are evaluated with input from community stakeholders and program participants (Grewal et al., 2008). Community participation facilitates a sense of ownership and helps ensure that programs are delivered in a culturally competent manner, both of which ultimately strengthen program sustainability (Ahmad et al., 2004).

Strengths-based: Rather than approach culture as a barrier to be overcome, health promotion should view culture as a strength and build upon cultural norms, values, preferences and practices (Padilla and Villalobos, 2007). Examples include incorporating strong family ties or traditional pre- or post-natal rituals into the format and content of health promotion programs.

Partnership Building with Health Professionals: Building partnerships and alliances with health professionals in the development and implementation of health promotion initiatives for immigrant and refugee populations is recommended and may involve the formation of coalitions and forums in order to develop strategies for specific health promotion issues (Seng, 2005) and may include health professionals who have frequent access to targeted populations (Bhagat et al., 2002).

Health Promotion Education Formats: Research has found that 'interactive' formats are more effective than passive or demonstrative formats (Hannula et al., 2008); the literature also recommends ensuring opportunities for participants and educators to form personal relationships to enhance feelings of trust and build rapport (Zarate-Abbott et al., 2008), ensuring repeated exposure to health messages (Ibid.), and ensuring health promotion education span the entire period from pregnancy through to infancy, as health promotion is most effective when of longer duration (Hannula et al., 2008).

Media Campaigns: Health messages delivered in media campaigns should be culturally and linguistically appropriate (van Eijdsden et al., 2006); should be tailored to the community's perceptions of health and healthy behavior based on their unique beliefs, culture and language (Flaskerud, 2007); should be developed at an appropriate literacy and health literacy level (Ibid.); and should be developed with input from the target community (Seng et al., 2005).

Community Outreach: Community outreach is an effective health promotion strategy for traditionally underserved populations (Padilla and Villalobos, 2007). Examples include door-to-door campaigns, business outreach, learning tours, and building health promotion into such activities as exercise classes.

Photonovel: The use of the participatory photonovel is recommended as a strategy for health promotion or education among immigrant and refugee populations; photonovels, created by participants, are highly visual, culturally and linguistically appropriate teaching tools that have been found to contribute to participants' self-esteem and empowerment and reduce social isolation (Nimmon, 2007).

1.0 INTRODUCTION

This report summarizes the findings of a literature review intended to identify evidence-based practices contributing to effective pre- and post-natal health promotion¹ for refugee and immigrant women. The majority of immigrants and refugees arriving in Calgary are women of child bearing age. However, pregnant immigrant and refugee women are less likely to access prenatal education classes provided by Alberta Health Services - Calgary (Wallace et al., 2002). This is of particular concern as lack of prenatal care, poverty and language barriers, all of which are present in the immigrant and refugee community, have been shown to contribute poor birth outcomes.

1.1 Immigrant and Refugee Population Statistics

Nearly one-fifth (22.1%) of the population served by Alberta Health Services – Calgary is comprised of immigrants and refugees (Statistics Canada, 2007). Of immigrants and refugees served, 22.5% are newcomers (having arrived between 2001 and 2006; Ibid.). The majority of newcomers arriving in 2005 applied under the skilled worker or family class immigration category (52.7% and 27.4%, respectively), and 6.9% were refugees (City of Calgary, 2007). About one-half of newcomers that year were female (51.8%) and of those, nearly one-half (45.3%) were of childbearing age (between the ages of 18 and 35; City of Calgary, 2007).

Newcomer immigrant and refugee populations face significant challenges upon arrival in the Calgary area. Of immigrants and refugees arriving in 2005, nearly one-half (43.2%) knew neither English nor French; female newcomers of childbearing age were much more likely to have knowledge of neither official language (62.2%; City of Calgary, 2007). Securing appropriate employment and adequate income have also been found to be critical challenges for new immigrants (CRSEO, 2005), and the average income of recent immigrants is one-half of that of Canadian-born individuals (Informetrica Limited, 2000).

1.2 Health of Immigrant and Refugee Populations

On the whole, non-refugee, recently arrived immigrants to North America exhibit better health than their native-born counterparts (Sword et al., 2006; Fennelly, 2005; Vissandjee et al., 2004; Newbold and Danforth, 2003; Hyman and Guruge, 2002; Hyman, 2001), exhibiting lower rates of diabetes mellitus, hypertension, heart disease and cancer (Ray et al., 2007). This finding is attributed in large to the self-selection of healthier people into the immigration process and to the health status criteria, stipulated by Canadian and American Immigration Acts, which must be met by candidates for immigration (Sword et al., 2006; Perez, 2002).

As recency of immigration declines, however, the health status of the immigrant population converges with that of the general population (Stampino, 2007; Perez, 2002):

The recently released Canadian findings on immigrant women's health from The Women's Health Surveillance Report found that immigrant women in Canada report good to excellent health in the first 2 years following their arrival, but this changes over time, with immigrant women being 30% more likely than Canadian-born women to report fair to poor health after 10 years in Canada (Morrow et al., 2008: 603).

¹ "Health promotion" is defined as "the population-based strategies that target major risk factors of disease, mostly through efforts to change health-related behaviour" (Marshall et al., 2006: 22) and includes "health education and patient awareness and outreach campaigns" (Ibid.: 23).

Over time, social isolation, poor economic conditions, and other cultural, behavioural, environmental and biological factors can lead to a decline in health status among immigrants (Sword et al., 2006), and research indicates that this ‘paradox of assimilation’ is particularly evident among immigrant women (Vissandjee et al., 2004).

American research shows that refugee populations experience poorer health than voluntary immigrants and native-born American populations, arriving in the host country with significant health concerns and exhibiting higher rates of cardiovascular infections, respiratory disease, and cancer (Desmuelles et al., 2004), as well as greater likelihood of experiencing symptoms of poor mental health, including post-traumatic stress disorder, major depressive disorder, and anxiety (Jamil et al., 2007; Palmer and Ward, 2007; Kinzie, 2006; Khanlou et al., 2002; Pumariega et al., 2005). In a Canadian context, Gagnon et al. (2006) reviewed the literature and found only two studies documenting the general health of refugees to Canada. The first study, conducted in the early 1990s, found the main health issues of government-sponsored refugees to include upper respiratory tract infections, impaired vision, dental emergencies, ear infections, gynaecological problems, and obstetrical conditions. The second study, conducted in 1985/86, found 10% of refugees seeking asylum in Canada to be in poor health, suffering from such health problems as nutritional deficiencies, stunted growth, anaemia, parasitic infections, syphilis, and inadequate vaccination, evidence of physical torture, and risk for tuberculosis.

1.3 Pre- and post-natal Health and Access to Health Care

Canada is recognized as having one of the lowest maternal mortality rates in the world (Count, 2005). Providing universal access to health care ensures that a high percentage of women residing in Canada receive high quality pre- and post-natal care (Count, 2005), which is associated with reduced morbidity and mortality in pregnant women as well as lower neonatal mortality and premature birth rates (Lin et al., 2008).

However, research shows that “minorities, disadvantaged individuals and those with less education and lower socio-economic status are likely to receive inadequate prenatal care” (Lin et al., 2008: 98), and that there are significant disparities in access to and uptake of prenatal care among immigrant and refugee populations in particular (Grewal et al., 2008; Landy et al., 2008; Sutton et al., 2007; Sword et al., 2006; Treaster et al., 2006; van Eijsden et al., 2006). Research further documents significant unmet learning needs related to pregnancy among immigrant and refugee populations (Reitmanova and Gustafson, 2008; Lin et al., 2008; Sutton et al., 2007; Sword et al., 2006), including for example significantly less knowledge about the use of folic acid supplements (van Eijsden et al., 2006).

The importance of adequate pre- and post-natal care is underscored by disparities in health among refugee and immigrant populations. Refugee and immigrant women have been found to be at increased risk for low birth weight infants, perinatal morbidity, and perinatal and neonatal mortality² (van Eijsden et al., 2006; Essen et al., 2002; van Dongen and Bennebroek, 2002; Bona et al., 2001), and non-English speaking patients without access to an interpreter have been found more likely than English-speaking patients and those with an interpreter to have birth by caesarean (Small et al., 1999). In addition, high levels of stress, commonly experienced by refugee women, are associated with low birth weight, reduced duration of gestation and preterm birth, bacterial vaginosis during pregnancy, increased risk for chromosomally normal spontaneous abortion, lower Apgar scores, smaller head circumference, and neuroendocrine

² The ‘healthy immigrant effect’ however has been observed with respect to maternal placental syndromes among urban immigrant women in Ontario, with risk decreasing with recency of immigration (Ray et al., 2007).

dysregulation (Vieten and Astin, 2008). Immigrant and refugee women are also more likely to experience postpartum depression³ (Stewart et al., 2008; Zelkowitz et al., 2008; Teng et al., 2007; Sword et al., 2006). A recent Canadian study of nearly 600 new mothers found that recent immigrants to this country had a five times greater risk of exhibiting depressive symptoms than Canadian-born women (Dennis et al., 2004, in Teng et al., 2007), and a study of postpartum depression conducted with new mothers in Montreal, Toronto and Vancouver found newcomer women to have a 3-5 times higher risk of postpartum depression, with refugee women exhibiting the highest risk (Stewart et al., 2008).

Disparities in pre-and post-natal health and health care are attributed in part to cultural differences (Oxman-Martinez and Hanley, 2006). Immigrant women have described experiencing clashes between their own ethnocultural or religious beliefs and the medical care they received in Canada (Reitmanova and Gustafson, 2008; Wallace et al., 2002; Mitchell et al., 2000). Sword et al. (2006) also suggest that health issues and health-related needs may go unreported due to cultural beliefs:

Women from certain cultures... might be reluctant to identify health concerns because reproductive health problems are perceived to be the consequence of inadequate health practices or other non-medical factors, such as immoral behaviour... they also might be considered as normal consequences of childbirth and something that a woman must endure... Additionally, the unacceptability of postpartum depression in some cultures can preclude women from acknowledging a mental health concern (722).

Cultural differences in the expression of symptoms poses a further barrier to accessing and receiving appropriate and effective health care (Scheppers et al., 2006). Morrow et al. (2008) conducted interviews with 18 recent Punjabi-speaking, Cantonese-speaking, and Mandarin-speaking immigrant women exhibiting symptoms of depression after childbirth in British Columbia and found participants to commonly express emotions through analogies; the authors note that this findings is consistent with previous research findings that “women express their feelings of depression in culturally specific terms and metaphors” (602).

The association between socio-economic status and pre- and post-natal health is well-documented. Women experiencing economic disadvantage in Canada are more likely to face stressful life events, chronic stressors and low gestational weight gain during their pregnancy (Count, 2005). As economic hardship worsens, women experience higher rates of adverse pregnancy outcomes, including preterm birth and intrauterine growth restriction (Kramer et al., 2000). Research suggests that women who are marginalised by way of their socio-economic circumstance more generally may have different expectations of prenatal education and exhibit a reluctance to attend prenatal classes (Comino and Harris, 2003). Given that researchers have demonstrated the increased risk of economic disadvantages among immigrant and refugee populations, and given the relationship between poverty and pregnancy outcomes, it is important to consider economic challenges when serving newcomer populations.

Language barriers are another well-documented barrier to pre- and post-natal health care among newcomer populations (Reitmanova and Gustafson, 2008; Zarate-Abbott et al., 2008; Teng et al., 2007; van Eijsden et al., 2006; Mitchell et al., 2000), and lack of knowledge and

³ While risk factors for postpartum depression among immigrant women are not well researched, small scale studies have identified premigration stress and current stressful life events, lack of social support, physical health problems, language barriers, and demands of multiple roles as likely contributors, and recent research has identified an association between postpartum depression and depressive symptoms during pregnancy (Zelkowitz et al., 2008).

familiarity with the Canadian health care system is believed to impair the ability of newcomers to appropriately access and utilize the services provided (Stampino, 2007; Teng et al., 2007; Wallace et al., 2002).

Pre-migration stress as well as present life stresses and lack of social support further contribute to poor pre- and post-natal health and barriers to health care. Given the significant life stresses experienced by many newcomers to Canada, even when immigrant and refugee women understand the importance of preventative health care, the effectiveness of health promotion programs are often hindered by the women's struggles in accessing transportation, translators, and health care providers who are sensitive to the migration experience (Zarate-Abbott et al., 2008; Teng et al., 2007; Palinkas et al., 2003). The limited availability of primary physicians in Canada has also impacted the health care experience of immigrants and refugees, contributing to the challenge of establishing a consistent and supportive relationship (CRSEO, 2005). Finally, a lack of social support is well-documented among newcomer populations (Scheppers et al., 2006), and has been associated with greater risk for postpartum depression in Canadian immigrants and refugees (Stewart et al., 2008).

1.4 Summary

Population statistics indicate that a significant share of the population served by Alberta Health Services – Calgary is comprised of immigrants and refugees, and that female newcomers of childbearing age are particularly likely to have limited English language skills. While the health of immigrants is relatively good in the early years after arrival, over time their health status declines, and the poor health of refugees is of notable concern. The pre- and post-natal health of immigrants and refugees in particular is known to be problematic, and health concerns have been associated with barriers to pre- and post-natal health care.

Following an explanation of the methods used to generate this literature review, we turn in the remainder of the report to identify dominant health promotion models as well as specific principles and practices that are considered promising for the development of appropriate and effective pre- and post-natal health promotion initiatives targeting immigrant and refugee populations. We conclude with a summary of recommendations, based on the evidence, for the development of such initiatives by Alberta Health Services – Calgary.

2.0 METHODS

English language articles published in peer-reviewed journals were identified with Academic Search Primer using various combinations of the search terms: health promotion, health, immigrants, refugees, Canada, models, interventions/strategies, programs, prenatal/postnatal/pregnancy and education. Literature was also garnered through a review of the websites of major health promotion and health institutions, including Centres of Excellence for Women's Health. Publications were deemed relevant for review if they focused on health promotion for immigrants, refugees, and women with diverse ethno-cultural backgrounds. Articles were excluded from the review if they pertained to health promotion for male populations or for persons living in refugee camps, as the focus of this report is on immigrants and refugees in their new permanent place of residence. The original report included articles published up to and including 2006, and the updated version includes articles published between 2007 and 2009.

3.0 HEALTH PROMOTION MODELS

Designing pre- and post-natal health promotion programs for newcomers requires an understanding of the various models of health promotion and the ways in which they are either appropriate for immigrant and refugee populations, or have the potential, through modification, to contribute to culturally sensitive and appropriate health promotion for these populations. The review of the literature revealed a number of major health promotion models, each of which is summarized in this section.

3.1 The Ottawa Charter for Health Promotion

The Ottawa Charter for Health Promotion (1986) defines health promotion as the process of enabling individuals to increase control over, and to improve, their health. Under this definition, achieving physical, mental and social wellbeing requires individuals or groups to identify and realize aspirations, satisfy needs, and change or cope with their environment. The Charter also recognizes that health promotion policies must identify barriers to the adoption of healthy public policy in non-health sectors and contribute to the solutions that would remove these obstacles (Ottawa Charter, 1986). More recently, health promotion under the Ottawa Charter model has shifted from a focus on lifestyle and behavioural determinants toward consideration of structural change, community development and the sense of empowerment required to promote healthy living (Denton et al., 1999), leading health promotion efforts to include awareness-raising campaigns, provisions of information and advice, influencing social policy, lobbying for change, and training in combination with specific health interventions (Speller et al., 1997). Health promotion for immigrant and refugee populations under the Ottawa Charter model would seek to determine and respond to the lifestyle and behavioural elements of health promotion but would also consider health promotion at the level of the community and broader social structures.

3.2 Determinants of Health Approach

Recent research has demonstrated the impact of such factors as income, housing, education, age, culture and gender on health and access to health care (Williams et al., 2008; Mitchell et al., 2000), and to a call for greater attention to the non-medical determinants of health in reducing health disparities (Williams et al., 2008; Sword et al., 2006). The Public Health Agency of Canada (PHAC; 2003; 2005) identifies determinants of health to include:

- Income and social status
- Social support networks
- Education and literacy
- Employment/working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services

-
- Gender, and
 - Culture.

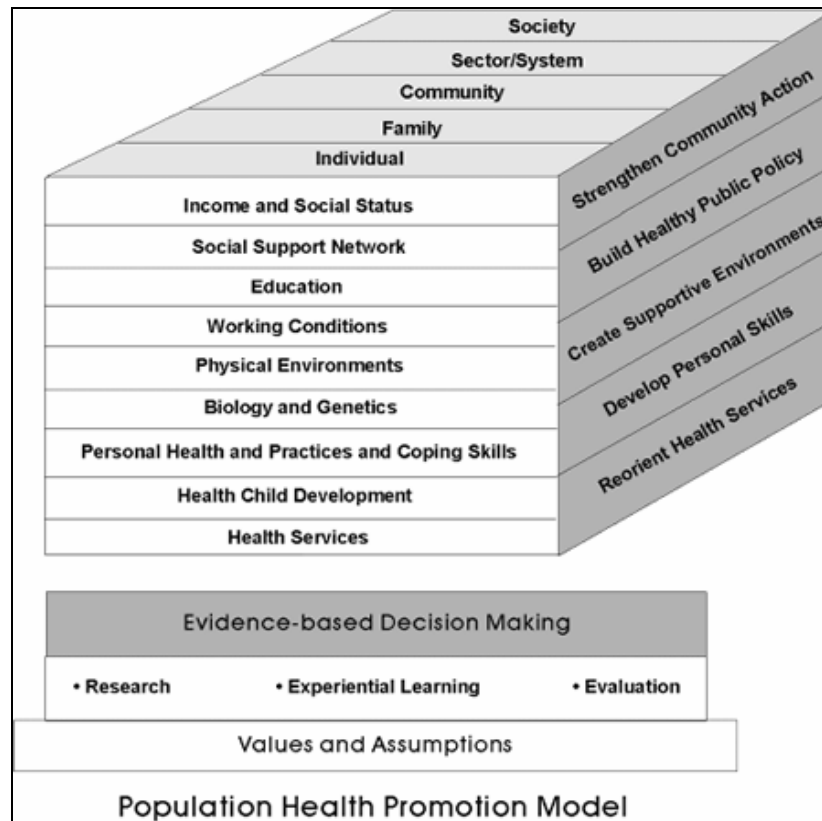
Additional determinants of health affecting immigrant and refugee populations have been identified (Vissandjee et al., 2004). Immigrant and refugee health is affected by the physical and psychosocial journey from country of origin to host country, a journey with associated risks of psychiatric disorders, infectious and parasitic disease, and chronic disease (Oxman-Martinez and Hanley, 2006; Palinkas et al., 2003); low income and poverty upon arrival (Shields, 2003); limited access to resources (Maritime Centre of Excellence for Women's Health, 2000); and language barriers (Ibid.).

Literature documenting the impact of health promotion initiatives that focus on the determinants of health of immigrant and refugee parents is beginning to emerge; Williams et al. (2008) for example conducted a review of studies documenting the promise of interventions on the social determinants of health of vulnerable first-time parents and concluded that such initiatives as home visiting programs are effective in improving health and access to health care. Sword et al. (2006) similarly suggest an important role for public health nurses in serving the needs of immigrant women through home visiting following childbirth, and Stewart et al. (2008) suggest social interventions, including home visitors and peer support groups may play an important role in addressing the lack of social support associated with postpartum depression in Canadian newcomer populations.

3.3 Population Health Promotion Model

The Population Health Promotion Model (PHPM) explains the relationship between population health and health promotion, and demonstrates how a population health approach can be implemented through action on the full range of health determinants by means of health promotion strategies (Hamilton and Bhatti, 1996). The PHPM, although not designed specifically for immigrants and refugees, can potentially be modified to address the needs of this population. Revising the determinants of health to include migration experience and examining other factors that may be missing from this model but present in the lives of immigrants and refugees may assist in tailoring the model.

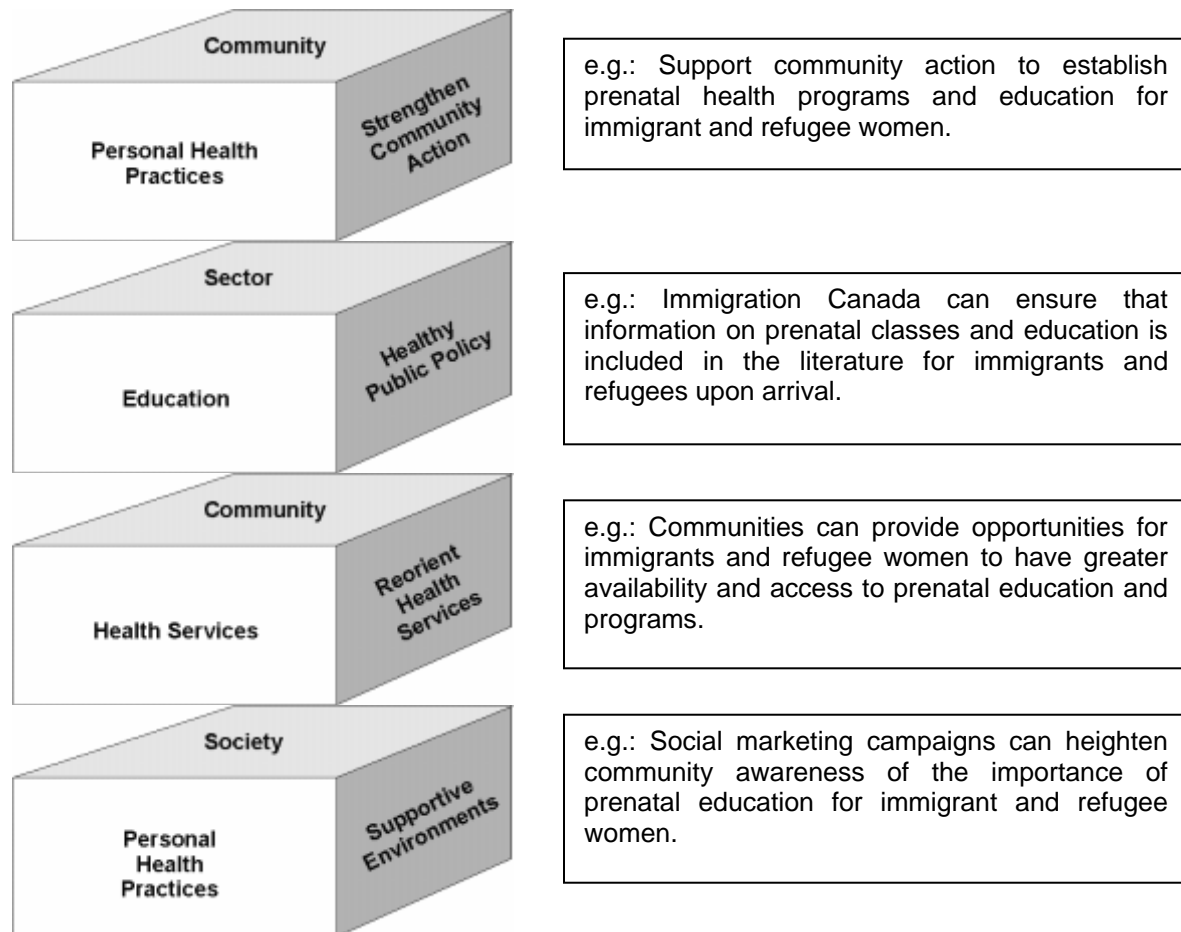
The Population Health Promotion Model



(Hamilton and Bhatti, 1996)

Because the PHPM offers strategies to address the health concerns of particular at-risk groups, it may be modified for application in pre- and post-natal health promotion among immigrant and refugee women, as the following diagram illustrates:

The Population Health Promotion Model Modified for Immigrant and Refugee Prenatal Health



(Modified version, Hamilton and Bhatti, 1996)

3.4 Planning and Evaluation of People-led Endeavours (PEOPLE)

According to Ma (2004), Planning and Evaluation of People-Led Endeavours (PEOPLE) has gained international support as an effective framework for health promotion. The PEOPLE system is comprised up of eight procedural steps:

1. Outline aims, philosophy and domain;
2. Do needs and wishes assessment;
3. Set goals;
4. Clarify the organizational structure;
5. Develop the action components;
6. Proceed with implementation;
7. Do regular reviews; and
8. Do periodic outcome evaluations.

The wide acceptance of this approach has been attributed to its focus on empowerment, social support, democracy, equity, trust and enjoyment.

3.5 Ecological Model

Ecological approaches to health promotion are community-based (designed and implemented in the community in partnership with community stakeholders); holistic (addressing a range of needs that may impact health); and dependent upon the knowledge, skills and expertise of local resources (in contrast to the 'medical' model of health care which privileges the professional as expert; Miller, 1999). Ecological approaches are considered effective for diverse populations because they enable the provision of contextually appropriate interventions and because they can serve to link community members to more formalized health care services as needed (Ida, 2007; Withy et al., 2007; Williams, 2006; Fraga et al., 2004).

An example of the ecological approach is the lay or peer health worker or educator program⁴, which is increasingly recognized as an influential strategy for health promotion among traditionally underserved populations (Barrio et al., 2008; Rhodes et al., 2007; Wasserman et al., 2007; Yu et al., 2007; Paskett et al., 2006; Norris and Alegria, 2005). In this approach, members of the target community who are identified as 'natural helpers' and perceived by the community as credible and trustworthy provide health counselling, support or education to community members who might otherwise not access the formal health care system (Rummel-Kluge et al., 2008; Wasserman et al., 2007). As members of the community, peer health workers or educators have the advantage of understanding the cultural context of health, including the community's norms, traditional practices and preferences, and as such can serve the community in ways that are highly culturally appropriate and sensitive (Barrio et al., 2008). Importantly, peer or lay health workers require the support and mentorship of health care professionals (Tse, 2002) and professionals should be educated in their role and be prepared to consult and work collaboratively with peer health workers in the community (Bhui et al., 2007; Norris and Alegria, 2005).

Cultural broker and liaison programs constitute another example of the ecological approach in the provision of health services to diverse populations. Cultural brokers or liaisons are health workers recruited from the target community who effectively liaise between mainstream health services and ethnocultural communities, acting as 'buffers' between clients and agency bureaucracy, and helping clients learn how to navigate the health system (Ton et al., 2005; Moffat and Tung, 2004; Abramson et al., 2002).

3.6 Summary

We have considered a number of health promotion models that may be particularly effective for health promotion initiatives targeting pre- and post-natal health of immigrant and refugee women. We turn in the next section to consider evidence-based principles and practices that contribute to the development of appropriate and effective initiatives more generally.

⁴ For a comprehensive review of the literature on the lay health worker model the reader is referred to a recent report produced for Alberta Health Services – Calgary *3 Cheers for the Early Years* (Jennifer de Peuter Chick, 2009).

4.0 HEALTH PROMOTION FOR REFUGEES AND IMMIGRANTS

Health promotion strategies designed for majority populations are generally not effective for diverse populations (Zarate-Abbott et al., 2008; van Eijdsden et al., 2006; Mitchell et al., 2000). The following section presents evidence-based principles and practices for health promotion with immigrant and refugee.

4.1 Cultural and Linguistic Congruence

Recent literature identifies a growing movement in public health to tailoring interventions to the specific needs of well-defined, at-risk populations (Wasserman et al., 2007). This movement recognizes that health promotion initiatives are most effective when they meaningful for the target population and congruent with the population's values, beliefs and practices (Torres et al., 2008; Treaster et al., 2006), and that individuals "have a better chance of achieving their health goals if they can participate with other people who are affected by the same or similar circumstances" (Laverack, 2006: 115).

Health promotion that is culturally and linguistically congruent with the target audience has proven effective for diverse populations. Powe et al. (2004, cited in Zarate-Abbott et al., 2008) conducted a randomized control study of the effectiveness of a colorectal cancer knowledge intervention using a culturally-sensitive video, calendar, poster and brochure, and found a significant increase in cancer knowledge within the intervention group compared to the control group. Similarly, Giarratano et al. (2005, cited in Zarate-Abbott et al., 2008) found that culturally sensitive health educational interventions in a cervical and breast cancer program for Hispanic women increased participants' receptivity to education and screening. Congruence is also desired by diverse populations; a recent study of Vietnamese mothers of young children in Ontario found that participants would welcome prenatal classes or breastfeeding workshops conducted in Vietnamese, as well as pre- and post-natal support from trained Vietnamese health workers or peers (Sutton et al., 2007).

4.1.1 Surface and deep structure modification

Health promotion programs may be adapted for the target population through 'surface structure modification' or 'deep structure modification' (Reese and Vera, 2007; Colucci, 2006; Goldstein and Noguera, 2006). Surface structures refer to "visible cultural expressions such as speech patterns, social interactions, and symbols" while deep structures refer to "systems of beliefs, perceptions, and other cognitive templates underlying behavioral patterns" (Torres et al., 2008: 149).

Surface structure modification represents minor changes to initiatives, examples of which include language modification (e.g., translation of intervention materials into the first language of the community) or format modification (e.g., matching the ethnicity of staff members with that of the target community; Zarate-Abbott et al., 2008; Colucci, 2006). While surface structure modification enhances the cultural congruency of health promotion initiatives, it may not be sufficient to ensure that the initiatives will be perceived by the target community as credible (Sawrikar and Katz, 2008; Reese and Vera, 2007). According to Torres et al. (2008), "...the focus of health promotion and health education needs to address the complex elements of deep cultural consciousness that affect people's choices" (149).

Deep structure modification refers to changes that render health promotion initiatives more fully culturally congruent, reflecting the values, beliefs, concerns, norms, practices and preferences of the target population (Tu et al., 2008; La Fontaine et al., 2007; Reese and Vera, 2007; Colucci, 2006). Whereas a surface structure language modification would involve simple translation of existing materials into the target language, deep structure modification would involve re-writing the materials, in the target language, such that the content becomes appealing and relevant to the cultural codes and norms of the population (Reese and Vera, 2007; Goldstein and Noguera, 2006).

The literature recommends either modifying the deep structures of existing health promotion programs or designing new programs, tailored to the target community, in collaboration with representatives of the target population (Torres et al., 2008). An example is Reitmanova and Gustafson's (2008) recommendation for designing female-only prenatal classes for Canadian immigrant Muslim women (because attending classes in which men are present contravenes Muslim religious beliefs); another is Grewal et al.'s (2008) recommendation that health care interventions be designed for recently immigrated Punjabi women in Vancouver that are respectful and inclusive of traditional Punjabi postnatal practices and rituals identified as important to this population.

4.1.2 Linguistic and visual congruence

To heighten linguistic congruence, the literature recommends developing health promotion materials in the first language and dialect of the target community (Barns and Almasy, 2005; MacKinnon and Howard, 2000):

...the primary obstacle for foreign-born women (in particular non-Western women) in receiving proper prenatal care – here reflected in the knowledge about and use of folic acid supplements – is the inability to speak and understand the language of the country of residence. Health promotion campaigns addressing these women therefore require linguistically appropriate, easily accessible information (van Eijsden et al., 2006: 1450).

The literature also recommends using emotional and tonal qualities that are normative for the target community, and ensuring that materials geared for low-literacy populations are highly visual, with generous use of images and symbols and other visual aids to support learning (Zarate-Abbott et al., 2008; Flaskerud, 2007). Health promotion materials should further incorporate visual images and colors that are relevant to and preferred by the target population, and ensure materials are written at a low level of literacy (e.g. grade 4; Tu et al., 2008). Knowledge of both effective and preferred methods of communication is also important in health promotion efforts (Centre for Addiction and Mental Health Policy, 2007).

4.2 Community-driven Health Promotion

Health promotion initiatives are optimally effective when they are 'community-driven,' or developed in collaboration with stakeholders of the target community; when they are tested for cultural relevance with a sample of the target community; when they incorporate community members as role models; when they are delivered within the community and with the help of community members; and when they are evaluated with input from community stakeholders and

program participants (Grewal et al., 2008; Reese and Vera, 2007; Wasserman et al., 2007; Goldstein and Noguera, 2006)⁵.

Community-driven health promotion for immigrant and refugee women surfaces throughout the literature as a cornerstone of effective programs⁶. Women's health agencies have identified a pressing need for more community development models of health care delivery for these populations and greater input on health promotion strategies by communities themselves (Weerasinghe, 2000). The importance of community involvement in the identification of issues and the development and implementation of health promotion initiatives reflects a movement away from focusing on the individual in health promotion, toward understanding women's health in the broader social context (Bhagat et al., 2002). It also reflects the belief that the development of an effective health promotion strategy requires a comprehensive needs and community assessment, which enables the identification of the appropriate target community and health issues (Palinkas et al., 2003).

There are a number of benefits to community participation in the development of health promotion programs. Community participation facilitates a sense of ownership and helps ensure that programs are delivered in a culturally competent manner, both of which ultimately strengthen program sustainability (Ahmad et al., 2004).

The literature provides a number of examples illustrating community involvement in women's health promotion:

- Gilles (1998) reviewed the health promotion literature and found that the impact and sustainability of health promotion interventions increased with community involvement in practical activities, including agenda setting, policy-making and implementation of programs at the local, regional and national levels.
- Bhagat et al. (2002) report on the use of a community mobilization strategy in British Columbia intended to improve the prenatal health of Punjabi immigrant women, a group traditionally underserved by prenatal care. Focus groups with Punjabi women revealed that one of the main barriers to prenatal care was the lack of awareness and acceptance of prenatal care within the Punjabi community. In response, the community mobilization strategy developed culturally-sensitive health promotion messages and organized a cultural festival in which the messages were distributed via flyers.
- Mayberry et al. (1999) describe Malama Na Wahine Hapai, a community-driven program meant to improve the pre- and post-natal health of Hawaiian, Filipino and Japanese women living on the Island of Hawaii. Community members, elders, and cultural healers provided insight into how pre- and post-natal care could be more culturally appropriate. Culturally appropriate interventions included the provision of gifts to women who maintained health-

⁵ Notably, community-based participatory research is also gaining recognition as a culturally appropriate and effective way to combine research and action for health promotion of immigrants, refugees and underserved ethno-cultural groups (Wasserman et al., 2007; Guruge and Khanlou, 2004; Meyer et al., 2003). Participatory research bridges the gap between research and action, situates individual health experiences within the broader socioeconomic, historical, political and institutional structures and dynamics, and contributes to the development of sustainable solutions and empowerment within immigrant and refugee communities (Guruge and Khanlou, 2004; Meyer et al., 2003).

⁶ The literature also cautions that community participation risks the deflection of responsibility away from powerful political and economic structures (Stone, 1992) and that it is not welcome in all cultures (Brownlea, 1987; Rikfin, 1983). The literature recommends assessing the value of community participation in individual cultural groups.

promoting behaviours during and following their pregnancy (reflecting the Hawaii Island gift-giving tradition) and celebrations for 'graduates' of health promotion programs and their families.

- The Vietnamese REACH for Health Initiative Coalition held a number of community forums to address barriers to Pap testing among Vietnamese-American women, in which more than 200 Vietnamese-American women and their families participated (Lam et al., 2003). The forums led to the development of a Community Action Plan to address the sociocultural and structural barriers to cervical cancer screening identified with the input of the target population. The Plan included developing media campaigns, a lay health worker program, a pap registry and reminder system, and a Vietnamese-staffed pap clinic.
- The Fresno County Refugee Volunteer Project brought leaders from the Cambodian, Hmong and Lowland Lao refugee communities together with leaders from refugee serving agencies and the Department of Health to produce a community-based health promotion network (Rowe and Spees, 1987). A conceptual framework to deliver services was derived from dialogue around the strengths of both the refugee communities and the Department of Health. The framework included a self-help concept (emphasizing the relationship between self-care and community development); a decentralized approach (focusing most activities on the family, the apartment complex, or the neighbourhood); a holistic approach (addressing the needs of the body, mind and spirit in relation to the environment); and a commitment to capacity-building (including the capacity to address health issues cross-culturally; building refugees' capacity to process health information and access services; and capacity of the health system to enhance accessibility to refugee populations).

4.3 Strength-based Health Promotion

Padilla and Villalobos (2007) examined the literature to identify the cultural experiences of Mexican American women and to suggest promising, culturally-appropriate health promotion strategies with particular emphasis on family and social context. One of three broad health promotion strategies identified was that of reconceptualising culture as a strength and drawing on cultural characteristics to improve health and access to health care, rather than understanding culture as simply a barrier. For example, the high value placed on the family on some cultures could be incorporated into health promotion initiatives by emphasizing the benefits that healthy behaviours would bring to the family. The provision of support and health education by lay health workers in the home is another example of an initiative that 'capitalizes' on close family ties. A third example of a strength-based approach is the pairing of folk healing practices with modern medical treatment, an example of which is the *nurse-curandera*,

...a bilingual nurse trained in folk healing who can provide the benefits of allopathic healthcare with the benefits of using practices that promote patient and family involvement in the healing process. The nurse-curandera uses her scientific knowledge to evaluate the safety of a folk remedy or treatment and refers clients to other healthcare providers when appropriate (Padilla and Villalobos, 2007: S30).

Strength-based approaches to health promotion are also recommended by Grigg-Saito et al. (2008). The authors summarize Green et al.'s (2004) practices for a strength-based approach that are relevant to health promotion, including:

- An empowering orientation building on families' strengths to do things for themselves;
- Cultural competence that views culture as a source of strength;

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- A relationship-based approach using program staff-participant relationships;
 - A family-centred approach focusing on the entire family in addition to the individual; and
 - A community orientation with sensitivity to history (418).

The authors also identify three ways in which strength-based approaches are beneficial to participants:

- By increasing participants' engagement in services;
- By increasing family empowerment; and
- By enhancing the ability of participants to build relationships and social support (418).

4.4 Partnership-building with Allied Health Professionals

Building partnerships and alliances with health professionals in the development and implementation of health promotion initiatives for immigrant and refugee populations is a common theme in the literature. Partnership-building may involve the formation of coalitions and forums in order to develop strategies for specific health promotion issues (Seng, 2005) or working with health professionals who have frequent access to targeted populations (Bhagat et al., 2002)⁷.

4.5 Health Promotion Education Formats

The literature provides a number of recommendations for effective health promotion education with immigrant and refugee populations. First, research has found that 'interactive' formats are more effective than passive or demonstrative formats (Hannula et al., 2008; Zarate-Abbott et al., 2008); MacKinnon and Howard (2000) provide as an example the provision of a cooking class to introduce newcomers to healthy Canadian ingredients. Second, the literature recommends ensuring opportunities for participants and educators to form personal relationships to enhance feelings of trust and build rapport (Zarate-Abbott et al., 2008). Third, repeated exposure to health messages is recommended; a recent evaluation of a culturally-sensitive workplace cardiovascular health education intervention in the U.S. found "repeated doses of information at each presentation were an important teaching strategy" (Ibid.: 221). Finally, it is recommended that pre- and post-natal health promotion education span the entire period from pregnancy through to infancy, as health promotion is more effective when of longer duration (Hannula et al., 2008).

4.6 Media Campaigns

Media campaigns are used in conjunction with other health promotion strategies to raise awareness of health issues among specific populations, and recommendations for designing campaigns that are effective for immigrant and refugee populations incorporate a number of evidence-based practices and principles already discussed.

⁷ Partnerships with physicians are particularly beneficial because physicians have been described by immigrant women as their major and preferred source of health information (Ahmad, 2004). As well, immigrant populations have cited that the main reason they do not take preventive measures for their health is because their physicians 'did not recommend it' (Jenkins et al., 1999).

Health messages delivered in media campaigns should be culturally and linguistically appropriate (van Eijdsen et al., 2006; Barnes and Almasy, 2005). Because immigrant and refugee populations are not a homogenous group, campaigns should be culturally and linguistically tailored to the individual community's perceptions of health and healthy behavior, based on their unique beliefs, culture and language (Flaskerud, 2007). The use of oral public service announcements or pictorial displays or comics for example may be most effective for target audiences with low literacy or low health literacy (Flaskerud, 2007).

Media campaigns should be developed with input from the target community (Seng et al., 2005). Community input can help ensure that media campaigns are culturally and linguistically relevant, appropriate and effective (Lam et al., 2003), and can provide advice on the most effective mediums for the transmission of messages, such as ethnic radio or television or displays in local ethnic clinics (Ahmad et al., 2004). Grigg-Saito et al. (2008) for example found through community consultations that local cable TV would likely be an effective medium for transmitting health promotion messages to a Cambodian refugee community in the U.S. because the majority of the target audience regularly watched the local ethnic television channel.

4.7 Community Outreach

The literature identifies community outreach as an effective health promotion strategy for traditionally underserved populations. Padilla and Villalobos (2007) provide an example of a program launched in Indiana in which a bilingual outreach coordinator provided cancer information to Latina men and women through visits to community centres, churches and health clinics. Additional community outreach strategies include home visits from bilingual and bicultural health care workers; small support groups held in participants' homes or in other settings considered familiar and comfortable; engaging nurse-community health advocates to increase access to health care; lay health outreach worker programs; and using mobile health units to reach vulnerable populations (Ibid.).

Research findings of Morrow et al. (2008), who conducted interviews with 18 recent Punjabi-speaking, Cantonese-speaking, and Mandarin-speaking immigrant women exhibiting symptoms of depression after childbirth in British Columbia, also support the need for outreach among immigrant women:

With respect to the role of health care practitioners, our study does support the increased role of community health nurses, because this is where women were most often identified as suffering from depression and where they felt most comfortable gaining support. Further, this group of practitioners has access to women in their homes, where they can more usefully work with women and families to assist in establishing supports that are needed (614).

Grigg-Saito et al. (2008) describe a number of outreach approaches used by the Cambodian Community Health 2010 Program to eliminate disparities in cardiovascular disease and diabetes in the Cambodian refugee community in Lowell, Massachusetts. Some of the more innovative outreach activities include:

Door-to-door team outreach: 2010 staff health educators went door-to-door in the Cambodian community to speak with otherwise socially isolated or hard-to-reach individuals about health services and various health topics.

Business outreach: 2010 staff visited Cambodian-owned businesses (markets, barbershops etc.) to distribute educational materials (posters, flyers and program brochures); doing so helped build partnerships and enabled staff to educate business owners who in turn referred customers to 2010 programs.

Learning tours: 2010 staff organized tours of local emergency rooms, police stations and clinics; tours served as “the initial bridge to the unknown places stigmatized by word of mouth in the community” (421).

Tai Chi/exercise: Individuals participating in other activities organized by the 2010 team were encouraged to participate in tai chi and other exercise activities; “program staff have found that group exercise provides comfort, internal protection, and shared competition among peers, creating a comfortable zone among friends who, through frequent contact, gradually build mutual trust with each other and with staff” (421).

Grigg-Saito et al. (2008) conclude that:

The ability to find what elements of the activities and events interest participants is essential to the continued success of the program. In a community filled with fear and distrust, it is difficult to draw people out of their safe environments into the outside world, into something unknown and new (423).

4.8 Participatory Photonovel

One of the more innovative health promotion interventions identified in the literature is the use of the participatory photonovel. Nimmon (2007) describes the use of this method with a small group of ESL-speaking immigrant women attending the Inter-Cultural Association of Victoria women’s group on settlement issues. The women identified a need for nutrition education, and following a presentation on nutrition by a public health nurse, the author had the women work together to create characters and a script for a photonovel. Photonovels

...are formulated like comic books, but they contain photographic stills with balloon-captioned text that is usually expository; that is, it is meant to inform the reader about something. A photonovel is participatory because it gives learners the opportunity to choose a specific topic and create the photonovel themselves (Nimmon, 2007: 338).

Interviews with participants upon completion of the photonovel revealed that participants felt proud of the photonovel they had created, felt it “helped them understand health information,” and felt it would be useful for other ESL-speaking immigrant women because it was written at a low level of English using simple words (338). The initiative was also considered successful because the process helped participants, who had indicated a lack of social support, form significant relationships with their peers:

By the time the photonovel project ended, comfortable relationships among the women had been established. They laughed together and argued good-naturedly about editing the photonovel (338).

In addition to increasing social connections, participants made comments around “increased self-esteem, confidence, and feelings of importance after having completed the photonovel” (338):

These are significant sentiments because there were many times in their initial interviews that the women touched on feelings of being minimized in our society, commenting on such topics as a lack of being represented in the media and in society, not being understood empathetically by health professionals, and not having access to medical care because of immigrant status. There were a lot of comments from the participants about how good it made them feel to have themselves represented in the photonovel (338-39).

A final positive outcome of this approach is that it encouraged participants “to think more critically about their situation and determine ways to take action to change their realities” (339). The author observed a significant shift in consciousness upon completion of the photonovel, leading the author to conclude that the photonovel method not only has the potential to increase comprehension of health education material, but also to increase “the ability to think critically and take control of one’s life” (339).

4.9 Summary

This section has identified several evidence-based principles and practices for health promotion with immigrant and refugee. It may be concluded that immigrant and refugee health promotion is most effective when culturally and linguistically congruent with the target audience; when community-driven; when strength-based; and when partnerships are cultivated with allied health professionals. Health promotion education should be interactive, relationship-based, repetitive, and of significant duration; and media campaigns should be culturally and linguistically appropriate and should be developed with input from the target community. Finally, community outreach and the use of participatory photonovel represent innovative methods of health promotion for immigrant and refugee populations. We turn in the next section to consider a number of evidence-based recommendations, based on the review of the literature presented to this point, for the development of pre- and post-natal health promotion initiatives targeting refugee and immigrant women by Alberta Health Services – Calgary.

5.0 RECOMMENDATIONS

5.1 Ottawa Charter & Determinants of Health Models of Health Promotion

1. Following the Ottawa Charter, it is recommended that pre- and post-natal health promotion for immigrant and refugee populations be designed in ways that enable participants to identify and realize their aspirations, satisfy their needs, and change or better cope with their environment;
2. Following the Ottawa Charter and the determinants of health approach, it is recommended initiatives support structural change identified as necessary for optimal pre- and post-natal health of immigrants and refugees, including changes in social policy, and incorporate strategies to address the full range of social, economic and political factors inhibiting the realization of optimal pre- and post-natal health;
3. Specifically, pre- and post-natal immigrant and refugee health promotion should take a holistic approach that addresses issues related to the migration experience, such as loss of family, experiences of trauma or torture, and feelings of uncertainty; and to the newcomer experience, such as social isolation, language barriers, and poverty;
4. Because refugees are at heightened risk for poor physical and mental health, health promotion should target the broader range of physical and psychological health needs;
5. Barriers to healthy lifestyles of refugees and immigrants include limited resources such as time for rest and for exercise; pre- and post-natal health promotion should address resource barriers experienced in everyday life, recognizing that addressing a wide range of healthy lifestyle barriers can contribute to pre- and post-natal health;
6. While health promotion should be provided in the first language of participants, it should also be recognized that non-English speaking refugees and immigrants and those with limited English language skills, limited English language literacy, limited first-language literacy, as well as limited health literacy experience barriers in accessing the full range of health-related services and supports. Health promotion should effectively overcome language barriers created by the program itself, but should also seek to address the wider scope of barriers within the health care system (and broader society) associated with limited language and literacy skills. Linking program participant to ESL classes and educating participants on interpreter services are two examples of how this might be accomplished.

5.2 Ecological Model of Health Promotion

1. It is recommended that pre- and post-natal health promotion for refugee and immigrant women take an ecological approach (community-based; holistic; utilizing 'local experts;' contextually appropriate) such as the lay or peer health worker or educator program or the cultural broker or liaison program, both of which have proven effective with underserved populations.

5.3 Cultural and Linguistic Congruence

1. Pre- and post-natal health promotion should be tailored to the target population, ensuring congruence with the population's values, beliefs and practices. For example programs that

build on the traditional or preferred practices of the target group but add new knowledge would be respectful and effective;

2. Programs should be designed for groups of culturally and linguistically similar individuals;
3. Deep structure modification of existing programs (e.g., re-writing health promotion materials in the first language and dialect of the target audience, rather than simply translating existing materials) or developing new programs tailored specifically to the target audience is recommended;
4. Materials should reflect the emotional and tonal qualities normative for the target population;
5. Materials should be written at the appropriate level of literacy and health literacy, and it should not be assumed that participants have literacy skills in their first language; materials for low-literacy populations should use short, simple sentences, should avoid jargon, should be written at a fourth-grade level, and should make generous use of graphics and images and other visual aids;
6. Preferred methods of communication of health promotion messages should be identified and used (e.g. oral communication may be preferred by some cultural groups).

5.4 Community-driven Health Promotion

1. Pre- and post-natal health promotion initiatives should be developed, implemented and evaluated in collaboration with stakeholders from the target community;
2. Initiatives should be tested for cultural and linguistic relevance and appropriateness with members of the target community;
3. Roles models from the target population should be incorporated, when possible, into health promotion programs;
4. Programs should be delivered within community settings considered familiar to and comfortable for participants.

5.5 Strength-based Health Promotion

1. Pre- and post-natal health promotion for refugee and immigrant populations should be premised on the notion that 'culture' is not a barrier to be overcome but a strength to be drawn upon;
2. It is recommended that values of importance to the cultural community, such as strong family ties or traditional prenatal rituals, be identified and incorporated into the format and content of health promotion programs.

5.6 Partnership-building with Allied Health Professionals

1. Pre- and post-natal health promotion programs for refugees and immigrants should cultivate and draw upon partnerships and alliances with health professionals;

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2. Programs should be developed in consultation with allied health professionals who can provide insight into effective strategies for specific health promotion issues or, in cases where health professionals work closely with the target population, can provide insight into the needs and preferences of the population;
 3. Physicians serving refugee and immigrant women should be aware of the health promotion program and provide linkages as appropriate.

5.7 Health Promotion Education Formats

1. Health promotion education is most effective when interactive rather than passive or demonstrative;
2. Education programs should encourage relationship-building between educators and participants to facilitate trust and rapport;
3. Participants should be provided with repeated exposure to important pre- and post-natal health information/messages;
4. Education should span the length of the pregnancy and follow through to infancy.

5.8 Media Campaigns

1. Health messages delivered in media campaigns should be culturally and linguistically appropriate;
2. Campaigns should be tailored to the individual community to ensure cultural and linguistic relevance;
3. Input from the target community (on language preference, cultural norms and values, and preferred or effective mediums of communication) should be sought and utilized in the development of media campaigns.

5.9 Community Outreach

1. Community outreach is an effective health promotion strategy for underserved populations and should be considered as a strategy for serving the pre- and post-natal health needs of refugee and immigrant populations;
2. Community outreach activities could include door-to-door outreach; building partnerships with local business for distribution of health promotion material and networking; offering 'learning tours' of local hospitals and clinics; and reaching target populations 'covertly' through exercise, cooking or ESL classes.

5.10 Photonovel

1. The use of the participatory photonovel is recommended as a strategy for health promotion or education among immigrant and refugee populations; organizers might consider developing the photonovel as an empowering educational intervention in pre- and post-natal health promotion programs.

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