A Review of Theory and Health Promotion Strategies for New Immigrant Women

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ABSTRACT

Background: There has been little empirical research on the best ways to influence women's health behaviour, particularly among women who are recent immigrants to Canada.

Methods: This paper presents information from a literature review conducted for the Ontario Women's Health Council on effective theoretical models and health promotion strategies for women.

Findings: Health promotion activities for all women should address theoretical variables as well as the broader determinants of women's health. New immigrant women represent a diverse group who often face multiple cultural, linguistic and systemic barriers to adopting and maintaining healthy behaviour.

Interpretation: Many theoretical constructs of potential importance to recent immigrant women have not been adequately researched. More research is also needed on the relevancy and the applicability of commonly used health promotion approaches for this group.

Canadian health survey data suggest that recent immigrants to Canada, particularly from non-European countries, are in better health than their Canadian-born counterparts.^{1,2} This is partly attributable to self-selection factors and partly to Canada's immigration process that selects the 'best' immigrants on the basis of education, language ability and job skills. Recent immigrant women are also less likely to engage in health risk behaviours or be overweight than native-born Canadians.³⁻⁵ Over time, however, this profile changes. Immigrants who have lived in Canada for more than 10 years experience a similar prevalence of chronic conditions and long-term disability as the Canadian-born population.^{1,2} The long-term process of immigration and resettlement may negatively influence critical determinants of health, such as income and social status, working conditions, the social and physical environments, and health practices. Many studies have found that health risk behaviours, such as the consumption of a high-fat diet, smoking and alcohol use, increase over time to resemble those of the majority culture.^{3,4,6-16} Furthermore, recent immigrant women are less likely to be screened for cervical and breast cancer and to participate in regular physical activity than their Canadian-born counterparts.^{4,17,18}

These findings present an obvious challenge for public health professionals and new immigrant communities, i.e., how to help new immigrants: maintain health-promoting behaviours, such as the consumption of a low-fat diet; adopt preventive health behaviours, such as regular cervical and breast cancer screening; and avoid the adoption of health risk practices (e.g., heavy alcohol use and smoking). This challenge is compounded by the fact that most of the theoretical models used in health promotion today are grounded in majority culture-based research and may not be appropriate for diverse subgroups in the population, such as new immigrant women.

This paper presents information from a recently completed literature review conducted for the Women's Health Council of the Ontario Ministry of Health and Long-Term Care. The main objective of the review was to identify best mechanisms to favourably influence health risk behaviours among women in Ontario. In the

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review, specific attention was placed on the identification of health promotion strategies appropriate to newcomers. The first part of this paper describes major theoretical models and presents our findings on the characteristics of successful health promotion programs for Ontario women in general. The second part of this paper highlights issues related to health promotion for new immigrant women in particular.

METHOD

Between May-September 1999, the University Health Network Women's Health Program (UHNWHP) conducted an appraisal of the published literature in the areas of health promotion and disease prevention to identify best mechanisms to influence health risk behaviour in women. The terms of reference included:

- A critical review of the major theoretical models that have been used to explain the adoption of health risk and health-promoting behaviours;
- Identification of exemplary health promotion programs or clinical trials in which health behaviours have been successfully modified; and
- Identification of recommended public health policies for the range of health behaviours reviewed.

The health behaviours reviewed included: smoking and alcohol/drug abuse, healthy eating, physical activity, healthy sexual behaviour, violence towards women, and PAP testing/mammography. The relevant literature was identified using key informants/experts, health databases and health websites. A total of 565 articles were retrieved dating from 1986 to the present, of which 65 pertained to immigrant women. The literature review included review articles, epidemiological studies, case histories, unpublished reports and personal communication. Once the relevant literature was identified, the quality of evidence was appraised using established criteria. In the case of epidemiological studies, 'acceptable' studies specified data source, study population, sampling frame and sample size (when appropriate), study measures (including reliability and validity when appropriate), methods of analysis, and study limitations (e.g., sources of bias, loss to follow-up). Case histories, unpublished reports and

TABLE I

Summary of Theoretical Models

Health Belief Model²⁰⁻²³

- Health behaviour is influenced by five factors: perceived susceptibility to a particular illness; perceived severity of the illness; perceived benefits in changing one's behaviour; perceived barriers to changing behaviour; and cues to action.
- People act to protect their health if they perceive that they are personally at risk of a particular illness and that a particular action will enable them to deal with that risk. When deciding to act, individuals weigh the potential benefits of the recommended response against the barriers of the action (e.g., financial costs).
- Perceived barriers are the strongest predictors of whether or not an individual will engage in health-protective behaviour, followed by perceived susceptibility.

Social Cognitive Theory²⁴

- Focus is on perceived self-efficacy; what one believes about one's capability to exert control over one's motivation, behaviour, or social environment in order to perform a certain action.
- Health behaviours are a function of outcome and efficacy expectations. Outcome expectation refers to an individual's belief that a certain behaviour will lead to a certain outcome. Efficacy expectation refers to an individual's belief regarding whether she is able to successfully execute the recommended behaviour.

Theory of Reasoned Action²⁵

- People eventually do what they intend to do, and the best single predictor of a behaviour is the intention to act in that way.
- To change behaviour, two sets of beliefs must be altered: 1) beliefs about the consequences of performing a certain behaviour and the evaluation of those consequences (attitude); 2) beliefs about what others think about the behaviour to be performed and the motivation to comply with those (subjective norm).
- Only when a health message targets salient beliefs do attitudes and subjective norms, and subsequently intentions and health behaviours, change.

Transtheoretical Model²⁶

- There are five stages of change, which represent ordered categories along a continuum of motivational readiness to change a problem behaviour.
- In the Precontemplation stage, individuals do not intend to change their behaviour because they are unaware that they are engaging in a risky behaviour.
- In the Contemplation stage, the individual is aware of the risky behaviour and begins to contemplate the need for change.
- In the Preparation stage, individuals make a commitment to change and take some action towards behavioural change.
- In the Action stage, the individuals perform the new behaviour consistently.
- In the Maintenance stage, the new behaviour is continued and steps are taken to avoid lapsing into the formerly risky behaviours.

personal communication were used if they included clear description of the research findings, programs and/or populations involved and their policy implications.

Detailed information on the methodology, including names of key informants, health databases, websites and bibliographic references, is available on the Ontario Ministry of Health Women's Health Council website, <http://www.womenshealthcouncil.com/E/index.html>.

FINDINGS

Much knowledge and experience has accumulated over the years on how to effectively motivate health behaviour. Four examples of theoretical models were prominent in the literature reviewed: the Health Belief Model, Social Cognitive Theory, Theory of Reasoned Action, and the Transtheoretical Model. What these theories had in common was their attempt to identify critical factors associated with behavioural changes, in order to plan, design and implement effective interven-

tions.¹⁹ A summary of these models is presented in Table I.

There was not a great deal of consistency in the literature about which theoretical models worked best for different health behaviours or for different population groups. Although cast as distinct, in practice, these models often overlapped. Theorists generally agreed that *positive intentions*, *barriers*, and *skills* were the critical predictors of most health-related behaviours.²⁷ *Intentions* refer to plans to carry out a recommended behaviour or action and are often used as proxies for actual behaviour. *Barriers* refer to conditions that inhibit individuals from carrying out a recommended behaviour, for example, cost, time and cultural beliefs. *Skills* refer to the ability to perform a recommended action and include constructs such as *self-efficacy*, or the degree to which an individual perceives that he or she is able to perform a recommended behaviour. Among women, *self-esteem*, the belief that a behaviour is consistent with an individual's positive self-image, was particularly critical.

TABLE II

Summary of Recommendations

- Use behaviourally-focused strategies, recognizing that many cultural concepts with potential relevance to health practices (e.g., collectivism, ethnic identity) have not been adequately researched.
- Focus on reducing informational, cultural, linguistic, economic and systemic barriers to care.
- Use an empowerment philosophy.
- Use community "link leaders", leadership and the media.
- Involve the community in planning, design and delivery of interventions.
- Be dynamic, as immigrants' attitudes, beliefs and behaviours change as part of an acculturation process.

The most successful health promotion interventions identified in our literature review addressed theoretical variables, namely perceived barriers, knowledge and skills development, self-efficacy and self-esteem. For example, it was clear from the literature review that health promotion programs for women need to be more accessible (e.g., extended hours, provision of child care), gender-sensitive, and comprehensive, addressing both health information needs as well as skills development. The best mechanisms to influence women's health behaviours identified by this review recognized that healthy social, political and economic environments enabled and supported healthy choices and combined behavioural, social and environmental change approaches. Successful programs stressed empowerment, enhanced social support and women's involvement in planning, development and delivery.

Several important issues related to health promotion for new immigrant women emerged from the review.

First, it was recognized that new immigrants are not necessarily a homogeneous group and there is substantial variation with respect to country of origin, socio-economic status, visibility and language ability. While in the 1950s the majority of Canada's immigrants originated in European countries, today more than one third of immigrants are from Asian countries.²⁸ Immigrants from non-traditional source countries, e.g., Asia, the Middle East, Latin America and Africa, often hold concepts about health and health care behaviour that differ from those prevalent in majority culture North American society.²⁹⁻³¹ It is also well established that immigrants, especially refugees, are disproportionately poorer than the general population, making poverty a confounder of any relationship between immigration and health. Furthermore, immigrants who lack fluent in the official languages are less like-

ly than immigrants who are fluent in English or French to be exposed to health promotion.³² In 1996, females accounted for 64% of recent immigrants who could not speak English or French. Among older recent immigrants (45-64 years), 79% of females and 64% of males could not speak English or French.³³

Second, the literature suggested the need to shift the focus of health promotion programs from interventions directed at broad or even targeted population segments to 'tailoring'. Unlike targeting – the process of identifying a population sub-group for the purpose of insuring exposure to the intervention by that group – tailoring implies the development of health messages and materials that are consistent with characteristics, needs and cultural beliefs of that group.³⁴ For example, in some cultures (such as Middle Eastern or Chinese), avoiding hot-cold or dry-moist shifts, and wind and drafts, staying warm and eating and resting well are behaviours associated with good health and well-being. For many immigrant women, physical activity is something that is integrated into everyday lives, particularly in areas where access to home heating, appliances and indoor plumbing is limited.^{35,36} Therefore the promotion of physical activity by joining a fitness class or going jogging may not be considered essential or appropriate.³⁶ There was a definite need for health promotion materials to be developed in different languages as well as that considered cultural and culturally-specific patterns of learning, for example, the use of songs, stories, and drama to disseminate health information. At present, many health agencies rely on translation services rather than developing their own culturally consistent health promotion material.

Third, many theoretical constructs that may potentially influence the health behaviours of new immigrants have not been identified. For example, in collectivist

communities, cultural norms dictate that family and community take precedence over personal needs; however, most current health promotion models emphasize the role of the individual.²⁷ In a study of Mexican-American women, strong family attitudes were found to be a stronger predictor of mammography use than other variables under investigation.³⁷ The role of ethnic identity in maintaining health behaviour was explored in a study of Southeast Asian refugees to Canada. Strong ethnic identity was associated with maintaining a traditional diet over time, suggesting that programs that promote cultural retention may increase the effectiveness of health nutrition counselling for this population.³⁸

Finally, it was recognized that new immigrant women face multiple barriers to maintaining or changing health behaviours, compared to women in the general population. These include: poverty, marginalization, gender gaps and the social processes which reinforce them (e.g., underemployment, multiple role burden, social isolation and discrimination).³⁹⁻⁴¹ These cultural, linguistic, economic and informational barriers must be addressed if new immigrant women and their families are to engage in optimal health practices.

As in the general population, exemplary health promotion programs for new immigrant women involved community in the development, planning and delivery of the programs, adopted outreach strategies and delivered programs at multiple settings. Other promising approaches involved the use of link or lay leaders (trained personnel from ethnocultural groups) to increase the relevancy of health messages and to reduce perceived barriers to behavioural change.^{42,43}

A summary of recommendations for health promoters working with new immigrant women is presented in Table II.

LIMITATIONS

Although the review of the literature attempted to be comprehensive, certain limitations must be acknowledged. First, many 'successful' programs have not undergone systematic review and do not appear in the research literature. This is because community-based (and other) programs do not always have the resources to

do research, and health promotion programs may impact on outcomes other than health behaviour and may be long-term.

Second, to date, little research has examined determinants of health (and health behaviour) that are specific to women, such as: family, social and community support, women's ease of access and degree of control over resources, the dimensions of women's work that can lead to stress (e.g., excessive or disruptive work hours, physically or psychologically hazardous work environments and the total burden of work which may include unpaid work as well as caregiving responsibilities) and gender role socialization.⁴⁴ Many of these determinants are particularly relevant for new immigrant women.

Finally, few Canadian studies have examined changes in the health behaviour of immigrants over time or factors associated with behavioural change. This information is critical to the development and evaluation of culturally consistent health promotion programs for new immigrant women.

SUMMARY

Findings of this critical appraisal suggest that health promotion activities for women in general as well as new immigrant women should address theoretical variables such as perceived barriers, knowledge and skills development, and self-efficacy as well as broader determinants of women's health. In considering the health promotion needs of new immigrant women, it was recognized that this group is diverse, may face multiple cultural, linguistic and systemic barriers to healthy behaviour, and that many theoretical constructs of potential importance to this group have not been identified. More research is needed on the relevancy and the applicability of commonly used theoretical models and health promotion strategies for new immigrant women.

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RÉSUMÉ

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