

Health Literacy Within the Reality of Immigrants' Culture and Language

Margareth S. Zanchetta, PhD, RN¹

Iraj M. Poureslami, PhD²

ABSTRACT

The Second Canadian Conference on Literacy and Health addressed issues of health literacy, culture, and linguistic diversity. This article aims to introduce the presenters' ideas, reports of the learners' discussion, and attendees' recommendations. There is also a literature review of the links between health literacy and use of health services among newcomers in Canada. Newcomers to Canada tend to be unfamiliar with the Canadian health care system in terms of navigating needed services and/or seeking health-related information. Health professionals report difficulties in communicating effectively with these populations about risk-taking behaviours. Educational resources and approaches only partially reach people from cultural minorities. E-health information does little for those with language and literacy limitations. Barriers to accessing information, specifically written material, are widely reported. Consequently, many ethnocultural groups do not participate in health promotion initiatives. Among newcomers to Canada, the problems of adapting to a new health culture are linked to both a lack of information about the new health care available and subsequently their experience with that health care system. There is also a structural barrier. It includes lack of access to preventive health care services and the lack of a formal and informal support network. This results in less effective use of these preventive services. Linguistic, religious, and cultural factors contribute to the newcomers' social isolation. Multidisciplinary work to enhance health literacy and awareness about health and healthy lifestyles will permit ethnocultural populations to develop their potential and more fully enjoy their lives in Canada. Simultaneously, health educators should have the opportunity to realize their limitations and challenges in dealing with the complexity of providing health education to this population. There remain gaps in our knowledge about the access and use of health services by subpopulations from different cultural groups in terms of their gender, learning practices, ways of navigating services, and help-seeking behaviours.

MeSH terms: Health literacy; Canadian society; newcomers; culture; language; service utilization; ethnocultural community; diversity

In this paper, we present key points about culture, languages, and health literacy using ideas from presenters, reports of the learners' discussion, and recommendations from participants at the Second Canadian Conference on Literacy and Health. We review published articles about health literacy and use of health services among newcomers in Canada. We also discuss issues of languages as tools to transfer popular and cultural knowledge about health and science, and to make obvious the interplay and dynamic relations between literacy, culture, and meaning of personal and collective experiences.^{1,2} The exploration of health literacy within the scope of languages and cultures gives us the opportunity to learn about other peoples' perspectives and preferences. Dyanne Affonso raised the importance of such exploration.³ She reinforced the necessary enlightening of the above-mentioned four as they are linked to health literacy. For her, health literacy within the multiplicity of languages and cultures also includes understanding the potential sources of impacts on peoples' future health knowledge and behaviours; and embodies the protection of their rights to free choice according to their understanding about health, medical science, and technology.

Canada is a multicultural society. Therefore, English and French are not the only languages of concern, particularly in terms of health and related issues.² In this paper, we do not propose a new definition of health literacy. The conference report corroborates our statement – health literacy, within ethnocultural diversity, is an underestimated problem. Languages and communication between health care providers and consumers is of particular importance. This issue constitutes an additional challenge because it also embodies the need to accommodate different views of the world, science, and health.^{4,5} Such communication goes beyond the goal of helping people to decode and transform health information into health knowledge and from there to healthier behaviours.¹

This challenge has multiple dimensions. They include understanding different realities. This means giving special attention to the cultural symbols and modes of appropriating knowledge according to each ethnocultural group. These include practices such as chanting, touching, and

1. Associate Professor, Faculty of Community Services, School of Nursing, Ryerson University, Toronto, ON

2. Adjunct Professor, Research Associate, Faculty of Health Sciences, Simon Fraser University, Vancouver, BC

Correspondence and reprint requests: Margareth S. Zanchetta, Faculty of Community Services, School of Nursing, Ryerson University, 350 Victoria Street, Office 468E, Toronto, ON M5B 2K3, Tel: 416-979-5000, ext. 4557, Fax: 416-979-5332, E-mail: mzanchet@ryerson.ca

storytelling; the meaningful use of sounds, music, visual imagery, and arts;³ interconnecting cultural values, scripts, and metaphors seen as expressions of being, thinking, believing, understanding, living, and doing;^{3,6} and the subsequent dynamic of interpreting diversities and particularities for accepting health education interventions.⁶ For these reasons, this article introduces health literacy as experienced by immigrant populations and the challenges faced by health professionals from the domains of health care, education, and research.

What we know: Updating Canadian knowledge about health literacy and cultural diversity

Lisa Merry's presentation⁷ pointed out the functional aspects of health literacy of foreign-born people in dealing with the organizational demands of the health care system. At their first contact with health services, they usually need to fill in questionnaires. Such situations may force them to reveal their unfamiliarity with the typical instructions, choices enumerated by letters and items, and filling in forms asking about personal health-related information.

Hughes⁸ discussed the interactions of health professionals with diverse ethnocultural populations. She showed that health professionals have particular difficulties in transmitting the idea of risk-taking to those who are less literate. This was particularly apparent in providing advice about tobacco control and the regular use of prescribed drugs. Furthermore, Ouellette and Geirson's⁹ research expanded on the meaning of the concept of risk. They showed that the meaning attributed to one's illness influences the decision to follow a prescribed regimen. In a workshop, Pouliot¹⁰ pointed out that people with reading limitations and those using a second language more likely prefer that health professionals use "short" words and speak slowly, regardless of the means of communication. Fauchon offered detailed information¹¹ about preferences regarding health and general information. People prefer information to be presented chronologically with subtitles, audio, captioning, and images to enhance comprehension.

Despite easily available health information, studies show that such information usually does not reach those people with

language barriers or limited literacy.¹² For example, Ellen Balka¹ showed that information from websites, DVD, CD-ROM, and distant communication technology had limited impact for less educated, non-white populations. Finally, attendees who were adult learners, health educators, and professionals criticized the inadequacy of educational resources and approaches to reach cultural minorities. As a result, such population groups tend to be excluded from health promotion initiatives. This jeopardizes the efficacy of health services.

What the literature says: Health literacy and use of service among newcomers in Canada – The roles of culture and language

For many newcomers in Canada, the problem is represented by a lack of access to preventive health care services and difficulties in adapting to a new health culture, particularly for those with limited knowledge of English or French.¹³⁻¹⁷ The ability of immigrants to access health care services in developed countries varies widely. It depends on their immigration status, country of origin, cultural and traditional beliefs, and ability to navigate services.¹⁶⁻²³ Although health insurance is universal in Canada, new immigrants lack access to formal and informal support to help them use preventive services effectively. This lack of access is assumed to be linked to linguistic, religious, and cultural isolation.²⁴⁻²⁸ Language and cultural barriers often mean that ethnic immigrants are not clear about the health care services, including health information, that are available to them. They are also not clear about their benefits. This adversely influences their ability to access the services and information.^{13,29,30}

As Canadian populations are becoming more diverse and people from different cultural and ethnic backgrounds represent a higher proportion of the population, we know little about how socio-cultural barriers to health care affect utilization rates and population health outcomes. Factors such as language and cultural barriers, traditional beliefs and practices, discrimination, and perceptions of shame that might contribute to the problem of access, have not been studied among newcomers in Canada.^{4,28,31-35}

Overall, knowledge of the unique patterns of health status, health care needs,

access to health, and barriers to health service use of immigrant populations is limited in Canada.^{34,36} Chief among these less well understood barriers are levels of basic literacy and health literacy in newcomer communities with diverse ethnocultural backgrounds.^{15,25} As a result, there appears to be a crucial gap in research-based knowledge regarding access to and use of health services from the point-of-view of disadvantaged subpopulations in Canada.

Evidence from the literature shows that upon arriving in Canada, newcomers are generally as healthy as or healthier than Canadian-born individuals.^{31,34} However, their health status may deteriorate in the years following immigration.³⁶ Their overall health picture reflects important health disparities that exist among poor and more vulnerable populations.^{34,36} As a result of language and cultural barriers, as well as a lack of information about and experience with their new health care system,^{5,12,37} the health of newcomers declines over time. This is because of relative underuse of preventive health screening and underdiagnosis and treatment of health problems.^{25,36,38} This deterioration may be lessened if services provided by the health care system became more accessible, and staff more linguistically and culturally sensitive. However, recent immigrants, among other vulnerable populations, generally do not actively navigate the health care system in Canada.^{18,21,35} The most cited reasons for newcomers not seeking health services are:

1. Barriers to access and services use;³¹
2. Lack of information about certain health services available;³⁹
3. Use of herbalists and other alternative health providers for their own and their family members' health issues;^{22,40} and
4. Lack of culturally sensitive or acceptable health services available for ethnic communities.

Addressing the separate or collective impacts of these factors will assist policymakers and health care providers to develop culturally acceptable/responsive health care systems in different communities in Canada to meet the health needs of these populations.

There are also other barriers. Some immigrants express discomfort discussing traditional practices with health care providers¹⁶ or asking for additional infor-

Target Population: First- and Second-generation Japanese Seniors⁴²*Goals:*

- Respond to the needs of medical services and emergency information in their language.
- Offer culturally sensitive education and material about chronic illness, medication, food, fraud, and recreation.
- Reduce social isolation with opportunity to share language and culture, and have better quality of life.

Who collaborates: 43 multilingual staff, 550 volunteers from the cultural community, and 59 long-term care facilities as well as other institutional community partners.

What is done:

- Friendly Visiting Program with social, cultural, educational, and leisure activities, trips and services.
- Provision of health care in their own language with translation of information on emergency services, illnesses, and community services.

How it works:

- Exercise, sing-along, discussion groups, videos presentation, Japanese lunch and family dinners.
- Services of escorting to medical appointments and assessments.
- Geriatric assessments by specialists who understand the Japanese culture.
- Help with translation for medication and treatment.

Signs of success:

- Less miscommunication around medication and treatment.
- Increase in reports of good/excellent health.
- Decrease in falls and flu incidents.

Target Population: African Blacks⁶*Goals:*

- Address the "quiet killer" in the community: diabetes.
- Promote a wide discussion of the disease within the community.
- Teach the community about healthy eating, healthy lifestyle, and stress management.

Who collaborates: Teachers, students, and volunteers among the communities' inhabitants as well as religious ministers.

What is done:

- Implantation of a Diabetes Prevention Program in four Black communities.
- Visiting the community asking people to volunteer for a community advisory committee.

How it works:

- Training volunteers to prepare healthy foods that are culturally appealing.
- Volunteers return to the community and demonstrate food preparation.
- Classes of physical activities with "on the spot" movements, reggae or calypso aerobics, yoga, as well as spiritual drumming and prayer.
- Distribution of "easy-to-read" literature and delivery of verbal information.

Signs of success:

- Dedicated volunteers nurturing partners' awareness of the need to transfer knowledge and skills among them and the communities.
- Volunteers give special attention to the language to deliver culturally sensitive information, mainly to those with reading and writing limitations.
- Partners are critical about the appropriateness of educative interventions regarding cultural symbolism and nuances, as well as people's interpretations.

Figure 1. Working with an ethnocultural minority to promote peoples' health and literacy

mation when they do not understand the health and medical information provided.^{17,25} Hence, in planning intervention approaches aiming to create educational and self-care health materials, it is crucial to be aware of and sensitive to the intended audience's age, gender, ethnicity, and religious and cultural beliefs.²⁰⁻²²

What we need to do*Innovations in National Policies*

Conference attendees expect significant changes to occur in policies that address health literacy and help to develop a broader national vision. Fairbairn⁴¹ suggested that policies go beyond the limits of geography, ethnicity, socio-economic condition, age, and gender. Attendees and presenters suggested an array of topics to include in such policies, such as:

- a) Defining strategies for collaborative work between the health care system and immigrant-serving agencies to promote short-term social integration of newcomers to Canadian culture and society (i.e., welcoming program);
- b) Supporting outreach to ethnocultural partners to establish collaborative

work between the Canadian Public Health Association and the National Literacy and Health Program as well as the Canadian Ethnocultural Council;

- c) Incorporating literacy profiles and language preferences of the health consumer into the identification section of personal medical files;
- d) Formally training health care providers to use plain language within a multicultural perspective; and
- e) Increasing cultural competency education to undergraduate and graduate health programs.

Renewing the Collaborative Practice

The conference report documents a common perception that in Canada there is a need for a more inclusive approach to collaborating with particular cultural communities. Collaboration would include key informants and opinion leaders in the communities. The latter would identify the underlying factors that influence recent immigrants' health literacy levels. This approach will eventually lead to the development of culturally sensitive measures to address health literacy issues and service

use among these communities. It will also assist health institutions to develop culturally competent materials to be used for in-service training of future physicians, nurses, and other health care professionals about cultural diversity, equality, and proper communication skills. For examples of collaborative work with communities, see Figure 1, which describes Robertson's⁴² and Rossi's⁶ practice experiences with ethnocultural communities.

To achieve the goal of community collaboration, Rose and Moody⁴³ advocated that literacy and health educators should work together in sharing knowledge and skills to deliver health programs to a multicultural population. This would be done in partnership with trusted institutions and community leaders, as illustrated in Rossi's speech.⁶ Jointly with the local communities, they can explore the existence of popular words used to speak about people's view of health and medical-related procedures and personal practices.⁴⁴ In Parisot and Berthiaume's presentation,⁴⁵ such popular language was discussed as being particularly helpful to developing education materials, sensitive to language and culture, for those with visual and other com-

munication impairments (e.g., audio and other computer-assisted materials). These resources will respond to the needs of people from cultural and linguistic minorities. They will help them to more precisely decode and use health information. The follow-up of a medical consultation seems to be also a critical situation, especially to get and apply information about prescribed drugs. An adult learner suggested that health agencies should have staff in touch with people from newcomer communities after their initial medical appointment. Altogether these measures aim to minimize misunderstanding of health information/medical instructions to ultimately provide safe and culturally competent health care within a congruent multicultural perspective.

What we need to know: Topics for new studies

Advancing Canadian expertise on issues of health literacy, specifically for our multicultural society, may reinforce Canada's international leadership in the field of health promotion. Democratic discussion, tolerance of criticism, participation of community learners, and involvement of policy-makers are the important features of the health literacy movement in Canada. Frankish⁴⁶ emphasized that the growing body of evidence regarding the importance of health literacy may demand the creation of a national information centre to support new studies, initiatives, and policies. However, many presenters highlighted the need for additional information to respond to the lack of knowledge on specific issues, such as cultural and language barriers to access and service use. The following ideas summarize the attendees' comments and suggestions for new studies in the health literacy area. They consider issues of gender, culture, and language of subpopulations in Canada:

1. Study men's ethnocultural perspective of health literacy, their cultural health behaviours including their understanding of common male diseases, their perceived information needs, and learning practices.
2. Propose and evaluate a new vocabulary to transmit ideas about medical technology to people who are unfamiliar with the language of a technological world.
3. Explore family cultural practices associated with male and female behaviours regarding food, medicines, seeking help, and promotion of individual and family well-being.
4. Analyze the effect of poverty and low literacy on the health conditions and practices within cultural and linguistic minorities.
5. Document how people from ethnocultural groups use the Internet to gain health information.

DISCUSSION AND CONCLUSION

Practitioners, policy-makers, and researchers need to join efforts to conceive innovative actions to alleviate or eradicate the deteriorating impacts over the health of those Canadians who are still unable to perform basic reading tasks required to function well in society.¹³⁻¹⁵ The conceptual understanding of health literacy seems to be more complex for immigrants because literacy in Canada presumes knowledge of at least one of the two official languages. More foreign-born minorities and newcomers do have difficulties reading English or French, in comparison to Canadian-born individuals.^{17,19-21} They might be highly educated in their home countries, but because of difficulty in communicating in one of the official languages, they are sometimes considered low literate or illiterate. Thus, they also face a lack of access to proper health care and appropriate jobs and live in inner cities and low-income neighbourhoods.^{5,12,15,17} For example, a recent German immigrant with a university degree, but limited knowledge of English or French, would score low on the Canadian Literacy Scale. However, the same individual would probably have scored high on Germany's Literacy test.² Similarly, a disproportionate number of minorities and newcomers are estimated to have health literacy problems. This limits their ability to take full advantage of health care services and programs. Furthermore, the protection and improvement of their own and their family members' health status may be compromised.^{24,47} Barriers to newcomers' health literacy are low education, language, culture, beliefs, and institutional factors. Solutions proposed to overcome these barriers range from cultural competence among health professionals

and cultural sensitivity of health care systems and more utilization of bicultural health providers.

Evidence from the literature and the state of knowledge as presented at the conference indicate that linguistic and cultural barriers, community and institutional discrimination, income disparity, and low health literacy level are interconnected. Together they influence minorities and immigrants' access to health services and eventually their health outcomes.^{2,28,35,48} Outcomes related to individual, family, and collective health should be the focus of a future collaborative agenda of policy-makers and literacy and health care professionals to develop a culturally acceptable and responsive health care system in Canada.

The challenges are numerous but there are huge opportunities to work, create, innovate, and learn together about health literacy, languages, and cultures. Efforts to improve health literacy in Canada have a double positive effect. First, they will help people to live more satisfactorily using health information to improve their understanding about their bodies, social behaviours, and potentialities. Second, they will assist health educators to recognize their own limitations and challenges in offering simple, effective solutions to the complexity of educating people about health, well-being, and quality of life.

In sum, the complexity of health literacy as an ethnocultural phenomenon is undeniable. The exploration should be pursued through the avenues of languages, culture, gender, age, economic status, or general literacy, and also through the synergies among all the determinants of health and health literacy.

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