Communicating Health Information: The Community Engagement Model for Video Production

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Abstract: The Community Engagement Model was developed as a tool for the production of health communication videos for broadcast on local television stations. The model, a hybrid of participatory video design and social marketing techniques, uses iterative design principles for both production and evaluation. This article reports on the use of this model for the design and production of a series of videos aimed at promoting awareness of the BC NurseLine (a 24-hour telephone health service) among Farsi speakers in the Greater Vancouver area. Statistical analysis of project-related data suggests that the use of an extensive, culturally engaged process to produce and evaluate the videos was integral to its success. The steps taken in this campaign are described to show how the Community Engagement Model can be used to produce effective, culturally sensitive, participatory media targeted at specific communities.

Keywords : Video production; Participatory video; Health communication; Multicultural; Community

Résumé: Le « Community Engagement Model » (modèle d'engagement communautaire) a été développé afin de produire des courtes vidéos de communication pour la santé, diffusées sur des postes de télévision locales. Le modèle, un hybride entre les techniques de vidéo participative et de marketing social, se sert

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des principes de design itératif pour la production ainsi que l'évaluation. Le présent document décrit l'utilisation de ce modèle dans la conception et la production d'une série de vidéos ayant pour but de mieux faire connaître le BC NurseLine (service d'info-santé 24-h de la Colombie Britannique) auprès de la communauté farsi dans la région métropolitaine de Vancouver. Une analyse statistique suggère que l'intégration d'un processus extensif et engagé au niveau culturel, tant dans la production que dans l'évaluation de ces vidéos, a été un facteur clé dans leur succès. Le processus suivi lors de cette campagne est décrit pour montrer comment le modèle d'engagement communautaire puisse être employé pour produire des médias participatifs, à la fois efficaces et adaptés aux spécificités culturelles, ciblant des communautés spécifiques.

Mots clés : Production visuelle; Vidéo de participatory; Communication de santé; Multiculturel; La communauté

Introduction

Canada is home to over 30 million people, and within this population, in 2001 one in six Canadians identified themselves as having a mother tongue that is neither English nor French (Statistics Canada, 2004). Some 200,000 immigrants settle in Canada each year (Canadian Heritage, 2004), and over 100 mother-tongue languages are spoken in Canada (Statistics Canada, 2002). In such a diverse country, health promotion strategies need to take innovative and inclusive approaches that reflect the distinctiveness of each community.

The provision of these services is crucial in a country where health care is seen as a central right of citizenship (Romanow, 2002). Recent advances in information technologies have resulted in innovative ways to bring health information to specific communities. One such initiative in British Columbia is the BC HealthGuide (BCHG) system, whose mandate is to provide a high-quality health care program where and when people need it. The program emphasizes self-care and provides information on how to prevent and manage illnesses, home treatment, and advice on when to seek help from a doctor or other professional. This system offers 24-hour-a-day access to a nurse via telephone (BC NurseLine), a printed BC HealthGuide Handbook, and the BC HealthFiles online health information system. A major emphasis of the BCHG system is the concept of accessibility, particularly with respect to providing services that people can access in their language of choice. To this end, the BC NurseLine offers a real-time translation service to enable people to talk to a nurse in over 100 different languages at no cost to the user.

Work undertaken to evaluate the BCHG program has tried to address the extent to which the ethnically and culturally diverse populations in British Columbia are using these services. Although the BC NurseLine advertises its translation services, data suggests that these services have been sparsely utilized. For example, from May 2003 to May 2004, there were only 12 requests for Farsi translation services (Ministry of Health, 2004). If a health service such as the BC NurseLine is to meet the goals of universal and equitable service delivery, such services must be accessible to a wide range of Canadians.

The underutilization of the BCHG's translation services in many ways

reflects the challenges inherent in promoting health services in a multicultural, multilingual society. Research on outreach programs for minority populations in the United States has found that reaching target populations is often difficult and that cultural factors play a significant role in mediating awareness of and access to health services (Kiger, 2003). Canadian research by Ahmad et al. has found that some immigrant populations do not perceive current health promotion strategies to be very effective, in part due to their inability to either access or comprehend many health promotion messages (Ahmad, Shik, Vanza, Cheung, George, & Stewart, 2004). These results underscore the importance of ensuring that health promotion activities are generated in a manner that ensures they are not only in the correct language, but are also culturally appropriate for the intended audience.

Having learned that utilization of the BC NurseLine service was lower than desired among certain populations, we undertook a collaborative research and intervention process aimed at increasing the utilization of the BC NurseLine. Our goal was to determine whether or not culturally sensitive videos could increase use of the BC NurseLine among the Farsi-speaking population of the Greater Vancouver area or GVA[1] (which includes Burnaby, Coquitlam, North Vancouver, Surrey, Vancouver, and West Vancouver). The 2001 census profile for BC estimated that there are over 24,000 Farsi-speaking people in British Columbia (BC Stats, 2003), many of whom live in the GVA.

This paper provides an overview of the media-based initiative that was undertaken to increase access to this health care service. For this process, we developed the Community Engagement Model, a hybrid model of video production that combines participatory and iterative design and social marketing. As we suggest, this model involves community members in the design of culturally specific health communication videos, which may actually increase the use of this service. In contrast with typical advertising and marketing approaches, our project drew extensively on the Farsi-speaking community to generate insights that informed the process before and during the video production phase, as well as the evaluation. Our evaluation of our production suggests the potential effectiveness of the Community Engagement Model and its implications for future iterations in media design.

In the next section of the paper, we provide an overview of the iterative video production design cycle, placing special emphasis on those aspects of the production cycle (pre-production, production, distribution, evaluation) that make this project unique. We describe our hybrid approach, which builds on the effectiveness of advertising and marketing and at the same time draws on the cultural anchoring and political and ethical commitments more typical of participatory approaches. The results of evaluation work provide us with some evidence, both qualitative and statistical, that the Community Engagement Model for video production developed here may be used in other contexts. However, as we argue, our approach also underscores the need to incorporate strategies from audience research in the iterative production process to successfully communicate to particular cultural and linguistic populations, such as Vancouver's Farsi-speaking community. As research indicates, communication to multicultural audiences will be ineffective if these strategies fail to acknowledge cultural difference[2] or, worse, when a campaign developed for one specific community is sim-

ply replicated for another.[3] Each community embodies unique and unifying characteristics. As such, promotional strategies—particularly those campaigns relating to something as culturally specific as health—need to acknowledge these differences.

Cultural competency, social marketing, and participatory video production

While there is some literature about cross-cultural health communication in the form of in-person, doctor-to-patient, and clinical exchanges, references to video- or television-based cross-cultural communication are sparse, especially in relation to health promotion. Much of the literature about health communication relates to international development settings, HIV/AIDS prevention, and other "high risk" health issues. In order to address the many issues that arise in the design of a culturally specific health promotion intervention, we draw on literature from three areas: cultural competency in health care promotion, social marketing, and participatory video design. Each of these is addressed briefly below.

In *Health Communication: A Multicultural Perspective,* Kar and Alcalay with Alex (2001a) define multicultural community as "a community where people from distinctly different cultures live, come into contact, and interact with one another to form a new way of life, both dynamic and different from each of its parts or cultures" (p. ix). As such, multiculturalism refers to more than just language, and cross-cultural communication should acknowledge what Kar et al. call "cultural competency." Cultural competency requires a deeper intercultural understanding than simply language competency, because words and phrases may communicate differently across cultural norms (Kar & Alcalay with Alex, 2001b). For example, Valdes and Seonae (1995) suggest that programs aimed at American Hispanics may need to include emotionally driven campaigns, use direct and to-the-point messages, engage "average-looking" actors, and tell a simple story. While some of these approaches may also appeal to other cultures, other approaches may not. As Kar et al. state, "There is no standard model of effective health promotion and disease prevention intervention, and even if there was one, it is not likely to be effective among all ethnic groups" (2001c, p. 339). Therefore, effective health-related promotion needs to produce messages that reflect not just an understanding of the language of a specific culture. These campaigns need to reflect a deeper cultural competency that is sensitive to the uniqueness of the culture.

Kar et al. (2001b) describe three levels of cultural competency: cultural understanding, cultural acceptance, and, most importantly, reciprocal relationship. Cultural understanding refers to a working knowledge of a culture. Cultural acceptance needs to embody characteristics such as sensitivity, respect, and accommodation of a culture. At the highest level, reciprocal relationships require trust through sustained communication and relationship between cultural groups. Kar et al. (2001b) explain that the higher the level of cultural competency, the more effective the health communication message. Trust has also been identified as a key element in other forms of communication strategies (Fischhoff & Downs, 1997; Slovic, 1997, 2000), and it was central to our messaging throughout the design and production of our videos.

A social marketing perspective sees the promotion of positive behavioural change as similar to the promotion of a product or service. Just as commercial

marketers attempt to influence consumers to purchase a specific product or service, social marketers hope to encourage individuals to adopt certain behaviours that are beneficial to themselves or society. By understanding the needs and attitudes of the target group, social marketers can develop programs to influence the voluntary behaviour of individuals (Andreasen, 1994, 1997; Rothschild, 1997). Social marketing has been readily adopted in several areas of health promotion, particularly anti-smoking campaigns and AIDS prevention campaigns in developing countries (Lefebvre & Flora, 1988; McKee, 1994). There have also been social marketing efforts that have focused on reaching culturally and ethnically distinct populations *within* North America. For example, Stanford University's Three Community Study found that media could influence behavioural change if campaigns addressed the everyday interpersonal activities of community groups (Solomon, 1981). There has also been recognition of heterogeneity in the lifestyles, behaviours, and values that underlie racial and ethnic distinctions (Anderson & Jackson, 1987; Flora, Schooler, & Pierson, 1997).

More recent work in the field of social marketing has examined the role of segmentation in dealing with culturally and ethnically diverse members of the population. Flora et al. (1997) identify a number of segmentation variables to consider when working with minority groups, including immigration status, family structure, degree of assimilation to the majority culture, and health beliefs and practices. Language is also an important factor to consider, as mere translation may lead to interventions that are "cultural hybrids" but fall short of being culturally sensitive or relevant (Flora et al., 1997).

Social marketers suggest that cultural sensitivity can be achieved by integrating members from the target community into the program design. Icard, Bourjolly, & Siddiqui (2003), for example, used a social marketing approach to increase African-American access to health promotion programs. The researchers relied on focus groups conducted by local African-American community members to develop health promotion materials and appropriate distribution channels. It is important to underscore that understanding the subtleties and complexities of a specific culture is impossible for outsiders to do in a short period of time; therefore, for any degree of cultural competency to occur, direct participation by community members is essential. Social marketing within a multicultural context suggests cultural competency and effective communication are enhanced through community participation in the development of health promotion interventions aimed at specific community groups.

Participatory approaches emphasize creating inclusive and empowering processes for a group or community. White and Patel (1994) describe participatory communication as a "people centered" approach to providing relevant information (or skills) for participants to engage their knowledge and experiences in action-solutions to their problems (p. 363). In line with the renowned Freire's (1973) vision of participatory pedagogy, both Pretty (1998) and Allen (2001) assert that beneficial participatory projects empower people by building skills, interests, and capacities that continue even after the end of the project. Satheesh (1999) takes a media democracy perspective and points out that "instead of literacy being pushed down the throats of . . . women and men, new media expressions can be found" (p. 6).

The concept of participation surfaced in media production in the 1970s, when development activist-educators became increasingly dissatisfied with the condescending and disenfranchising modernist approaches of the time (White, 1994). During this time, Freire (1973) coined the term "conscientization,"[4] which entails the raising of consciousness of one's environment and situation, one's abilities and identity, and "one's alternative for freedom of action" (White, 1994, p. 24). Freire argued that empowerment is achieved through conscientization.

In the context of video-making, the idea of the participatory process also grew from dissatisfaction with mass media's approach to representing social problems, as well as with corporate-run, top-down, unidirectional, and undemocratic mass-media channels (Crocker, 2003; Varghese, 2003). In the late 60s, the National Film Board of Canada (NFB) launched the *Challenge for Change* project, which aimed to reinvent video production as a tool for social change and empowerment in small, developing communities in Canada. Participatory video practitioners and theorists generally cite the film *Challenge for Change* (Reid, 1968) as the first experiment in participatory video technique (Crocker, 2003; Odutola, 2003; White, 2003). The *Challenge for Change* project on Fogo Island, Newfoundland, in particular, sought to produce films that were not *about* people but *by* people. The "Fogo Process"[5] as it came to be known, meant that the process of filmmaking was as valuable (if not more so) as the film itself (Crocker, 2003). The Fogo Process was quickly adapted in international development work, and several essential elements of participatory video production have been identified.[6] For decades, most participatory video practice and literature was based on work in "developing" countries. Other notable examples of using participatory methods in the creation of video production models are the Kheda production model (Agrawal, 1994), the BBC's Community Programs Unit's Open Space Program, and the Participatory Broadcasting Model (Varghese, 2003). These models all serve as a foundation for the development of the participatory aspect of our production model.

While the emphasis of such work has remained the empowerment of those who participate in the production of videos, Kar et al. (2001c) suggest that media use can significantly enhance and complement health-related programs and can lead to empowerment through uptake of targeted messages aimed at change. Kar et al. (2001c) suggest that a sustainable program that empowers and effectively communicates must incorporate partnerships with target communities and must include a solid evaluation of its effectiveness. As Richardson writes, "There is a need for greater information about outcomes, and what people feel about them, in order to understand what participation means in practice" (Richardson, 1983, p. 125).

It is for these reasons that in developing the Community Engagement Model, we turned to audience research techniques that try to measure the success of a campaign.

Creating the Community Engagement Model

In many ways the objectives of participatory video production and social marketing are in opposition. Participatory video production strives to empower participants, often at the cost of the product, whereas social marketing is trying to sell

behaviour. It is our contention that aspects of both of these processes may provide a model for video production that can be used to communicate health messages to a specific community.

A truly participatory video project would suggest that the quality of the video is irrelevant. We did not train community participants in the technical aspects of production. Instead we engaged the community in developing the cultural competency of our producer-facilitators and ultimately of the communication product. In this shift in emphasis, the Community Engagement Model differs from a conventional participatory approach that stresses the process and de-emphasizes the product. Our model maintains a focus on the outcome or product of the process in relation to its intended audience. In part, this was necessitated by the context in which we were working.

The BC NurseLine video project was charged with the task of communicating a provincial health service to a culturally specific community through a predefined set of professional deliverables (broadcast television constraints). The objective to produce videos that effectively communicate health messages through established broadcast distribution channels necessitated a product containing specific information, delivered at an acceptable production quality. Yet the element of community leadership and engagement that characterized this project also meant that it differed significantly from both traditional social marketing and video production techniques.

The project was undertaken in conjunction with the BC Ministry of Health and the ACTION for Health research project, funded by the Social Sciences and Humanities Research Council of Canada (SSHRC). The Media Analysis Lab in the School of Communication at Simon Fraser University undertook the actual video production work. The Media Analysis Lab has a video production facility that is used for both teaching and research, specializing in the production and analysis of educational media. The Media Analysis Lab's production training program allows process-based production methods, audience and media analysis techniques, as well as social implications to be included in the teaching of contemporary television and film production practices. The BCHG video project was undertaken by a group of faculty and program graduates because it fit within the mandate of the lab to create media in the areas of education, advocacy, and community development. It is in this environment that the Community Engagement Model for video production was developed.

Although the intention of this project was to increase the use of the BC NurseLine within the Farsi-speaking community, we also hoped to develop more general and transferable design guidelines for producing media that promotes health services for culturally specific groups. The design guidelines we developed employed an iterative process intended to inform future health service promotions targeted to cultural minority groups beyond the one specified in this project.

Iterative design cycle[7]

Iterative design processes demand a reflection on each stage's effect on the entire design at each stage of the production cycle. While a common part of product development in industrial design, iterative design is also seen in social marketing literature (McKee, 1994) and includes phases of analysis; planning; development,

testing, refining; implementation; assessing in-market effectiveness; and feedback to the first stage. The key to the iterative design cycle is that assessment and analysis is undertaken in order to give feedback to the process to improve the design.

In a standard video production cycle, the basic stages of iteration can be divided into the following four quadrants (Murphy, 2003): pre-production, production, post-production, and review phases. In the iterative sequence we developed, there are at least three cycles of iteration before the video is brought to completion. Given the mandate of this particular production project, all aspects of the production design cycle had to be modified to emphasize the cultural competency and communication effect of the product on the target audience of Farsi-speaking residents of the GVA.

Pre-production is the planning and writing stage of production. It usually includes the creation of the script or storyboard from which the production is based. An understanding of the context and intention of the project is important; consequently, research and a significant understanding of the audience for whom the product is intended are also necessary.

The culturally sensitive nature of this project required quite an extensive pre-production stage that included an environmental scan to determine the demographics of the Farsi-speaking community as well as an analysis of geographic concentrations such as location and distribution of the community. This also included an assessment of the cultural composition of the community, including family size, living conditions, and socioeconomic status. Pre-production focus groups with community members were held to gain insight about issues such as who they trusted for medical information and where they get their medical information. These focus groups also provided contacts for community members who were engaged throughout the production as actors, writers, and consultants.

During the pre-production stage, an expert advisory panel consisting of members of the community who are professionals from related fields (health, television production) was created to advise on culturally specific questions as they arose. Furthermore, workshops were staged that involved community members in script writing and provided cultural grounding for script development. Final consultation with community members and the advisory panel regarding script ideas was done to review scripts and storyboards for cultural accuracy and credibility.

Pre-production focus groups not only gave invaluable insights into the Farsi-speaking community, but also provided contacts to community members who were involved throughout the process. The pre-production focus groups also indicated that the Farsi-speaking community in the GVA identifies the most effective way to learn about the BCHG services was through "word of mouth," a method identified as effective by Wagner and Hibbard (2001). The Farsi-speaking community rates the advantages and disadvantages of engaging in health-related activity based on the experience of others and from the advice received from highly trusted, well-educated individuals such as doctors who are also Farsi-speaking. Given the importance of trust in communication strategies that was revealed in our research on this particular community, the identification of trusted individuals for health information provided the basis for the script writing of the video productions.

It was decided that the best way to provide "word of mouth" from community members' experience was through the creation of vignettes or short dramas that recreate specific experiences. The scenarios for the vignettes were developed with the intention of presenting community members engaged in resolving health-related problems using the BC NurseLine. Development of the scripts for numerous vignettes was done in consultation with the expert advisory panel, and four scenarios were chosen based on their appropriateness to the use of the BC NurseLine. To include the representation of trusted medical professionals and to provide an evaluative comparison with the vignettes, a documentary script was also developed. The documentary script was designed to provide health information (specifically about the BC NurseLine) directly from a Farsi-speaking doctor in an interview. Other community members and medical professionals were interviewed either in Farsi or with Farsi translation.

Using producer-facilitators who were trained in traditional television production practices throughout the process to do most of the technically challenging tasks (operating cameras and lights, managing continuity, editing, graphics, et cetera) provided an integration of these practices with the participatory aspects of the production. It was therefore necessary for these producer-facilitators to be sensitive to participatory video design and allow community members to feel comfortable contributing to the process.

The actual production stage of this process required the recruitment of community members who in effect played themselves in vignettes that were developed in the pre-production stage. The actors and locations were all situated within the target community to give a realistic look and to make implicit cultural references that added to the reception of the video product. The recruitment of community members to participate in the production consisted of contacting relatives and acquaintances of our contacts in the community, which branched out as the project progressed. The community members found this stage of participatory process engaging and empowering because they were involved in a television production and because they were able to make comments and suggestions about details in the production aimed at making it more accurate or credible. For example, they suggested the inclusion of culturally specific household items in the background of a shot and changes to the script language that would be more appropriate to the context.

The videos were produced in Farsi. They included one 13-minute documentary, which provided direct health information and included interviews with health professionals and members of the community explaining health issues and the use of the BC HealthGuide and NurseLine, and four short vignettes (under two minutes long), which were dramatizations targeted toward specific age groups identified in the pre-production stage as being the groups most likely to require the NurseLine. The short vignette videos were based on health issues common to the target population. All videos can be viewed online at http://www.bchealthguide.org/multicultural.stm.

The four vignette-based videos addressed abdominal pain (targeted at parents with young children); flu prevention (targeted at the elderly); bicycling injuries (targeted at parents of teenagers); and issues related to nursing of infants (targeted at new mothers) (see Images 1 and 2).


Images 1 & 2: Flu prevention—Elderly figure; Bike injury—Parents of teenagers

During the postproduction stage it was essential to have constant consultation from a Farsi-speaking health expert. This was necessary to ensure that both the language and health information were accurate, consistent, and appropriate throughout the editing and titling process. Draft edits of the productions were reviewed and commented on by community members before final cuts were made. Finally, all sponsors of the project reviewed the videos. Once the final edits were made, the videos were shown during Farsi programming on three local television stations (City TV, Channel 4, and Shaw Multicultural channel) between October and December 2004. Each of the short videos was shown 12 times, for a total of 48 viewings, and the documentary was shown 6 times.

The final stage of this iteration was to evaluate and review all aspects of the process. This included discussions with participants and producer-facilitators to evaluate and reflect on the use of the Community Engagement Model, as well as an extensive evaluation of the influence of videos on their intended audience.

Evaluation method[8]

The videos were evaluated using telephone surveys, translation-service usage data, and focus groups. These methods respectively allowed us to evaluate the viewership of the videos, assess the impact the videos had on increasing use of the BC NurseLine by Farsi speakers, and develop insights about the level of cultural competency the videos attained.

Telephone survey

The telephone survey was developed based on information gathered from the preproduction focus groups as well as a panel discussion held in the Iranian community involving scientists and health professionals. The survey was pilot-tested with a group of 8 Iranian families and was refined using input from these sessions. The final survey was administered over the phone in Farsi. A sample size of 800 people was randomly selected from Iranian-language phone books in the GVA. All Farsi-speaking adults (age 19 or older) who were residents of the GVA during the airing period of the video were eligible for the survey.

The development of the evaluation questions drew on Ajzen and Fishbein's (1980) theory of reasoned action. Factors such as intention, subjective knowledge, accessibility of service, understandability, and cultural sensitivity were incorporated into the questions. Participants in the telephone survey were asked

if they had seen the BCHG videos and, if so, which ones. They were also asked general demographic questions, how they access health information, and specific questions regarding the BCHG services and their use. All participants in the survey were asked if they would like to be involved in one of the postintervention focus group sessions planned for spring 2005.

Of the 800 people randomly selected for the telephone interview, 590 agreed to participate (response rate 74%). The majority of these respondents were female, between the ages of 35 and 64, had at least an undergraduate or college education, and were in good or better health. The average number of hours of television watched per week by the participants was 12 (range 0-100 hours), with women watching slightly more TV (13.2 hours per week) than men (11.2 hours). Overall, 36% of respondents (n = 590) had seen either the BCHG videos or the documentary. However, only 67% of the respondents actually watched television programming in Farsi, meaning that just over half (54%) of those who watched Farsi TV had seen the Farsi-language BCHG videos. Most importantly, the telephone survey provided us with participants for our focus groups.

Focus groups

Focus groups were held after airing of the videos in order to gain insights about viewer reactions to a range of issues such as production values, format, cultural appropriateness, impact, and educational value. It should be noted that the preproduction focus groups, which were done prior to the initial video script and scenario development, differed from the postproduction or evaluation focus groups in that they were asked more general questions about the community, culture, and practices. Findings from the telephone survey were used to develop the core discussion questions for seven evaluation focus group sessions. The people who agreed to participate in the focus groups were divided into seven groups with the intention of isolating factors that differed between the documentary video and the vignettes.

Between 10 and 15 participants were randomly selected to form the first three focus groups, which were considered the "control groups." Group A viewed both the documentary and at least one vignette, Group B viewed at least one vignette but not the documentary, and Group C viewed the documentary but no vignettes. A further 50 participants who had not seen any of the videos were randomly selected to form Group D, or the "experimental group." Group D was randomly divided into four subgroups:

D1 – All videos are watched and discussed.
D2 – Only the documentary is watched and discussed.
D3 – Only the short vignettes are watched and discussed.
D4 – Discussion without watching any of the videos.

In total, 88 individuals (50 female; 38 male) who had participated in the telephone survey agreed to take part in the 7 focus groups between March 5, 2005, and April 10, 2005. The following is a summary of the key findings from these focus groups.

Almost all participants indicated that watching the videos had improved their knowledge of the BC NurseLine program. Many of the participants (68%)

reported that watching the video(s) was the first time they had heard anything about the program. A number of participants who saw the videos indicated that they were previously unaware that the BC NurseLine program offered a translation service in Farsi. Respondents almost unanimously reported that watching the videos had encouraged them to utilize the BC NurseLine, and they intended to promote the service to others (mainly family and friends). Some misunderstandings about the BCHG services were indicated, such as how much it costs (it is free) and whether or not there was a difference between the NurseLine and emergency services (9-1-1) (there is).

The majority of respondents said that they had found the videos to be informative and that they learned something about the NurseLine and other health information. A few comments suggested that information about how to access the NurseLine was insufficient and needed to be more detailed. In general the documentary was found to be more informative than the vignettes, but a number of people stated that the documentary was too long. It was suggested that the length of the documentary would drive viewers to change the channel before it was finished. There was also a suggestion to include information for youth, a demographic left out of our documentary and vignettes.

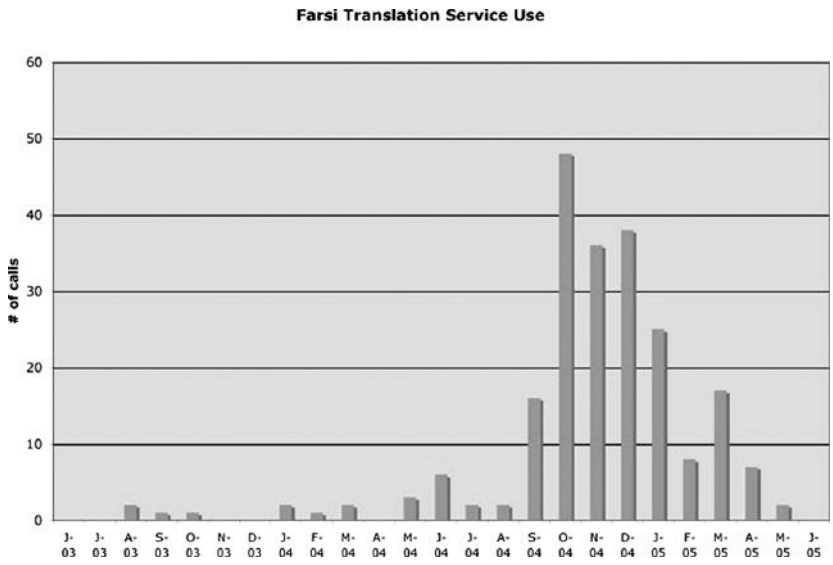
Participants almost universally indicated that they perceive health care professionals, particularly medical doctors, to be the most credible messengers of health information. This was emphasized even more if the doctors were well known in the community. In fact, title and prestige was the most important factor identified by participants in determining the credibility of a health messenger. It was suggested that the appearance and context of the health messenger was important to their credibility as well. Comments indicated that the doctor in the documentary should be wearing a white coat and be situated in a clinic or hospital. The language used by the doctor in the documentary should be more straightforward and without technical terms or medical jargon to be more accepted by a wider audience.

Discussions arose in a number of the focus groups relating to the fact that Iranians traditionally prefer to receive medical help and advice from a doctor face-to-face and will generally have difficulty accepting advice from a nurse over the phone. The vignettes were generally considered culturally appropriate due to their similarities with Iranian traditions and values. However, the use of the highly trained health care professionals in the documentary gave it a great deal of credibility.

Translation–service use data

The most direct indication that utilization of the BC NurseLine increased in our target population after our video intervention is the number of callers to the NurseLine who used the translation service in Farsi. The statistics for callers to the CanTalk translation service (who conduct NurseLine call translations) was provided by the Ministry of Health. The number of callers to the BC NurseLine who used the translation service between September 2003 and June 2004 was 16. The number of callers to the BC NurseLine requesting Farsi translation increased significantly (see Figure 1) in the following year, with a distinct increase around the time of the airing of the videos (between October and December 2004), as well as a moderate increase in September 2004, just after the videos had been produced.

Figure 1



Although there was an awareness of the BC NurseLine among members of this community prior to the airing of the videos, calls to the NurseLine requesting Farsi translation were very few. The number of calls jumped in volume significantly around the time the videos were aired, which suggests that culturally appropriate videos can be used to get health messages out to culturally specific communities. Additionally, there was an increase in the use of the Farsi translation service just prior to the videos being aired (September 2004). This change may point to the importance of the participatory video production process itself; the Farsi community members who helped to create the videos may have spread word of the service to friends and family. This interpersonal communication function illustrates the importance of both process and product in raising awareness of health issues within the community. It should also be noted that the calls to the NurseLine declined over time after the original airing (October to December 2004), which suggests that this type of intervention does not encourage long-term changes in behaviour. For this a more sustained intervention might be warranted.

Final reflections

Our experience with this project suggests that the Community Engagement Model for video production, which involves the participation of target-population members in all aspects of the production, focuses on the experience and processes, and also considers the outcomes of the videos, can be an appropriate means for producing effective health promotion information for specific communities. Furthermore, the methods of evaluation suggest the usefulness of creating measurable outcomes for this hybrid approach of video production as a health promotion intervention.

Although the airing of these culturally specific videos was effective with our target population, there were indications made during focus groups that Farsi-language print media would also be an appropriate place to target health promotion messages. And here, it is important to note that iterative design processes may point the way to other options. A closer examination of media use patterns of the target audience prior to the production of the health promotion message would have been helpful. This might have suggested that a multiple-media approach would have been more effective (i.e., print media, television, and possibly Internet).

We had hoped to determine which format of video (vignette or documentary) was most successful in encouraging use of the NurseLine, but we were ultimately unable to evaluate this. The production of videos could have incorporated the evaluation method more in its design, because the comparison between the short vignettes (less than two minutes) and the longer documentary (13 minutes) is disproportionate given the difference in format. If there had been more consistency in format between the dramatized vignettes and the documentary, the evaluation could have been able to identify effective communication strategies more specifically through direct comparison. The disparity between formats in the videos made it difficult to draw conclusions about the comparison of direct presentation of information (medical professionals in the documentary) and the indirect presentation of information ("word of mouth" from community members in the vignettes), as the focus-group selection was designed to do. However, the focus groups were useful in identifying which elements of all videos resonated with the target community. Although we were unable to determine whether indirect messaging (vignettes) or direct messaging (documentary) was most effective in reaching our target audience, we have learned that the Community Engagement Model, applied to the production of health promotion media, can be an effective model for targeting communication messages to specific communities.

Most importantly, our focus groups and follow-up research indicated the importance of enlisting and instilling trust in the viewer as key to creating effective health communication. Determining specifically who and what situations the Farsi-speaking community trusts was a crucial factor to the success of the video productions and, as Kar et al. (2001b) suggest, this trust can be developed through continued reciprocal communication with the community.

In conclusion, health-related promotions in Canada need heightened sensitivity when communicating with a diverse population. The design of effective communication media is a complex and involved process that is made particularly challenging when communication needs occur across cultures. The BC NurseLine video project, from start to finish, gave us an opportunity to experiment with participatory design strategies and video production practices, while maintaining an awareness of cultural sensitivity, to produce a high-quality product. Throughout this project, members of the Farsi-speaking community provided input and made suggestions that were implemented and evident in the final product. The hybrid approach used in this project directed efforts toward producing effective materials to communicate health services information to a larger Farsi-speaking community in the GVA. Instead of focusing on the empowerment of just

those people involved in the production, our aim was to support empowerment (about health) within the broader population that we hoped would see the videos and act (by using the BC NurseLine) on the basis of the targeted message.

Such an approach is particularly relevant in the context of health-related promotion in Canada, where universally accessible health care is seen as a right of citizens. Yet, faced with a situation where significant numbers of Canadians may not speak English as a first language, we must contend with how best to deliver health care information in ways that are linguistically and culturally appropriate and effective. As in the case of the Farsi population of the GVA, this means more than translating information from the dominant language and culture: the values of the target community must be incorporated into the process and convincingly communicated in the visual imagery and the text.

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Notes

1. This population was chosen as the focal point of our intervention in part because of interest within the Farsi-speaking community, as well as the availability of labour appropriate for this task.
2. See Kar & Alcalay with Alex's *Health Communication: A Multicultural Perspective* (2001a) and the continuum of responses to cultural difference diagram/table in the appendix.
3. See critiques of health communication models designed for a gay White community applied to American Black and Hispanic populations (Bayer, 1994; Patton, 1990, cited in Myrick, 1998).
4. Paolo Freire (1973) also coined the critical term "assistentialism," which refers to projects and programs that are more focused on addressing symptoms rather than causes; as such, the community becomes a recipient of aid rather than a participant in aid.
5. Developed by scholar Donald Snowden of Memorial University and filmmaker Colin Low.
6. These include productions that actively engage participation and serve as a "catalyst for interaction and participation" (Shaw & Robertson, 1997, p. 12); foster individual and group development; overcome barriers of literacy; represent a tool for social transformation; build community; raise critical awareness and consciousness; democratize media; increase self-advocacy and representation; develop capacity, skills, and self-reliance; allow participants to see themselves reflected in a mass medium; encourage knowledge-sharing; liberate; and empower. See Communication for Change, 2003; Crocker, 2003; Dudley, 2003; Moore, 1986; Okahashi, 2000, Satheesh, 1999; Shaw & Robertson, 1997; White, 1994, 2003; and White & Patel, 1994 for elaboration of the elements of participatory video production.
7. The authors unanimously agree that this *Canadian Journal of Communication* article (submitted September 2006) contains the original text describing this project. Other publications of this project appear in the *Journal of Applied Research on Learning* (Poureslami, Murphy, Rootman, Nicol, & Balka, 2007b) and *Medscape General Medicine* (Poureslami, Murphy, Nicol, Rootman, & Balka, 2007a).
8. See note 7.

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