

Changing immigrants' attitudes towards intentions to use the BC HealthGuide Program: Culturally specific video messaging for health promotion

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Abstract: Little is known about ethnocultural communities' perceptions of the BC HealthGuide's services. This study investigated perceptions of the Iranian community of the Greater Vancouver Area (GVA) about these services, and explored a model for introducing the services to other ethnic communities in British Columbia. Eight hundred individuals participated in a telephone survey followed by nine focus group sessions. There were low awareness and utilization rates at the beginning of the study. Nonetheless, attitudes, perceptions and utilization rates improved substantially following the screening of culturally appropriate promotional videos. Watching the videos has encouraged participants to use services and the majority was satisfied with the services they received. Improved utilization rates were maintained at the follow-up focus group stage.

Background

In recent years, great emphasis has been placed on the need for consumer health information and self-care resources (Wagner & Hibbard, 2001; Currie *et al.*, 2001; National Institute of Health [NIH], 2006; Norman & Skinner, 2006). Increasingly, health departments in Canada and other developed countries are implementing government-sponsored health and self-care information programs delivered directly to the public via telephone, the Internet, and other innovative means (Carroll & Broadhead, 1997; Murray, 2004; Institute of Medicine [IOM], 2004). It is assumed that these approaches can alert individuals to the symptoms of disease, encourage them to develop healthy behaviours, help them to prevent injuries and infections, and allow them to monitor and/or manage symptoms from home (Calvano & Needham, 1996; Murray, 2004; NIH, 2006), thereby reducing the unnecessary use of facility-based medical care (Moore, LoGerfo, & Inui, 1980; Wagner *et al.*, 2001). However, for these resources to be effective, individual consumers require a minimum level of health literacy and knowledge of the health-care system's dominant language (in this case, English) (Murray, 2004; MLANET, 2006) in order to be "able to access, understand, evaluate and communicate" (IOM, 2004) the available information (Norman & Skinner, 2006). Internet health resources in particular require a specific skill set, such as basic reading and writing skills in the language in which the information is available, and a working knowledge of computers and Internet navigation (Carroll & Broadhead, 1997; Currie *et al.*, 2001). These skills are now widely referred to as "eHealth literacy" (Norman & Skinner, 2006; MLANET, 2006). Although consumer-directed health information resources hold great potential for improving public health and easing demands on health systems (Calvano & Needham, 1996; BC Ministry of Health [BC MOH], 2006), their value depends largely on the ability of their intended users to access and use them effectively (IOM, 2004; MLANET, 2006).

The British Columbia Ministry of Health provides a comprehensive health information program, the BC HealthGuide (BCHG) program, which was introduced in the province in April 2001 (BC MOH, 2004). The program consists of four components: the BC HealthGuide handbook; the BC NurseLine (a toll-free telephone service); BC HealthGuide Online (a health information website); and BC HealthFiles (fact sheets). The BCHG handbook, a self-care reference guide, provides basic, medically reviewed guidelines on how to recognize and cope with over 190 common health concerns (BC MOH, 2004). The BC NurseLine (BCNL) is a toll-free service, operating 24 hours a day, 7 days a week, staffed by specially trained registered nurses who provide confidential health information and advice (BC MOH, 2005). Between 5:00 p.m. and 9:00 a.m., a BCNL pharmacist is also available. BCHG OnLine is a comprehensive Internet website with widespread, medically reviewed health information, and BC HealthFiles are a series of one-page, easy-to-understand fact sheets covering a wide range of public and environmental health and safety issues (BC MOH, 2006). The BCHG program health information is updated regularly.

This comprehensive health information program is designed to benefit the health of BC's population as a whole by improving consumer access to timely and accurate health information and advice expanding consumer awareness of ways to manage personal health risks and conditions, alleviating pressure on emergency and physician services, and reducing costs due to inappropriate use of the health-care system (BC MOH, 2004; BC MOH, 2005; BC MOH, 2006). However, little is known about the use of these services by BC's ethnocultural communities, the reasons they are prompted to use them, and their level of satisfaction with, and attitudes towards, these resources. Having learned from BCHG annual reports (BC MOH, 2004; BC MOH, 2005; BC MOH, 2006) that utilization of the BCHG program was lower than desired among certain populations (including Aboriginals, minority groups, and newcomers), we undertook a collaborative research and intervention process aimed at increasing the awareness and utilization of these services in the Iranian community. This community is the province's largest Middle Eastern immigrant group, a fast-growing community, which has almost doubled in size since the late 1980s (from 12,000 in the 1990s to 22,000 in 2001) (Statistics Canada, 2006). Studies have found that the health beliefs, attitudes, and practices of Iranian immigrants in Western societies are influenced by their world view, social structures, language, and cultural values (Omeri, 1997; Johns Hopkins University, 2000; Safdar, Lay, & Struthers, 2003). The goal of this study was to determine whether culturally relevant Farsi-language videos could be used effectively to increase awareness and utilization of the BCHG program among the Iranian population in the GVA (which includes Burnaby, Coquitlam, North Vancouver, Surrey, Richmond, Vancouver, and West Vancouver). This study also sought to develop a model for video production and dissemination that adopts a participatory design and community engagement approach to the delivery of health information (Oduola, 2003; Mohabeer, 2004). Furthermore, we devised a method of evaluating this type of intervention in order to identify any changes and modifications in the target population's beliefs and attitudes toward self-care resources (Kar, Rina, & Shana, 2001; Dudley, 2003). In this paper, we provide an overview of the project and propose that the model outlined here may be effectively transferred to other Middle Eastern populations with success.

The intention of this project was to increase the use of a health service (the BCHG program) within a specific Middle Eastern population (the GVA's Iranian community) through the airing of culturally relevant videos. The study also compared various communication models, such as direct and indirect messages (Kar, Rina, & Shana, 2001), and various modes of delivery, such as facilitated group sessions and at-home viewing, to determine the best model for introducing BCHG program resources to other ethnocultural communities in BC. We hoped to develop more general and transferable design guidelines for producing media intended to promote self-care health services among culturally specific groups. The design guidelines developed are part of an iterative process intended to inform future health service promotions targeted to various cultural minority groups, not only the one specified in this project.

Methods

Video production

The culturally relevant nature of this project required an extensive pre-production stage, involving:

- 1) initial demographic research on the target community;
- 2) analysis of geographic concentrations, such as location and distribution of the community;
- 3) assessment and analysis of the cultural composition of the community, including family size, living conditions, and socio-economic status;
- 4) focus groups and in-person interviews with members of the target community to gain insight into issues (e.g., their trusted sources of health information);
- 5) the input of an expert advisory panel consisting of members of the target community who are professionals in related fields (such as health, culture, and television production);
- 6) script writing and development workshops with members of the target community to provide cultural grounding; and
- 7) final consultation with members of the target community and BCHG staff to review scripts and storyboards for cultural accuracy and credibility.

The findings from the pre-production focus groups and interviews suggested that most members of the Iranian community in the GVA believe “word of mouth” to be the most effective means of learning about the BCHG services. This means was identified as an effective communication approach for many ethnocultural communities (Kar, Rina, & Shana, 2001). The target community also relied on the experiences of others and on the advice received from highly trusted, well-educated individuals, such as Farsi-speaking doctors, when determining the advantages and disadvantages of various health-related activities. Given the importance of trust in communication strategies, particularly in minority groups (Dudley, 2003), the identification of trusted individuals for the delivery of health information was key to the development of the videos produced in this study (Crocker, 2004).

It was decided that the best way to provide “word of mouth” accounts of community members’ experiences was through the creation of short dramas recreating specific experiences. The scenario for these dramas was that of a member of the target community resolving a health-related problem by using the BC HealthGuide

services (Odutola, 2003; Mohabeer, 2004). The scripts were developed in consultation with the expert advisory panel (consisting of community members, health-care professionals, and BCHG program staff). Four scenarios were chosen based on their relevance to the audience and the BCHG program.

In order to include representation from trusted medical professionals and to provide a factual basis for the videos, a “documentary” script was also developed. The documentary video was designed to provide health information (specifically about the BC NurseLine and BCHG handbook) directly, by means of an interview with an Iranian physician in a guest–host setting. The documentary video also included personal interviews with community members, medical professionals, and BCHG staff about the features of BCHG services. The interviews were conducted in Farsi or with Farsi translation.

The actual production stage required the recruitment of community members who, in effect, played themselves in short dramas based on Iranian cultural beliefs and practices. This participation was valuable because not only did the community members find it engaging and empowering to be involved in a television production but they were also able to make suggestions throughout the production process so that the drama would be more accurate and credible (Kar, Rina, & Shana, 2001; Dudley, 2003; Odutola, 2003; Mohabeer, 2004). For example, community members suggested the inclusion of culturally specific household items in the background of the shot, as well as changes to the script to make the dialogue more appropriate to the context. The actors and locations were from the target community so that the dramas would appear realistic. Cultural references were incorporated in order to improve the reception of the videos by the target community.

The final videos were all produced in Farsi. They included one 13-minute documentary, which provided direct health information, and four short (under two minutes) dramatizations targeted towards the specific age and gender groups that had been identified in the pre-production stage, as well as in BCHG reports (BC MOH, 2004; BC MOH, 2005; BC MOH, 2006), as being the groups most likely to require the BCHG services. The scenarios of the short videos were based on health issues common to the target population.

During the post-production stage, constant consultation with Iranian health experts was essential, so as to ensure that the language and the health information were accurate, consistent, and appropriate throughout the editing and titling process (Sakurai *et al.*, 2002; Lasker & Weiss, 2003; Odutola, 2003; Crocker, 2004). Draft edits of the productions were reviewed and commented on by all sponsors of the project and by selected community members before final cuts were made. The developed videos were aired on local TV channels that provide Farsi programming (i.e., City TV, Channel 8, and the Shaw multicultural channel) between October and December 2004 (prior to the data collection phase of this study). Each of the short videos was shown 12 times, for a total of 48 viewings, and the documentary was shown six times.

Sampling

A two-stage quasi-experimental study, which used a combination of quantitative (structured telephone interviews) and qualitative (initial and follow-up focus groups) research methods, was then implemented

with a selected sample of the target population (Lasker & Weiss, 2003). The study sample was recruited (applying a systematic random sampling method) using the Iranian white pages and public residential telephone books in seven major district areas of the GVA (Burnaby, Vancouver, North Vancouver, West Vancouver, Richmond, Surrey, and Coquitlam). Eligibility in the study was based on two criteria: participants must be Iranian adults over 19 years of age (either born in Iran or born in Canada with one or both parents' having immigrated to Canada in the past 10 years), and participants must have been residents of the GVA during the period that the videos were aired..

Data Collection

Telephone Surveys

In the initial quantitative phase, a randomly selected sample of 800 eligible residents from the 22,000 members of the GVA's Iranian community participated in a structured telephone interview. The survey questions were developed on the basis of information gathered from the pre-production focus groups and interviews, as well as a panel discussion involving scientists and health professionals, conducted in the GVA Iranian community. The survey was pilot tested with a group of 10 Iranian families and was refined after their feedback. The final survey was administered in Farsi over the telephone. Ethics clearance for the study was given by the University of Victoria (Victoria, British Columbia) and Simon Fraser University (Burnaby, British Columbia) ethics committees.

Participants in the telephone survey were informed that their participation in the study was voluntary. Once their consent was given, they were asked whether they had seen the BCHG videos that had aired on local television channels, and if so, which ones. They were also asked general demographic questions, questions regarding their access to health information, and specific questions concerning the BCHG services. All participants in the survey were asked whether they would like to be involved in one of the post-intervention focus group sessions planned for the spring of 2005.

Focus Groups

In the qualitative phase, 98 people were selected at random from the 300 participants who volunteered during the telephone interview to participate in discussion groups. Those selected were invited to seven focus group sessions held in the spring of 2005. Findings from the telephone survey and advisory panel discussions were used to develop the core discussion questions for the focus group sessions. The questions mainly focussed on participants' knowledge and experience of the BCHG program and other self-care services, the link between Iranian cultural beliefs and health-care practices, the characteristics of credible health-care professionals and health information providers, and their willingness to receive health-related information through the medium of television.

Participants were allocated to particular focus groups, according to which, if any, of the videos they had reported viewing at home. Forty-five participants who had seen the videos at home were assigned to the first three focus groups. There were between 12 and 18 individuals in each of the following groups: Group A (who had seen both the documentary video and at least one of the short drama videos), Group B (who

had seen just the documentary video), and Group C (who had seen at least one of the short drama videos but not the documentary video). These were considered the “control groups.” IOM, 2004 A further 53 participants who had not seen any of the videos at home were assigned to Group D or the “experimental group.” Group D participants were randomly divided into four subgroups:

- Subgroup D1: Participants watched all the videos and discussed them during the focus group.
- Subgroup D2: Participants watched only the documentary and discussed it during the focus group.
- Subgroup D3: Participants watched only the short drama videos and discussed them during the focus group.
- Subgroup D4: Participants engaged in a discussion without watching any of the videos during the focus group.

In addition to these seven gatherings, two follow-up focus group sessions were also held in November 2005 to assess the participants’ use of, and satisfaction with, the BCHG services one year after the videos were initially aired. Of the participants in the primary focus groups (N=98), 33 individuals agreed to participate in the follow-up discussion sessions. These individuals were subdivided at random to form the follow-up focus groups.

Key Findings

Of the 800 people who were contacted for the telephone interview, 590 (74%) agreed to participate. The majority of these respondents were female (65%), between the ages of 35 and 49 (52%), with at least an undergraduate or college education (56%), and in good or better health (65%). Overall, 36% of respondents (N=212) had seen either the BCHG short drama videos or the documentary at home. However, only 67% of the total sample reported watching any Farsi-language television programming, which means that just over half (54%) of those who watch Farsi TV had seen the BCHG videos.

The initial findings from the telephone survey highlighted the poor awareness levels and low utilization rates of the BCHG program among participants prior to viewing the videos. For many participants (67%), the videos were their first exposure to any information about the BCHG program, in spite of the fact that the BCHG handbook and informational package were mailed to all households in BC in April 2001 and are still available in all hospitals, walk-in clinics, and pharmacies across the province. Almost all participants reported that watching the videos had encouraged them to use the program (98%) and that they intended to promote the services to others (87%). In addition, the majority of participants who had accessed at least one of the BCHG program services (i.e., the online services or the handbook) reported being satisfied with the services they had received (88%). The majority of participants (59%) in the follow-up focus groups held one year after the airing of the promotional videos reported continued utilization of, and overall satisfaction with, the BCHG resources. According to statistics provided by the BC Ministry of Health (BC MOH, 2006), the number of callers to the BC NurseLine who requested Farsi translation increased significantly (about 1200% around the time of the airing of the videos (between October and December 2004) and showed a moderate increase in September 2004, just after the videos had been produced.

Participants in the initial and follow-up focus groups almost unanimously indicated that they perceive health-care professionals, particularly medical doctors, to be the most credible providers of health information (89%). This credibility was enhanced if the doctors were well-known in the community. In fact, title and prestige were the most important factors identified by participants in determining the credibility of a health advisor. It was suggested that the appearance and setting of the health advisor were important to their credibility as well (Bibel, 2003). For instance, the participants commented that “the doctor in the documentary should be wearing a white coat” and “the doctor should be situated in a clinic or hospital.” They observed that the language used by the doctor in the documentary “should be more straightforward and without technical terms or medical jargon” in order to gain acceptance from a wider audience. When asked about Iranian cultural beliefs and health-care practices, the majority of participants (63%) indicated that “self-care resources in general might be unsuited to Iranian culture” and “this divergence had thus far prevented many Iranians from using the BCHG program adequately.” Participants commented that “Iranian culture does not traditionally place a strong emphasis on preventive health care,” and “many Iranians (particularly older generations) tend to seek out health advice only when they perceive that they have a serious condition” or “when it is an emergency.” A common perception was that “health advice received from nurses or translators over the telephone or from the Internet is not as trustworthy as that received face-to-face from a doctor.” These findings support the results reported by other researchers (Omeri, 1997; Johns Hopkins University, 2000; Safdar, Lay & Struthers, 2003). In addition, the focus group discussions revealed areas of confusion about the BCHG program regarding “how the program coordinates with other health services, such as doctors’ visits and emergency services,” as well as “concerns about the quality of care offered.”

The majority of participants (68%) indicated that they believed that the wider GVA Iranian community could be encouraged to embrace preventive health-care services in general, and specifically the BCHG program, provided that promotion of the program was culturally relevant, sustained, and targeted directly to their community. The overall response of participants to the videos was positive, and most participants (71%) believed that the videos had the potential to be effective in their community. During the focus group discussions, however, a number of recommendations were made for the improvement of the videos, relating to the storylines, the characteristics of actors, and the promotion of the BCHG program in general.

Although a majority of participants (69%) believed that young people would be the most receptive to the BCHG services (as they are “more adaptable and less likely to be settled into habits”), it was noted that targeting only young people, without including their parents and grandparents, would have the potential to create conflict within households. Thus, it was proposed that promotional messages and media channels should target all age groups, and vary their message according to the interests and needs of each group. For example, the participants recommended the Internet, English-language television channels, schools and universities, and youth volunteer groups as channels for promoting the program among young people. For older groups, the channels would include Farsi-language newspapers and magazines, local Farsi TV channels, community gatherings, and well-known, respected volunteers from the community.

The participants' reactions to the two communication models (direct/documentary and indirect/drama) appeared to be significantly affected by personal preferences, with relatively equal numbers stating a preference for each type. In general, it seemed that the direct documentary model was considered to be both more informative and more professional, and thus improved the credibility of the BCHG program in many participants' views. The indirect dramatic model, on the other hand, was generally thought to be very well-suited to Iranian cultural practices and norms; the dramas presented the BCHG services as helpful and relevant. Therefore, it seems that using a combination of the two communication models would be most effective in promoting the BCHG program.

The focus group sessions were very popular among participants, and the general opinion (expressed by 89% of the participants) was that facilitated group sessions were more effective environments for learning about the BCHG program. Similar findings were reported in other studies investigating the effectiveness of facilitated group discussion on adult learning (Johnston, Petty, & Young, 2001; Canadian Policy Research Network, 2007). Viewers in the group sessions said that they experienced fewer distractions while watching the videos than they would have at home and that they appreciated the opportunity to discuss the topics and issues raised. At the same time, the convenience of watching videos at home and the opportunity to discuss the issues raised with family members appealed to a number of participants. Thus, it would seem prudent to use a combination of facilitated group sessions and mass media exposure to promote the BCHG program in order to ensure wide dissemination of the messages, as well as to provide concerned and motivated citizens with an opportunity to raise questions and discuss relevant issues (Sakurai *et al.*, 2002; Dudley, 2003; Crocker, 2004; Mohabeer, 2004).

Limitation

A major limitation of this study is that it is confined to the Iranian community, which is only one of the many Middle Eastern communities in the GVA. However, although Middle Easterners vary ethnically, culturally and linguistically, they do share a core of common values and behaviours that include, but are not limited to, beliefs and attitudes toward health and illness (Lipson & Meleis, 1983; Safdar, Lay, and Struthers, 2003). The Iranians who participated in this study came from many regions of Iran and many ethnic groups (i.e., Azeri, Kurd, Lor, Pars, Arab, Baluchi, Turkmen, etc.). Many of their beliefs about health resemble those of other subpopulations in the Middle East (Lipson & Meleis, 1983). Therefore, we believe that the results of this study are applicable to other Farsi-speaking communities and Middle Easterners living in BC.

Discussion and Conclusions

Although the BCHG program offers useful services, its recognition and use among the GVA's Iranian immigrant population have, until now, been low. Before the airing of the videos, there was some awareness of the BCHG program among members of this community, but calls to the NurseLine requesting Farsi translation were very infrequent. These calls rose significantly (a twelve fold increase) around the time the videos were aired, suggesting that culturally relevant videos can be used to get health messages out to culturally specific communities (Kar, Rina, & Shana, 2001; Dudley, 2003). Additionally, there was an

increase in the use of the Farsi-translation service just prior to the broadcast of the videos. This change may point to the influence of the participatory video production process itself (Sakuari *et al.*, 2003; Dudley, 2003). The Iranian community members who helped to create the videos probably mentioned the service to friends and family. The effect of this communication illustrates the importance of encouraging participation in both the development and the final product, which raises awareness of health issues within the community (Kar, Rina, & Shana, 2001; Crocker, 2004). The findings of this study strongly suggest that Iranians living in the GVA are open to alternatives to routine health-care services and channels for receiving health information (Omeri, 1997), including the use of online preventive and self-care resources such as the BCHG services.

As noted in the discussion of health literacy, the first component of health literacy is the ability to access appropriate health information (IOM, 2004; Rootman & El-Bihbety, 2006; Zanchetta & Poureslami, 2006). In addition, given that cultural beliefs and practices (Bibel, 2003; Zanchetta & Poureslami, 2006), as well as gender (Marmot & Wilkinson, 2000), are acknowledged to influence health and literacy, the BCHG program should consider the demographic and cultural characteristics of the various ethnic communities living in British Columbia in their efforts to provide accessible consumer health information (Kar, Rina, & Shana, 2001; Wagner *et al.*, 2001). Furthermore, promotional activities and services that are targeted directly to particular communities' needs (Marmot & Wilkinson, 2000), priorities (Zanchetta & Poureslami, 2006), and challenges (Sakuari *et al.*, 2002; Bibel, 2003) have the potential to greatly improve the BCHG program's use among BC's population at large, including its ethnocultural communities.

In this study, easy access to information was provided by means of culturally relevant videos introducing a government-sponsored consumer health information program. These videos were made in the Farsi language, targeted according to gender and age, used community members as actors, dealt with relevant topics, and portrayed common cultural traditions. The noticeable and sustained improvement in attitudes towards, and self-reported utilization rates of, the BCHG program among the participants in this study following the viewing of culturally relevant promotional videos highlights the potential to modify cultural beliefs regarding preventive health care, provided relevant messages are delivered appropriately. However, although BCHG data and charts indicate that the frequency of requests for Farsi translation services on the part of callers to the BC NurseLine reached a high between October and mid-December 2004 (during the airing of the videos), the frequency of requests for this service declined to pre-project levels within eight months (BC MOH, 2006). While requests for Farsi translation services may not be a perfect measure of the success of the videos (because they do not represent the Iranians who spoke English when using the NurseLine), the decline in requests for translation services over time suggests that the message must be repeated regularly if increased utilization rates are to be sustained. Whether the increased utilization rates affect participants' health outcomes or improve their health requires further investigation.

The findings of the focus group sessions indicate that the facilitated group discussion approach used in this study was beneficial to the participants; it provided them with an opportunity to discuss self-care services and preventive measures, and share their questions and knowledge with other group members. Participants

were able to gather information from each other in a setting where their cultural beliefs, experience, and personal concerns were acknowledged and respected. We suggest that facilitated group discussion be used to promote self-care services among ethnocultural communities, as it has been shown by other researchers (Johnston, Petty, & Young, 2001; Canadian Policy Research Network, 2007) that this forum creates a safe learning environment, which supports both behavioural modification and adult learning.

In conclusion, we suggest that culturally relevant and targeted audiovisual media, involving the participation of target population members in all aspects of production can be an effective means of providing accessible and understandable health information to specific ethnocultural communities.

Future studies should be undertaken to show the long-term impact of this type of intervention on behavioural and cultural modification, and should be designed to determine the frequency of repetition necessary to sustain behavioural and attitudinal changes. In addition, it would be useful to determine whether or not repeating the same message over time leads to sustained increases in utilization rates or whether “fresh” messages are required in order to sustain increased use.

..... Footnotes

1. The addition of David Murphy and Ann-Marie Nicol as co-authors of this article was made on October 16, 2007 at the request of the original co-authors, Drs. I. Poureslami, I. Rootman, and E. Balka
2. Ibid.

..... Authors' note

This article is a modified version of a presentation given at the Public Health Association's 97th annual conference in Vancouver, May 2006. Available at: http://www.cpha.ca/english/conf/archive/097_anl/documents/bcplacestream-session4.doc

..... Acknowledgements

The authors thank a number of individuals from the BCHG program, Simon Fraser University's School of Communication, and the Iranian community of the GVA for their support and assistance in this project. We especially recognize the support of Mr. Kevin Brown, Director of the BCHG program; Ms. Johanna Morrow, Manager of the BCHG program; and Mr. Dave Murphy, Director of the Audio-Visual Laboratory, School of Communications, Simon Fraser University. Financial support for the research was provided by Social Sciences and Humanities Research Council of Canada, through the Initiative for a New Economy Grant, as well as by the Michael Smith Foundation for Health Research.

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..... How to cite this article

- Poureslami, I., Murphy, D., Rootman, I., Nicol, A. & Balka, E. (2007, April). Changing immigrants' attitudes towards intentions to use the BC HealthGuide Program: Culturally specific video messaging for health promotion. *Journal of Applied Research on Learning*, 1(1), Article 3, pp. 1-12.