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‘Parent-centred and culturally-competent literacies for health promotion with newly arrived African communities: a literature review’

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Key Messages

When considering culturally competent health literacy in newly arrived communities the following key concepts are important:

**Health literacy and literacy**
People practice and use literacy in many ways. People use text or the written word, oral literacy (or the spoken word), visual literacy (or images) and technological literacy (through the use of information and communication technologies). They also draw on other people who mediate health-related information. People’s identities and their access to social networks shape their use of literacy practices and their engagement with health promoting activities. Literacy practices are not static. Initiatives to improve health literacy need to be responsive to the social context (e.g. migration experience; life history; gender; ethnicity; religion; life stage; education) and integrate expertise from both the health promotion and the adult literacy fields.

**Collectivism and authoritarianism**
Most western cultures, such as Australia, support an environment that promotes individualism. With parenting, this translates to parenting styles that place high priority on children’s autonomy, individual achievement, self-expression and egalitarianism. However, African (and other) cultures place a high priority on collectivism and authoritarianism as the norm. Authoritarianism is characterized by the imposition of an absolute set of standards, the valuing of obedience and respect for authority. In this sense the collectivist cultures discourage self-assertion and autonomy, and the goal of parenting is the promotion of interdependence, cooperation, compliance without discussion, and inhibition of personal wishes.

**Acculturation**
Acculturation of immigrants and refugees is a complex and dynamic interaction that takes place between groups settling in the host country and the people, culture, environment, politics and systems of the new country. The impact of acculturation on the health and wellbeing of new arrivals is significant and there are several models of acculturation described in the literature. A way to support health appears to be through a combination of maintenance of beneficial traditional elements of life as well as adopting useful host cultural skills.

**Cultural competence**
The literature frames ‘cultural competence’ as the evolution of the terms cultural sensitivity and cultural awareness. The concept is important as it shifts focus from the individual to the organisation and systems. The ethos of cultural competence is a reflective practice and ongoing process of learning, valuing and interacting cross-culturally at an individual, organisation and system level.
Key themes

Eight key themes arose from the review of international peer-reviewed and non-peer reviewed literature around health and wellbeing, particularly relevant to families during the newly-arrived period. Salient points are summarised below:

1. Pre-migration and migration

People re-locating to Australia may have been forced to leave due to war, instability or persecution or have chosen to leave their countries of origin for reasons of lifestyle or opportunities. Experiencing significant delays in movement and living in refugee camps or ‘intermediate countries’ is common for refugees. Migration may have been relatively simple or traumatic. Regardless, pre-migration life and experiences provide the backdrop to current life and adjustment is necessary with timely and appropriate support.

2. Decision-making

Post-migration family health decision-making is impacted by loss of family and social networks. In collective societies, decisions are made with the help of, or by elders, family and friends. Isolation from social ties and the individualistic nature of Australian society mean that parents are often forced to make decisions by themselves without usual sources of information, support or familiar services and treatments.

3. Social support

Family, friends and community are central to a healthy and happy life. For immigrants and refugees the importance of these connections is even greater post-migration. Social support aids adjustment to their new life. It provides access to support and fosters wellbeing. There is a variety of sources and types of social support described in the literature. These are concerned with sharing information, resources, emotional support and practical help. Difficulties can arise with immigrants supporting new arrivals as well as family in the country of origin, with little time or financial capacity to do so.

4. Family relationships and life

Resettlement of families and their quality of life and relationships is impacted by the loss of extended family and community. Differing rates of acculturation between generations may influence family interactions. Families report a wide variety of experiences and feelings, from contentment to distress, and some actively work to manage the consequences of migration.

5. Parenting in the context of migration

Parenting in a new country and culture presents many additional challenges. These include challenges with communication and language, helping with homework and culture clashes (individualistic vs collective ideals) and maintaining culture. Other key issues post-migration are the diminished level of childcare and support as well as mothers taking up employment due to financial stresses. Changing circumstances mean that cultural ideals of parenthood and expectations of children may not be fulfilled.
6. Gender
Moving from patriarchal, collective societies with clearly defined gender and social roles to Australia (where there is significant perceived movement towards gender equality and more freedom for women), presents many challenges to families. There may be changes in gender roles and responsibilities, difficulties fulfilling prescribed roles in a new environment, changes in expectations and progressively a shift in gender ‘norms’.

7. Concepts of health and wellbeing
Health and wellbeing are intimately connected to family and community for immigrants and refugees. Wellbeing is seen to be influenced by many other factors such as housing, employment and acceptance by the host country. Illness and distress may be exhibited through somatic symptoms. Concepts such as prevention and treatment may not mirror western medical models.

8. Health service system
There are significant and consistent barriers to health service utilisation for immigrants and refugees that are reported in the literature. Language, availability of interpreters, quality of communication, discrimination, availability of appropriate information, awareness of services and preventative care, transport and financial issues all impact on health service usage and therefore on family health and wellbeing.
Definitions
The following terms are frequently used in the literature and in this report:

**Acculturation** describes phenomena that result when groups of individuals having different cultures come into first-hand contact, with subsequent changes in the original cultural patterns of either or both group (Redfield, Lenton et al. 1936). Under this definition, acculturation is not a linear process where an individual moves from being traditional to being assimilated, but rather a multidimensional phenomenon.

**Cultural competence** is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations (Cross, Bazron et al. 1989 cited in Eisenbruch 2004).

**Health literacy** is the degree to which people are able to access, understand, appraise and communicate information to engage with the demands of different health contexts in order to promote and maintain good health across the life-course (Rootman and Ronson 2005).

**Health promotion** is a process of enabling people to increase control over and to improve your health. Health promotion, through investments and actions, acts on the determinants of health to create the greatest health gain for people, to contribute significantly to the reduction of inequities in health, to ensure human rights, and to build social capital (World Health Organisation 1997).

A **migrant** is ‘any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country’. This definition was broadened to be ‘understood as covering all cases where the decision to migrate is taken freely by the individual concerned, for reasons of ‘personal convenience’ and without intervention of an external compelling factor’ (UNESCO 2005).

A **refugee** is any person who, due to ‘a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it [Geneva Convention of 1951, Article 1A (2)].
1.0 Introduction

1.1 Background

In a culturally diverse Victoria, the Department of Human Services (DHS) has recognised the importance of understanding the values and beliefs of newly-arrived populations, as a basis for informing culturally competent health promotion. This document details a review of the literature as part of the project, ‘Parent-centred and culturally-competent literacies for health promotion with newly arrived African communities’. The project is being conducted in response to DHS’ interest for local research to address what is currently a limited understanding of culturally competent health promotion and health literacy that articulates with the beliefs and values of African families during the early re-settlement period (see Appendix 1). The overarching aim of the study is to better understand the health literacy of newly-arrived African parents in Victoria. The project is being conducted by a cross-sectoral, cross-disciplinary research team (see Appendix 2) and led by the Centre for Community Child Health.

The research uses a community-participatory approach that engages African communities. It is being conducted in collaboration with an African Review Panel (ARP). The ARP acts as a de facto steering committee. It advises on cultural issues at all stages of the study, in addition to assisting with community mobilisation and participation. A second group of advisors are the Project Partners, who represent African communities, state and international government, academia from Victoria and interstate, local health service providers, non-government organisations and peak bodies working closely with issues affecting re-settlement for African families. The Project Partners advise on cultural competence in health, health literacy, community-based service provision, family support, social disadvantage and adult learning issues and data collection.

The literature review forms an essential part of the research methodology. Underpinning this literature review are the key concepts of health literacy and cultural competence. Both are evolving fields in their own right. To provide a broad and accurate picture of where this cutting edge field is moving, we incorporate peer-reviewed and non-peer reviewed literature.

As the accumulating literature in these fields is vast, this report details how the literature review was shaped, the methods used and the evidence that has emerged. The body of literature reviewed for this report will be augmented in later stages of the overall study when, in line with good research practice (Willis, Daly et al. 2007) we return to the literature to interpret the findings that arise from the data collection phase.

While epidemiological and other quantitative research is important in identifying risk factors, prevalence and incidence or in measuring the effectiveness of interventions with migrant populations that is not the focus of this review. Our focus, in this report, is on research into deeply-held views, assumptions, meanings and lived experiences of life events, culture and beliefs as they relate to newly-arrived populations re-establishing themselves in host countries.
1.2 Shaping the literature review
This section addresses the scope and input from key informants that have shaped the parameters of this review.

1.2.1 Working definitions of cultural competence and health literacy
At the beginning of this report we defined several terms that are used throughout the literature review. In this section, we re-state what is generally understood by two of the key terms, cultural competence and health literacy, as they provide important context to this report and the wider study:

**Cultural competence** is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations (Cross, Bazron et al. 1989 cited in Eisenbruch 2004). Cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services. To become more culturally competent (National Health and Medical Research Council 2006), a system needs to:
- value diversity;
- have the capacity for cultural self-assessment;
- be conscious of dynamics that occur when cultures interact
- institutionalise cultural knowledge
- adapt service delivery so that it reflects an understanding of the diversity between and within cultures (RACP 2004).

**Health literacy** is the degree to which people are able to access, understand, appraise and communicate information to engage with the demands of different health contexts in order to promote and maintain good health across the life-course (Rootman and Ronson 2005).

1.2.2 Input from key informants
The literature pertaining to the health and wellbeing of newly-arrived migrants, to cultural competence, health promotion and health literacy is vast. In order to tailor a review of the literature to be most relevant to the promotion of the health and wellbeing of African families settling in Victoria, the review has been shaped by expert opinion and by input from the ARP, the study’s team of Chief Investigators, with the Project Partners and with key community workers.

Key points arising from these discussions included:
- Consensus that there is limited understanding within the health sector of the lived experience of pre-migration and migration. This is particularly true for health workers beyond those services that work closely with newly-arrived migrants. A deeper understanding of life experiences of migration is required, as this is connected to the ways in which people seek and use information post-migration. This view is supported in the literature (Papadopoulos, Lees et al. 2004; Pavlish 2007).
- The need to focus on key processes operating within African culture. These include: collective versus individual decision-making, authority, hierarchy, honour and respect especially in relation to parenting.
• Consider the strong element of African way of life that ‘my business is your business’ and therefore include literature about knowledge transfer, social support and networks as this enhances everyday life.
• The importance of connecting children to African culture and values, particularly in the context of growing up in Australia.
• Recognition that Africans living in Australia are not a homogeneous group with shared views or experiences. There is diversity within diversity. Discussion topics of spiritual healing and rituals could alienate some parents who either feel that they have moved on from traditional health practices or for whom these practices are considered private and personal.
• The importance of keeping the literature review broad and to avoid being overwhelmed by literature that details each cultural/language/ethnic group’s particular sickness beliefs and self-care practices. These are complex and constantly changing so pursuit of this literature would not be productive to the study.

1.2.3 The scope of the review
In response to the input by key informants (see above) the scope of the review includes issues that are fundamental to African communities settling in Victoria. These include:
• culture and acculturation
• collectivism versus individualism. This incorporates:
  o respect, particularly across generations
  o hierarchy within the African social structure
  o knowledge building
  o knowledge exchange
  o decision-making within families and community
  o family dynamics and relationships
• authoritarianism
• knowledge and experiences pre-migration
• social and cultural capital / re-creating community

The literature search subsequently integrated these notions. It includes international studies that have investigated the views, health beliefs and cultural values, and experiences of participants. In particular, it includes literature related to those communities newly arrived to a host country and who are negotiating the use of a new health care system and health promoting initiatives during re-settlement.

The literature review addressed the following question:

What is known about the beliefs, values and culture that are fundamental to newly-arrived African families to connect with and respond to culturally competent health literacy and health promotion initiatives?

The review involved comprehensive searching of peer-reviewed and non-peer-reviewed, English-language, primary studies and reviews of literature, qualitative research from the medical, public health/health promotion and social science literature since 1985 and from current websites detailing scholarly and cutting edge work in these fields. It also incorporated citation searching and hand searching of key journals and contact with experts. Inclusion criteria were developed and data were extracted using standard data extraction attributes, modified to ensure relevance to this study.
2.0 Methodology

2.1 Selection criteria

*Inclusion criteria* were developed according to the aim of the literature review. Inclusion criteria comprised:

- Articles and reports published between January 1985 and January 2008. The time frame was chosen on the basis of the burgeoning health promotion literature that emerged subsequent to the Ottawa Charter in 1986, international research following mass migration globally and current thinking.
- The study population: newly-arrived immigrants or refugees from non-English speaking countries. The definition of ‘newly-arrived’ was kept broad on the basis of advice from African community workers and the ARP that indicated many issues related to arrival persist long after initial resettlement.
- Qualitative studies that explored participants’ experiences and views.

*Exclusion criteria* comprised:

- Epidemiological and other measurement-based research (given the focus on the lived experience of migration, cultural beliefs and values);
- long-term migrant populations;
- intra-country migration;
- clinical descriptions of participant illness experiences;
- health problems exclusive to specific cultural or ethnic groups; health professional perspective of refugee or immigrant health;
- training of health providers;
- health perspectives of children or adolescents;
- workplace or occupational health-related issues for migrant populations.

2.2 Search strategy

The literature searches were conducted during July 2007-January 2008. The titles and abstracts of the studies yielded by the search were screened to exclude those that clearly did not meet the inclusion criteria. Hand-searching of reference lists of included papers occurred and relevant articles were obtained. All articles included in the literature review were originally written in English, however, there were no limits placed on the literature search regarding language. Inclusion of the French-based literature was included where possible. Papers from *Mots Pluriel* (an International review of letters and articles on social science subjects) were searched for relevant material. However in general the inclusion criteria were not met as articles were often opinion pieces or case studies about an author’s experience.

2.2.1 Search terms

Search terms focussed on the following areas: culture, family, health and social networks (see Table 1). A series of refinements occurred to search terms and how they were combined to ensure that they were inclusive and logical yet would yield appropriate literature and incorporated relevant search terms. Not all search terms were transferable across search engines; therefore each search looks different but was carried out with the same logic and guidelines (see examples of different database searches in Appendix 4). Some search terms did not appear in one or more databases and in this case, other terms were used that were approximate or included the term or keyword in its scope. The search was constructed to yield manageable output for the size and timeframe of the literature review.
Table 1: Example of relevant search terms and keywords

<table>
<thead>
<tr>
<th>Refugees</th>
<th>Attitude to health*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture*</td>
<td>Health education*</td>
</tr>
<tr>
<td>Minority groups*</td>
<td>Cultural competenc$ (key word)</td>
</tr>
<tr>
<td>“emigration and immigration”</td>
<td>Health literacy (key word)</td>
</tr>
<tr>
<td>“transients and migrants”</td>
<td>Community networks or social support</td>
</tr>
<tr>
<td>Acculturation or cultural diversity</td>
<td>Health services accessibility</td>
</tr>
<tr>
<td>Culture</td>
<td>Health services/*ut [Utilization]</td>
</tr>
<tr>
<td>culture$ and linguistic$ divers$ (key word)</td>
<td>Social capital</td>
</tr>
<tr>
<td>Family</td>
<td>Social change</td>
</tr>
<tr>
<td>Health</td>
<td>Social network</td>
</tr>
<tr>
<td>Health promotion*</td>
<td>Social support</td>
</tr>
<tr>
<td>Health behavior*</td>
<td></td>
</tr>
</tbody>
</table>

* These terms were exploded

2.2.2 Peer-reviewed databases search

Medline (1965-present)
PsychInfo (1967-present)
Cumulative Index to Nursing & Allied Health Literature (CINAHL) (1960-present)
CSA Sociological Abstracts (1952-present)
Excerpta Biomedica Database (EMBASE) (1974-present)
Educational Resources Information Center (ERIC) (1966-present)
The Cochrane Collaboration (1988-present)

2.2.3 Non-peer-reviewed literature and website search

Key websites of organisations and of content areas relevant to immigrant and refugee health or studies in general were reviewed. Materials were sought relating to immigrant health, families and decision-making such as general qualitative research, reports or reviews of qualitative studies on topics.

Qualitative research and literature reviews of qualitative research were rare in the non-peer-reviewed literature and websites. Those that were located did not meet the inclusion criteria. Many websites of organisations reviewed contained information useful to health and service provision for those working with immigrants and refugees (factsheets, policy, reports, website links and other resources) or for immigrants and refugees themselves. Again, however, this information did not meet inclusion criteria.

Australia

- Centre for Culture, Ethnicity and Health (www.ceh.org.au): factsheets and resources developed for work with CALD communities, links to other sites. Library catalogue searched but relevant documents not available online.

- Ethnic Communities Councils Australia (www.fecca.org.au) (separate website for each state and territory). Practical tips and links on topics such as employment, as well as policy information.

- Diversity Health Institute, New South Wales (www.dhi.gov.au): Information stems from a coalition of public health organisations working with CALD communities. Research, education and training, links to membership organisations, translated materials and a library.
• Refugee Health Research Centre, La Trobe University (www.latrobe.edu.au/rhrc): Useful background documents. Research publications and reports are refugee focused; however they do not look at perceptions of health in relation to family and decision-making.

• Victorian Transcultural Psychiatry Unit (www.vtpu.org.au): Research articles, reports and books (to be purchased online). These publications only updated to 2000.

• Asylum Seeker Resource Centre (www.asrc.org.au): Information on the centre, volunteering, advocacy and donating money. The Information Clearinghouse carries resources for asylum seekers, advocates, health practitioners, mental health workers, educators and students.

• Centre for Immigration and Multicultural Studies, Australian National University (cims.anu.edu.au): very basic site with research papers on topics around white Australia and policies, detention centres and the English in Australia.

• Multicultural Mental Health Australia (www.mmha.org.au): Factsheets, information and resources for consumers and health professionals. Translated materials available.

• Victorian Foundation for survivors of Torture and Trauma (www.survivorsvic.org.au): Policy, information, provider guidelines and school resources.

**International**

• National Centre for Cultural Competence, Georgetown University, Washington (gucdc.georgetown.edu/nccc): Definitions, policies, research, assessment tools, resources and information for organisations, providers, individuals and educators. Consultants in cultural competence available.

• The Commonwealth Fund (www.commonwealthfund.org): publications and policy resulting from independent researchers they fund on health systems topics. Grants and programs are targeted at vulnerable populations with the aim to improve health services and systems.

• Evidence for Policy and Practice Information and Coordinating (EPPI) Centre (eppi.ioe.ac.uk): ‘how to’ documents for research methods and systematic reviews, evaluation, primary research and reviews. No information on the health of immigrants/refugees.

• Center for Comparative Immigration Studies, University of California (www.ccis-ucsd.org): Information on education and courses, research projects and staff. Publications and monographs focus on political and border control aspects of immigration, rather than health.

• Refugee Studies Centre, Oxford University (www.rsc.ox.ac.uk): Produces the Journal of Refugee Studies and the Forced Migration Review. Main focus is on internal displacement, not on resettling in new countries. Articles are country and politic specific, non-health focus with the exception of HIV/AIDS topics.

• **Mots Pluriel** (1996-2003) (motspluriels.arts.uwa.edu.au): Mots Pluriel (an International review of letters and articles on social science subjects) was searched for relevant material. Articles were often opinion pieces or case studies about an author’s experience.
Government


- Department of Immigration and Citizenship, Australian Government (www.immi.gov.au): Programs, publications, policy, agendas and information on immigration. Research online generally featured the economic impact of migration with a work force focus. By country characteristics of those living in Australia (community information summaries) available.


2.2.4 Search results

Total articles obtained: 791
Excluded papers: 754
Included papers: 37
Additional papers*: 57
Total articles included: 94

*Additional articles were included drawing on pre-existing literature reviews on health literacy (Green, LoBianco et al. 2007; Green 2008) and acculturation, as well as from the reference lists of peer-reviewed and non peer-reviewed literature.

2.3 Data extraction and quality appraisal

Duplicate references were removed. Literature collected through the search strategy was assessed against the inclusion and exclusion criteria and data was extracted from relevant articles using a modified data extraction form (Van de Voorde and Leonard 2007). Data extraction headings included: reviewer, date, author, date, title, journal, volume/issue, page numbers (bibliographic details), original language, research setting, study aims, participants, methodology, theory, hierarchy level, main findings, articles to retrieve from reference list and additional comments.

Independent, double reviewing for relevance and quality was carried out by two reviewers. Upon completion, peer-review of the literature findings was undertaken by the African communities themselves, with support from the research team.
Quality of the selected literature was ranked according to the Qualitative Hierarchy of Evidence for Practice (Daly, Willis et al. 2007) (see Appendix 3). This hierarchy uses four levels of evidence that provide a basis for practice. From strongest to weakest, these include: generalisable studies (Level IV), conceptual studies (Level II), descriptive studies (Level III), and single case studies (Level 1). Features of each study type are listed in Appendix 3.

Relevance, independently judged by two researchers was ascertained, and decisions compared. Relevance, strength and duplication of themes was discussed iteratively until an agreed synthesis was produced that allowed interpretation of all data (Lucas, Arai et al. 2007). Six papers solely focussed on anthropological and sociological theory were not ranked using the hierarchy.

3.0 Findings

3.1 Overview of the literature
This overview refers to the 37 studies from the database searching. The findings from additional literature are incorporated into the reporting of the concepts and themes (detailed in Section 3.2).

- The literature reflected research derived from a diverse range of disciplinary areas. These include anthropology, psychology, psychiatry, social work, nursing, medicine, health services and health promotion. Disciplinary fields were not always identifiable or made explicit.

- Issues investigated in the literature included immigrant and refugee perspectives of health and illness, acculturation and wellbeing, resettling after trauma, social support and social capital, parenting and family issues, using health services and decision-making around health.

- The most common qualitative methodology used in the selected literature was in-depth semi-structured interviews, followed by focus groups. Ethnographic studies frequently included participant observation as part of its methodology.

- Four studies that elaborated on theories relevant to social capital and acculturation were included on the grounds that these enhanced our understanding of relevant concepts that were not always evident in empirical studies.

- Many studies specified the use of social theory as a basis of informing the research. These included phenomenology; social capital theory and feminist theory. Some studies cited the use of theory underpinning methodology, including: grounded theory; ethnography; narrative theory.

- Some papers were derived from the same study and did not include details of the original theoretical framework, the approach to sampling or to data analysis (e.g. Lipson, 1995, 1997). This posed some difficulties in making an assessment of the strength of the evidence.

- Sampling of participants was not regularly described although some was purposive. Participant recruitment was commonly through community workers or health services and through snowball sampling. Generally there were between 20-30 participants per study. Total number of participants, range of sample sizes is to be calculated.
The literature included papers from both developing and non-developing settings. The majority of papers were from English-speaking host countries studying participants from migrant and refugee backgrounds. The research participants in two articles (Almedom 2004; Pavlish 2007) were located in refugee or displacement camps in Africa. These papers were included as they provided context to the conditions that refugees had come from and to their health culture. Geographical locations of eligible research papers include: United States of America, England, Eritrea, Rwanda, Australia, Canada, Sweden, Finland, and the Netherlands.

As much of the literature concerned families, settings were commonly homes and health services in host countries, with the exception of the aforementioned studies (Almedom 2004; Pavlish 2007), set in displacement/refugee camps.

Populations studied ranged from the newly-arrived refugee or immigrant, to those that had been settled longer-term as well as second generation immigrants. More specifically, participants were generally adults, often parents with the exception one study of Sudanese children and young people. In addition some qualitative research was also conducted on a variety of workers (social workers, settlement workers etc) to complement the data on immigrants and refugees.

3.1.1 Quality assessment
The majority of database-derived studies (24) were assessed as descriptive (refer Table 2 below). As detailed in Appendix 3, descriptive studies illustrate practical rather than theoretical issues. These studies demonstrate that a phenomenon exists in a defined group and identify practice issues for further consideration.

Conceptual studies comprised five in number. They are characterised by theoretical concepts that guided sample selection and may be limited to one group about which little is known or a number of important sub-groups. Conceptual analysis recognizes diversity in participants’ views. These studies identified the need for further research on other groups, or urged caution in practice. These are regarded as well-developed studies that are capable of providing good evidence, particularly if residual uncertainties are clearly identified.

Table 2: Quality assessment of peer-reviewed literature

<table>
<thead>
<tr>
<th>Level of evidence</th>
<th>Number of papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalisable (Level 1)</td>
<td>1</td>
</tr>
<tr>
<td>Conceptual (Level 2)</td>
<td>5</td>
</tr>
<tr>
<td>Descriptive (Level 3)</td>
<td>24</td>
</tr>
<tr>
<td>Case study (Level 4)</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong>*</td>
<td><strong>37</strong></td>
</tr>
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</table>

* 6 relevant theory papers

3.2 Evidence regarding key concepts
This section reports on the literature addressing six key concepts. In reporting on the concepts found in the literature the same study may be featured in more than one part of the review.

3.2.1 Health literacy and literacy
The term ‘health literacy’, a discrete form of literacy, is a relatively recent concept that builds on the concepts of both literacy and health (Freebody and Freibourg 1997; Nutbeam 1998; Nutbeam 2000; Nutbeam and Kickbusch 2000). In thinking about
what ‘health literacy’ is, we firstly draw on the literature that depicts what ‘literacy’ means.

The traditional and dominant definition of literacy is primarily as a set of technical skills that conventionally include reading, writing and calculating (UNESCO 2004). Yet, there is a richer understanding of literacy that includes a wider range of skills needed to make meaning and participate in society (Street 1995; Hamilton 2006). This literature recognises that literacy is constantly shaped and re-shaped by social processes and community contexts such as history, biography, family, education and culture (Street 1993; Freebody and Freibourg 1997) and that adults have their literacy needs met using many different types of literacy and communication modes (Cope and Kalantzis 2000).

Literacy also includes having the abilities to understand and use ‘the dominant symbol systems of a culture—alphabets, numbers, visual icons—for personal and community development’ (Centre for Literacy of Quebec 2000). This latter definition is better able to account for the range of skills involved in literacy and is being used in recent public health research (Green 2007). It reflects the interactive processes involved in everyday information exchange and it reflects the dimensions involved in grasping the meaning of messages that are central to making critical judgement and decisions in health-related settings.

Definitions of health literacy shift according to the context in which they are being applied. For the purposes of this review of the literature, we use Rootman & Ronson’s (2005) definition of health literacy, as specified in the Definitions section and Section 1.2.1.

Nutbeam (1998) highlights that there are personal and social benefits associated with health literacy:

‘Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people’s access to health information and their capacity to use it effectively, health literacy is critical to empowerment’.

A growing body of work of health literacy research and policy activity is emanating predominantly from Canada, the United States and the World Health Organisation. The U.S. government’s flagship health policy, Healthy People 2010 (United States Department of Health and Human Services 2000), gives some prominence to health literacy. It frames health literacy within a discourse of fairness, equity and the need to reduce health disparities. Other initiatives relevant to the international policy context include Canada’s National Literacy and Health Research Program that produced, as one of its outcomes, a national health literacy agenda (Canadian Public Health Association 2003) and England’s ‘Skilled For Health’ program with its focus on building health literacy within adult populations with low basic literacy skills.

In Australia, there are currently no formal alliances that address health literacy. A framework for working across the health-literate interface in the Australian context, currently under development (Green 2008), identifies five key components that address working across the health-literate interface. In Victoria, the Department of Human Services has begun to invest in health literacy research, through a suite of projects that includes this present study, to generate scientific knowledge to inform policy to improve the health of vulnerable communities (Department of Human Services 2006).
Health literacy measurement has had a recent boost internationally through the OECD’s international Adult Literacy and Life Skills Survey (ALLS). In Canada, the United States and more recently in Australia through the second wave of data collection, adult health literacy proficiency scores have been generated as part of national adult literacy surveys (Canadian Council on Learning 2007; Stableford and Mettger 2007; Australian Bureau of Statistics 2008). In Australia’s ALLS, initial analysis indicates that approximately sixty per cent of Australians scored at Level 1 or 2 (the lowest 2 of 5 levels). A further thirty-five per cent of the population was assessed at Level 3 and six per cent at Level 4/5 (Australian Bureau of Statistics 2008).

Small scale health literacy assessment, including Spanish versions of some measures, is more concerned with exposing literacy deficits in clinical sub-groups and understanding that the uptake of health-related information is compromised. This is now well documented in research studies and reports (Agency for Healthcare Research and Quality 2004; Institute of Medicine 2004). Health literacy measurement is neither designed nor intended to capture cultural competence or the use of literacy in everyday health promotion. This highlights the need for an investigation beyond measurement, with a view to bridging that gap to make health literacy more culturally competent and to move away from a one-size-fits-all approach.

Recognition of the need to match health information with appropriate reading levels is evident in a recent review of the literature by Rudd, Anderson, Nath and Oppenheimer (2007). This demonstrated that more than 800 published studies indicate that the reading grade levels needed for health materials far exceed the reading abilities of high school graduates. This well-established mis-match has prompted the adoption of a plain language approach to health communication, to design reader-friendly materials (Schwartzberg, VanGeest et al. 2005). A salient point emerging within this literature, however, is that easy-to-read text may still not enhance comprehension of audiences with low functional literacy (Houts, Doak et al. 2006). In fact, the evidence suggests that they may be more helpful to good readers and only marginally helpful to poor readers thereby, albeit unwittingly, contributing to a widening gap in the ability to acquire health-related knowledge between population groups.

Oral literacy

The use of the spoken word, or oral literacy, is a major feature of managing and transmitting knowledge (Ong 2002). It is used to preserve and pass on practical knowledge, beliefs, traditions, information about personal relationships and everyday matters through generations (Reid 1982; Cohen and Somerville 1990; Halverson 1992; Dunn 2001), including messages about wellbeing (Berndt 1982). Not relying on an interaction between text and reader, speech represents an alternative type of interactivity for social interaction and knowledge sharing. As Snyder, Jones and Lo Bianco point out, speech is able to be ‘consumed immediately’ (2005:13). Orality draws on relationships and interactions between people, allowing them to participate in a shared meaning making (Hamilton 2000). The spoken word, in terms of its function in communication for people, is an important medium by which information is shared. The importance of the spoken word within a health promotion context has received little attention. However, it offers a useful conceptual tool with which to understand the construction of health-related knowledge and engagement with health promoting activities.

1 A critique of the range of instruments used to assess health literacy has been comprehensively conducted elsewhere (Frankish et al 2006; Davis et al 2005).
**Visual literacy**

‘Visual literacy’ is the use of images to support both text and the spoken word in a bid to reach their intended audiences (Finan 2002) and is a concept relevant to health literacy. The images are ‘read’ or understood within the viewer’s prior experience, values and socio-cultural belief systems (Morgan and Welton 1992).

Pictures are being used to successfully open up participation of populations with limited literacy. The use of pictures in health has been used to capture attention, enhance recall and maximise adherence to a message (Houts, Doak et al. 2006). Examples include the integration of pictures in project to promote healthy nutrition for immigrant groups (Nimmon 2007), in health surveys about healthcare experiences (Shea, Aguirre et al. 2005) and immunisation programs that have used animated cartoons (Leiner, Handal G et al. 2004). The evidence suggests that they are particularly promising for assisting people with low general literacy to understand and to use health-related information. Their effectiveness appears to be enhanced when development and delivery incorporates issues of demography, culture and gender (Poureslami, Rootman et al. 2007) and when done in consultation with the target audience during design and implementation phases (Morgan and Welton 1992; Dowse and Ehlers 2001; Nimmon 2007).

3.2.2 Language and communication

Evidence consistently indicates that language is fundamental to accessing information and connecting families with resources. Limited or absent English language skills present a significant barrier in communication and access to information (Perreira, Chapman et al. 2006). These language barriers can also limit help-seeking behaviour and social and professional interaction with the wider community (Senturia, Sullivan et al. 2005). Indeed, Senturia, Sullivan et al (2005) report that lack of English language skills can be actively used to isolate women experiencing domestic violence.

Although language barriers affect most new immigrants whose first language is not that of the host country, the ability to overcome initial language difficulties is not the same for everyone (Portes and Landolt 1996). The literature indicates that many Vietnamese/American women still have difficulty speaking and/understanding English after living in the United States for 10, 15 or 20 years. These continued difficulties are due to their child care and housework responsibilities and their lack of economic resources, which deny them the opportunity to learn the new language (Bui 2003). This suggests that acculturation is less a result of progressive improvement over time and more a function of women’s socioeconomic conditions and the division of labor in their households that affect their opportunities for self-improvement.

In Colic-Peisker and Tilbury’s (2003) exploration of immigrant and refugee resettlement styles, attitude to acquiring English language skills was notable. Those who were considered ‘passive’ re-settlers and took a ‘victim’ or ‘endurer’ approach often reported that they were too old (not always reflective of chronological age) to learn English. They felt that their pre-migration loss was irreparable, compared with ‘active’ re-settlers who focused on acquiring language skills (to greater and lesser extents) to allow participation in the workforce or wider community. Language barriers were reported to contribute to work-related injuries and to obtaining work in general, causing great strain on immigrants, their families and the wider community.
3.2.3 Diversity

Australia is a culturally-diverse nation with more than 200 ethnic communities (Multicultural Mental Health Australia 2007) and hundreds of language groups (National Health and Medical Research Council 2006). In 2006, it was estimated that around one in four Australians were born overseas (Australian Bureau of Statistics 2007). Diversity has enriched the Australian community in a multitude of ways. It also presents challenges to health services to provide culturally-responsive information and care. Mainstream services with ‘one size fits all’ frameworks and service delivery ignore the heterogeneity of the population and may serve to exacerbate health disparities between mainstream and minority groups. The Victorian Department of Human Services produced a Cultural Diversity Guide to begin to address these needs across government services (Department of Human Services 2006).

There is an ongoing need for cultural competence in health care moving away from following prescriptive instructions in dealing with ‘other’ to something personalised and contextualised that is adaptable and evolving. Many aspects of cultural competence match and complement patient-centred care and would improve care for individual service users and communities regardless of their cultural background (Beach, Saha et al. 2006).

3.2.4 Acculturation

There are several theories that attempt to explain the effect of migration on health and wellbeing. These include:

1. the ‘healthy migrant effect’ where ‘people in good health are more likely to meet eligibility criteria, and to be willing and economically able to migrate’ (Donovans, d’Espaignet et al. 1992; NSW Health 2004:16);
2. the ‘migration-morbidity’ hypothesis that suggests ‘migrants would be expected to have worse mental health than their host society due to pre and post migration stressors’ (National Health and Medical Research Council 2006:16); and
3. the ‘transitional effect’ that suggests that ‘the health advantage that some migrants show disappears over time’ (National Health and Medical Research Council 2006:16).

These are discussed in detail elsewhere (National Health and Medical Research Council 2006).

The classic view of acculturation is that given time, immigrants and refugees will adjust to life in their host environment and assimilate. In reality, as explored theoretically in the literature, the relationship between immigrants and their host country is complex. Pre-immigration factors, cultures, environments, family cohesiveness, cultural differences, policies, and social, physical and stress factors all play a role in how interaction between players and structures occurs and evolves (Rissel 1997; Renzaho, Swinburn et al. 2008). This evolution is dynamic and does not occur in a linear fashion, where migrants move from one end of an axis (traditional) to the other (assimilation) (Renzaho, Swinburn et al. 2008). Nor is the interaction one-sided or experienced the same way for each individual or ethnic community.

Several acculturation models are explored in the literature. Linear assimilation models are often used in public health research in spite of the more complex and inclusive multidimensional acculturation theories and models available (Abraido-Lanza, Armbrister et al. 2006). Renzaho, Swinburn and Burns (2008) argue for a model that categorises immigrants into four categories depending on their level of acculturation: integrated (bicultural orientation); marginalised (loss of traditional...
culture but rejection by host); traditional and assimilated. Acculturation is described as occurring at both a group level (including structural, cultural, physical, biological, economic, cultural and social dimensions) and individual psychological level (including behaviour, values, acculturative stress, adaptation strategies and identity) (pers comm. Renzaho, 2008). Literature on the measurement of acculturation, the use of a range of reliable acculturation scales, and issues relevant to the translation of these scales into other languages is also available; however this literature lies outside the parameters of this review.

The impact of acculturation on immigrant and refugee health and wellbeing is significant. There is a literature addressing the particular contribution of acculturation demands on post-migration psychological distress. Whilst we do not systematically review this large body of literature, throughout the review we highlight some of the issues related to acculturation that have a bearing on this study. This literature suggests both a positive effect of acculturation on health (Hovey and King 1996; Sundquist, Bayard-Burfield et al. 2000; Gonzalez, Haan et al. 2001; Hovey 2001; Knipscheer and Kleber 2007) and a negative association in terms of higher mental ill-health (Burnam, Hough et al. 1987; Nguyen and Peterson 1993).

Evidence of the impact of acculturation on health practices is reported. Whilst individual health practices were not a focus of this literature review, one example was changes in breast-feeding practices reported by Vietnamese women settling in Australia during the 1990s. As a result of the influence of the social, cultural, and economic environment of the host country (including having to return to work soon after childbirth) women were deciding not to breast-feed their infants (Rossiter 1992).

According to Thurston and Vissandjee (2005), the migration experience should be considered a determinant of health in its own right. These authors argue for the importance in attending to the individual factors (social support, genetics, health practices, child development) but focusing on social factors at the meso- (welfare, civil society, economic institutions) and macro-levels (the State, symbolic institutions). Other studies highlight the need for culturally sensitive counselling, better employment support and community support and increased availability of religious support groups to offset the loss and grieving and to help migrants realise new hopes and goals to make re-settlement less stressful (Khan and Watson 2005).

A starting position for better health is likely to involve a balance of holding on to supportive and identity-enhancing cultural traditions, moderate ruminating about pre-migration life and acquiring host culture skills needed to find employment, (Rogler, Cortes et al. 1991; Lafromboise, Coleman et al. 1993; Knipscheer and Kleber 2006; Knipscheer and Kleber 2007). Not only is it important for the health workforce to be aware of acculturation issues, but also for the adult education sector (Fernando 2006) to recognize the impact of these factors on learning in the host country.

3.2.5 Cultural competency

The term ‘cultural competency’, first used by Georgetown University, Washington in the 1980s, has gained popularity in response to the growing recognition of health inequalities between the mainstream and minority cultural groups (Beach, Saha et al. 2006). There is, however, yet to be a universally accepted definition of the term.

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Research, practice and policy development regarding cultural competence in health care is evolving and has been generated mostly in North America. The US Department of Health and Human Services has invested in ‘Health Literacy and Cultural Competency’ as a key interest. Its aim is to improve decision-making capacity and health care delivery. Georgetown University established the National Center for Cultural Competence to increase capacity of mental and general health service programs to provide culturally competent services from design to evaluation. The Commonwealth Fund has also supported the research and publication of a variety of papers concerning the topic such as ‘The Role and Relationship of Cultural Competence and Patient-Centredness in Health Care Quality’ and ‘The Evidence Base for Cultural and Linguistic Competency in Health Care’.

Other work has emanated from Europe and New Zealand (Stewart 2006) and cultural competency is gaining momentum in Australia. The NHMRC (2006) published a ‘Cultural Competency in Health’ guide which looks at policy, partnerships and participation. The publication includes a model developed by Eisenbruch, Rotem et al (2001) which describes the interplay between the different levels of the health system that are all related to cultural competency: systemic, organisational, professional and individual levels (Eisenbruch, Rotem et al. 2001). The Diversity Health Institute (NSW) published a position paper on cultural competence in health care ‘Cultural Competence in Health Care’. Cultural competence guidelines and protocol have been produced by the Ethnic Communities Council of Victoria. Multicultural Mental Health Australia has available on its website factsheets and a cultural competency resource directory (see www.mmha.org.au/information/cultural-competency-resources).

3.2.6 Collectivism versus individualism

Most western cultures such as Australia support an environment that promotes individualism where parenting styles prioritize children’s autonomy, freedom, individual achievement, self-expression, individual thinking, personal choice, and egalitarianism (Hui and Villareal 1989; Greenfield, Keller et al. 2003). However, for African and other traditional cultures, collectivism and authoritarianism is the norm. We have reviewed aspects of this large literature to introduce the concepts as they relate to this study, rather than report on this literature more widely. Authoritarianism is characterized by the imposition of an absolute set of standards, the valuing of obedience and respect for authority (Baumrind 1971). In this sense the collectivist cultures discourage self-assertion and autonomy, and the goal of parenting is the promotion of interdependence, cooperation, compliance without discussion, and inhibition of personal wishes (Greenfield, Keller et al. 2003). These parenting styles often operate successfully in their original contexts; however difficulties arise when the post-migration context supports the opposite style.

Greenfield, Keller et al (2003: 471) assert that ‘independence (individual) orientation and interdependence (collective) orientation are on a collision course in multicultural societies’. Moving from a collective society to an individualistic environment such as Australia has implications for parenting, gender roles, relationships and expectations for child behaviour. It also affects decision-making processes in terms of who is consulted when decisions for family health and welfare are to be made. Decisions may move from being made by a family or community to being made by an individual parent in the absence of family support or as a result of expectations from health professionals.
3.3 Evidence regarding themes from the literature

This section reports on the literature addressing key themes identified in the literature.

3.3.1 Pre-migration and post-migration

When reviewing literature on family health and decision-making of immigrants and refugees in their host country, experiences and attitudes before migration, such as in refugee camps should also be considered. Many factors affect the loss of identity and sense of self-control pre-migration as well as post-migration. These factors include social degradation, racism, feelings of marginality, changing family roles, guilt and sorrow (Samarasinghe and Arvidsson 2002). These can act to protect or erode personal and family health and wellbeing.

An insight into the turmoil and insecurity experienced by those living in a refugee camp was reported in Pavlish (2007). Congolese women interviewed in a Rwandan refugee camp described feeling like they had left ‘the good life behind’. They also reported being forced into prostitution to be able to provide necessities for their families. Mothers worried about their daughters’ welfare and spoke of losing hope for the future. Men reported similar issues and thoughts but also spoke of fearing for the future and having no ‘peace in the heart’ without being able to fulfil their role as father.

Almedom (2004) highlights differences between the health of displaced persons in two Eritrean camps due to features of both the relocation and the refugee camp infrastructure. It was reported that maintaining social connections, affirming belonging and reconstructing safety, order and normalcy had positive effects on refugee health. Despite the positive situation in one camp, continued displacement did stretch emotional, physical and material resources. Three types of social support were discussed: emotional; cognitive (including information, knowledge and advice); and material support that helped sustain health in the camps and could be applied post-migration (Jacobson 1986). Appropriate timing when providing the different types of support was emphasised.

Bates, Baird et al (2005) provide policy recommendations around ensuring those working with refugees have adequate background knowledge of experiences in the refugee camp to aid in anticipating possible barriers. They also recommend training in communication techniques to deal with unanticipated cultural misunderstandings. Education was advised to dispel a commonly reported myth that maintaining cultural identity impedes settlement. The need to develop flexible, culturally competent health and education systems to support refugees was emphasised.

Despite the multiple burdens experienced as a result of migration, the evidence indicates that refugee families display resilience and motivation in their adaptation to a new cultural and social setting (Samarasinghe and Arvidsson 2002). Their research identifies the importance of (i) primary prevention to reduce stressors and counteract harmful circumstance; (ii) secondary prevention aimed at protecting family structures; and (iii) tertiary prevention as intervention to re-establish stability in families.

3.3.2 Decision-making

Decision-making processes for immigrant and refugee families that successfully operated pre-migration are disrupted by separation from support networks through war, persecution or geography. Parents are often forced to make decisions without the previous input, support and general knowledge regarding health and local services and service providers to care for their families. This demands the
development of new, more independent decision-making. A variety of models for parental decision-making have been described in the literature.

In the decision-making process of Mexican-origin mothers the importance of husbands in managing child health was emphasised (Clark 2002). The author describes a process of symptom recognition, tentative diagnosis, coalescence of social network (generally husband) around the diagnosis and treatment plan, then seeking formal health care. However often mothers treated children with home remedies or visited Mexican pharmacies instead. Less acculturated women relied on their partner, not only for a second opinion and support to seek further treatment, but also for transport.

Dramatic changes to social, cultural and economic environments impact on health-related decision-making. Rossiter (1992) provides multiple examples of this post-childbirth when Vietnamese women have been unable to follow traditional practices. In the interests of being accepted and surviving in the new host country, mothers decided to adapt to mainstream practices of the host society. Traditional practices of breast feeding, food restrictions, confinement and keeping warm were abandoned, often due to having to follow Australian hospital systems, lack of support and financial pressures meaning mothers returned to work.

Not all studies attribute separation from home country with disruption to decision-making processes. Battacharya (2005) reported that Indian immigrants continue to rely on support and advice from family members still located in their country of origin when making decisions. This support was often rewarded by providing financial support.

Several authors have documented the decision-making phases of immigrant and refugee parents. Leduc and Proulx (2004) observed a triphasic model of health service utilization in immigrant parents in the United States. Parents firstly made contact with one or more health services, then selected a service via a filtering process based on attributes of the services e.g. language and past experiences and lastly consolidated their choice. At each stage they relied upon family, friends, neighbours, and, to a lesser extent, health care and other professionals. Location, opening hours, interpersonal and technical quality of services, and language spoken by health professionals and staff were key deciding factors.

Five phases of decision-making were identified by Liang (2005) when observing Taiwanese parents in the US. The health of the child was firstly assessed and examined by parents, after which time formal (written information) and informal (friends, parents) information sources were sought. Parents chose either natural/traditional or medical care practices. The child’s health was then reassessed and next steps of watchful waiting, a medical check-up or a prescription request. The study highlights the importance of good communication processes between parents, having correct and adequate health information, in multiple languages where possible.

### 3.3.3 Social support

Immigrant and refugee families arriving in Australia have often come from unstable environments and have lost many sources of support through migration. Wakefield & Poland (2005) assert that in order for migrant populations, to live happy, productive lives, social support, both emotional and practical is required. In addition to coping with routine stresses of moving, gaining social capital and social support can be an extra challenge due to the psychosocial distress of mourning people, places and
culture. Further, the political and social environment that is encountered post-migration can be hostile and unsupportive.

Several different types of support were identified in the literature. Simich (2003) looked at instrumental and emotional support as well as information as forms of social support. Post-migration, refugees seek out formal instrumental support such as government services, immigration officials and interpreters. The affirmational aspect of emotional support from family or peers is seen as important to reassure refugees and provide hope of having a good life in the new country. Social support regarding advanced, accurate information about what to expect (in regard to housing, employment and education) is seen as desirable and beneficial as it assists immigrants in imagining the possibility of wellbeing post-migration (Simich 2003).

Family ties remain strong and central to life despite distance and resettlement in a new country. Family and community are important not only in managing family care but also in terms of self-care (Colic-Peisker 2002). Social support is particularly important in chronological stages of decision-making and coping. These stages include the period of overseas refugee selection through to arrival in the host country where the presence of social support in the form of family or peers is a key factor in deciding where to live and can be the motivation for internal relocation post-migration (Simich 2003).

Peers were found to be key sources of information and social support for Indian immigrants in America (Bhattacharya 2005). They provided advice on daily life, for example, information about transport and shopping as well as cultural advice and language tips. Having a visible Indian community was seen as a source of pride and strength to participants. Connection with the Indian community protected to some extent, against isolation and acculturation stresses.

Being away from the home country does not absolve adults from responsibilities to the broader family. Shandy (2003) reported that Sudanese refugees in the US communicate with family members in Africa through all available forms of communication. As immigration is often achieved through the pooling of family resources, responsibility to support and/or help others immigrate is very important and can be a heavy burden. In a study of Filipinas in Australia, women discussed having to sever family ties in the Philippines as a result of not being able to fulfil their financial obligations (Thompson, Manderson et al. 2002). The high cost associated with travel home and phone calls also reduced family connections and left them without confidents.

Colic-Peisker and Tilbury (2003) discussed the reliance of the Australian government on formal and informal ethnic community support in the resettlement of immigrants. Formal support from the ethnic community such as the essential employment of bilingual workers has, however, decreased in the last two decades to force immigrants into mainstream services. This raises concerns about the cultural appropriateness of services and care provided. For true resettlement to begin and continue, ethnic communities are often required to provide constant informal support through social engagement and advice on managing daily life in the host country. Bhattacharya (2005) highlights the difficulty that Indian immigrants have in helping others settle into American life when they have little or no time to provide support them. Participants described introducing new arrivals to other community members but being unable to provide anything but basic assistance, and even that was considered by some to be impossible. Providing informal community support is more challenging for smaller, less well established communities such as African communities in Australia.
Attachment to place, familiarity with surroundings and identity (gaining a sense of self from place) link people to their environment (Fullilove 1996). Displacement interrupts and threatens these processes and the result can be nostalgia, disorientation, and alienation. Fullilove (1996) suggests that for a place to be considered ‘good enough’ one needs to feel settled in home, neighbourhood, region, to know neighbours and interact to solve problems. Resettlement in a new place requires the mourning of the former place and establishing attachment, familiarity and identity with new place. This process can be helped or hindered by the political and social environment of the host country.

When possible and due to structural pressures, new arrivals tend to live in areas populated by people of the same nationality or ethnicity. This can provide a source of information and cultural continuity as well as material and emotional support. Colic-Peisker (2002) highlights the tensions between immigrant community living and modern life in a consumer and economically driven society. She suggests that governments dislike migrant clusters as they function on bartering and trading systems and do not contribute to the wider economy. This can create a hostile political environment and lead to policies spreading the location of newly arrived immigrants and refugees, which is a potential threat to mental health.

Many research participants described experiencing hostility and discrimination from the broader community (Samarasinghe and Arvidsson 2002; Papadopoulos, Lees et al. 2004; Khan and Watson 2005; Tiilikainen 2005). However, Cuban refugees in one study generally reported satisfaction with the support environment in the United States (Barnes and Aguilar 2007). Two major sources of practical support nominated were other Cubans and re-settlement agencies. Emotional support was provided by other Cubans and in some cases English speaking friends. Many study participants used Cuban and local support networks and government services successfully. These findings were unusual as generally when discussing social support, supportive interactions with members of the host country are not reported by immigrants and refugees, with the exception of service providers. Acceptance and empathy as well as their opposite expressions were experienced by immigrant participants in a Swedish study and were directly linked to wellbeing during reporting (Samarasinghe and Arvidsson 2002).

Social networks amongst community members do not always, however, promote health. McMichael and Manderson (2004) suggest that, in the case of Somali refugees, social networks in the community can prevent women from using and creating social capital in the wider community to resettle. There were also significant barriers created by community members concerning maintaining family structures and gender roles around women seeking help or trying to leave abusive relationships (Bui 2003; Senturia, Sullivan et al. 2005).

### 3.3.4 Family relationships and life

The loss of extended family connections and changes in family dynamics emerged as one of the most significant aspects of migration and acculturation (Samarasinghe and Arvidsson 2002; Perreira, Chapman et al. 2006).

Weine, Muzurovic et al (2004) developed a model to describe changes in families displaced due to war, however it may be applied to any immigrant families adjusting to a new country and family dynamics. The model concerned changes in: family roles and obligations; family memories and communications; relationships with other family members; and family connections with the ethnic community and nation state. Families used a variety of strategies to manage the consequences of change such as rebuilding trust and communication, planning to visit or maintaining strong contact with extended family and teaching children about their culture and country.
A study of families experiencing involuntary migration by Samarasinghe & Arvidsson (2002) identified four qualitatively different categories that characterise the health of families. These categories are ‘distressed’, ‘contented’, ‘frustrated’ or ‘dejected’. Families in the distressed category were further divided into those ‘feeling despair’ and those ‘feeling hopeful’. Contented families were categorised as ‘being accepted’, ‘being employed’ and ‘having future plans’. Four sub-categories of frustrated families were ‘being unable to cater to all demands’, ‘feeling worried’, ‘feeling guilty’, ‘not being appreciated’ and ‘having flashbacks’. Lastly families in a dejected condition were categorised as ‘feeling unwelcome’, ‘being unemployed’, ‘feeling isolated’, ‘being marginalised’ and ‘losing the closeness’. Many of these categories and subcategories highlight the range of difficulties experienced by immigrant families socially, economically and psychologically.

American foster parents of Sudanese refugee children encountered a variety of challenges when trying to establish their new family (Bates, Baird et al. 2005). Several cultural misunderstandings around food were described (‘eating well’ vs greed, eating leftovers when unfamiliar with refrigeration, lack of prepared meals, gender roles with cooking). A common misunderstanding arose over regarding conflicting cultural expectations of eye contact with authority figures (direct eye contact versus avoidance). Typical affectionate displays between children of the same gender were misinterpreted by some foster parents. It was found that family roles were complicated and emotional bonding was delayed or did not occur between foster children and their new families. It was suggested that this occurred due to a combination of the children’s age, their separation experiences, relative lack of experience with family life and differing expectations between parties. Different expectations about the role of eldest children, for example, created power struggles and parents felt their authority was challenged. Foster parents were surprised that some children would act out, be aggressive or resistive and that Sudanese girls were not displaying the submissive behaviour anticipated.

Pereira, Chapman and Stein (2006) recommend that policy makers and practitioners capitalise on the resiliency of first-generation parents, by supporting them to build skills in parent-child communication and bicultural coping taking a dynamic rather than stereotypical approach to ethnicity. Identifying community-based resources for immigrant families and fostering development of more of these resources was also recommended.

3.3.5 Parenting in context of migration

Research investigating parenting consistently reports that migration imposes major challenges for parents in raising children. Parents are required to manage societal factors (such as social position, racism and discrimination and environmental factors), family factors (structures, roles, values, beliefs and goals), and child factors (age, gender, temperament, health status, physical characteristics) (Perreira, Chapman et al. 2006). At the interface of these factors parents are working, adapting to a different social system and having to manage diversity and access to resources. Whilst immigration is often precipitated by economic or political instability in a home country, the literature also indicates that, in the case of Latino families in one study (Perreira, Chapman et al. 2006), the decision to immigrate is based on a parenting decision.

The role of a mother is demanding in any context however expectations of what a ‘good’ mother is can be particularly challenging post-migration with reduced social support and additional pressures from language and financial problems. Liamputtong
(2006) describes motherhood and migration as a double burden. Becoming a mother was a transforming experience for Southeast Asian women and the belief was held that motherhood was a moral career. Caring for children and family was seen as compromised by long work hours, meaning women had to weigh up much needed money with time with their children. Language barriers were also noted as making motherhood more difficult as communication with children was compromised as was their ability to help with education, a key role of mothers. Parenting in a new culture with different ideals of what a good mother is, was an ongoing challenge. Post-migration difficulties with children following peers instead of their parents were also discussed. Ethiopian women in Finland also described the difficulties raising children in a new country without significantly reduced support, financial resources and time (Tiilikainen 2005).

The transnational perspective of acculturation can be applied to parenting and describes building parenting identity based on home country and host country (Deepak 2005). This perspective incorporates the way people continue to visit their home country, maintain cultural (music, gossip) and religious ties (Deepak 2005). The importance of teaching children respect and family centred behaviour including loyalty, reciprocity and solidarity toward family are central to Latino parenting and parenting in collective societies in general (Perreira, Chapman et al. 2006). Cultural expectations and ideals may vastly differ between the country of origin and host country and children of immigrants may adopt behaviours and attitudes perceived unfavourably by their parents and community (Deepak 2005). The result of this may be intergenerational conflict, which is commonly described by immigrant parents post-migration or creative ways to address new tensions.

The family unit must also adjust to different structural conditions and social systems. These include a disruption to parenting support systems and dealing with macro level issues. As with some other immigrant communities, south-Indian immigrants came from extended kinship networks. Their social hierarchy dictates that men and elders have more power than women and youth. Deepak (2005) explores the constraints and possibilities of migration and how immigrants negotiate to strengthen or stress family systems. Decision-making previously taken on by elders is somewhat maintained for these families however other parenting responsibilities becomes solely carried by parents. Parents discussed overcoming challenges such as fear of the unknown, racism, loss of social support and navigating foreign environments (work, school and neighbourhoods) (Perreira, Chapman et al. 2006).

Acculturative Family Distancing is a theoretical construct developed by Hwang (2006:397) which describes ‘the distancing that occurs between immigrant parents and children that is a result of immigration, cultural differences, and differing rates of acculturation’. This construct highlights the verbal and non-verbal communication breakdowns and the clashes of cultural values between the former collective societies and the new individualistic society that can occur between immigrant parents and children. Hwang hypothesizes that these issues will increase over time spent in the new country and as a result families may be at risk of mental illness and family dysfunction.

The maintenance of cultural heritage through food is considered important in immigrant communities. Somali parents reported wanting their children to eat Somali food, however peer pressures and difficulty transporting traditional food often meant that a western-style lunch box was packed (Burns, Webster et al. 2000). Children would then be given a ‘decent’ meal (i.e. a Somali meal) for dinner. Food is considered important to health and central to Somali culture and some mothers were concerned that since arrival in Australia diet, physical activity and appetite had
changed for the worse. It was also noted that children needed closer supervision in Australia, which added to time pressures felt by mothers.

First-generation parents are motivated and seek active support for themselves and their children. Immigrant parents use support services when they are available and accessible (Perreira, Chapman et al. 2006). New skills that parents adopted to cope with challenges concerned increasing social support and communication with their children, bicultural coping skills and relating in an empathetic and respectful way with adolescent children (Perreira, Chapman et al. 2006).

### 3.3.6 Gender

Several studies reported evidence of women adapting better than men to life in the host country (Kopinak 1999; Papadopoulos, Lees et al. 2004). Despite issues of being overloaded in their extended roles (Lipson and Miller 1994), re-settlement in a western country provided opportunities for newfound freedom and liberty and to become more active in public life. This increased freedom can create conflict as gender roles and cultural guidelines are negotiated. Shandy (2003) highlighted Somali men’s concern about the ‘unreasonable freedom’ given to women in Western countries.

The literature reports women and men’s experiences of having left behind ‘a good life’ (Pavlish 2007). Notably, this referred to having adequate food and resources, clear roles of women caring for children and helping husbands with agricultural activities, bartering, selling and buying food. Evidence regarding adaptation for men post-migration, indicates that they experience great difficulties to adjustment due to significant changes in their social status (Papadopoulos, Lees et al. 2004). It was also reported that men experience great frustration by not being able to fulfil their gender role as provider (Samarasinghe and Arvidsson 2002).

Immigrant men are often reported to have greater access to information, freedom of movement and more opportunities pre and post-migration to socialise, study and work than women (Senturia, Sullivan et al. 2005). As women are the primary carers of children within the family, the study by Senturia, Sullivan et al (2005) highlights the difficulty in being able to access information and assistance with health-related issues in their lives such as domestic violence. Gender issues were specified in terms of information gathering, the welfare and legal system and social support; exposing the difficulty immigrant women can have accessing and understanding financial and legal information.

Differences in immigration behaviour and health between men and women were reported for Bosnian refugees in a small Canadian study (Kopinak 1999). Bosnian women had an average stay of 18 months in an intermediate country (between Bosnia and Canada) and were often without male support. The resettlement period was hectic but they expressed pride at their ability to cope and the importance of learning English emerged as a key theme. Gender differences were noted with women reporting experiencing more problems (financial, emotional, physical) during displacement than men in the first country of resettlement. Experiences of resettling in the intermediate country appeared to equip women to resettle in Canada competently, whereas men had shorter transition times and did not learn these skills of resettlement, therefore had more trouble 'catching up'.
3.3.7 Concepts of health and wellbeing

Concepts of health and wellbeing were broad in the literature reviewed and generally embodied a social model of health. Health was defined as incorporating concepts such as belonging, peace, resiliency and family unity (Kopinak 1999), while happiness was considered a prerequisite for health (Papadopoulos, Lees et al. 2004). The corollary of this is that some people believed that sickness is caused by disease and mental illness and caused by both supernatural and psychosocial causes (Papadopoulos, Lees et al. 2004). McMichael and Manderson (2004) argued that well-being is not just about contemporary social structures & activities; it is also affected by how people use the past to give meaning to the present.

Difficulties with the immigration system, housing, unemployment and finding employment appropriate to qualifications, social services, social isolation stress of adaptation and settlement were linked with ill health (Papadopoulos, Lees et al. 2004). Most of the participants sought the help of their general practitioner in the first instance of illness although some had experienced difficulties accessing health services due to language problems and poor understanding of the primary healthcare system (Papadopoulos, Lees et al. 2004). Culture shock, low self-esteem, social isolation, employment barriers due to unrecognized professional skills and a key health indicator, low socioeconomic status also affects the health needs of migrants (Stewart and Do 2003).

For Vietnamese migrant women, barriers to accessing health services were exacerbated by health beliefs that did not support prevention and treatment (Stewart and Do 2003). These beliefs included that poor health is due to old age and that one should not inconvenience doctors and uneasiness about consulting a male doctor for sexual health matters.

Concepts relating to mental health and illness including their definitions and causes are influenced by culture (Thompson, Manderson et al. 2002). There is reportedly a distinction between the highly stigmatised ‘mental’ problems and ‘emotional’ problems which stem from loss of family ties. For Filipina immigrants in Australia, mental illness is seen as originating from isolation, a loss of social support and the change from collective to individualistic society. Emotional problems on the other hand are seen to arise from ‘everyday problems’ related to socioeconomic, social and cultural changes post-migration.

Tiilikinan (2005) explored social suffering and social memory in Ethiopian women as expressions of illness and experiences. The concept of social suffering includes pre-migration suffering from war, violence and life in refugee camps and post-migration suffering from ‘everyday [social] violence in host countries’ such as marginalisation, unfriendliness and unemployment. Women often described body pain and illness in relation to life difficulties post-migration including the hostile social environment experienced. It was described as unhealthy is to be without one’s kin, they are security, reputation, support, strength and considered vital to life.

A study of displaced Tigrinyans living in a refugee camp reported that extended time in the camp without knowing the future was seen as the cause of women losing peace of mind, with some losing their memory or ‘mind’ (Almedom 2004). Thinking too much, worrying and sighing was reported to be prevented by living in the same village communities (in the camp) and keeping track of news on a popular news radio station.
Research that systematically explores traditional belief systems of African women about health promotion and disease prevention is very limited (Carroll, Epstein et al. 2007). An understanding of health promotion beliefs is especially important when refugees are unfamiliar with principles of preventive health care endorsed by the United States, so that preventive health programs can be tailored to such groups incorporating their health beliefs. Thus, the purpose of this article is to explore the cultural and experiential foundation of health promotion and preventive health care in Somali refugee women. Many of these studies cite an “understanding divide” (i.e., cultural differences) that results in limited provision of preventive health care services, possibly due to differences in health beliefs, health literacy, or barriers to health care access. Participants in this study also defined their well-being in terms of being able to function in their role as mother, wife, and caregiver of the family, maintaining the household structure. Women who had concerns about their health or spoke of others in poor health often did so by describing how their health impaired their ability to perform household duties and care for their children.

Provision of language- and culturally-specific support, information and education are important (Senturia, Sullivan et al. 2005). Limited English impacts on immigrants’ and refugees’ ability to obtain driving licences and limited income and transportation options can impact on attendance.

3.3.8 Health service system
During the first years post-migration parents reported learning about health services by chance as health concerns came second to finding work and accommodation. Pre and post-immigration experiences, culture and opinions of family and friends contributed to their perception of health services (Leduc and Proulx 2004). The selection criteria of parents were made up of factors from and comparisons between the host and original country. Over time parents adjusted service usage from walk-in services to the regular sources of primary care. In the vast majority of families ethnic matching (seeking health workers from the same ethnic origin) appeared to be secondary to professional competence in determining the services selected.

Lack of awareness of health and support services is particularly salient to newly-arrived families (Senturia, Sullivan et al. 2005). Interviews with Vietnamese migrant women revealed their limited knowledge of health systems and services in Australia (Stewart and Do 2003). Most health related knowledge obtained was by word of mouth from their doctor or community. Even with knowledge of available health services significant barriers exist to prevent or block access. As with many newly arrived families language difficulties, transportation and time restraints and health literacy are major issues to overcome when accessing health services. Public transport systems can be difficult to navigate and require language skills and other life skills that are not always present on arrival. During the resettlement period most time is taken up organising essentials and orientation to the new surrounds, with children to care and families to care for time is further limited to discover and use health services. The resulting lack of access has a flow on effect to prevention, treatment and wellbeing of newly arrived families.

Information seeking and gathering is crucial to understanding health systems and using health services. Lipson (Lipson and Omidian 1997) defined four main problems experienced by Afghan refugees in the US: economic and occupational problems; health-care access; family and children's issues; and immigration issues/ethnic bias. For all problems it was noted that information was a key feature. She described that the scarcity of information and cultural differences in types, purposes and transmission of information. These factors were heavily influenced by isolation and cultural differences in interactions.
Accessing and using health services to care for sick children is a major challenge for parents living in a foreign country. The main barriers to care include cost of services and treatments, distance, discrimination and lack of bilingual workers or interpreters (Clark 2002). Negative perceptions of health encounters were commonly reported by Mexican-origin mothers in the US and are likely to be passed on by word of mouth to other community members. It was reported that mothers felt that conditions and treatments were not adequately explained to them by health care professionals as they thought the mother would not be smart enough to understand. The study also mentioned that there was underutilisation of most health services but overutilisation of emergency services, indicating that preventative measures and treatment for less significant medical events may be avoided until serious and urgent action is needed.
4.0 Conclusions

The wider study that this literature review addresses explores the factors central to the successful provision of culturally competent health promotion for African parents settling in Victoria.

This literature review began with the question:

What is known about the beliefs, values and culture that are fundamental to newly-arrived African families to connect with and respond to culturally competent health literacy and health promotion initiatives?

From searching the literature we have found no other studies that bring together the breadth of issues described in this report.

This review opens up issues that are often described in the anthropological and social sciences literature but emerge as central to supporting and promoting health and wellbeing appropriately.

In the context of re-settlement, families are managing multiple, complex issues and re-negotiation of roles, social networks, information gathering and decision-making.

Families and individuals adopt different styles of resettlement that are based on available resources and skills pre and post migration as well as attitudes and aspirations, hope for the new life.

The evidence and concepts detailed in this report will be taken forward into the fieldwork of this study.

The implications of this literature review are that an open and flexible research method is required to explore local knowledge, and explore the impact and potential benefits of a new approach. The outcomes will contribute to culturally competent health literacy and health promotion for African communities in the Victorian context. Moreover, the evidence this generates for addressing health literacy for newly-arrived African communities will be immediately transferable to addressing health literacy within other communities and for promoting health specific to other health issues on a wider scale.
References


Appendix 1

**PROJECT BRIEF TITLE: Health literacy and effective health promotion with vulnerable communities**

1. Research Question being addressed

| Describe and explain key factors that influence the ability of one or more vulnerable communities of interest in Victoria to understand health information and respond to health promotion initiatives? |
| Preference will be given to research proposals that adopt a community based participatory research (CBPR) model that engages communities. |

2. Rationale for the Project

| Health promotion initiatives in Victoria have been successful in preventing illness at a population level. There is evidence of inequalities in the success of health promotion initiatives particularly among vulnerable communities (such as some low income groups or some culturally and linguistically diverse groups). Local research is needed on the factors that inhibit health promotion among vulnerable communities and on the solutions that would support successful health promotion with communities. The research should work closely with at least one selected population group and provide clear recommendations to guide health promotion policy and program development. |

3. Project Aims and Objectives

| All project proposals must clearly respond to the broad project rationale stated above. Although a range of specific project proposals will be considered and are encouraged, the Public Health Branch also has a particular interest in the following distinct areas: |

**Nutrition and healthy eating**

This research project would provide an in-depth analysis of how food choices interact with literacy (defined broadly) and cost considerations of people experiencing disadvantage, and provide strategies to address the impact this has on their eating and shopping patterns.

**Islamic women's health promotion project**

Islamic women are a growing part of the Victoria community, however there is limited understanding of how their needs are addressed by current health promotion practices. This project would provide a better understanding of effective, culturally responsive health promotion strategies to address health needs and support health promotion priorities. This work would be informed by existing local health promotion innovations as well as identifying unaddressed needs and reflect an overall commitment to human service delivery in a multi-faith and ethnically/culturally diverse society.

**Health literacy in newly arrived African communities**

There is limited understanding of how the health needs of newly arrived African communities are addressed by current health promotion practices. This research project would assist the Department of Human Services better understand the ‘health literacy’ of newly arrived African communities in Victoria. This project would

i) investigate cultural understanding(s) of health needs (including the values
and traditions associated with healthcare in the country of origin, and alternative / traditional forms of therapy),

ii) the experiences (and expectations) of newly arrived African communities in relation to health services and health promotion, and

iii) develop principles and processes to enable health promotion initiatives to respond to these needs and issues.

4. Partners / Steering Committee

Engagement of the community being researched is acknowledged as a critical success factor for effective health promotion and health inequalities research. Research proposals must demonstrate a method and strategies to ensure engagement. In addition, informing health promotion practice requires the engagement of the health promotion / community welfare sector and relevant government agencies. Research proposals must demonstrate a willingness to work with government and relevant non-government organisations.

5. Outcomes / Deliverables (for program, for the wider sector)

The research must enable health promotion practice to respond to and reflect the needs of vulnerable communities. The specific outcomes will depend in part on the particular approach to the research question and the particular context examined and it is expected that research proposals clearly outline realistic outcomes. These projects must complement and contribute to the work of DHS e.g. Public Health Branch, Primary and Community Health Division and the Refugee Health Nurse Program, and support the DHS policy directions (for example as outlined in the DHS Cultural Diversity Guide and the Refugee Health & Wellbeing Action Plan).

6. Dissemination Strategy – for researchers & for policy, program, practice settings

There is a strong expectation that research proposals must address the issue of translating research results into practice (local health promotion practice and health promotion policy at a broader level). The research must be incorporated into relevant evidence and good practice resources for the development and management of health promotion initiatives in Victoria.

7. Contact Details - for queries related to this Project Brief:

Lynn Holt Telephone 9096 5244
Sue Casey Telephone 9096 7217

8. Contact Details - for queries related to the administration of the Research Project Funding Round:

Kay Munro or Sylvia Petrony, Research & Biotechnology Section
Telephone: 03 9096 5190
Appendix 2

Research team
Ms Julie Green (Principal Investigator), Research Fellow, Centre for Community Child Health, Murdoch Childrens Research Institute
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Professor Elizabeth Waters, Professorial Fellow, Public Health and Health Equity, McCaughey Centre, School of Population Health, University of Melbourne
Professor Maurice Eisenbruch, School of Psychology, Psychiatry and Psychological Medicine, Monash University
Professor Joseph Lo Bianco, Chair and Professor, Language and Literacy Education, Faculty of Education, The University of Melbourne
Professor Jennie Popay, Professor of Sociology and Public Health, Institute for Health Research, University of Lancaster, Lancaster, England

Complementary advisory groups
The research team will work with 2 complementary advisory groups:

1. an African Review Panel (ARP) (facilitated by co-investigator, Dr. Renzaho, who is a member of the African community in Victoria) consisting of community leaders and parent representatives. The ARP will advise on all aspects of the project, including the literature review, engaging communities, data collection and dissemination of information); and

2. Project Partners, a multidisciplinary advisory group to ensure input from experts on cultural competence in health, health literacy, community-based service provision particularly for newly-arrived communities, and adult learning for migrant communities.
### Appendix 3


#### A hierarchy of evidence-for-practice in qualitative research: summary features

<table>
<thead>
<tr>
<th>Study type</th>
<th>Features</th>
<th>Limitations</th>
<th>Evidence for Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single case study (Level IV)</td>
<td>Provides rich data on the views or experiences of one person. Can provide insight into specified, setting.</td>
<td>Does not analyze applicability to other contexts.</td>
<td>Alerts practitioners to the existence of an unusual phenomenon.</td>
</tr>
<tr>
<td>Descriptive studies (Level III)</td>
<td>Sample selected to illustrate practical rather than theoretical issues. Record a range of illustrative quotes including themes from the accounts of ‘many’, ‘most’ or ‘some’ study participants.</td>
<td>Do not report full range of responses. Sample not diversified to analyze how or why differences occur.</td>
<td>Demonstrate that a phenomenon exists in a defined group. Identify practice issues for further consideration.</td>
</tr>
<tr>
<td>Conceptual studies (Level II)</td>
<td>Theoretical concepts guide sample selection, based on analysis of literature. May be limited to one group about which little is known or a number of important sub-groups. Conceptual analysis recognizes diversity in participants’ views.</td>
<td>Theoretical concepts and minority or divergent views that emerge during analysis do not lead to further sampling. Categories for analysis may not be saturated.</td>
<td>Weaker designs identify the need for further research on other groups, or urge caution in practice. Well-developed studies can provide good evidence if residual uncertainties are clearly identified.</td>
</tr>
<tr>
<td>Generalizable studies (Level I)</td>
<td>Sampling focused by theory and the literature, extended as a result of analysis to capture diversity of experience. Analytic procedures comprehensive and clear. Located in the literature to assess relevance to other settings.</td>
<td>Main limitations are in reporting when the word length of articles does not allow a comprehensive account of complex procedures.</td>
<td>Clear indications for practice or policy may offer support for current practice, or critique with indicated directions for change.</td>
</tr>
</tbody>
</table>
Appendix 4

Database searches

- **MEDLINE**
  1. refugees/
  2. exp minority groups/
  3. "Emigration and Immigration"/
  4. "Transients and Migrants"/
  5. 1 or 2 or 3 or 4
  6. acculturation/
  7. (cultur$ and linguistic$ divers$).mp. [mp=title, original title, abstract, name of substance word, subject heading word]
  8. exp culture/
  9. cultural diversity/
  10. cultural competenc$.mp.
  11. cross-cultural comparison/ or cultural diversity/ or ethnology/
  12. cultural capital.mp.
  13. 6 or 8 or 9 or 10 or 11 or 12
  14. exp health/
  15. illness.mp.
  16. Health Knowledge, Attitudes, Practice/
  17. exp health behavior/
  18. exp Attitude to health/
  19. exp medicine, traditional/ or superstitions/
  20. social isolation/ or social alienation/
  21. community networks/ or social support/
  22. communication/ or communication barriers/ or disclosure/ or language/ or negotiating/ or nonverbal communication/
  23. mental health/ or "religion and psychology"/
  24. 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23
  25. Anthropology, Cultural/
  26. Qualitative Research/
  27. 5 and (13 or 7) and 24 and (25 or 26)

- **Sociological abstracts:**
  1. Health and knowledge and culture and (migrant or refugee)
  2. (Social capital or cultural capital) and culture and (migrant or refugee)

- **CINAHL:**
  1. refugees/
  2. "emigration and immigration"/ or "transients and migrants".mp. [mp=title, subject heading word, abstract, instrumentation]
  3. 1 or 2
  4. exp culture/
  5. (cultur$ and linguistic$ divers$).mp. [mp=title, subject heading word, abstract, instrumentation]
  6. acculturation/ or cultural diversity/ or cultural values/ or ethnic groups/ or ethnography/ or folklore/ or superstitions/
  7. Cultural Competence/
8. cultural capital.mp.
9. social capital/ or social networks/ or Support, Psychosocial/
10. attitude to health/ or health beliefs/
11. attitude to illness/ or attitude to mental illness/
12. Medicine, Traditional/
13. Social Isolation/
14. Social Alienation/
15. Community Networks/
16. Social Networks/
17. Support, Psychosocial.mp. [mp=title, subject heading word, abstract, instrumentation]
18. Social Capital/
19. COMMUNICATION BARRIERS/ or COMMUNICATION/
20. community development.mp.
21. Language/
22. mental health/ or "religion and psychology"
23. exp community health services/
24. 5 or 20 or 17 or (4 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 18 or 19 or 21 or 22 or 23)
25. Anthropology/
26. exp Qualitative Studies/
27. 25 or 26
28. 3 and 24 and 27
29. limit 28 to yr="1985 - 2007"

- PsycInfo
1. refugees/
2. immigration/
3. 1 or 2
4. (cultural$ and linguistic$ divers$).mp. [mp=title, abstract, heading word, table of contents, key concepts]
5. exp sociocultural factors/ or multiculturalism/ or "racial and ethnic differences"
6. health promotion/ or health attitudes/ or exp health behavior/ or exp health education/ or health knowledge/
7. community development/
8. social capital/ or human capital/ or exp social networks/
9. social networks/ or social support/
10. exp Health/ and exp Family/
11. "culture (anthropological)"/ or society/ or cross cultural psychology/ or cultural sensitivity/ or ethnology/ or multiculturalism/ or sociocultural factors/ or traditions/
12. acculturation/
13. cultural competency.mp.
14. health knowledge/ or health attitudes/ or health behavior/ or health education/ or health promotion/ or "mental illness (attitudes toward)"/ or "physical illness (attitudes toward)"
15. communication/
16. cross cultural communication/
17. communication barriers/
18. 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17
19. exp qualitative research/
20. anthropology/ or ethnography/ or ethnology/
21. 19 or 20
22. 3 and 18 and 21