MENTAL HEALTH PROMOTION THROUGH EMPOWERMENT AND COMMUNITY CAPACITY BUILDING AMONG EAST AND SOUTHEAST ASIAN IMMIGRANT AND REFUGEE WOMEN

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ABSTRACT

This article presents a demonstration project that used inclusive health promotion to address the mental health needs of East and Southeast Asian immigrant and refugee women in Toronto. The project demonstrated that effective mental health promotion must consider the social determinants of health, and integrate the principles of social inclusion, access and equity into practice.

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INTRODUCTION

Migration stress has been identified as one of the major determinants of immigrant mental health. As individuals and families go through the transition of settlement, they are often faced with increased stress related to the demands of adjusting to a new way of living: loss of family and social network (Stewart et al. 2008), loss of gainful employment and socio-economic status (Dean and Wilkson 2009; Picot, Hou and Coulombe, 2008), changes in roles and intergenerational conflicts (Chuang, Su and Tamis-Lemonda 2009; Este and Tachble 2009) and difficulties in social integration and accessing health and social care due to language and systemic barriers (Sabatier et al. 2008; Yee 2003). Immigrant and refugee women experience additional stress because they bear the extra burden of caring for their spouses, children, elders and other family members (Guruge and Collins 2008; Williams 2008; Zadeh, Geva and Rogers 2008).

Canada's immigration patterns have changed significantly since the 1970s. Over the past three decades, over half of all newcomers are from Asia; China, Hong Kong, Korea, Taiwan and Vietnam have been on the top ten source countries of immigrants.[1] Studies have shown that Asian immigrant and refugee women tend to have a much lower rate of health service utilization compared to their counter parts in general (Lee 2002; Li and Browne 2000; Tu et al. 1999). While some researchers attribute this low health service utilization to Asian cultural values, or health beliefs and practices (Chiu et al. 2005; Gilbert et al. 2004; Tsang 2004), other studies highlight the systemic barriers for newcomers to access services (Bottorff et al. 2004; Fung and Wong 2007).

This article presents the processes and outcomes of a demonstration project that used inclusive health promotion to address the mental health needs of East and Southeast Asian immigrant and refugee women in Toronto. The project considered and incorporated the diverse and unique contexts of the six target communities in its design and implementation. Consequently, the project demonstrated that effective mental health promotion must consider the social determinants of health, and integrate the principles of social inclusion, access and equity into practice.

THE PROJECT FRAMEWORK: PROMOTING HEALTH THROUGH COLLECTIVE EMPOWERMENT

In 2001, the authors collaborated with an ethno-specific mental health agency (Hong Fook Mental Health Association) to carry out an action research project funded by the Ontario Women's Health Council (OWHC) to identify the mental health needs of immigrant and refugee women from Cambodia, Hong Kong, Korea, Mainland China, Taiwan, and Vietnam, who lived in the Greater Toronto Area. The goals of the project were to promote mental health literacy among the women from the six communities and support them to make informed choices about their mental health needs and access to care. The project included two components: community assessment and peer-to-peer empowerment education.

Recognizing that our mental health is influenced by a myriad of socio-environmental factors beyond biology and genetics (Jackson 2004; Mawani 2008; World Health Organization 2001), this project used a comprehensive empowerment approach to promote mental health among women and their families in the six project communities. Empowerment refers to "a social action process that promotes participation of people, organizations and communities towards the goals of individual and community control, political efficacy, improved quality of life and social justice" (Wallerstein 1992, 198).

WOMEN'S HOLISTIC HEALTH PROMOTION: INTEGRATION OF THEORY, RESEARCH AND PRACTICE

There is a growing impetus for evidence-based policy and practice in health promotion; however, most knowledge translation and exchange (KTE) activities tend to privilege the interactions between researchers and policy-makers (Mitten 2007); frontline service providers and users are seldom included in the KTE process. With funding support from the Ontario Women's Health Council (OWHC), the Women's Holistic Health Promotion Project was able to engage community members, service providers and organizations to take part in an action research and follow-up program design. To ensure that the project was inclusive, a Community Advisory Committee with members from each community was established to advise the project at every stage. Furthermore, the project used an unconventional method to hire its staff. Recognizing that newcomers experienced systemic barriers to employment, the project made it a point to eliminate 'Canadian work experience' as a job requirement and hired five newcomer women. It also hired three Canadian-born or 1.5-generation young women who desired to connect to their cultural roots through community work. Bringing a diverse project team together facilitated cross-cultural exchange.

PHASE I – COMMUNITY ASSESSMENT: DOING RESEARCH WITH AND NOT FOR THE COMMUNITY

Effective health promotion starts from the perspectives and experience of the community members. Using mixed methods of focus groups, in-depth interviews and surveys, we conducted a community needs assessment to explore how women in the target communities conceptualized mental health, experienced migration and settlement, defined their mental health needs, and managed their stress and health. A total of 22 interviews with service providers (including spiritual leaders) of the six communities were conducted to gain a general understanding of the historical, cultural and local systemic environment that the women of the target populations faced.

The research respected community self-determination and exercised flexibility to enable the communities to define their research questions and needs. For instance, the Cambodian communities preferred to engage in KTE of previously completed research instead of engaging in a new research because of 'research fatigue'. Similarly, community consultation with stakeholders suggested the need to respect the distinct historical, political and cultural differences among the Taiwanese, Mainland Chinese and Hong Kong Chinese communities; as a result, the project re-allocated its resources to meet the unique needs of the three communities to ensure that all the research and empowerment education activities were conducted accordingly.

Fifty-four women, of 25 to 75 years of age of diverse socioeconomic backgrounds, participated in the in-depth interviews sharing with us the challenges they faced, the strategies they used, and the resources they mobilized in re-making their life in Canada. A total of 102 women, of 18 to 60 years of age, took part in 13 focus groups, where women articulated their conceptions of mental health and mental illness, as well as discussed factors that affected and helped maintain their mental health. The women participants' diverse articulations of mental health challenged the stereotypical characterizations of Asian women and the dominant Western views of mental

health; they viewed mental health and its social determinants as inseparable (Wong and Tsang 2004).

Developed in consultation with the Community Advisory Committee, a community survey of 1,000 self-administered structured questionnaires was conducted to identify the women's health status, and the relation between their mental health beliefs and help-seeking behavior. Contrary to the common discourse that immigrant women are reluctant to access mental health care because of stigma associated with mental illness, the survey results showed that the most important factor predicting attitudes towards seeking professional help was the women's perceived access to culturally appropriate services (Fung and Wong, 2007).

PHASE II – PARTICIPATION AS A PATH TO EMPOWERMENT

Informed by the results of the community assessment and guided by the framework of empowerment and capacity building, Phase II of the project emphasized the social determinants of mental health. It consisted of two key components: 1) health communication; and 2) empowerment education to promote health literacy, self-efficacy and collective empowerment.

1) Health Communication: Mental Health As Understanding

The goal of the campaign was to raise awareness of the mental health issues faced by women in the six project communities and the mental health resources available to them. The campaign theme of "Mental Health as Understanding" was identified from the preliminary findings of the focus groups and through consultation with our Community Advisory Committee. The Campaign included a 30-second Public Service Announcement (PSA) on TV and radio, and other print media in the six target communities. The PSA captured the following themes:

- the challenges for newcomers to gain adequate employment as they experience cultural, language and systemic barriers
- financial hardship experienced by low-income immigrant/refugee families in the settlement process;
- relationship tension and conflicts related to re-negotiation of gender roles in Canada;
- intercultural and intergenerational differences within the family; and
- the challenges of sole parenting for women whose partners have to work in Asia to support the family financially.

As part of the Health Communication Campaign, a Holistic Health Infoline for Women was set up to provide information and referral in the five project languages. A total of 236 calls to the Infoline and 552 calls to Hong Fook's Intake Line were received over a period of 3 months immediately following the campaign; these calls represented a 67% increase in comparison to the calls received over the 3 months before the campaign.

2) Peer Leadership Training and Peer-to-Peer Outreach

The Women's Holistic Health Peer Leadership Training Program was developed based on adult learning theory and critical pedagogy (Freire 1971). It aimed to support the participants to identify their individual and collective strengths to overcome the cultural and systemic barriers they encounter in their daily lives. In this context, empowerment is not about service providers giving power to women in the community. Rather, it is about creating opportunities for women to participate meaningfully within their communities and integrate into society at large (Labonte 1994).

Furthermore, the peer leadership training used a train-the-trainer model, whereby the project staff went through an intensive course of training that consisted of 10 sessions. Upon its completion, the project staff recruited women from their respective communities to take part in the peer leadership project; they also applied their new knowledge and skills to train more women to become peer leaders. The training program was free of charge and in return the women peer leadership course graduates were encouraged and supported to do holistic health promotion outreach and education to other women or families in their own cultural communities.

Two project manuals were developed for the leadership training: 1) a training manual used by the project staff to train the women peer leaders; and 2) a workshop manual used by the women peer leaders to facilitate discussion groups and workshops among their peers in the communities. The manuals covered a range of topics derived from the research results and existing literature, including collective learning, migration and settlement experience, women's identity and family relations, social determinants of health, effective communications, stress management, and collective actions to promote health.

In April 2002, the first round of "Women's Holistic Health Peer Leadership Training" program recruited over 161 women from the six project communities to form 11 peer leadership groups. Over a period of five months, a total of 127 women peer leaders completed the training program These peer leaders were proactive in their peer outreach; they collaborated with other community agencies and faith organizations to provide workshops and outreach activities on holistic health. Between July 2002 and March 2003, they conducted over 79 workshops and outreach activities, reaching 5,029 participants. They also put together a collective book project, *Beyond rice & noodles—Our stories, our journey*, to share their migration

stories and their strategies of maintaining health in the midst of hardships.[2] The women peer leaders' commitment and successes were celebrated at the Women's Holistic Health Peer Leadership Graduation Ceremony held in October 2002.

In addition to the above collective actions, the women leaders also demonstrated increased self-efficacy in political action beyond their cultural communities; for example, during an advocacy campaign to "Save Medicare", the Korean peer leaders collected over 10,000 signatures from the Korean churches, street campaigns, and from their social networks to present to the provincial legislature. Towards the end of this pilot initiative, the original peer leaders were supported to become co-facilitators in the training of new groups of peer leaders. This model provides leadership opportunities, skill building and expansion of social support network.

SUSTAINABILITY

Sustainability of health promotion programs is a well-recognized challenge among practitioners, administrators and policy-makers alike. Many innovative and effective programs delivered by small agencies eventually dissolve due to the lack of strategies and resources to sustain these programs. Furthermore, there is not a clear definition of sustainability (St Leger 2005). To develop sustainable programming, an organization must have a clear definition of what constitutes sustainability and what are the necessary conditions. In the context of this project, sustainability means the agency's ability to continue the empowerment education and outreach beyond the funding provided by the OWHC. Thus, program sustainability is dependent on other resources in addition to funding, such as the program's fit with the organization's mandate; its flexibility to be modified to meet the changing needs of the community; its ability to outreach to the intended clients, and the capacity of the key stakeholders (Sheirer 2005).

Upon the completion of the pilot project, the peer leadership initiative took on a life of its own. Hong Fook adopted empowerment and peer leadership as its program mandate in mental health promotion. Many women peer leaders continued to do outreach activities in their communities, where they met many individual and families experiencing mental health problems. They recognized that stigma associated with mental illness was a significant barrier to promoting mental health and collective empowerment; they expressed the need for additional training on mental illnesses and anti-stigma strategies. Based on their feedback, Hong Fook worked with the peer leaders to develop materials for a new phase of training, which focused on two key topics: mental health and illness as a continuum, and stigma as a determinant of health. This time, the agency also included men who were interested in the peer training.

Before 2001, Hong Fook had a total of 50 volunteers committed to community outreach and promotion. In 2003, Hong Fook integrated empowerment and capacity building into its health promotion program. The agency has since increased their pools of volunteers to more than 200 holistic health women and men peer leaders who do outreach at the grassroots level to provide culturally appropriate health information and to influence community attitude in reducing stigma about mental illness.

CONCLUSION: INCLUSIVE AND EQUITABLE SERVICES AS BEST PRACTICES

The peer leadership training and outreach initiative, which started as a pilot project in 2001, has proven to be an effective and sustainable health promotion program. Over the past eight years, project staff have reviewed and reflected on the processes and outcomes of this initiative and shared this knowledge with researchers, service providers and policy makers (Wong et al., 2002; Wong, 2003; Wong, Wong and Fung 2003; Wong, Wong & Yoo, 2009). Within the mental health field, there is a recent call for moving mental health promotion into the mainstream. The Hong Fook peer leadership training initiative has demonstrated that mental health promotion is achievable through the use of collective empowerment and capacity building as key strategies. More importantly, best practices are 'best' only if they are relevant and effective. To be effective, we must go beyond the popular discourses of 'cultural competence' and 'cultural sensitivity' to integrate the principles of social justice, access and equity into the research-policy-practice cycle to guide interventions at the grassroots, and mandates and directions within health organizations and public policy in the government sector, with the common goal of addressing the social determinants of mental health.

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FOOTNOTES

[1] All information about the top ten source countries of immigrants to Canada since 1979 is retrieved from the annual statistics tables provided by Citizenship and Immigration Canada. Available online: http://www.cic.gc.ca, retrieved on June 2, 2004.

[2] Altogether, four project publications were published and made available for service providers and women peer leaders. They were: "Women's Holistic Health Peer Leadership Training: Training Manual"; "Embracing Our Body, Mind, and Spirit: Holistic Health Promotion for Women: Community Workshop Manual"; "Stress and Mental Health Pamphlet"; and "Beyond Rice & Noodles—Our Stories, Our Journey: Health Strategies of East and Southeast Asian Immigrant Women". They are available from the Hong Fook Mental Health Association Webstie, http://www.hongfook.ca/en/health_info/OtherPublications.asp.