Multicultural Heart Health Partnership

Exploring Best Practices for Heart Health with Culturally Diverse Communities

Final Report – September 6, 2001
Dedication

This paper is dedicated to the memory of Carrie Choi. Carrie was a Masters of Health Sciences student in Community Nutrition at the University of Toronto. Her community nutrition placement with Toronto Public Health included assisting with the literature review for this project. Carrie died in a tragic car collision on June 30, 2001. She was bright, energetic, talented and dedicated. She will be missed by all who knew her.

Acknowledgements

This project was guided by the members of the Multicultural Heart Health Project, including:
Loan Ta, Parkdale Community Health Centre (Co-chair)
Krista Fry, Scadding Court Cafe (Co-chair)
Alice Lam, Queen West Community Health Centre
Anthony Cheng, Heart & Stroke Foundation
Baljit Dongriaih, Riverdale Immigrant Womens’ Centre
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Gheeta Sharma, Women's Health In Women's Hands
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Patty Wong, Regent Park Community Health Centre
Sandra Almeida, Access Alliance Multicultural Community Health Centre
Sonja Nerad, Access Alliance Multicultural Community Health Centre

Research, project management, analysis and writing were conducted by consultants Glen Brown, Alan Li and Wendy Pinder. Carrie Choi and Christopher Smith assisted them in the literature reviews.

Focus groups were organized and facilitated by Carmen Viloslavich-Vera, Isabel Palmar, Loan Ta, Tuyet Le, Baljit Dongraih, Jayanthi Reynold, Ewa Milewska, Alice Lam and Alan Li.

We are very grateful to the community members who participated in focus groups and the health promoters who participated in interviews. They were generous with their time and wisdom.
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**Introduction**

The Multicultural Heart Health Partnership (MHHP) is a project of the Toronto (South Region) Heart Health Partnership. The “Best Practices for Heart Health with Culturally Diverse Communities” is a major project of MHHP. In this first phase, the project set out to explore cultural and linguistic issues that would impact on heart health and on health promotion strategies for several linguistic groups in Toronto. A second phase of the project will build on this work to develop heart health promotion strategies that can further explore these ideas.

The seven linguistic groups selected were:
- Cantonese
- Polish
- Portuguese
- Punjabi
- Spanish
- Tamil
- Vietnamese

We reviewed some of the available literature describing health promotion issues and strategies related to diverse populations in general and the above populations in particular. Focus groups of 6 to 10 members of the selected populations were held to explore their health behaviours and attitudes. ‘Key informant’ interviews were conducted with one to three people who provide health services to each of the language groups, to seek their experience and advice on health behaviours and strategies. A discussion paper was presented to a workshop with MHHP representatives; their input is reflected in this report.

**Cautions**

A number of cautions should be highlighted in reading this report and in developing related heart health promotion strategies.

- A common language does not equate to a homogenous culture. Some of the linguistic groups in this study represent widely diverse geographic backgrounds with very different cultures and traditions. Even those groups that tend to represent a definable geographic ‘homeland’ will have as much diversity within them as between them and other linguistic groups. Factors of age, gender, ‘acculturation’, social class and income will have as much impact on heart health behaviour and attitudes as language.
  
  *As Pasick et al note, “studies have repeatedly shown racial and ethnic differences overwhelmed by indicators of social class” in their impact on health. Even within a*
more defined culture, the authors note “the use of culture to subdivide population groups for intervention targeting will be crude at best.”

- The recruitment process for focus groups participants did not create a random sampling of the population. Participants were recruited by MHHP members and contacts, most of whom work in community health centres (CHCs). Many of the focus group participants had some association with CHCs or other health promotion programs, and are therefore more likely to be knowledgeable about and motivated by health information. They are also less likely to be socially isolated.

- The literature review for this project was neither exhaustive nor exclusively scientific. Given time limitations, we restricted our review to sources and documents we hoped (often in vain) would be ‘high yield.’ We included in our review documents published by other agencies or news media that have not been subject to scientific rigour. They may reflect the biases of their authors or the limitations of their methodologies.

- The use of the term “Best Practices” in the project title may itself be misleading. The term has no standard definition, but implies some measure of evidence-based legitimacy. There is limited data on the effectiveness of health promotion strategies, in particular those aimed at specific populations. One definition of best practice is provided by Burke et al from the Association of Ontario Health Centres: “Best practices aim to (1) adapt practice in ways that suit the particular issue and context and (2) share stories, tools and understanding so that we don't keep reinventing the wheel. Best practices include the incorporation of: philosophy and values, guidelines for practice based on evidence, indicators of positive intervention and processes of staff, volunteer and community involvement.”

**Action Research**

With the above cautions in mind, we are confident that this report represents a significant contribution to existing knowledge about heart health issues. The research method recognized and validated the knowledge that exists within the linguistic communities themselves. We valued the lived experience of our focus group participants, and solicited the expertise of health promoters working in the communities.

All of the focus group discussions were held in the language of the group. Facilitators fluent in the language and familiar with health promotion led the focus group discussions while translators helped the consultants understand the content. We believe that this process allowed for a fuller contribution from, and discussion between, focus group participants whose first language is not English.

**Cultural Competency & Cultural Tailoring**

The provision of health services best suited to specific population groups has been the subject of much study and debate in recent years. The theory and practice is often called “cultural competency”. One definition suggests it is “a set of congruent behaviours,
attitudes and policies that come together in a system, agency or profession that enables that system, agency or profession to work effectively in cross-cultural situations.” (Chung, 1992).

Three characteristics have been suggested by Proctor et al for practitioners to become culturally competent; “First, the practitioner needs to be aware of his or her own beliefs and attitudes about racial and ethnic minorities in order not to impose these feelings on his or her patient. Second, practitioners need to understand and be aware of the world views of the patient without judging them. The practitioner also needs to be aware of how race, culture, and ethnicity affects personality and personal choices, as well as life experiences. Third, the practitioner must be able to use culturally competent skills when interacting with a racially or ethnically minority patient.”

Pasick et al offer a useful definition for culture as it relates to health promotion: “Culture is revealed through the unique shared values, beliefs and practices that (1) are directly associated with a health-related behaviour, (2) are indirectly associated with that behaviour and/or (3) influence acceptance and adoption of the health education message.”

The same authors suggest an important variation on cultural competency. They propose “cultural tailoring” as “the development of interventions, strategies, messages and materials to conform with specific cultural characteristics. The evolution from targeting to tailoring moves us beneath the surface of race and ethnicity to the factors that more directly influence behaviour and health. These include the values, beliefs and traditions of different cultures within communities, as well as the living environment and opportunities or lack of opportunities that affect health behaviour and cultural expression.” They argue that serving multicultural communities requires the capacity to “reach across populations when possible but to tailor as necessary.”

They suggest that tailoring could best be employed by “segmenting the community not by ethnicity, but by differential health risks.” This would suggest education strategies could be tailored to such systemic health risks as income, environment, and social supports and to such individual risks as age, lifestyle, and prior heart health illness.

Heart Health

Heart disease is the number one cause of death among men and women. The Heart and Stroke Foundation of Canada estimated the total cost to Canada of cardiovascular disease in 1993 as $19.7 billion.

The risk of heart disease can be influenced by genetics and age, but is also influenced by environmental, social, economic and ‘lifestyle’ variables. Health promotion interventions therefore include both community development models and risk-reduction models.

More information about heart health can be found from organizations such as the Heart and Stroke Foundation (www.hsf.ca or 1-800-473-4636) or the Heart Health Resource Centre (www.hhrc.net of 1-800-267-6817).
Our discussions and interviews during this project tended to focus on the cultural and linguistic impacts on lifestyle variables, especially diet, exercise and smoking. We would be remiss, however, if we did not begin with the most significant determinants of heart health: economic and social conditions

**Economic and Social Conditions Affect Heart Health**

In a soon to be published report, York University associate professor *Dennis Raphael* reviews the extensive body of research that indicates “the economic and social conditions under which people live their lives, rather than medical treatments and lifestyle choices, are the major factors determining whether they fall prey to cardiovascular disease.”

The report identifies “social exclusion” caused by poverty and exclusion from civic participation as a key factor in heart disease and stroke. The report is particularly timely because of recent and ongoing “societal changes that increase the numbers of Canadians living on low income and foster social exclusion.” He notes further that policies which create greater income inequality undermine the heart health of all Canadians, not just the poor.

The impact of poverty and social exclusion are particularly acute for Canadians from racial, ethnic or linguistic minorities. For new immigrants, the transition to a new home and culture has economic and social costs. Moreover, systemic racism suppresses the employment status and income of non-white Torontonians regardless of their education or duration of residence. Recent studies by *Ornstein* and by *Galabuzi* demonstrate that racialized groups (the authors’ preferred term for non-white people) earned less, were more likely to be unemployed, and were less likely to have highly-paid jobs than white people. The gaps between racialized and non-racialized individuals were true whether they were recent immigrants or Canadian-born and regardless of education levels.

The impacts of poverty and social exclusion on heart health are numerous and interrelated. A few examples:

- Stress – of poverty, of unemployment, of physically and emotionally demanding jobs – is a direct factor in heart health and may also impair motivation for lifestyle change.
- Lack of time or energy due to over-demanding or multiple jobs limits opportunities for exercise, purchase or preparation of food, participation in health promotion programs, etc.
- Lack of money or resources to acquire a nutritious, balanced diet.
- Access to exercise venues (gyms, pools, etc) is increasingly restricted by cost.

Many of these issues were identified – without prompting from facilitators – by focus group participants. The stresses and time limitations created by low-paying jobs were raised repeatedly as barriers to healthy practices. The costs of nutritious food and of exercise venues were also frequent complaints.

Efforts to address the social and economic determinants of heart health could therefore be the highest priority of health promoters. It is possible that that such efforts would also be
valuable in developing trust and motivation for behaviour change among the communities most affected by those conditions.

**Recommendation 1:** Health promoters should maintain alliances with social justice organizations to advocate for policies which reduce poverty and income inequality.

**Recommendation 2:** Health promoters should maintain alliances with equity groups to advocate for policies which reduce systemic racism and improve conditions for immigrants and ethno-cultural groups.

**Recommendation 3:** Health promoters should maintain partnerships and joint referrals with agencies that provide services to ease settlement for immigrants.

**Recommendation 4:** Health promoters should be explicit in their education programs and literature about the impact of social and economic factors on heart health, and about the need for advocacy to address those factors. (Although many health promoters currently address social policy as part of their work, those efforts tend to be invisible in the “consumer” literature and programs. Consumers could perhaps become their own advocates for social policy change if given sufficient ammunition.)

**The Environment and Heart Health**

As this report is being written, Toronto is emerging from a record summer of smog alerts. Although our literature search did not attempt to find evidence of heart risk from smog, our common sense suggests the risk would be high. We also suspect that current conditions could be a significant de-motivator for heart health behaviour change; it is conceivable on smog days than sitting on a couch smoking a cigarette is less harmful to your health than a vigorous walk outdoors.

The impact of smog risk is higher for people on lower incomes, who are less likely to have air conditioning in their homes, workplaces and social spaces.

**Recommendation 5:** Health promoters should maintain alliances with environmental groups to advocate for policies that support a clean and safe environment.

The issue of air pollution was not raised frequently by focus group participants (this may be influenced by the fact that the groups were held before the summer smog attack). However, a remarkable number of participants, across many of the groups, expressed concern about additives, pesticides and genetic-modifications in their food. Although we are not aware of any evidence that such additives are risk factors for heart health, we believe that such concern signals a healthy interest in eating ‘good food’. Some participants linked this concern to the concern that mass-produced fruits and vegetables were less tasty and mass-produced meats were more fatty.
Recommendation 6: Heart health promotion programs and literature should assist people with advice on finding (or growing) healthy, fresh, nutritious and tasty foods. These themes should be linked in a positive way.

Common Issues and Strategies Across All Groups

A number of common issues and strategies arose from the literature, focus groups and interviews.

- All groups and practitioners welcomed and/or desired information in their own language and in plain language. Ideally, materials should be ‘culturally appropriate and original’, not just translations from English. Some materials already exist for all the linguistic groups in this study, but their quality, distribution and visibility seem highly variable. There does not appear to be a central clearinghouse to produce, distribute or publicize materials.

Recommendation 7: Resources should be provided to ensure culturally appropriate educational materials for each of the seven languages. Ideally, these should be original texts, not just straight translations from English materials. Informational brochures would be the most cost-effective, but video materials would also be advisable if resources permit.

Recommendation 8: A lead agency should be identified in Toronto to serve as a resource centre for brochures and related materials. At minimum, the centre should be a central distribution site for existing materials. If additional resources permit, the centre could also coordinate the production, distribution, promotion and reproduction of brochures and related materials. Potential agencies could include the Heart Health Resource Centre, Toronto Public Health, the Heart & Stroke Foundation or the Health Resource & Wellness Centre at Toronto Western Hospital.

- A number of participants and interviewees indicated a need for very practical and specific information on healthy food choices. Some said they knew it was a good idea to eat healthy, but did not know what that entailed. We also heard a number of misconceptions in the focus group discussions that affirm the need for more practical information.

Recommendation 9: Culturally and linguistically appropriate Information resources should be produced and distributed which provide concrete examples of healthy and non-healthy food choices. The materials should reflect and validate dietary traditions for the linguistic group and that provide recipes or cooking tips.

- All groups indicated that peers were a major source of information about health and health programs. Many indicated that their interest in a health issue was peaked when they or someone they knew had a related health problem. Although peer-based knowledge is common in all cultures, it may be even more crucial in minority groups.
whose social networks help protect them from being overwhelmed by the dominant culture.

**Recommendation 10:** Health promoters should recruit and support peer leaders to develop and share their health knowledge with their communities. (This could include a role in distributing information resources from recommendation 7)

**Recommendation 10b:** Health promoters should recruit and support heart event survivors to become peer leaders in sharing their lessons learned with their communities.

- All groups indicated a desire for social and learning opportunities in their own language, and praised the workshop programs they participated in CHCs. (This might be partly biased by the fact that most focus group participants had a prior association with CHC programs). Many people also noted that the information or activities they sought was most important for their families or communities, not just themselves.

**Recommendation 11:** Health promoters should continue to offer and widely publicize heart health workshops in the languages of the communities. The workshops should build on people’s desire to help not only themselves but their families and communities. Workshops should be practical (eg exercise lessons, cooking classes) and, when possible, feature ‘experts’ as presenters.

- All groups indicated that they sought health advice and health services from both allopathic (Western medicine) and non-allopathic practitioners. In many cases the non-allopathic practitioners were the first resort, and more likely to be consulted on preventative issues. This may provide an important avenue for health promoters to spread their messages and recruit program participants.

**Recommendation 12:** Health promoters should develop relationships with complementary therapists and solicit their support in encouraging healthy heart behaviour, distributing heart health information and informing clients of heart health programs.

- Many groups and interviewees expressed concern that current heart health promotion is not reaching as wide an audience as needed, and that this was particularly critical for socially isolated groups and people whose first language is not English. A number of suggestions surfaced to address this.

**Recommendation 13:** Health promoters should develop a strategy and related materials to transmit heart health information via ethnic media. This could include regular health columns, question & answer columns, media events, interviews, etc.

**Recommendation 14:** Health promoters should develop relationships with service providers for immigrant communities (ESL, skills training, etc) to solicit their support in encouraging healthy heart behaviour, distributing heart health information and informing clients of heart health programs.
Recommendation 15: Health promoters should maintain relationships with religious leaders in identified linguistic communities to solicit their support in encouraging healthy heart behaviour, distributing heart health information and informing members of heart health programs.

Recommendation 16: Health promoters should develop relationships with school boards and teachers to educate students about heart health issues and to encourage students to share heart health information with their families.

Recommendation 17: Health promoters should provide culturally appropriate heart health information to newsletters for community organizations such as community centres and food banks.

Recommendation 18: Health promoters should encourage publication of culturally appropriate heart health information on a website such as the Heart Health Resource Centre web site.

Innovative Programming

Throughout the research for this project, the programs we encountered addressing heart health issues for diverse communities impressed us. We want to offer a few examples to illustrate the innovative, culturally appropriate programs that may suggest “best practices” for future work.

- Theatre of the Oppressed: participants act out real-life stories in five-minute plays that portray a health issue (such as poor diet). Participants are then involved in discussing solutions to the problems. This is an empowering program, rather than telling people what to think.

- Cooking Demonstrations: Practical, hands-on cooking demonstrations allow people to learn healthy recipes in an enjoyable atmosphere.

- Culturally appropriate Materials: The Heart and Stroke Foundation publishes a number of brochures in different languages that address heart risk issues and solutions. For example, their Punjabi brochure suggests changes in cooking methods to reduce fat content in traditional South Asian cuisine.

- Historic Walks of the Neighbourhood: Parkdale Community Health Centre hosted walks that provided fun, exercise, and education about the participants’ neighbourhood histories.
**Issues and Strategies for Each Linguistic Group**

The following comments reflect information gathered from focus group participants, interviews, and a variety of documents. We have not attempted to validate this information.

We have attempted to highlight ‘Culturally Specific Strategies” in the final column. These are suggestions which came from multiple sources (focus group participants, key informants, etc) or seemed uniquely suited to the group.

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<thead>
<tr>
<th>Linguistic Group</th>
<th>Community &amp; Culture</th>
<th>Factors Influencing Heart Health</th>
<th>Generic Strategies</th>
<th>Culturally Specific Strategies</th>
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<tbody>
<tr>
<td>Cantonese</td>
<td>Highly educated; strong reliance on tradition, including traditional Chinese medicine; emphasis on balance, including with food; strong emphasis on food (what you take into your body); some element of fatalism (you inherit from previous generations); strong emphasis on spiritual harmony; health is a reward/punishment for behaviour; you are just a link in the chain of your family; the opinion hierarchy relies on the patriarch, but is highly influenced by the matriarch; one defers to the person with most education; balance western information with eastern philosophy</td>
<td>Possible low awareness of smoking risk and of diabetes risk. Stress and lack of time. Lack of clear information on foods. Cost of healthy food. Younger generation eating more junk food. Many people engage in physical activity; it is part of culture (including tai chi). Lack of access to gyms. Smoking is social activity. Some dietary practices healthy (soups, teas).</td>
<td>Use organizations &amp; people with authority. Increase use of mass media. Public outreach in malls. Encourage ‘well person’ physicals.</td>
<td><strong>Promote culturally relevant exercises (tai chi, etc).</strong> Clear information on smoking and other risk. Target parents for food information. Reinforce benefits of healthy Chinese diet practices.</td>
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<td><strong>Polish</strong></td>
<td>Strong sense of community; strong respect for elders; religious leaders have strong influence</td>
<td>Some diet traditions from homeland are unhealthy; family members may pressure to keep unhealthy foods in diet; social situations make diet restrictions hard; varying levels of trust in doctors; herbal teas are common; eating at home is common (although changing with younger generation); people like gardening; not much exercise; not enough access to Polish-speaking health care professionals, especially nutritionists and other specialists.</td>
<td>People are eager to share information with their friends; encourage people to laugh; encourage “buddies” for exercise; encourage owning dogs for exercise; emphasise that healthy/natural food tastes better</td>
<td>Polish media are cooperative; desire for more Polish-language programs and materials; Need for Polish health programs in Mississauga; More people would attend workshops if speaker was a specialist/expert;</td>
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<td><strong>Portuguese</strong></td>
<td>Very different cultures from different homelands (Portugal, Brazil, Angola, Azores, etc); there is some sense of joint community through common language and programs; newer immigrants tend to be more assimilated than previous generations; many work very long hours and are therefore difficult to reach; people are very concerned about other’s perceptions</td>
<td>Stress; excessive work; Olive oil a key dietary ingredient; not much variety in diet – lots of meat and potatoes; lots of fish; jobs tend to be physical so no desire for additional exercise; higher than average smoking in men; cost of food; desire for taste (and misconception that healthy food has no taste); fear of pollution</td>
<td>Need language-specific programs and materials; need good information on exercise; advocate for healthy ‘fast food’ alternatives (rice &amp; beans, salad, etc); use theatre for programs; cooking demonstrations are popular.</td>
<td>Portuguese media is very powerful, willing to cooperate with health promoters; some church leaders will assist with distributing some materials &amp; messages; new mothers are an eager audience. Need to mobilize communities, not individuals Emphasize healthy, tasty dietary traditions (spices, olive oil);</td>
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<td>Punjabi</td>
<td>People live in large family structures; strong sense of community; neighbours help each other; there is high respect for grandparents; some grandmothers will tend to several families' children; grandparents make many of the food decisions; people believe in life after death and in rebirth; religious centres play a strong role; people have strong faith in doctors, even for non-medical issues; South Asians have a much higher rate of heart disease than other ethnic groups. People are physically active, but may not think of it as 'exercise'; there is more drinking in the younger generation; smoking is not common, especially in the home. Unhealthy dietary traditions include many foods fried in oils or ‘ghee’ butter. Stress is an important factor. Much use of herbal medications.</td>
<td>People want information from other people, not media; religious leaders might be approached to spread messages.</td>
<td>Workshops need to incorporate the need to socialize and eat.</td>
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<td>Spanish</td>
<td>Large diversity in geographic and cultural backgrounds; strong desires for better quality of life; families tend to be patriarchal; Latin culture emphasizes social priorities and environments; Latin families are extended, strong and very social; food is social activity. Many people are without official status</td>
<td>Concern with environment/additives; use of home remedies and informal advice; poverty, cost of food; lack of time; diets may include too many fried and fatty foods;</td>
<td>More social learning opportunities; use family structure for programs.</td>
<td>More workshops in Spanish.. Music and food attract people. Use Hispanic media, networks to attract people. Latin culture would see exercise as social, not individual; Weekend workshops may not work.</td>
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<td>Tamil</td>
<td>High respect for elders, especially grandmothers; elders do grocery shopping; strong belief in life after death; neighbours help each other (for instance, with baby sitting). Focus on holistic health. High regard for religious leaders. Traditional beliefs</td>
<td>Stress, lack of time; drinking and smoking are common; cost of good foods; inability to read package ingredients; lack of clear information; exercise not part of lifestyle because of workloads; smoking linked to social events. Heart health is perceived to be a men’s issue.</td>
<td>Provide clear information on healthy/non-healthy foods; work with religious leaders</td>
<td>More information in Tamil; cooking classes; use Tamil media and other services to publicize. Link to other efforts to ease transition to Canada; Emphasize</td>
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<td>Vietnamese</td>
<td>Strong hierarchy of authority, with doctors ranked very high, family members second; focus on holistic health approaches; high value on moderation; mostly women do cooking; women and young children shape decisions around food.</td>
<td>Prevention is not a priority; people think in the present; cooking is not 'measured'; limited knowledge about exercise; there was more physical activity in home country; smoking is widespread with older generation men, for whom it is a social activity; little knowledge of dangers of 2nd hand smoke; in Vietnam, lard and salt are common in diet; social pressures to overindulge at parties.</td>
<td>Practical, hands-on workshops with real value for participants. Focus on families; use health experts; encourage word-of-mouth. Be creative, link messages to daily living. Involve people at planning stages.</td>
<td>Emphasize community, sense of belonging, in workshops. Get community leaders involved. Consider honoraria for peer leaders. Raise awareness through Vietnamese media. Some 'taboo' topics (sexual health, marital relationships and addictions) require creative, tactful responses.</td>
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