

IMMIGRANT YOUTH IN CANADIAN HEALTH PROMOTING SCHOOLS: A LITERATURE REVIEW

JEUNES IMMIGRANTS AU SEIN DES ÉCOLES AXÉES SUR LA PROMOTION DE LA SANTÉ AU CANADA : UNE REVUE DES ÉCRITS

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Résumé de l'article

Cet article explore la documentation empirique, théorique ainsi que la littérature grise traitant des jeunes immigrants et des écoles axées sur la promotion de la santé. Nous y faisons l'examen du concept de promotion de la santé et la manière dont celui-ci peut façonner le contexte de ces écoles. En utilisant le Canada comme exemple, nous examinons les tendances démographiques actuelles chez la jeunesse immigrante. Nous définissons également plusieurs termes-clés tels qu'immigrant, jeunesse et santé. Notre étude met en lumière d'importants fossés cognitifs en lien avec le rôle de l'éducation et la migration comme préalables à la santé et au bien-être des jeunes immigrants. Celle-ci aborde aussi des approches qualitatives et éducationnelles. Nous terminons en formulant des suggestions de pistes de recherches concernant la recherche sur les jeunes immigrants dans le contexte des écoles axées sur la promotion de la santé.

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ABSTRACT. In this essay, we review empirical, theoretical, and substantial grey literature in relation to immigrant youth and health promoting schools (HPS). We examine the health promotion youth concept to consider how it may inform the HPS model. Using Canada as an example, we examine current immigrant youth demographics and define several key terms including immigrant, youth, and health. Our review highlights important knowledge gaps related to the role of education and migration as antecedents to immigrant youth health and wellbeing as well as qualitative and educational research approaches. We conclude by providing recommendations for future immigrant youth research in the context of HPS.

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RÉSUMÉ. Cet article explore la documentation empirique, théorique ainsi que la littérature grise traitant des jeunes immigrants et des écoles axées sur la promotion de la santé. Nous y faisons l'examen du concept de promotion de la santé et la manière dont celui-ci peut façonner le contexte de ces écoles. En utilisant le Canada comme exemple, nous examinons les tendances démographiques actuelles chez la jeunesse immigrante. Nous définissons également plusieurs termes-clés tels qu'immigrant, jeunesse et santé. Notre étude met en lumière d'importants fossés cognitifs en lien avec le rôle de l'éducation et la migration comme préalables à la santé et au bien-être des jeunes immigrants. Celle-ci aborde aussi des approches qualitatives et éducationnelles. Nous terminons en formulant des suggestions de pistes de recherches concernant la recherche sur les jeunes immigrants dans le contexte des écoles axées sur la promotion de la santé.

Contemporary society continues to witness the relocation of different groups of people to more socio-politically stable settings. As well as increasing population figures, immigrants contribute to many aspects of host nation culture, including health, education, and economy. The ability of immigrants to successfully

integrate into existing cultures is dependent on factors such as class, education, duration of residence, and the context of migration (Hauck, Lo, Maxwell, & Reynolds 2014; Ogbu & Simmons, 1998; Ramanathan, 2015). Whereas some immigrants relocate willingly for socio-economic reasons, others, such as refugees and slaves, by virtue of their powerlessness, may have little control over their migration patterns. This review contributes to the conversation on how health promoting schools (HPS) impact and can be transformed to more effectively benefit immigrant students and their families. To our knowledge, there is no literature review, in recent years, that has focused on immigrant youth and HPS in the context of Canada. We present review findings under three areas: a history of health promotion, HPS, and immigrant youth. In the first section we discuss our review approach and define several key terms. This is followed by a presentation of the main themes arising from the literature review. We conclude by providing recommendations for future immigrant youth research in the context of HPS.

OUR REVIEW APPROACH

In this paper we appraise empirical, theoretical, and substantial grey (e.g., government documents) literature surrounding immigrant youth and HPS. This review was conducted to support a research project examining African immigrant secondary school students' participation in HPS. The review has a North American focus because its corresponding study was based in Canada. Except for germinal works, the review included literature published within the last 10 years. The review method employed in this essay was guided by established protocols (Jesson, Matheson, & Lacey, 2011; Mertens, 2015). Several databases and search engines were used including ProQuest, Oxford Journals, SAGE Journals online, WorldCat, PubMed, and EBSCO CINAHL. The following search terms were used: immigrant (adolescents / students / youth) health, health promotion, and comprehensive school health / HPS. All relevant publications were organized into an annotated bibliography composed of the following sections: methods, key findings, and conclusion. The next step involved sifting through the annotated bibliography for common categories and grouping them, using basic content analysis procedures (Hsieh & Shannon, 2005). This process produced three main themes, namely, history of health promotion, HPS, and immigrant youth, which were interpreted using Cooper and White's (2012) qualitative research framework. We believe Cooper and White's critical-based framework of biography, history, governance, post-modern, and philosophy provides a crucial foundation for contemporary health studies. Drawing on Cooper and White, the genesis of health promotion was explored as it was considered germane to the development of the HPS concept. Additionally, the immediate and broader social influences on immigrant youth health were particularly interrogated throughout the essay. We begin by defining five key terms: immigrant, youth, health, social determinants of health, and health equity.

Immigrant

Newbold (2005) and the United Nations (UN, 2002, 2013) defined *immigrant* as a person who has relocated to a new jurisdiction. This view of immigrant does not explicitly address legal issues associated with traversing national boundaries. Expanding upon these definitions, Statistics Canada (2010) considered place of birth as well as particulars of residency: “[immigrants are] persons residing in Canada who were born outside of Canada, excluding temporary foreign workers, Canadian citizens born outside Canada and those with student or working visas” (para. 1). By emphasizing residency, Statistics Canada alluded to what appears to be an exclusive notion of immigrant. It looks like Canadian Council of Refugees (2010) and Citizenship and Immigration Canada (2012) subscribe to Statistics Canada’s perspective of immigrants. Temporary residence persons can significantly contribute to host nation’s social context, hence, it is important to regard them as immigrants. For the purpose of this review, we defined immigrant as an individual who has permission from immigration officials to reside in a foreign country permanently or temporarily. For example, foreign students with valid study visas were regarded as immigrants within this review.

Youth

Similar to immigrant, the term *youth* has several interpretations. According to the UN (2007), youth are individuals aged 15 to 24 years. Despite its use by the United Nations Educational, Scientific and Cultural Organization (UNESCO, n.d.) and Statistics Canada (2012), this perspective of youth excludes contextual factors such as cognition and relationships with the social environment. For the purpose of this review, we adopted Airhihienbuwa’s (2007) definition of youth, which accounts for social context: “[youth] is that period in a person’s life between childhood and adulthood. This period may include preteen, teen, and some post teen years” (p. 77).

Health

The World Health Organization (WHO, 2006) interpreted *health* as a synthesis of factors outside the sickness and cure or biomedical model: “[health] is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (p. 1). Unlike Huber et al. (2011), who viewed health as the capacity to thrive, the WHO definition addresses bodily, cognitive, and environmental dimensions of health as suggested by many researchers in the field (Bourgeault, 2010; McPherson, 2012; Spitzer, 2012). While emphasizing the clear biological aspect of health, the illness and healing or biomedical approach misses other crucial contexts of human life such as politics, economics, and history. For the purposes of this review, the WHO definition was adopted. We use the expanded term *health and wellbeing* as way to provide a broader context to enrich this review.

Social determinants of health

Raphael (2009) defined the social determinants of health (SDH) in relation to community and production. WHO (2016) included the various contexts of human life in their SDH discussion: “The social determinants of health are the conditions in which people are born, grow, live, work and age” (para. 2). McGibbon and Etowa (2009) noted that the SDH are “well-recognized antecedents to health and well-being” (p. 41). Each of these definitions, it can be said, position SDH within human-created constructs, such as gender, race, class, and colonization. The work of McGibbon (2012) linked the SDH to health inequities and politics, suggesting that to study health equity is necessarily to interrogate underlying issues of power and social justice.

Health equity

Braveman and Gruskin (2003) defined equity in health as elimination of differences in capacities to interact successfully with the various determinants of health and wellbeing. McGibbon (2012) and Edwards and Di Ruggiero (2011) viewed inequities in health not as abstractions but as oppressive forces produced and perpetuated in everyday life through complex interactions between human individuals and social structure. Further, McPherson (2012) regarded equity in health as a political, social justice, and ethical issue, which should be addressed categorically in public policy. Similar to social determinants of health, health inequities are grounded in socio-eco-politics and critical theory perspectives. In the following section, we discuss the three themes emerging from this review: a brief history of health promotion, HPS, and immigrant youth.

A BRIEF HISTORY OF HEALTH PROMOTION

This brief history of the health promotion concept is explored in three chronological phases that are linked to key conferences and documents. The Lalonde Report (1974), the Declaration of Alma-Ata (WHO, 1978), and the Ottawa Charter (WHO, 1986) were three crucial and internationally recognized documents that form landmark phases in the development of the health promotion concept.

The Lalonde Report

In 1974, the then federal Minister of National Health and Welfare Canada, the Honourable Marc Lalonde, made a remarkable addition to the field of public health as the first Canadian (and likely global) public figure to recognize determinants of health outside the traditional illness and cure or biomedical approach. Lalonde’s (1974) historic report, *A New Perspective on the Health of Canadians*, is thought to be the first document to officially coin the phrase “health promotion” (Bell & Joly, 1998). Despite the impact of the Lalonde Report on moving the health promotion model forward, the report’s concepts

were perceived to advance the commodification of the human body, triggering undue expectations of monetary gains by the medical practitioners because of its focus on individual health choices (Labonte & Penfold, 1981). The notion of lifestyles, which pays more attention to individuals rather than social context, is widely regarded as the major deterrent to early health promotion efforts because, in fact, people make health choices in relation to many “historical, political, social and economic” (McGibbon, 2012, p. 19) conditions.

The Declaration of Alma-Ata

Alma-Ata, a city in what was then Russia (Kazakhstan, since 1991), hosted the first international conference on primary health care, which is the provision of health care in the context of both the biomedical model and the various determinants of health (Public Health Agency Canada, 2012a). Similar to Lalonde’s (1974) report, the conference recognized determinants of health outside the conventional biomedical approach, including concerns about health inequities within and among countries. The participants at the Alma-Ata conference reiterated the definition of health, which included physical, emotional, and social factors and foreshadowed the integrated approach to health that was later adopted by Canada in 1986. This renewed interest in health was understandable considering the historical timing of the conference. It was held during the Cold War and after the Vietnam War and the sexual revolution, when the status quo in many aspects of society was being questioned (Herold, 1984; Mann 1967). Given this context, the delegates at the Alma-Ata conference recognized social, economic, and political circumstances as significant for health and wellbeing. By acknowledging the role of conditions outside the traditional biomedical strategy, the declaration of Alma-Ata (WHO, 1978) portended the emergence of both health promotion and population health concepts. Population health is an integrated approach to public health with a particular emphasis on the social determinants of health (Public Health Agency Canada, 2012b).

The Ottawa Charter

On 21 November 1986, the city of Ottawa hosted the first known international conference on health promotion. The Ottawa Charter (WHO, 1986) was a publication of this conference, which recognized determinants of health outside the conventional biomedical model, calling for an integrated approach to public health. According to the WHO (n.d.), the 1986 Charter acknowledged personal health choices people make and further encouraged a collective and broader outlook on public health. Since that time, the health promotion concept has been adopted worldwide with the central theme being the recognition of people as significant actors in and determinants of their own health. Further, the Charter’s framework highlighted the importance of relationships, especially of individuals with other people and surrounding material resources.

The Ottawa Charter (WHO, 1986) has, however, been discredited by some scholars for at least two reasons: firstly, for alleged lack of rigorous empirical evidence to support its themes and, secondly, for its inadequate emphasis on the social determinants of health (McQueen & De Salazar, 2011; Potvin & Jones, 2011; Raphael, 2008). While noting these shortcomings, it is reasonable to say that the Ottawa Charter brought to the fore the need to look beyond the hegemonic biomedical approach to health, encouraged a sense of community, and underlined the role of the social environment on health status. Although health promotion has influenced various public health interventions, the early 1990s saw the rise of a competing concept – population health. This concept placed concrete emphasis on fundamental needs of people beyond the customary biomedical strategy to include the social determinants of health.

Given the aforementioned limitations of the health promotion concept, in North America, there was clear interest in a reconceptualization of health promotion to address the impact of social determinants of health within the emerging *population health promotion* model (Hamilton & Bhatti, 1996). Unlike health promotion, population health had a more positivistic tone (Bell & Joly, 1998), which would arguably attract jurisdictions that prioritize quantitative research. Because of its insistence on community, health promotion as enshrined in the Ottawa Charter (WHO, 1986) contradicts neo-liberal ideologies' emphasis on individuality. We note the absence of reference to education in the Ottawa Charter; this aspect became a focus only in succeeding WHO conferences. Although the Ottawa Charter set a distinct standard, subsequent WHO health promotion conferences advanced the health promotion conceptual framework. These conferences (WHO, 1997; WHO, 2009; WHO, 2013) situated health promotion and HPS within social constructivist and critical theory perspectives.

HEALTH PROMOTING SCHOOLS (HPS)

In 1952, Turner proposed the first known comprehensive approach to school health programming. Similar to the Ottawa Charter (WHO, 1986), Turner used the term *community*, demonstrating her insistence upon the significance of shared intentions between schools and their milieus. From an education perspective, it is important to note that Turner underlined the central role of health education in school health promotion. However, like the Ottawa Charter, and reminiscent of the earlier strict biomedical approach to health policy and planning, Turner's early model poorly emphasized other dimensions intersecting and impacting human life, such as politics and history.

The developing HPS model

Allensworth and Kolbe (1987) proposed a more elaborate school health framework. The model by Allensworth and Kolbe expanded upon Turner's (1952) earlier design with the addition of various school-based projects: combined school and community health promotion, physical education, food services,

counselling, and health promotion for teachers and staff. Consistent with the Ottawa Charter (WHO, 1986) recommendations, Allensworth and Kolbe's expanded model depicted the school as a self-sustaining entity with teachers, students, other school staff, and principals enmeshed in a supportive school environment. This model shows the integration of various human services in a concerted effort to achieve both health and educational goals. Unlike Turner, Allensworth and Kolbe's model does not underline the centrality of health education to HPS. Rather, their emphasis is on a diffuse array of health areas. Allensworth and Kolbe's model separates physical education from health education, and does not address some issues of contemporary importance, such as sexual health education and mental health education. Sawyer et al. (2010) and Macnab (2013) called for the provision of sufficient time for students to develop their own concepts regarding health issues and topics in HPS programming.

According to the literature (Flaschberger, Gugglberger & Dietscher, 2013; Leger, 1998; Simovska, Nordin & Madsen, 2015), the role of teachers in HPS is not well defined. A focus on teachers is critical because they are key to effective student interactions with health services. To the extent that teachers are responsible for teaching health education subjects such as sexual health education, physical education, and health and human services, which greatly influence students' health consciousness, the success of HPS arguably hinges on the teacher and the curriculum. The following programs, currently in use today, strongly emphasize educational dimensions such as pedagogy and the curriculum: Denmark HPS (Jensen, 2002) and Schools for Health in Ireland (2013). Except for Schools for Health in Ireland, the other HPS models considered in this review do not actually refer to the Ottawa Charter (WHO, 1986) or the health sector's definitions of health promotion. This is not surprising considering that the Charter does not highlight the role of schools as health promotion sites.

HPS research

There are two overarching HPS research approaches, emphasizing the biomedical and education fields of study. Despite extensive recognition of the central role of teachers and the curriculum in HPS programming, educational research on the contribution of schooling to health decision-making is reported to be scant (Lee 2009; Venka, 2012). Busch, de Leeuw, de Harder, and Schrijvers (2013) observed uncertainty regarding the effectiveness of the HPS model, particularly in relation to role of parents and the impact of school environments on students' health and wellbeing. They also noted the existence of a discernible gap in the use of qualitative research designs to examine HPS. Consistent with the work of Busch et al. (2013), findings by Bonell et al. (2013) and Samdal and Rowling (2011) raised questions about the significance of HPS across diverse cultures, highlighting the need for culturally relevant health promo-

tion. There are several on-going health promotion initiatives across Canada in areas such as nutrition, sexual health, substance (ab)use, and physical activity (APPLE Schools, 2009; Pan-Canadian Joint Consortium for School Health, 2016; Tri-county Health Promoting Schools, n.d.). Studies conducted in Canada (Deschesnes, Trudeau, & Kébé, 2010; McIsaac, Read, Veugelers, & Kirk, 2013; McIsaac, Sim, Penney, Kirk, & Veugelers, 2012) underscored the importance of culture and collaboration among HPS stakeholders. However, there is little discussion in the literature regarding how the HPS school environment affects students and their families. Particularly, there is a dearth of Canadian-based empirical studies that examine the impact of HPS programs on school populations or stakeholders (including students, teachers, staff, and parents) from diverse cultures.

Students are significant actors in social structures such as schools and their participation in HPS is vital. It is widely agreed that meaningful student participation is a key indicator of the effectiveness of HPS (de Róiste, Kelly, Molcho, Gavin, & Nic Gabhainn, 2012; Griebler, Rojatz, Simovska & Forster, 2014; Simovska, 2007). As posited by Simovska (2004), student participation in HPS encompasses active engagement in school activities, acquisition of substantial health knowledge, critical thinking, and is context-driven and political. Simovska (2004) identified two distinct modes of student engagement in HPS, namely *token* (or passive) and *genuine* (or active). Students' involvement in HPS is influenced by multiple factors including program design, students' personal backgrounds, school organization, other school stakeholders, and the school's immediate community (Griebler et al., 2014; Simovska, 2007; Simovska & Carlsson, 2012). Griebler and colleagues recommended further exploration of the role of students' personal, historical, and cultural circumstances, and how these shape and are shaped by HPS. In the following section, we describe some of the features of immigrant youth as noted in the research literature.

IMMIGRANT YOUTH

In addition to the daunting task of transitioning to adulthood in a fast-changing world like other youth across the globe, immigrant youth are forced to negotiate alien social structures. It is essential for researchers working with immigrant youth to consider distinctions within and between different immigrant populations because immigrants come from diverse historical and political backgrounds (George & Bassani, 2013; Gushulak, Pottie, Roberts, Torres, & DesMeules, 2011). For example, African nations generally have very strong cultural ties bound by a philosophy of unity known as *Ubuntu* (Murove, 2014). Similarly, *fatalism*, the belief that human life is all predetermined, is considered to be a key aspect of Chinese and Korean conceptions of health and wellbeing (Heiniger, Sherman, Shaw, & Costa, 2013). While an awareness of peoples' shared intentions provides a sense of their typical outlooks to life, it is important to consider individual contexts because many personal-social

constructs, including reflexivity, gender, and class, influence health consciousness, beliefs, and practices. As argued by de Róiste et al. (2012) and Griebler et al. (2014), health promotion that is tailored to an individual's needs in the context of their culture encourages genuine participation, which is antecedent to successful interaction with health resources.

Social demographics of Canadian immigrant youth

Research on immigrant youth health in Canada focused primarily on the larger provinces of Ontario, Quebec, Alberta, and British Columbia (Gushulak et al., 2011; Wideman-Johnston, 2014). According to the 2011 Canada census, 14.5% of people who migrated to Canada between 2006 and 2011 were youth aged 15 to 24 years, with most of them settling in large urban areas such as Toronto, Vancouver, Montreal, and Calgary (Statistics Canada, 2011). Between 2005 and 2014, more than 357,000 youth migrated to Canada and became permanent residents (Citizenship and Immigration Canada, 2015). The latest Canadian census (Statistics Canada, 2014) revealed an influx of immigrant youth from all continents of the world, with countries in Asia and Europe providing the highest numbers. Our review of the social demographics of youth who immigrate to Canada revealed three key issues. Firstly, as of 2014, nearly 1.9% (approximately 662,000 people) of Canada's population consisted of immigrant youth, many of whom reside in provinces with major urban centers. Secondly, immigrant youth health research from smaller provinces, such as Nova Scotia, appears to be scant. Thirdly, data for youth with temporary residence status appears to be missing.

Health and wellbeing of immigrant youth

According to Wideman-Johnston (2014), social determinants of health, emotional wellbeing, and health equity are some of the major health issues affecting immigrant youth in Canada. Wideman-Johnston's work highlighted the personal-social and history as important aspects of immigrant youth health and wellbeing. As indicated by Edwards and Di Ruggiero (2011), the health and wellbeing of immigrant youth is influenced by many social determinants of health such as gender, class, and education. A deep understanding of the role of multiple contexts is pivotal to immigrant youth health research. Edwards and Di Ruggiero recommended a comprehensive investigation of immigrant populations' social contexts. There is growing interest in migration as an important dimension of immigrant health research. In particular, the need to account for the impact of *pre*, *in*, and *post*-migration is a recurring suggestion in the literature (Hui & Barozzino, 2013; Perreira & Ornelas, 2011; Vo, 2014; Williams & Sternthal, 2010). While Williams and Sternthal placed class at the center of migration discourses, Brookfield (2005) considered race and gender to be more important. More recent literature (Ford & Airhenbuwa, 2010; Perreira & Ornelas, 2011; Thomas, Quinn, Butler, Fryer, & Garza, 2011) situated race and racism at the heart of immigrant health conversations.

DISCUSSION

The intersection of school stakeholders' health and wellbeing with several human-created constructs, such as culture, gender, and politics, makes HPS programming a complex undertaking. HPS as sociocultural artifacts are contested territories because they are embedded in socio-eco-politics. Our literature review highlights a need to ground HPS programming in education discourses, and to clarify the significance of health promotion concepts to the teaching practices of Canadian educators. This argument brings to the fore the role of teacher education and professional development with regards to health promotion in schools. The fact that it was more than 10 years after the Ottawa Charter (WHO, 1986) that the WHO, the global health custodian, focused on schools as health promotion settings is cause for concern. We call upon the WHO to expressly include education leadership in the formulation of policies in the area of health promotion because school and schooling are arguably key contexts of human health and development.

The ever-increasing diversity of school populations in Canada and many other countries warrants continuous appraisal of school-based health promotion. It is arguable that the success of health promotion in schools is dependent upon the relevance and quality of health services provided to school populations. We acknowledge Simovska's (2004) and the WHO's (1997) emphasis on student engagement, which underlines the importance of examining how immigrant youth perceive their participation in HPS. It is crucial to understand immigrant youth's historical situations in order to promote self-consciousness and advocacy. Attending to students' personal-sociocultural contexts can encourage authentic engagement with health and education resources, which can ultimately empower their decision-making. We believe it is imperative to consider the health perspectives of immigrant students who are not only integral components of HPS, but like other youth worldwide, have capacities to influence their own health and wellbeing. In the context of this literature review, we make the following recommendations:

1. Quantitative-oriented research designs have dominated HPS research despite calls for more qualitative studies into the role of schooling in students' health decision-making. Because teachers, pedagogy, and the curriculum are central to HPS programming, the need for qualitative educational research approaches is apparent, such as critical pedagogy, critical race theory, and (participatory) action research methodologies.
2. There is a paucity of empirical knowledge on the impact of HPS on immigrant school populations in Canada and, particularly, areas without large urban centers such as Atlantic Canada. This knowledge gap should also be a focus for future research.

3. This review highlighted a need to further interrogate the role of migration, specifically, pre-, in-, and post-migration, as a determinant of immigrant youth health and wellbeing. For example, future research should include in-depth studies about how conditions within and without countries of origin shape immigrant students' conceptions of school and schooling and health and wellbeing.
4. The intricate nature of immigrant youth and HPS research demands diverse interpretive frameworks, particularly social constructivist and critical theory methodologies. This is because many social determinants of health, such as race, gender, class, colonization, and migration, intersect to form complex systems that influence immigrant youth health and wellbeing. Given the many sociocultural constraints to immigrant youth integration into the Canadian culture, their participation in HPS is potentially contestable. A lack of dialogue on the positioning of immigrant youth in schools, between various concerned parties (such as government, school boards, and teachers), may compromise the quality of education provided to these students. Future research and practice should seek specific ways to understand immigrant youth worldviews in order to provide them with relevant and well-coordinated educational services.

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