University of Alberta

Exploring Understandings and/or Knowledge of Maternity Nurses in Caring for Immigrant/Refugee Women of African Origin

By

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Abstract

Background: A variety of factors may interplay between nurses and maternity clients of diverse ethnic origins to disrupt effective ethnocultural care encounters. **Study Aim/Research Questions:** The aim of this study was to explore maternity nurses care experiences with African immigrant/refugee women. **Methodology:** Focused ethnography. **Methods:** Data collection through a purposive sample using semi-structured interviews. **Location/Setting:** Maternity units of three acute care hospitals of Alberta, Canada. **Participant Number & Characteristics:** Twelve maternity nurses of RN or LPN designation. **Approach to Analysis:** A cyclical, iterative process of data collection & analysis with Atlas.ti6©. **Findings:** Maternity nurses use multiple ways of gaining knowledge and information to negotiate ethnocultural care encounters. Awareness of larger social structures that impede deeper critical reflection and assessment is needed. **Implications:** This research study has the potential to affect positive learning outcomes amongst nurses such as improved therapeutic communication, care decision making and subsequent nurse-client relationships in ethno-cultural encounters.

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Chapter 1- Topic of Research Interest

This chapter gives an overview of the research problem and the reason for the pursuit of additional information in maternity nursing care with immigrant African women. The background of the Canadian context regarding immigration and health is then given to further elucidate reasons for more focused research on immigrant health such as this research project. Specific examples of challenges immigrant African women face in Canada are given to direct attention back to the focal area of research. The research purpose, research questions and limitations are described in this introductory chapter to summarize the gains and insights proposed through this research. A list of definitions is also provided for terms used in the text to provide more depth of meaning for each term. The following chapters of this thesis include a literature review, methodology description, methods section, data analysis, discussion conclusion section. Appendices are also included with references made to them according to their relevance throughout the text of this thesis.

Statement of Research Interest

Maternity services are a main point of entry into the Canadian health care system for immigrant women; birthing ventures being a natural point in

time when women seek the help of others. Alberta is one of the four top provinces which receive immigrants/refugees from African countries. Studies have shown there are a variety of challenges for maternity nurses in caring for immigrant women of African origin yet very little Canadian nursing research exists on immigrant/refugee women and health care providers' experiences. Decades after the development of transcultural nursing, nursing clinicians are still challenged with the integration of ethno-cultural care into their everyday practice. The front line application of cultural competence, awareness, sensitivity and most recently, cultural safety continues appear to lack depth and breadth of meaning. Both individual and systemic factors exist that have eroded nurses' ability to provide individualized, holistic care. Language and communication, inability to understand the immigrant women's perspectives and responsive behaviours within a predominantly 'biomedicalized' Western health care system, as well as larger institutional issues of racism and discrimination are sources that create disconnectedness in our nurse-patient relationships and are some examples of barriers to effective ethno-cultural care. With an increase in recent newcomers from African countries, how are nurses truly able to provide meaningful care if they are not equipped to negotiate encounters with diverse patients?

Background in the Canadian Context

Whether man, animal, insect or plant, living creatures of the world experience selective movement from one location to another, be it for man-made or natural reasons. Migration of human kind, however, is filled with the greater social/societal complexities of interactions between distinct groups. Whether it is an abrupt collision or more subtle fusion, negotiating between-group relationships are an inevitable reality. Canada used immigration as a population expansion policy. Canada's economic growth and prosperity was, and still is, largely dependent on the migration of many diverse ethno-cultural groups. Rapid recruitment of many people was necessary to develop government infrastructure, industry and to secure the vast geography of Canada. Canadian history is rich with successes and failures, of developments and impasses. In examining our experiential history with immigration, it is notable that Canada continues to struggle with transition and resettlement. One such indicator of struggle and challenge is immigrant health (Beiser, 2005; Hyman 2001). Canadian researchers report a variety of medical conditions of concern upon arrival or soon thereafter such as tuberculosis, syphilis, and mental health decline, however variations exist dependent on factors such immigrant status, language proficiency, and educational level(Beiser, 2005; Hyman 2001). Broader social determinants of health are also noted to be in precarious state for recent immigrants such as lack of credential recognition and subsequent employment, low income, lack of social supports and inability to access health services

(Newbold, 2009; Raphael, 2007). In examination of the immigrant health phenomena, we must look at possible influencing factors or issues that contribute to immigrant health: the concepts of welfare state, multiculturalism, and immigrant health paradigms. The perceptions and thoughts of the receiving country on the values and norms of immigrants, acceptance of diversity and descriptions of health phenomena make a difference in how immigrant realities unfold. If the will of the host country and its governing structures do not accept the responsibilities of the social welfare of immigrants, any supportive contingencies for the precarious conditions brought on by migration cannot be realized.

Welfare state and political ideologies. The term welfare state is a term used to describe the level of state acceptance to reduce societal inequalities through the provision of social services (Raphael, 2007). In Canada, the welfare state gained popularity in the Post World War 2 era but more significantly became the central political focus of social democracy. Both formal and informal structures contribute to welfare state in Canada. Programs such as Social Assistance and Unemployment Insurance provide minimum income and economic security as a contingency to events such as sickness or unemployment and are amongst some of the income security programs associated with welfare state support (Raphael, 2007). Welfare state programs are administered and delivered locally, provincially, or federally or in combination, thereof (Graham et al, 2009). Canadians also have a strong sense of civic duty as seen in the creation

of less formal welfare state structures such as trade unions, volunteers and non-governmental agencies (NGO's). To what extent does the welfare state extend support to immigrants?

Citizenship and Immigration Canada (CIC) is an example of a formal federal structure supporting immigrants that is intended to positively influence and facilitate integration into Canada "by creating opportunities for individuals to migrate to Canada to make an economic, social and civic contribution while realizing their full potential, with a view to becoming a citizens" (CIC, 2010, "Vision," para 4). Programs born through this structure such as the Provincial Nominee Program (PNP) and Resettlement Assistance Program are meant to facilitate socio-economic integration, the former designed to secure employment and permanent residence and the latter designed to provide financial support upon the refugees' first year of arrival to Canada (CIC, 2010). Gaps and tensions in the extent of welfare state can be attributed to the competing political ideologies of liberalism, neo-liberalism/neo-conservatism. The ideology of liberalism puts the responsibility for well-being on the individual or family whereas neo-liberalism or neo-conservatism is mainly guided by individual self-interest allowing competitive market forces in making material progress (Graham et al, 2009). As our society is rife with private enterprise, the existence of such dominant ideologies influence and oppose the extent of welfare state and socially determined views of health and ensuing support we give to immigrants. The degree to which we value immigrants and their contributions to Canadian

society is influenced by such ideologies and draw our society away from supportive issues. The irony being, these ideologies deny the existence of barriers that hinder self-interest, economic contribution and material progress. If the will of the host country and its governing structures do not accept the responsibilities of welfare state, any supportive contingencies for the precarious conditions brought on by migration cannot be realized.

Multiculturalism: equality does not mean equity. Multiculturalism in Canada is defined as being equal in law and opportunity regardless of race, ethnicity, religion or language (CIC, 2010). The ethno-cultural diversity and the spirit of social inclusion embedded in legislative documents such as the Multiculturalism Act of (Government of Canada, 1982) are well known throughout the globe. Yet researchers continue to report health related disparities and under utilization of health services amongst immigrants (Gushulak & MacPherson, 2006; Beiser, 2005; Hyman 2001). The notion of equality in multiculturalism legislation does not necessarily mean equity or fairness in the everyday reality of immigrants. Pluralism actually creates competition between groups and eventually, not all groups can remain equal. Should we be more critical of the realities of achieving equality and equity for all groups?

On the surface of societal etiquette we have mastered some rudimentary ability to identify and accept difference and, at times, deny

difference in efforts to promote inclusion. Did multiculturalism do more to emphasize our difference and further distance us from each other? We have not consistently figured out how to negotiate a relational approach that creates genuine human connections while accepting diversity. Much of our social graces around accepting diversity skirt around the tougher issues of racism, discrimination and the resulting power imbalances; disreputable remnants of colonization and the views of 'The Other', namely those of 'non-white' status. The concept of Other and Othering is a process of differentiating oneself or the 'mainstream', however, it can conjure positions of domination and subordination (Johnson et al., 2004). Denying the existence of such historically oppressive views disallows us to critically examine possible reasons for health disparities. The dominant perspective of Western thought remains the main critical lens through which we filter information on diversity. We argue that the ways in which immigrants, particularly minoritized immigrants, respond in seeking and interacting with health services may be well entrenched in the socio-political and historical discourses of colonialism and feelings of subordination from the dominant culture. How then do we ensure our health services, our measurement indicators, and our views on health and illnesses are appropriate and comprehensive? In as much as we think we can describe or identify health phenomena and provide solutions or strategies, how can we ensure effectiveness? Equity takes much harder relational work. In order to improve strategic accuracy, we need to enter dialogues with acknowledgement of racism,

discrimination and awareness of dominant Western thought as influencing immigrant health. Perhaps multiculturalism should only be seen as unlocking the door to truly embracing diversity. In order to open the door, we need to wade into deeper waters of examining the everyday practices or our health care services providers as well as the larger institutional structures that impair our equitable embrace.

Paradigms of immigrant health: Taking caution in overgeneralizations.

Over the past decades of observing the intersection of immigration trends and health, Canadian researchers have developed immigrant health paradigms. The sick immigrant paradigm of the mid-20th century speaks to the cautiousness of nation states in admitting migrants who may be a threat to public health and economic well-being (Beiser, 2005). The healthy immigrant effect observed an overall greater health of newly arriving immigrants with less chronic illness and disability than their Canadian counterparts. This was then followed by a convergence described as the shift in healthy immigrant trends towards those patterns of morbidity and mortality that resembled host country populations (Newbold, 2009; Beiser, 2005). As Beiser (2005) noted, neither the sick nor healthy immigrant framework can adequately describe immigrant health phenomena. The oversimplification of conceptualizations of health and illness may also be contributing to immigrant health disparities. This is also seen in health care systems where there is a strong focus on biomedical health views and the erosion of holistic health care. Oversimplification of health phenomena

can homogenize and/or reduce a health care provider's ability to accurately assessment and subsequently provide care. As Beiser (2005) noted we need to search for a model that takes into account more detailed immigrant characteristics and the complex diversity of immigrant subgroups. So much variation in health phenomena relate to more refined subgroup indicators such as immigrant class, level of education and language proficiency (Newbold, 2009; Beiser, 2005). Selective approaches that address the needs of immigrant subgroups and open the door to acknowledging the complexities of phenomena as they manifest in each individual are needed to decrease the gap in disparities.

Establishing the Need: Alberta Maternity Services and Immigrant/Refugee Women from Africa

Discussions with a Multicultural Care Services Coordinator and Patient Care Services Coordinator within Alberta revealed the need for exploring maternity care in relation to immigrant and refugee women of African origin in the Edmonton area. Therefore, this study is grounded in the realities of maternity care provision for this population group. Immigration from African countries has increased steadily throughout the 20th century and will continue to increase into the 21st century (Mulder & Korenic, 2005). A variety of African immigrant/refugee groups are migrating to the province of Alberta. Statistics Canada (2006) reported that Somali refugees are proportionally higher in the Edmonton area as are Sudanese and Rwandan refugees. The Multicultural Care

Services Coordinator noted that data which distinctly separate maternity patients according to country of origin or ethnic group as well as their immigration status are not formally recorded in hospital records and therefore, provide a rationale for using the broader category of immigrant and refugee women of African origin population reference in this proposed study. Data regarding language interpretation needs are recorded by multicultural care service workers, which have shown increased needs for language interpretation for refugees from African countries including Francophone speaking countries such as Somalia, Djibouti, Congo, Burundi, Rwanda, Cameroon, Ivory Coast, Benin and Senegal. Africa and the Middle East are top source areas for refugees who are particularly at risk for health disparities (Stewart, 2003; City of Edmonton, 2006). In particular, the Somali women, primarily single mothers with large families, reported difficulties finding opportunities to learn English and access health care services, which consequently created a barrier to integration into the broader Canadian community (Stewart 2003). Although this study does not seek to relate the needs of one particular African source country for immigrants and refugees, the study by Stewart (2003) exemplifies the challenges refugee women face as they resettle into their Canadian surroundings. In speaking with staff at immigrant/refugee receiving agencies, a variety of challenges exist for immigrant African women including but not limited to language difference/communication barrier, lack of income, social support, transportation, and disappointment with lack of Francophone presence in

Alberta. The complexity of challenges only increases when considering the various immigrant classes and ethno-cultural origins of African immigrant subgroups; necessary layers of dimensions to consider as they manifest in different expressions of thought, behaviours and responses. The changing profile of our diverse population groups from African countries requires exploration into the interface between African newcomers and our health service providers in order facilitate appropriate integration and social inclusion. More specifically, it is of interest to hear the experiences of maternity nurses and their various articulated understandings of how they care for immigrant and refugee women of African origin.

Purpose of the Study

The purpose of this study is to gain insights into various elements of nurses' cultural care encounters with immigrant/refugee women from African countries such as barriers, challenges, strengths and problem-solving abilities. Ultimately, the purpose of this study would be to provide maternity nurses with a richer understanding of individual and systemic nurse and non-nurse related factors that influence the application of effective, ethno-culturally congruent care. The aim of such a question is to provide insight into the various ways maternity nurses fulfill perinatal care for refugee women of African origin. It is anticipated that findings of the study will help to gauge the achievements of maternity health services with respect to the integration/inclusion of the

multiple African ethnocultural subgroups in the Albertan, Canadian context. Multi-level government initiatives speak of the need to include integration of health services to help with resettlement of newcomers. The Prairie Metropolis Centre (PMC) is one of five national centres where researchers, community and multi-level governmental agencies interface and knowledge share creating sound policy research to facilitate and enhance immigrant resettlement and integration into Canada. My supervisor Dr. Gina Higginbottom is a Research Affiliate of the Prairie Metropolis Centre (PMC) situated in the research domain of *Welcoming Communities: The Role of Host Communities in Attracting, Integrating and Retaining Newcomers and Minorities*. Research within the domain of *Welcoming Communities* examines ways in which Canadian cities and communities can receive and integrate immigrants, refugees, and minorities (PMC website). This research study has been funded by PMC.

Significance to the Field of Nursing

Given the changes in our Albertan ethno-cultural landscape over the last several years, knowledge and understanding of specific ethno-cultural care for African immigrant/refugee women is needed for maternity nurses to be able to provide effective care. Insights into the everyday experiences of nurse clinicians will help to identify barriers to care, gaps in knowledge as well as strengths or successes in the provision of ethno-cultural care. Research findings from this study may be helpful in enhancing transcultural education and

streamlining conceptual elements especially those related to cultural safety for front line application; a necessary stepping stone towards nursing knowledge transfer and capacity building not only in first tiered cities, but second and third tiered cities, as well as rural regions of our province.

Research Question/Expanding Research in the Canadian Context

What are maternity nurses' understandings and/or knowledge of caring for refugee women of African origin? What are positive and negative experiences, and/or strengths and challenges nurses face in providing care to any ethnic group under this broader term African origin? How do nurses navigate through their care experiences with African immigrant women? What types of information have nurses acquired in regards to refugee women of African origin? What is happening in the Albertan/Canadian context? The research questions posed are explored using the qualitative methodology of focused ethnography.

Definitions

Acculturation – a process that involves the change in attitudes and behaviours associated with a person's culture once they come in contact with another culture. According to Berry's (1986) two dimensional model of acculturation, there are four possible outcomes: assimilation (movement toward the dominant culture), integration (synthesis of the two cultures, separation

(reaffirmation of traditional culture) and marginalization (alienation from both cultures).

African origin – Multiple African ethno-cultural subgroups fall under this definition. Centuries of global migration and colonialization have produced a great deal of ethno-culturally diverse subgroups; for example, ethnic groups with origins from the Middle East, India, and Europe and/or those representing major world religions such as Islam, Hinduism, Christianity and Judaism can be found in African countries. The broad term is used for the purpose of allowing the nurses to share their own interpretation of this definition in order to determine their depth of knowledge in this regards not as a reductionist term.

Antenatal Care – Care given to pregnant women prior to labour and delivery. Antenatal care may involve any combination of physician/obstetrician, nurse, mid-wife and doula support depending on the women's choice and circumstance, as well as knowledge of resources and availability of resources; may also be called pre-natal care. Antenatal care usually starts at about 8 – 12 weeks of pregnancy and includes physical examinations, and education/information around nutrition, exercise, and breastfeeding.

Culture – a dynamic and complex concept that inextricably links the values, beliefs, traditions and expressions of individual, familial and community identities with socio-economic, political, and historical circumstances including all structures and discourses that promote or deny culture (Meleis, 1996).

Cultural competence – refers to an ability to interact effectively with people of different cultures. Cultural competence comprises four components: (a) Awareness of one's own cultural worldview, (b) Attitude towards cultural differences, (c) Knowledge of different cultural practices and worldviews, and (d) cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures (Campinha- Bacote, 2002).

Cultural safety – Originally developed as an educational framework in 1991 by Maori nurse, Irihapeti Ramsden, this concept moves beyond transcultural concepts of cultural competence to acknowledge and analyze the power imbalances, institutional discrimination, effects of colonization and relationships with the colonizers as they apply to health care and nurse-client relationships (Nursing Council of New Zealand, 2005).

Doula – A birthing assistant who provides nonmedical and non-midwifery support during perinatal care. (Doula C.A.R.E. website, http://www.doulacare.ca/)

Ethno-cultural – Rather than using the term *cultural* this term attempts to address the complexity of describing subgroups of populations; the combination of ethnicity and culture is meant to address not only values, beliefs, customs, habits, and ways of thinking and behaviours but also includes a host of dynamic characteristics such as affiliations with religion, nation states and/or tribal groups

that transcend national boundaries, and biological phenotype, all of which can be very heterogeneously expressed by the many subgroups found in African countries as well as globally. The description of any ethno-cultural group should also be thought of as fluid, constantly evolving through space and time influenced by socio-economic, political and geographical factors.

Ethno-culturally congruent care – tailoring care practices to incorporate culturally specific needs; a combination of the following characteristics and/or a willingness to seek and develop them are needed to effectively apply ethno-culturally congruent care: ethno-cultural knowledge, awareness and sensitivity.

Feminist post colonial perspective – a form of feminist philosophy that acknowledges not only gender but the social classes and ethnic identities of women in the post-colonial setting as being influenced and constructed by the economic, political and cultural fallout of racism and colonization (Narayan, 2000).

First, second and third tiered cities – These terms are common amongst city and business planners; definitions vary in details of structure and function, however, the main concept of this term in this research study is to help visualize the structural size differences between a first tier city (>1 million in population), a second tier city (between 1 million and 300,000) and third tier city (< 300,000) (Meeting Planners International, 2009, http://www.businessfacilities.com/bf_04_02_cover.asp). The functional

significance of these terms in relation to immigrants pertains to the amount of resources available to facilitate integration and re-settlement; usually there is more resource allocation to first tier cities.

Immigrant & Refugee Categories- The permanent status categories for admission of immigrants into Canada include: economic immigrants (independent/skilled worker & and business professionals), family class (sponsorship from family & citizens), refugees (accepted on the grounds of persecution in their country of origin). The variety of immigrant categories of newcomers resettling into Canada is notable as key demographic differences such as those of socio-economic nature will have unique impacts on health and health seeking behaviours.

Liberalism – The original ideology of liberalism evolved in the eighteenth and nineteenth centuries as a change-oriented perspective in which individualism was central to material progress. Nineteenth century liberalism was economically referred to as laissez-faire but with the post world war infusion of social democracy, this ideology evolved to acknowledge some government intervention to reduce social and economic inequalities (Graham, Swift, & Delaney, 2009).

Multiculturalism – This ideology in Canada was adopted as an official policy in 1971 and emphasizes the value of immigration and ethnic diversity. The concept of pluralism is central to a multicultural society as diverse groups are

considered equal in law and opportunity and theoretically can maintain their unique ethno-cultural identities and expressions (Dewing and Laman, 2006).

Neo-conservatism – a political ideology that advocates more freedom and personal initiative, , a rejection of collectivist values, and less government presence in aiding the social and economic advancement of individuals; synonymous with the term neo-liberal (Graham, Swift, & Delaney, 2009).

Post-partum Care – Takes place immediately after childbirth; care practices vary according to type of delivery (normal vaginal, the use for extraction devices such as forceps or vacuum, or the need for cesarean section), use of pain control methods, presence of episiotomy, vaginal tears or female circumcision. Assessments of pain and discomfort, mobility, bowel and bladder are significant aspects of the care process during this time. Hospital transit time also varies from 24 – 48 hours up to a few days. The post-partum period includes 6 weeks after childbirth and in Alberta includes at least one visit from a community based nurse.

Transcultural Nursing Theory – Originally developed by nurse theorist, Madeline Leininger in 1978, this theory describes a culturally specific focus of meaningful care given to peoples of diverse cultures for the goal of providing culturally congruent care (Leininger, 2007).

Social democracy – the rise in popularity of this movement came through the formation of the Canadian Commonwealth Federation (CCF) under the

leadership of Tommy Douglas of Saskatchewan in the mid 1940's. This political party later came to be known as the New Democratic Party (NDP) and continues to maintain membership in Canadian Parliament. This movement strives to abolish socio-economic inequalities and is responsible for universal health care, pensions, a human rights code and the development of Canada's social safety net (Graham, Swift & Delaney, 2009).

Social determinants of health – identify aspects of social and economic conditions which affect the health of individuals as well as populations including but not limited to income, education, childhood, food, housing, employment, social support networks, physical environment, gender, health services, genetics and culture; all of which contrast from the biomedical approach and individual behavioural risk factors to health (Raphael, 2007).

Welfare state – The concept of welfare state is about the extent to which governments or the state provide their citizens with the means to live secure and satisfying lives through public policy or legislated means (Raphael, 2007).

Chapter 2- Literature Review

The literature search strategy outlines the systematic approach to literature retrieval and subsequent paucity of Canadian articles. An exploration of migration with specific references to experiences of immigrant/refugees from African countries as well as maternity care in the Canadian context is provided as the perspectives shape the socio-political, historic and professional environments within which this study is located. Transcultural nursing concepts are discussed and the challenges nurses face as they negotiate ethno-cultural care encounters are explored in detail.

Literature Search Strategy

A comprehensive review of qualitative and quantitative research on immigrant/refugee women and maternity services in Canada was conducted. Search strategies were developed in collaboration with a librarian from the University of Alberta Library Sciences department. The following strategies were used to retrieve relevant research literature for this critical review.

Electronic Bibliographic Databases. The following databases were used:

CINHAL

MEDline

EMBASE

Global Health

PsycINFO

SCOPUS

Web of Science plus Conference Proceedings

ProQuest (Dissertations & Thesis Full text)

Internet

Systematic internet searches were also performed. The online information was accessed via the Google search engine; other websites included the Joanna Briggs Institute and Canadian Institute for Health Information.

Hand searching key journals. The most recent editions of key journals, which are not indexed on the data bases named above, were searched by hand for further relevant articles.

Scanning reference lists in key articles. This was especially useful in identifying relevant sources of "grey" literature. Books such as *Care and Consequences* (Gustafson, 2000) and the *African Diaspora in Canada* (Tettey & Puplampu, 2005) were found in this way. Citation searches were undertaken on key papers and authors.

Search Strategy Terms & Inclusion/ Exclusion Criteria

Database searches used Boolean logic [AND and OR] to combine different search terms together. The use of truncations [$ or *] were also be used to expand the search from root forms of the search words as needed. In discussion with the library sciences consultant, controlled vocabulary and key word terms for immigrant/refugee women and maternity services were used rather than using rigid inclusion criteria. Letters, editorials and commentaries were excluded. The emphasis was on Canadian literature and references from key policy and theoretical papers were used. Relevant international research emerges, was also included. Examples of the controlled vocabulary search terms are as follows:

Immigrant Women: immigrant women, refugee women, minority women, African women, knowledge and attitudes, beliefs, influencing factors

Maternity Services: Obstetrics, maternity nurses, knowledge and attitudes, beliefs, influencing factors, transcultural nursing

Culture: Culture, religion, ethnicity, cultural safety, culturally congruent care

A list of the search strategy and numbers of documents in each database were prepared and documents found to be relevant were saved to RefWorks (see Appendix A for search strategy list).

Search Restrictions

The literature search was limited by date and language, which are listed below:

Date: 1990 – 2010

Language: English [time frames exclude the possibility of translation]

The results of the literature search indicate the literature gap in nursing research from an Albertan Canadian perspective. Only one of the maternity research articles from Canadian researchers (Chalmers & Hashi, 2000) focused solely on immigrant/refugee women from an African country (ies) (see Appendix A). Five qualitative, one systematic review and one meta-analysis with Canadian content were found. The articles were: a)Stewart (2003) interviewed Somali refugees in regards to their perceptions of community support resources; b) Small et al (2008) drew data from Canada as a part of a six country meta-analysis on pregnancy outcomes in Somali women; c)Reitmanova and Gustafson (2008) interviewed immigrant Muslim women regarding maternity health and care needs; d) Spitzer (2004) examined the perceptions of both minority women and nurses and quality of care in relation to the constraints of health care reform; e) Gagnon (2009) performed a systematic review on migration and perinatal health in western industrialized countries; f) Johnson et al (2004) interviewed immigrant South Asian women and nurses to describe 'othering' practices and its

effects; and Chalmers and Hashi (2000) interviewed Somali women regarding their birth experiences after earlier female genital mutilation.

Migration in Canada

Canada as a multicultural society has a long standing history of embracing diverse immigrant groups because of the strategy of utilizing immigration as a means of population expansion and nation building (Canadian Heritage, 2008). Canadian immigration history is rich with accounts of pre and post confederation settlers (Perin, R., 2010; Kelly & Trebilcock, 2000). Immigration was seen as a strategy to secure the vast geography of Canada in a race to build a strong and prosperous nation (Kelly & Trebilcock, 2000). The political and social positioning of Great Britain, France and United States strongly influenced the early trends of immigration (Kelly & Trebilcock, 2000). Britain and France continued to be strong competitors in global colonization with both countries influencing the recruitment of European immigrants to Canada (Kelly & Trebilcock, 2000). The United States hungered for immigrants to strengthen their independent nation state and firmly stake claim to the expansive geography that lay so close to their Canadian competitor (Kelly & Trebilcock, 2000). The desire for immigrant groups was not equal and formally expressed in documents such as the Chinese Immigration Act (Kelly & Trebilcock, 2000). Preferred immigrant groups came from various strata of European societies ranging from wealthy business class to the labour class groups such as Ukrainian and German who made significant

contributions to Canada's rural economy (Perin, R., 2010; Kelly & Trebilcock, 2000). Other ethnic groups such as Chinese, Japanese, and East Indian, filled short-term hard labour positions in the transportation, mining, and logging industries and were not necessarily welcomed to partake in formal citizenship (Perin,R., 2010; Reitmanova, 2009; Kelly & Trebilcock, 2000;). Despite the practices of discrimination and racism in Canadian immigration history, the movement towards greater social inclusion, respect and recognition of ethnically diverse immigrant groups continued to gain momentum (Perin,R., 2010; Kelly & Trebilcock, 2000).

Although the proportions of immigrants to Canada were highest in the first quarter of the century at 22%, the percentage ranges have not varied greatly between 1911 and 2001, maintaining percentages between 15% - 22% (City of Edmonton, 2006). While in approximately the first seventy years of 20th century the majority of immigrants were of European origin, the 1980's, signaled a turning point with larger percentages of immigrants from Asia, the Middle East followed by Europe, the Caribbean and Central America, Africa, United States, Oceania and other countries (City of Edmonton,2006). The concept of multiculturalism as stated through the 1971 Multiculturalism Policy of Canada and the Multiculturalism Act of 1985 communicated equality of law and opportunity as well as respect regardless of race, ethnic origin, language or religious affiliation and supplied significant momentum for the shift in migration

trends (CIC, 2008). As government policy changed, societal attitudes towards greater social inclusion were slowly but surely changing.

Canada recognizes the significant socio-cultural and economic contributions of immigrants and continues to benefit from the diverse skills and experiences of immigrants who positively address Canada's future labour market and demographic needs as well as support the country's international role and geopolitical presence (Canadian Heritage, 2008; City of Edmonton, 2005). *"Immigration is the key to nation building and our economic prosperity*" (CIC, 2005, p.7).

In the Albertan context, a growing share of recent immigrants chose to settle in Alberta during the past five years, according to the 2006 Statistics Canada Census. About 9.3%, or 103,700, of the 1.1 million new immigrants who came to Canada between 2001 and 2006 settled in Alberta; a 6.9% increase from the last census in 2001 (Statistics Canada, 2006). In Alberta, the census enumerated a total of 527,000 foreign-born individuals, who represented 16.2% of its population. This proportion was the third-highest in Canada, after Ontario and British Columbia (Statistics Canada, 2006). The Alberta Government (2005) has recognized the growing needs of our recent immigrant groups and has formulated an immigration support policy framework in order to facilitate resettlement issues including "resolving personal health issues in a system with which they are unfamiliar" (p.6). A variety of resettlement issues for

immigrants/refugees may contribute to an inability to effectively engage in health-seeking behaviours and interactions. Immigrant groups are diverse in nature and present unique needs that should not be considered homogenous (Statistics Canada, 2006).

Experiences of Immigrant/Refugee Populations from the Continent of Africa[1]

Lindsay (2001) states that the "African population in Canada is growing considerably faster than the overall population…born outside of the country…and are relatively recent arrivals" (p.7). It is important to highlight that immigrants from Africa steadily grew throughout the decades from 0.5% in 1961, 5.8% in 1980, and then 7.6% in 2001 (City of Edmonton, 2006). African immigrants to Canada claimed single and multiple ethnic origins; 51% reported they were either Black or African, 11% Somali, 6% South African, 6% Ghanaian, and 5% Ethiopian (Lindsay, 2001). The continent of Africa, however, is rich with global migration history producing an enormous range of African ethnocultural orientations, traditions, and linguistic groups and should not be envisioned as a homogenous group of peoples. Growing populations of African immigrants are also settling in provinces other than Ontario and Quebec. Alberta, along with

[1] There is a great deal of complexity to the African identity. Peoples of the continent of Africa embrace a multitude of heterogeneous ethno-cultural expressions. It is not intended to adopt reductionist term the enormous range of ethnicities, linguistic groups (including Francophone), traditions, values and beliefs held throughout African peoples is acknowledged.

British Columbia, has the third highest concentration of African populations in Canada preceded by Ontario and Quebec (Lindsay, 2001; City of Edmonton, 2006). French-speaking Africans make up about 24% of newly arriving Francophones to Alberta (Mulatris, 2008). It is important to note the federal initiative, *Strategic Framework to Foster Immigration to Francophone Minority Communities* as supporting the movement of French speaking peoples including Francophone African immigrants to various parts of Canada as a means of sustaining the Francophone-Canadian identity, hence, the increased settlement of French speaking immigrants to Western Canadian provinces (CIC, 2003). Despite Canada's dual language status ,however, Francophone African immigrants to Western Canadian provinces experience lack of support from Canada' official language minority communities in addition to other settlement challenges (Quell, 2002; Madibbo, 2005).

Other resettlement challenges have been reflected through social and economic participation in Canadian society (Lindsay 2001). Unemployment rates for African populations in Canada were higher in 2001 than the national average, 13.1% versus 7.4% (Lindsay, 2001). Interestingly, Lindsay (2001) states,

Fifty percent of Canadians of African origin reported that they had experienced discrimination or unfair treatment based on their ethnicity, race, religion, language or accent in the past five years, or since they arrived in Canada. A majority (87%) of those who had experienced discrimination said that

they felt it was based on their race or skin colour, while 62% said that the discrimination took place at work or when applying for a job or promotion (p. 16).

Lower incomes and a lack of social and governmental supports also add to the everyday resettlement challenges African immigrants face as compared to their Canadian counterparts (Lindsay, 2001; Stewart, 2003). Income is a social determinant of health and is linked to many aspects of our lives that impact health status such as education, working conditions, social exclusion, food security, housing, premature mortality and disease (Newbold 2009;Raphael, 2008; Beiser 2005). This indicates the importance of multisectoral policy and program improvements that "empower immigrant groups to develop and maintain their own ethno-specific institutions and health-promoting practices" (Hyman, 2001, ¶ 5). The relationship between immigration and health is highly complex, involving not only socio-economic, cultural, behavioural, environmental and biological factors, but also pre and post immigration history (Statistics Canada, 2005; Ogilvie, 2008).

Although researchers (Newbold 2009; Raphael, 2008; Beiser 2005) have shown the direct impacts that social determinants of health have on immigrant experiences, very little evidence specific to Francophone African immigrants in the Canadian context and maternity health services have been reported. It is therefore relevant to review the literature pertinent to immigration from the

continent of Africa in general. Refugees of African origin such as those from Somalia and Rwanda are not top source countries of immigrants, yet immigrants from this area are particularly at risk for health disparities (Stewart, 2003). In looking at the perspectives of Somali and Chinese immigrants and refugees in the metropolitan areas of Toronto, Edmonton and Vancouver, Stewart (2003) noted that the Somali community primarily consists of single mothers with large families. Somali women of these communities reported difficulties finding opportunities to learn English that consequently created a barrier to integration into the broader Canadian community.

Maternity Care Services

Stewart (2003) also noted that pregnant Somali refugee women had difficulty accessing health care services complicated by Somalis' preference to seek care from women physicians as per their Muslim tradition. There may be additional challenges for Somali women during the intrapartum period as women may have experienced female genital mutilation (FGM)/ female circumcision (FGC) (Harper Bulman & McCourt, 2002; Chalmers & Hashi, 2000). Chalmers and Hashi (2000) reported high rates of cesarean section, at 50%, amongst the Somali women with FGC even though this intervention was only wanted by 1% of the women interviewed. Somali women expressed concern with the lack of sensitivity of health care providers, stigmatization and lack of understanding of FGC as influenced by western feminism and did not feel their

pregnancy and birth care needs were met (Chalmers & Hashi, 2000; Canadian Children's Rights Council, 2010). Reitmanova and Gustafson (2008) recommended strategies for increased inclusiveness of immigrant women of Muslim faith in maternity services by providing culturally and linguistically appropriate services and related health information, increased social and community supports, as well as improved responsiveness of health care providers to ethnically diverse needs. The recommendations were born out of the narratives of immigrant Muslim women settling in St. John's, Newfoundland. Amidst the day to day functional challenges of transition and resettlement, women of Muslim faith revealed feelings of discrimination, insensitivity, and did not feel nurses understood their cultural and religious practices (Reitmanova and Gustafson, 2008). Spitzer (2004) reveals the relationship between Canadian health care reform and the ensuing business approach to care as having negative impacts on obstetrical nursing care of First Nations and immigrant women. Workload, brevity of patient stay, along with the emphasis on completion of tasks were identified as constraints to quality of nursing care leading nurses to avoid time consuming interactions with patients (Spitzer, 2004). These avoidance patterns were seen by the women as acts of racism and marginalization. The narratives of South East Asian, Vietnamese, and First Nations women exemplified the disparate experiences in which, " the economy of care does not allow for the time-consuming interactions that may ensue when linguistic barriers or noncompliance with hospital-designated standard postpartum activities such as

showering, walking, and breastfeeding are anticipated" (p. 501). There is a counter argument to make in relation to this statement. Economy of care also demands efficiency of care. Interactions with patients who speak English as an additional language may be more efficient if a translator is provided. Where effective translation is not available communications may be protracted. Although women of African origin were absent from this study, the visible minority status of these women may provide insight into potential parallel challenges for immigrant African women's experiences with Canadian maternity services. In a systematic review of migration to western industrialized countries and peri-natal health, Gagnon et al (2009) found real differences in the impact of immigration by geographical region of origin. North African migrants had a higher odds ratio of feto-infant mortality [OR: 1.25, 95% CI: 1.10 – 1.41] and African migrants had higher odds ratio of pre-term birth [OR: 1.29, 95% CI 1.04 – 1.60] as compared with their cohorts from the receiving countries (Gagnon, 2009). The systematic review did not reveal reasons for disparities but implications for nurses' and health care providers indicate the need to consider ethnicity as a significant aspect of maternal health assessments in order to ensure health perinatal outcomes. Small et al (2008) looked at pregnancy outcomes of Somali women post migration to the countries of Australia, Canada, Belgium, Sweden, Finland and Norway. Somali women were significantly less likely to use epidurals during the labour process than their receiving country counterparts; in Canada the proportions of epidural use were 8.3% for Somali

women and 23.4% for receiving country women (Small et al, 2008). This research study noted that Somali women disliked interference with the birthing process; however, it is also postulated that language and communication challenges may contribute to differences in epidural use (Small et al, 2008). Raised caesarean section rates in Somali women were not explained by clinical risk factors; however, researchers suggest the inexperience of health care providers in caring appropriately for infibulated women as well as language and communication difficulties (Small et al 2008). Some limitations of this meta-analysis include variation of information routinely collected during pregnancy and birth where some interesting indicators such as perineal status and post partum hemorrhage could not be used in the core set of indicators (Small et al, 2008). The results from both the Gagnon (2009) and Small et al (2008) studies illuminate implications for nursing care which once again point to the need to integrate ethno-specific considerations into assessment and care strategies to accurately respond to the women's needs and circumstances. Although the Canadian Maternity Experiences Survey (Public Health Agency of Canada (PHAC), 2009) included immigrant women living less than five years in Canada as a portion of the survey sample, data remained pooled and undistinguished from other groups of women creating the limitation of asking refined questions about how experiences may unfold amongst various subgroups (Chalmers et al 2008; PHAC, 2009).

International Research Evidence and Literature

Other single international studies of various African immigrant women's maternity care experiences were also examined as a result of the paucity of Canadian research articles. Challenges experienced by African immigrant women included lack of language support and communication, lack of understanding cultural differences, poor management of female circumcision and overall feelings of racism and discrimination (Harper Bulman & McCourt, 2002; Leval et al, 2004;Cross-Sudworth, 2007). Harper Bulman & McCourt (2002) noted that hospital-based midwives had stereotypical assumptions of Somali women in that nurses believed Somali women had natural mothering skills, did not need much for pain relief and preferred to be instructed rather than receive information and choices. Staff also underestimated the level of English fluency and relied on informal interpreters rather than planning for formal interpretive services which evoked stress and anxiety in the Somali women (Harper Bulman & McCourt, 2002). A Swedish study by Bergreggen et al (2006) looked specifically at circumcised immigrant African women and reported that female circumcision did affect maternity care. Women from Eritrea, Sudan and Somalia reported feelings of difference, vulnerability and of being judged in a paternalistic health care system. Bergreggen et al (2006) recommend the need for health care personnel to receive training and support to meet culturally specific practices in a more respectful way.

The research studies show recurring evidence of disparities in maternity care amongst African immigrant women and other visible minority women. A research gap, however, does exist in the literature from a Canadian perspective that focuses on immigrant/refugee African women.

Maternity Care in the Canadian Context

Maternity services are a vital portion of our Canadian health services that are utilized to provide healthy beginnings for immigrant populations. As one of many facets of our publicly funded system, maternity services are medically necessary services upheld to the principles of universality and accessibility found in the Canada Health Act including (Government of Canada, 2004). According to the Canadian Institute for Health Information (CIHR), "pregnancy and childbirth are the leading causes of hospitalization in Canadian women accounting for 24% of acute care stays in 2000-2001" (2004, p. 15). The spectrum of care included in maternity services revolves around the health of the woman and unborn child and includes prenatal or antenatal care and education, home deliveries, screening and diagnostics, as well as post partum and infant care home support (CIHR, 2004).

Health care professional mix and hospital staffing. Even though midwives and informal caregivers play a significant role in the perinatal experience of many women across the globe, the Canadian experience is very different. Canadian physicians provide 88% of prenatal care and about 64%

reported being involved in some aspect of maternity care (Canadian Institute of Health Research (CIHR), 2004). Family physicians may attend deliveries but may also transfer care to an obstetrician, mid-wife, or another family physician for delivery of babies. A variety of nursing staff provide 24 hour hospital based maternity care on both labour and delivery and post partum units. Since the majority of women utilize hospitals for deliveries, this puts nurses as the primary front line health care provider supporting women through the labour, delivery and post partum period. Nursing staff range from trained midwives to registered nurses (RN) and licensed practical nurses (LPN) but the majority of nurses are registered nurses. Labour and delivery nurses most commonly have a 1:1 patient/nurse ratio whereas postpartum nurses most commonly have 5:1 or 6:1 patient/nurse ratio. Care of the mother and baby as a unit is the central premise of post partum care. In 1994 midwifery was designated as a health profession under the Alberta Health Disciplines Act (Government of Alberta, 2010). Midwifery services became publicly funded in 2009 and midwives continue to practice in primary care networks, clinics, clients' homes, birthing centres and hospitals. The renewal of midwifery care is still a new concept in Alberta and it will take time to observe changes in trends towards choices in health care providers, settings for birthing as well as change in staff mix in the hospital setting.

Mother and baby care. Each woman experiences labour, delivery, and post partum differently and nursing staff need to attend to each woman's

experience accordingly. The following summary of maternity nursing care gives a general description of hospital based maternity care. Nursing staff use standardized criteria, including assessment of cervical dilation and effacement, to determine active labour stage and subsequent admission onto a labour and delivery unit. Nurses conduct ongoing assessments during labour which include the following elements:

> …the woman's well-being and ability to cope; the woman's vital signs; the frequency, duration, and strength of contractions; the degree of pain; the descent, flexion, rotation, and position of the presenting part of the baby; the degree of effacement and dilation of the cervix; the fetal heart rate; the amniotic fluid (colour, odour, consistency); and the vaginal "show". (PHAC, 2002, ¶ 4)

Constant communication between nurse, woman and/or family is necessary to ensure care decision-making is meeting the needs of the woman. This includes collaboration on pain management, comfort strategies, and the use of familial support systems. Many options are available for pain relief such as narcotics, epidurals, inhaled anesthetics and non-pharmacological methods, but this requires informed communication to the woman and/or family. Episiotomies are not routinely performed in Canadian hospitals anymore as research showed better outcomes with an intact perineum (PHAC, 2002). Healthy, normally progressing labour often results in a vaginal delivery and possibly the use of

vacuum or forceps extraction. However, a variety of complications that endanger both maternal and infant health may occur in which a cesarean section is needed to deliver the baby. Dyadic care in which the mother and infant reside together during the hospital stay is the current norm and starts as soon as possible after delivery (PHAC, 2002). Dyadic care is deemed as fostering parent-infant bonding and the development of a close parent-infant relationship. Establishing early bonding can affirm the parent's sense of confidence and accomplishment and is associated with successful breastfeeding (PHAC, 2002). This model of care has also combined the roles of nursery and post partum nurses so that one nurse can give complete care of mother and baby in one location allowing for more interactive and family integrated infant care, teaching and guidance at the mother's bedside.

Community Care. A brief description of the community linkage is given here as one of the hospital based nursing roles is to ensure linkage of care continues in after hospital discharge. Discharge from hospital based post partum units may occur between 6 – 72 hours after delivery but most commonly occurs around 24 hours post partum for a normal healthy delivery. Healthy Beginnings is the current post partum community support program available to all women through community health centres across Alberta. Discharge information is relayed to the respective community health centres and nurses contact families about 24 hours after discharge to arrange home visits and/or telephone assessments. Home visits by public health nurses include physical assessment of

mother and baby as well as breastfeeding and nutritional support, assessment of maternal coping skills, post partum depression screening and information on immunizations. If women are identified as having difficulty speaking English, community nurses arrange for interpretive services to be present at home visits. The Multicultural Broker's Agencies which are independent to provincial provision are the most frequently used services for facilitating the interface between immigrant women and nurses. Families usually receive 1-2 visits and more if necessary. Breastfeeding support is commonly available through community health centres but varies in delivery depending on each community's resource capacity. Larger health centres may have exclusive lactation consultants and 24 hour phone consultations but smaller centres may use existing community health nurses expected to carry out multifaceted care. Antenatal support is available for high risk pregnancies usually through a hospital based outpatient program.

Overview of Transcultural Nursing

Nurse-client interactions with ethno-culturally diverse individuals are a reality in the Canadian context. Growing population diversity means an increased likelihood of interacting with people of diverse backgrounds. Interactions and exchanges between ethno-culturally diverse peoples bring with them an awareness of differing attitudes, beliefs, values and a multitude of social constructs that are contextually bound to culture. Nurses have recognized the

impact of cultural diversity on the nurse-client relationship and the need to incorporate transcultural nursing into educational curricula and practice. In fact, transcultural nursing theory founder Leininger pioneered concepts around cultural care in 1978 creating an impact on culture or health services over three decades ago. Leininger (1995) states,

> Our world continues to change and is bringing people close together in one world with many diverse cultural values, beliefs and lifeways. With these global cultural changes have come new expectations and challenges in nursing to prepare nurses through transcultural nursing education to become competent, sensitive, and responsible to care for people of diverse cultures in the world (p.3)

Nurse theorists such as Leininger (2007), Giger and Davidhizar (2002) and others are respectfully credited with paving the way to formally introducing cultural concepts in nursing. The purpose of such theoretical frameworks was to guide nurses in acknowledging the unique cultural viewpoint of their patients/clients as a legitimate and necessary element of holistic care. As Baker (1997) states, "Leininger exhorted nurses to recognize their own cultural biases, hold them in abeyance in cross-cultural encounters, seek out their client's cultural perspectives and provide culturally congruent care" (p.5). Culturally congruent care involves facilitating and enabling an individual's acts or decisions within a cultural context in order to provide meaningful, beneficial care that

leads to health and well-being (Leininger, 1995). Leininger's work, however, has been heavily critiqued in recent decades as focusing on a 'checklist' approach and failing to take into account discourse dynamics such as racism and discrimination. Baker (1997) also describes Giger and Davidhizar's cultural theory as similar to Leininger's in providing a framework for assessing clients' cultural beliefs, norms, and values for the purpose of avoiding ethnocentric assessments and providing care that is "responsive to the recipient's cultural perspective (p.5)." This transcultural assessment model assesses each individual as a culturally unique person according to the six cultural phenomena of communication, time, space, social organization, environmental control, and biological variations.

Campinha-Bacote (2002) continued to evolve the concepts around transcultural nursing for health care services towards a process oriented approach where health care providers see themselves as becoming culturally competent rather than being culturally competent. The cultural competence practice model of Campinha-Bacote's work described a set of terms that would enable a nurse to identify a client's cultural similarities and differences to establish mutual goals of care: cultural awareness, cultural humility, cultural knowledge, cultural skill, and cultural desire (Gustafson, 2005; Campinha-Bacote, 2002). The benefit of this process oriented approach allows health care providers to acknowledge the fluid and dynamic nature of culture. Transcultural nursing theory and cultural concepts continue to evolve in meaning. For

example, the definition of culture is no longer characterized in a bound and static way. Nurse scholars such as Meleis (1996) have come to understand culture as a dynamic and complex concept describing culture from a nursing perspective as,

> the sum of ethnic, racial, gender, sexual, and economic experiences that frame the values, beliefs, and responses of individuals, families, and communities. Culture is affected by structures and discourses that may promote or deny all aspects of that culture, and these structures and discourses become interwoven and imbedded in the responses and experiences of individuals to health and illness. Cultures cannot be examined, explored, or understood outside their politics and their histories, nor should they be extracted from the power structures of any group (¶ 18).

This rich, multi-dimensional definition of culture captures an integrated network of meanings that are responsible for influencing peoples' responses to health and illness. In this sense, nurses could move away from static concepts of culture towards being more open and flexible as we come to understand our culturally diverse patients. The process orientation of cultural competence allows nurses to flow back and forth in level of knowledge and understanding in response to the dynamic variations in ethnocultural expressions of their patients. Competency, therefore, "will always be in a process of becoming" (Duke et al, 2009, p.41).

Gustafson (2005) gives a critique of Transcultural Nursing Theory (TCN) through a critical cultural perspective pointing out that TCN was developed from a Western liberal ideology standpoint that focused on a broadly defined but narrow application of culture. The social location of the nurse, namely the Western nurse, was the benchmark with which to view and compare the 'Other', thus perpetuating the power imbalances of social hierarchies both within and beyond nursing (Gustafson, 2005). TCN theory's Western liberal viewpoint does not take into consideration the current reality of our ethnoculturally diverse nursing professionals, the unique dynamics and very different social location of minoritized nurses (Gustafson, 2005; Serrant-Green, 2001). Gustafson (2005) and Browne (2007) also acknowledge emerging post colonial feminist perspective as contributing to the further evolution of how nurses should critically examine and approach ethnocultural interactions. The newer concept of cultural safety was originally introduced through the academic work of Irihapeti Ramsden, a Maori nurse whose early work includes, *"Kawa Whakaruruhau: Cultural safety in nursing education in Aotearoa"* (NAHO, 2009; Ramsden, 2005, 2000). Cultural safety is an evolving term especially since gaining global popularity over the last several years. The Nursing Council of New Zealand has defined culturally unsafe practice as, "any actions that diminish, demean or disempower the cultural identity and well being of an individual" (Wood and Schwass, 1993, p. 5). Key aspects of culturally safe care involve the awareness of historical power imbalances, institutional discrimination, and the nature of interpersonal

relationships and how these forces create systematic inadequacies in the receipt of care by ethnic minorities (Ogilvie et al., 2008; Ramsden 2000, 2005). The development of the term cultural safety acknowledges the wider social issues of health inequalities in relation to discrimination, racism and dominant Western culture's view of 'The Other' (Gustafson, 2005; Serrant-Green 2001). Delving deeper into the depth of these definitions of culture and cultural safety allows nurses to critically reflect on our practices and more accurately orient our knowledge. Ultimately, the conceptual understandings gained should lead us back to a humble process of becoming, creating a genuine connection between the nurse and the individual and patient empowered care outcome.

Maternity Nursing Challenges in Providing Culturally Congruent Care

Nurses are professionally committed to the provision of culturally congruent care. The Code of Ethics for Registered nurses from the Canadian Nurses Association includes the value of fairness in which nurses are responsible to provide care "in response to clients' needs and are respectful of race, ethnicity, culture, spiritual beliefs or marital status gender, sexual orientation, age, health status lifestyle or physical attributes" (Keatings & Smith, 2000, p.144). Thus, rooted in the nursing professional values system, the Canadian Nursing Code of Ethics supports the inclusion of providing culturally competent care.

There are a variety of elements that are critical to effective provision of maternity care that revolve around the fundamental step of establishing rapport and communication (Meddings & Haith-Cooper, 2008). The process of care from initial admission assessments to ongoing labor and delivery and postpartum support are affected by the nurse's ability to understand the client's experience (Meddings & Haith-Cooper, 2008). Creating a trusting relationship with the client is vital to opening up communication. Challenges exist within the nurse's ability to establish rapport and communication when placed in a ethno-cultural context (Meddings & Haith-Cooper, 2008; Reitmanova & Gustafson, 2008; Harper Bulman & McCourt, 2002).

We know that there is disparity in cultural values and beliefs between nurses/carers and their clients that affects the provision of culturally congruent care. A variety of factors may interplay to create disconnect from the ideals of effective communication such as language barriers, intercultural differences, and pre and post immigration experiences (Reitmanova & Gustafson, 2008; Harper Bulman & McCourt, 2002; Meddings & Haith-Cooper, 2008). This incongruence or lack of commonality between the nurse and client can have damaging effects on the establishment of a trusting relationship and impacts the choices and decisions made by women in the nurse's care which may result in adverse emotional and physical outcomes and cultural pain which is described as "suffering, discomfort, or being greatly offended by an individual or group who shows lack of sensitivity toward another's cultural experience" (Meddings & Haith-Cooper, 2008,p. 34). This is also evidenced by Harper Bulman & McCourt, 2002, where Somali refugee women communicated that language barriers were the most important problem to address in maternity care as all other issues could only be addressed after language barriers were resolved. Johnson et al (2004) also noted othering practices that negatively affected the interactions between South Asian immigrant women and nurses. Johnson et al (2004) described observations of nurses' othering practices included essentializing, culturalist, and racializing explanations. Brief explanations for these terms are: (a) essentializing acts which make overgeneralizations about culture, race, social background, (b) culturalist acts which focus on culture as the reason to explain

all observed behaviours and phenomena, and (c) racializing acts which draw simplistic and patronizing generalizations based on appearances (Johnson et al, 2004). The incidences of othering practices allude to the larger institutional and social structures that propagate discrimination either overtly or covertly. Despite Canada's widespread multiculturalism discourses, intentional and unintentional acts of racism, identity and difference still occur; a fallout of our denial of dialogue in this respect and of our de-politicized ideal of multiculturalism.

Challenges in providing culturally congruent care lie not only in relation to interpersonal relationships but in the larger institutional context. Health care institutions are also increasingly challenged to ensure nurses and other health care providers are equipped to provide culturally congruent care. Jeffreys (2006) notes that "heightened patient acuity levels, the nursing shortage, poor nurse retention, inadequate staffing, rapidly changing culturally diverse patient populations, managed care, and limited resources create numerous, ongoing challenges for HCIs [Health Care Institutions] " (p.118). Spitzer (2004) noted that increase workloads and time constraints contributed to the development of 'economy of care' where nurses felt "compelled to avoid interactions with patients deemed too costly in terms of time" (p.490); the results of which were overwhelmingly experienced by marginalized women. Recognizing strengths, challenges, stressors, and facilitators that influence a nurse's ability to provide culturally congruent care are necessary to ensure nurses feel sufficiently equipped in culturally competent care practices. For this reason, further

explorations into immigrant health encounters are necessary to continuously update cultural knowledge.

The challenge for health care professionals in regards to culturally congruent care and culturally safe care is to understand the diverse nature of immigrants and the need to become responsive to their heterogeneous ethno-cultural expressions. Given the complexity of information needed to integrate and synthesize effective, culturally congruent and safe care, it is a challenging imperative for maternity nurses to maintain current knowledge and understanding of the diverse ethno-cultural groups for whom they provide care. It is imperative that nurses continue to increase their knowledge on how to provide optimal care in this dynamically changing social environment of immigrant populations. The evolution of definitions and concepts around how to approach ethnocultural interactions have to acknowledge the wider socio-political structures as well as the complexity of culture. Whether nurses utilize any number of roles such as clinician, educator, researcher, or advocate, nurses are situated in an opportune position to effectively achieve culturally congruent care.

Conclusion

Just as Canadian migration patterns and ethno-cultural formations have evolved over time, so too should our ways of developing our ethno-cultural nursing knowledge. It is important to acknowledge change, understand how to

clearly interpret it, and proceed with the proper tools and concepts that will equip nurses to effectively achieve culturally congruent care. Ground level experiences of migrant women and front line health care professionals continue to communicate the existence of disparities. More Canadian inquiry is required for our changing immigrant profiles; in this case, Francophone refugee women from African countries. What conceptual elements and everyday discourses do nurses draw upon as they negotiate care? What influences nursing decision-making in ethno-cultural interactions? This study sought to add to ethno-cultural nursing knowledge by exploring current knowledge and understandings of maternity nurses as they care for Francophone immigrant/refugee women of African origin in the Albertan Canadian context.

Chapter 3 – The Methodology of Focused Ethnography

Devoting a chapter to describing the methodology of focused ethnography will bring clarity to the underlying principles of this research approach. More specifically, it will provide systematic rationale for framing the research questions, collecting and analyzing data, and interpreting the results. A general overview of qualitative research will be given to highlight the basic foundation of inquiry for the specific description on focused methodology. The related ontological and epistemological viewpoints will also be described since methodology is a result of our understanding of what the nature of knowledge and how we have come to know the world (Dew, 2007). The role methodology plays in research will be described in order to emphasize its importance throughout the research process. Finally, the methodological choice of focused ethnography and its characteristics for this research study will be provided.

Qualitative Research versus Quantitative Research

Qualitative research designs stem from a naturalistic, interpretive paradigm or worldview which is characterized as acknowledging subjective, contextual, multiple realities of knowledge gained (Driessnack , Sousa & Mendes, 2007; Dew 2007). Naturalistic inquiry simply means no pre-selected variables, no prior assumptions, and no prior commitment to any one theoretical view are made to allow for the phenomenon of interest to present itself as if it were not under study (Sandelowski, 2000). Qualitative research also uses an inductive

approach which moves from a set of facts to more abstract concepts whereas deductive reasoning moves opposite in direction from theory to the more specific (Streubert Speziale & Rinaldi Carpenter, 2007). The main ontological underpinning of qualitative research lies with Interpretivism. The ontology of Interpretivism views the person or research as inseparable from reality or the life-world and the epistemology that knowledge is intentionally shaped through a person's lived experience (Weber, 2004). This allows researchers to explore the unique, human interpretations, experiences and interactions as a valid approach to knowledge generation. This is a great departure from positivism, knowledge generation based on objective reality commonly associated with quantitative research and scientific method. The ontology of Positivism views the person or researcher as being separate from reality or the life-world and the epistemology that knowledge exists beyond the human mind (Weber, 2004). Here in Table 1, Weber (2004) shows a conceptual brief created by Jorgen Sanderson on the main distinctions between Positivism and Interpretivism:

Table 1. Positivism versus Interpretivism

Metatheoretical Assumptions About	Positivism	Interpretivism
Ontology	Person (researcher) and reality are separate.	Person (researcher) and reality are inseparable (life-world).
Epistemology	Objective reality exists beyond the human mind.	Knowledge of the world is intentionally constituted through a person's lived experience.
Research Object	Research object has inherent qualities that exist independently of the	Research object is interpreted in light of meaning structure of

	researcher.	person or researcher's lived experience.
Method	Statistics, content analysis.	Hermeneutics, phenomenology, etc.
Theory of Truth	Correspondence theory of truth: one-to-one mapping between research statements and reality.	Truth as intentional fulfillment: interpretations of research object match lived experience of object.
Validity	Certainty: data truly measures reality.	Defensible knowledge claims.
Reliability	Replicability: research results can be reproduced.	Interpretive awareness: researchers recognize and address implications of their subjectivity.
Weber, R. (2004). The rhetoric of positivism versus interpretivism: a personal view. *MIS Quarterly 28*(1), iii-xii.		

Other important epistemological underpinnings that are often given reference in qualitative research are constructivism, feminism and post colonialism. Constructivism is the way in which humans generate knowledge and meaning through a lived experience, feminism seeks to counter the male dominated orientation of knowledge, and post colonialism takes into account the Western dominated discourses that pervade research and knowledge generation (Streubert Speziale & Rinaldi Carpenter, 2007;Clough and Nutbrown, 2007). Many more detailed distinctions exist in philosophical underpinnings within types of qualitative research the deep roots of which are embedded in naturalistic and interpretive perspectives. Ontologies, epistemologies and theoretical frameworks referred to in various qualitative approaches can overlap but are largely in keeping with the interpretivist paradigm. Variations in approaches are most likely influenced by the main research pioneers of each of

the methodologies. Whether philosophical underpinnings are qualitatively interpretive or critical in their approach, researchers acknowledge the influences on their positionality, reflexivity being of key importance; the transparency of which affords a persuasive rationale for the significance of their work.

The nursing discipline has accepted ontological and epistemic claims at the roots of both quantitative and qualitative research adding depth to the nursing perspective of empirical knowledge generation. Carper (1978) identified four ways in which nurses come to know: empirical knowing, aesthetic knowing, personal knowing, and moral knowing. Empirical knowing relates back to the positivist paradigms where reality is apprehensible through objective data, measurement and generalizability towards the generation of knowledge. This way of knowing is crucial in circumstances where control and generalizability are important, however, less valuable when the subject of inquiry cannot be made objective (Streubert Speziale & Rinaldi Carpenter, 2007; Carper, 1978). Aesthetic knowing, for which there is no formal description or measurement, is based on subjective expression in the understanding, interpretation and creative development of nursing care (Carper, 1978). According to Streubert Speziale & Rinaldi Carpenter (2007), aesthetic knowing, "in nursing provides the framework for the exploration of qualitative research methodologies" (p. 6). Personal knowing requires the ability to self-actualize, comfort with ambiguity, and patience in understanding for the purpose of creating authentic relationships and a genuine nurse 'presence' in nurse-patient/client interactions (Streubert

Speziale and Rinaldi Carpenter, 2007). Moral knowing is another abstract concept of how individuals come to know a situation; this requires openness to different philosophic positions in order to discern what should be done in a given situation (Streubert Speziale & Rinaldi Carpenter, 2007; Carper, 1978). May (1994) and Sandelowski (1994) expanded on the idea of knowing related to nursing knowledge by introducing the term abstract knowing. Abstract knowing acknowledges the intuitive connections the researcher must make that go beyond the research process in shaping knowledge (Streubert Speziale and Rinaldi Carpenter, 2007; Sandelowski, 1994). Carper (1978), May (1994) and Sandelowski (1994) provide validation for nursing knowledge generation through qualitative approaches that reflect their personal patterns of reflection and creation of meanings (Streubert Speziale & Rinaldi Carpenter, 2007).

There are many types of qualitative research methodologies such as phenomenology, grounded theory, and ethnography. Subgroups also exist within the various main categories and add to the complexity as descriptions of methodologies continue to evolve and expand over time. Choosing a qualitative methodology is related to the purpose of the research study, in this case, exploring the complexity of understandings and experiences where no *a priori* assumptions or theories exist and deeper analysis is needed rather than a simple description. In order to move forward with the inquiry, we need to understand the ontological and epistemological underpinnings that influence methodology.

The Role of Methodology in Research

Methodology brings congruence to the entire research process. As mentioned through the above explanation of the general qualitative and nursing underpinnings of ontology and epistemology, methodology helps the researcher declare positionality. It connects each part of the research design through a foundational perspective. The methodological perspective allows the researcher to ensure a consistent approach to viewing and seeking answers to the research questions thereby adding systematic strength to the inquiry process. In this research study, a variety of social, political, historical and current events contribute to how Canadian nurses are changing our understanding of cultural knowledge. Just as our wider social context changes, so does our need for understanding change. What is happening? How do we describe it? How is this social experience created and given meaning? What is the moral intent and expression of my positionality behind my research question(s)? A myriad of questions can be asked on the subject of healthcare services as it intersects with culture. Methodology helps the researcher articulate research questions with informal questions asked in the field in a more significant way. More specifically, research claims can be located within the traditions of enquiry that help to uncover and justify research assumptions (Clough & Nutbrown, 2007). Issues of political context also come to light as the specific questions posed involve policy, practice and professional development of the nursing profession. Therefore, methodology, "sets out with specific purpose from a particular position, and

aims to persuade readers of the significance of its claims; these claims are always broadly political" (Clough & Nutbrown, 2007, p.15).

Choosing Focused Ethnography

Focused ethnography was the methodology of choice for this research study. The origins of this methodology stem from anthropologically derived ethnography research. Famous traditional ethnographers include Bronislaw Malinowski whose work in the Trobriand Islands advanced the practice of participant observation, Franz Boas whose 1948 study on Inuit culture signaled the development of contemporary ethnography and Margaret Mead whose descriptions of gender characteristics and roles in three different New Guinea cultures further explored the debate on 'nature versus nurture' (Streubert Speziale & Rinaldi Carpenter, 2007; Roper & Shapira, 2000; Morse, 1994). Interestingly, Transcultural Nursing theorist, Leininger was an anthropologist and student of Margaret Meade before becoming a nurse. Ethnographers embraced the epistemic claims of Interpretivism's subjective lived experience and rejected the distinction between the validations of kinds of societies. For example, Boaz in particular understood all societies to have a history, and all societies to be proper objects of anthropological society. In order to approach literate and non-literate societies the same way, he emphasized the importance on studying human history through the analysis of other things besides written texts. Counter to the arguments of ethnocentricisms and imperialism, Boaz supported

the concept of cultural relativism, the acceptance of cultural variations (cultural norms, beliefs, traditions) (Streubert Speziale & Rinaldi Carpenter, 2007). The Chicago School of Sociology are also connected with the evolution of contemporary ethnography and is responsible for infusing hermeneutics, the analysis of subjective textual expression of a person's life-world and practical pragmatic philosophies along with field research within local context as opposed to foreign based research(Streubert Speziale & Rinaldi Carpenter, 2007). Throughout the decades, many types of ethnographies have been created as more disciplines incorporated this methodological approach. Definitions continue to evolve but variations include but are not limited to classical, systematic, critical, interpretive or hermeneutic, particularistic, cross-sectional, ethno-historical, visual, ethnoscience, ethnonursing and focused ethnography (Streubert Speziale & Rinaldi Carpenter, 2007; Roper & Shapira, 2000; Miles & Huberman, 1994; Morse, 1994). Even with such large numbers of variant styles, ethnographies contain some overlapping and interrelated elements. The following table contains a list of common ethnographic characteristics drawn from Streubert Speziale and Rinaldi Carpenter (2007), Boyle (1994) and Roper & Shapira (2000). As Boyle (1994) declares, these characteristics are not exclusive and somewhat artificial in distinction but the categories provide clarity especially for novice researchers such as me in the journey to better understand this methodology.

Table 2. Characteristics of Ethnography

Characteristics of Ethnography	
Researcher as an instrument	The ethnographer becomes a conduit for information shared by the group. The primary ways the researcher becomes an instrument through interviewing, observing, recording of cultural data and examining cultural artifacts.
Holistic & Contextual Focus on Culture	The purpose is to understand the lifeways of individuals connected through group membership. It is the search for culture that gives researchers the context in which to study and to offer their interpretations of what are seen using techniques such as participant observation and interviews.
Emic & Etic perspective	The research tries to identify the *insider* views but also draws from the outsider framework of definitions and explanations in order to make sense of what is being observed.
Cyclic nature of data collection & analysis	This is the challenge of ethnography as there are no clear boundaries on similarities and differences between cultures. Asking one questions leads to another and so on and so forth. The researcher tends to be engaged in a continuous process of interviewing and observing, reviewing and analyzing, returning to fieldwork, etc.
Reflexivity	Researchers must realize that they alter the culture and have the potential to lose their objectivity more than is typical in the conduct of research. The researcher should be aware that by being present in the culture, it is changed. The duality of being a researcher and a participant allows the researcher to obtain insights derived from datum sources: meanings are co-constructed through active, reciprocal relationships. Reflexivity can lead to greater understanding of the dynamics of particular phenomena and relationships found within cultures.
Boyle, J.S. (1994). Styles of Ethnography. In J. Morse (Ed.), Critical issues in qualitative research methods (pp. 159-185). **Streubert Speziale, H. J., Rinaldi Carpenter, D. (2007). Qualitative research in nursing: Advancing the humanistic imperative. New York: Lippincott Williams & Wilkins.** **Roper, J.M. (2000). Ethnography in nursing research. Thousand Oaks, CA: Sage Publications.**	

Nursing academics began using ethnography in the 1960's and include pioneer nurse researchers such as Madeline Leininger and Pamela Brink (Morse, 1994). In fact, Leininger (1985) coined the term 'ethnonursing' as a research method which blends practice concepts from anthropology and nursing. Ethnography or ethnographic methods have been used by other nurses such as Morse, Roberson, and Boyle to explore nursing paradigms which usually focus on health beliefs and practices and their relation to social factors (Boyle, 1994). According to Muecke (1994), "ethnography conveys a coherent statement of a people's local knowledge…important for health care program development and as a guide to specific nursing interventions" (p. 197). Most nurse ethnographers focus on distinct phenomena within a specific group, usually small in number and context which was born out of financial, time and resource constraints of conducting classical, long term ethnography; this lead to the development of the term focused ethnography (Roper & Shapira, 2000; Muecke, 1994). The micro-ethnography or focused scope allows researchers to target a specific phenomena of interest engaging with people who have knowledge and experience relative to the phenomena (Muecke, 1994). The classical characteristic of holistic and contextual perspectives allows for a better understanding of the complexities of common situations and careful attention to the emic and etic perspectives can all add to the principle outcome of ethnographies; the iconic thick, rich description of "why people do what they do or believe as they do" (Roper & Shapira, 2000, p.9). Focused ethnography applies an inductive and iterative

process where knowledge is continually tested and reconfirmed in a cyclical fashion between data collection and data analysis. Higginbottom (2004) noted that the sample size for focused ethnography can be limited in number and may have only one participant. Not only do the characteristics of a focused ethnography fit methodologically well with this research study, but also offer a pragmatic solution for the scope of a master's level thesis.

Conclusion

Such an understanding of methodology is needed in order to weave these foundational threads through my entire research design. The descriptions of qualitative research, ethnography, then focused ethnography all serve to illuminate my positionality as I declare my research question and purpose. This methodology fits well with the proposed study as it will focus on the sub-cultural group of maternity nurses' and explore their understandings, how they interpret their common behaviours and experiences of providing care for immigrant/refugee women of African origin. The focused time frame, context and participant numbers provide a feasible yet valid choice for a master's level thesis. The qualitative research journey is a convoluted one. Exploring the underlying philosophies of a chosen methodology and their grounding roles in the research process are essential as methodology acts as a compass to guide the researcher to fulfill a journey well traveled.

Chapter 4- Methods

The literature review section showed through research studies, examples of disparities in cultural values and beliefs between nurses/carers and their clients that affect the provision of culturally congruent care. Language difference and ensuing communication difficulties, as well as behaviours of "Othering" practices as defined by Johnson et al (2005) are some of the ways that distance nurses from their patients. The nursing profession continues to be challenged to integrate the care needs of ethnoculturally diverse patients into their everyday clinical practice (Reitmanova & Gustafson, 2008; Harper Bulman & McCourt, 2002; Meddings & Haith-Cooper, 2008). In the context of our immigrant/refugee populations from African countries, how are nurses responding to ethnocultural interactions? Sufficient examples in the Canadian context are limited to gauge nurses' strengths, challenges, stressors, and facilitators that influence a nurse's ability to provide culturally congruent care. An exploration of this kind is necessary to ensure nurses feel sufficiently equipped to negotiate ethnoculturally diverse encounters. This qualitative, focused ethnography study aimed to describe the ways in which maternity nurses experienced caring for immigrant/refugee women of African origin. This section will describe the research methods used to help explore this research aim.

The methods section is a research design map; for some a portrait, for others a recipe and yet for others a forged path of how the researcher created

the journey towards the findings. The methods section is composed of the following segments which describe the way in which the research study was conducted: setting, sample, participant, recruitment, data collection, reflexivity, ethics, rigour and limitations. A description of the research setting will add a sense of the participants' work environment within which their experiences with African immigrant women were encountered. The sample section will describe the sampling style used to select the maternity nurse participants. The participant section will then describe the profile of the twelve maternity nurse participants. The process and procedures of recruitment are described to give details to the ways in which participants came to know and agree to participate in this study. The data collection strategy of semi-structured interview is described as the primary strategy for obtaining data. Reflexivity as an important aspect of focused ethnographies will be included in this section. I will provide my reflective insight into my personal positioning that creates the subjectivity I come with as an instrument of research. Ethics information is included in this section to elaborate on the ways thoughtful engagement of ethical principles was applied. Study rigour and limitations are also included to demonstrate an awareness of the strengths and limitations of this research study. In summary, the research methods will help elucidate the research design, in doing so, provide details to help gauge its appropriateness with the chosen methodology, identify areas of improvement, and allow for potential replicability to confirm or expand on the research results (Bui, 2009).

> *If I go out into nature, into the unknown, to the fringes of knowledge, everything seems mixed up and contradictory, illogical and incoherent. This is what research does; it smoothes out contradiction and makes things simple, logical and coherent. (Szent-Györgyi, 1980)*
> (In Morse, 1994, p.1)

Setting

The study was conducted at three hospital facilities located in mid-sized and large city centres in Alberta, Canada. All facilities had distinct Labour & Delivery and Post Partum units from which nurses were recruited. Nurses who worked in Labour & Delivery units at the larger facility typically did not work cross over shifts onto the Post Partum units, whereas, there was some cross over work in the mid-sized facility. The facilities were equipped to handle a range of birthing methods from normal vaginal birth to cesarean sections. The larger facilities were also equipped to receive highly complex patient intake of both mothers and babies from many smaller scale Alberta hospitals. Dyadic care, a nursing care philosophy in which both mother and baby are cared for as a unit, was the mode of maternity service delivery at both facilities. The facilities operate their maternity services at full capacity on a daily basis never having 'free' beds for more than a few hours if at all. Additional obstetrical training of nursing staff varied and was found to be dependent on place of education, country of education, skill level (RN, LPN or midwife) and experiential level. For example, Canadian RN graduates did not need additional obstetrical training to work on Labour and Delivery or Post Partum units as they receive comprehensive

training including obstetrics within the baccalaureate program. LPN's worked primarily on Post Partum units and also did not have additional obstetrical training beyond their existing LPN course requirements to work within the environment of Post Partum units. Internationally trained nurses had a greater tendency to have additional focused obstetrical training and were often certified midwives in their country of training. Some of the RN participants did, however, take additional obstetrical training beyond their formal nursing program.

Interestingly, the temporal setting of this research study is also worth noting. Much of the 'active' phase of research involving recruitment and data collection occurred during the Alberta Health Services restructuring. Although micro-level restructuring was minimal during this time, there was an element of uncertainty as far as employment and financial security at all organizational levels. Such a large scale remodeling and centralization process proved to impact the study indirectly. Recruitment was considerably slowed down due to circumstances beyond my control that limited my attendance at regular unit meetings and unit visits. Administrative contacts also reduced their availability to communicate and collaborate on this study as their time and energy was redirected towards mitigating impending budget cutbacks and staff tensions.

Sample

Purposeful sampling was the technique of choice to request maternity nurses who have worked with immigrant/refugee women of African origin. Purposeful or purposive sampling is a type of non-probabilistic sampling which involves participant selection based on first-hand experience of the phenomenon of interest (Streubert Speziale & Rinaldi Carpenter, 2007; Richards & Morse, 2007; Roper & Shapira, 2000). This sampling approach is synonymous with the focused ethnographic methodology as it allows the researcher to select a specific group of participants in order to contextually explore the knowledge and understandings of maternity nurses (the subcultural group of interest) in caring for immigrant/refugee women of African origin (looking for shared meanings, group features). A snowball technique was also used towards the end of recruitment where two participants were approached through key contacts to recommend other individuals to participate in the study (Higginbottom, 2004). Sample size in qualitative research is difficult to ascertain, although Guest et al. (2006) suggests that 12 interviews are sufficient to reach data saturation. Data saturation occurs when no new information is incurred during data collection (Roper & Shapira, 2000). Ethnographic studies can range in sample size from 15 – 35+ participants (Guest et al. 2006; Reitmanova & Gustafson, 2008; Johnson et al., 2004; Harper Bulman & McCourt, 2002). Higginbottom (2004) suggests sampling is "determined by the number of participants in the subculture or group…in this respect, it may not be possible to specify in advance the number of

participants" (p. 11). Higginbottom (2004) noted that the sample size for focused ethnography can be limited in number and may have only one participant. Considering the above parameters and previous studies of similar content (Higginbottom, 2006), as well as discussion with thesis supervisor, a sample size range of 12-20 participants was estimated to reach data saturation. The actual point of data saturation occurred for some thematic areas around participant 9 but 12 participants were sought to ensure thoroughness of saturation on all points of interest. It is recognized that the sample focus provided perspectives of maternity nurses and not a wholly comprehensive picture of the phenomena. The study worked within the boundaries of a master's thesis; however, it is acknowledged that perspectives of African immigrant/refugee women receiving maternity care are also important to understanding the phenomena.

Participants

Maternity nurses from three Albertan hospitals volunteered to take part in the study. Originally, this study designed was to target nurses who cared for refugee women of African origin, however, initial interviewing revealed that the immigration status of maternity clients is not consistently captured making it difficult for nurses to reflect on specific refugee care experiences with certainty. The term was then adapted to 'immigrant/refugee' in order to help nurses draw from a broader set of experiences utilizing an emergent design as is synonymous with qualitative research (Roper & Shapira, 2000). The following demographic

information was collected from the participants: name, position title, and number of years of nursing experience, city and country of nursing education, country of origin, ethnicity, and languages spoken (see Appendix N for details). The participants identified themselves as either registered nurses (RN) or licensed practical nurses (LPN). The range of nursing work experience was 5 – 30+ years as an RN, LPN or in their international experiences as a midwife. All but one nurse received a Canadian nursing education. Most nurses did not have formal transcultural nursing education but a number of participants had attended hospital based cultural seminars, two nurses explored written material on transcultural nursing and three had international nursing experiences in developing countries of South America and Africa. All but two nurses were Canadian born and English was the primary language spoken.

Recruitment

A variety of recruitment strategies were employed to recruit maternity nurses. Recruitment initiatives commenced after receiving University ethics and facility specific administrative approval to conduct research at the facilities of interest (see Appendices J, K, L, M). Originally, recruitment was pursued at one large facility; however, recruitment efforts were expanded in the fourth month of the study to include two more facilities as participant numbers were low. After receiving an ethics amendment approval, the two additional acute care facilities were approached for facility specific administrative approval.

Facility administrators ranging from program directors, managers, and clinical educators were contacted to ask for input on effective methods of communication to maternity nurses. At all facilities, an invitation was given to attend an administrative meeting in which the research study was communicated to maternity unit manager(s) and clinical educators. Recruitment posters and information packages and research poster advertisements were given to the unit managers of Labour and Delivery and Post Partum. The package consisted of a written newsletter containing the details of the research study, and follow up contact information (see Appendices C, D & E). The packages and posters were placed in the staff lounge. Interested nurses were given an option of contacting the researcher by mail using the enclosed self-addressed envelope, by phone, by email or by placing their expression of interest in an enclosed, locked receiving box that was left on the wards' staff lounges. An administrative assistant and key contact were asked to check the locked box. The box design allowed for checking for presence of letters by these individuals without unlocking the box and gaining actual access to the response letters. The boxes were checked for replies on a weekly basis and the contacts notified the researcher if collection was necessary. Most participant contact was made through email notification. A request was also be made to verbally communicate information to nurses via nurse managers during ward rounds and/or shift change reports. The researcher was invited to give presentations regarding the research study on several occasions at the various sites during differing staff shift

lines so that nurses were more familiar with the researcher and the contents of the study to help further inform their decision to participate. Nurses were also encouraged to report reasons for declining study participation but none were ever reported. The reason for non-participation was not for formal documentation as no consent would have been given by the non-participant to use such information; however, this information may have highlighted a remediable oversight or flaw in recruitment strategy or research design. Once the participants indicated interest in the study, a meeting time was scheduled at the participant's convenience. A parking reimbursement fee of ten dollars was given as needed. The study details were given which included potential benefits and harmful consequences. The University of Alberta Health Ethics Research Board (HREB) written informed consent letter and consent signatory form template was used (see Appendices F & G). The participants were then given opportunity to discuss questions or concerns with the researcher and the options of non-participation either before, during, or after the research study was made explicit during this time. The participants were given the written consent information letter in order to ensure they had contact information of the researchers and HREB to ensure re-contact could be made as needed. Demographic information (Appendix H) and data collection only proceeded after the consent form was signed.

Data Collection

Ethnographic data collection and analysis are cyclic in nature and proceeded with the researcher engaging in a continuing process of interviewing, observing, reviewing, analyzing data and returning to the field to do more of the same (Roper and Shapira, 2000). Ethnographic data collection can be conducted through a variety of activities such as participant observation, interviews and field notes Richards & Morse, 2007; Roper & Shapira, 2000; Morse, 1994). In focused ethnography, Richards & Morse (2007) state that "data making may include only some of the strategies that define ethnography. For instance, fieldwork may be omitted, and data may consist only of interviews" (p.58). Data collection in this respect involved semi-structured interviews on an individual basis with participants. The semi-structured interview allowed for a conversational style interview yet focused on collecting information regarding the research question. Exploring the maternity nurses' understanding of their experiences was thought to be well captured through the moments of one-to-one in-depth conversation. Participant observation was beyond the scope of time and resources for this small scale study. For example, the ethical consent required would be more complex as patients and families of diverse backgrounds would be involved in the observations. As a nurse researcher, I know that I engaged in some level of informal observation each time I visited the facilities, but given the sensitive and intimate nature of such observations surrounding the birth of a child as well as the additional ethical considerations for research

involving diverse populations (Trimble & Fisher, 2006), this type of data collection was not pursued. Through these deliberations, I felt the focus was on the maternity nurses and the sharing of their narratives, reflections of experiences and how they chose to represent their clinical realities. Questions evolved from the three basic types of ethnographic questions which are descriptive, structural and contrast. Specific questions focused on perinatal care giving practices unique to immigrant/refugee women of interest and sought to explore knowledge and understanding of existing practices as well as internal and external influences on providing culturally specific care. Questions also included factors that challenged the participants' ability to adopt certain culturally specific care practices. Much care was taken to ensure questions are appropriate as well as meaningful enough to obtain accurate information which will serve to answer the research question. Questions were formulated and re-checked for acceptability with the thesis supervisor. Focal areas of data collecting included: the depth and breadth of nurses' cultural knowledge, effective and ineffective problem solving experiences in relation to cultural encounters and nursing care practices, perceptions of barriers and challenges nurses face in providing care and perceptions of barriers and challenges nurses' thought their clients faced in care encounters (See topic guide in Appendix I). Transcripts were also reviewed after each interview to assess the ability of the topic guide to answer the research questions. Interviews took place in a private room either at the University of Alberta or hospital facility locations according to

the expressed wishes of the participant. Special care was taken in the hospital settings to locate a room far away from the maternity units to better assure the ability to keep participants anonymous. Interviews were audio taped using a digital voice recorder and lasted between 60 – 90 minutes. Post interview notes were also taken to record non-verbal communication and context and to record reflective thoughts. The digital voice recordings were then uploaded onto an encrypted computer located in a locked, secured office space on the University campus. Secure file transfer protocol (ftp) upload sites[2] through the University of Alberta are not available to graduate students. Upon consultation with two computer specialists (one from U of A and one independent) as to the next best and secure option, interviews were burned onto CD's and secured courier services were used whereby signatures were required for receipt of the package to the transcriptionist. Transcribed interviews were couriered back in the same way along with the original CD's. Subsequent data analysis is described in the data analysis chapter.

Reflexivity

Reflexivity involves, "being deliberately aware of oneself, one's responses, and one's internal state in relation to a specific situation and at the same time attempting to understand the patient and the situation" (Roper &

[2] File transfer protocol or ftp is the protocol for exchanging file over the internet. This is particularly beneficial for the exchange of large data files that cannot ordinarily be sent via email messaging systems. http://www.webopedia.com/TERM/F/FTP.html

Shapira, 2000, p. 26). This research study does not use patients as participants; however, the basic principle remains the same. In order to begin this type of data collection, the researcher needs to understand the concept of reflexivity whereby the self-awareness and self-reflection by the researcher must occur in order to acknowledge potential areas of subjectivity during data collection (Streubert Speziale and Rinaldi Carpenter, 2007; Roper & Shapira, 2000; Muecke, 1994). Along with such introspection, the research also must acknowledge their positioning with respect to the 'world' they are researching and the way in which they are affected by it (Morse, 1994). The insider and outsider (emic and etic) viewpoints are important to consider as the researcher explores reasons the group of interest is directed towards certain decisions and behaviours.

In this study, my insider or emic perspective comes from two distinct viewpoints: the immigrant and the nurse. Although most of my upbringing has occurred in Canada, my family is the first generation of immigrants from our family in India. I lived the immigrant experience in many ways. Socio-economic hardships were an accepted way of life in making the transition to a new country. During the 1970's, migration of people from India was not as commonplace as today. Discrimination was overt and included many forms of social exclusion such as housing segregation, racial violence, slurs and non-access to some stores. This was a time period in which my family had very low social capital. Even though the increased acceptance and understanding of multi-ethnic groups in Canadian society has dramatically changed over the last three

decades, racism and discrimination remain in today's word in more subtle yet 'sensed' forms. I have had negative experiences as what I would call a 'visibly, ethnically distinct' maternity patient which make me wonder how many other women have had similar experiences. Such ranges of immigrant experiences have retained residual effects that still affect my current viewpoints and process of research inquiry in this study.

Canada has been the location of all of my nursing education. My professional training and designation afford me similarities to the participant group of interest. I have trained and worked in a variety of acute care settings across Alberta for over twenty years. I feel that I also have an emic viewpoint from a nursing perspective. I have seen the health system change from de-centralization back to centralization and the affects of such how large systems changes have affected the way nurses are able to provide care. In the larger health systems context, nurses also have very low influence on health care delivery decision-making. Nurses are increasingly challenged to provide care in the context of many constraints including increased workloads, budget cutbacks, staffing shortages, and the predominant biomedical perspective of health care. I am still situated in an acute care facility and feel the tension between trying to achieve ideal nursing care and negotiating what constrains or prevents me from my ideals. Choosing to further my education by means of graduate studies in nursing was a way to help affect positive change for my nursing colleagues. I do

feel camaraderie with my professional peers and sense of commitment to contribute a just portrait through my research activities.

My outsider viewpoint stems from my researcher role. As such, I have a commitment to look at my research, dissect, integrate, and look beyond both of my emic viewpoints. This etic role allows me systematically explore my research with a scientific, intellectual stance thus providing me with tools to develop a balanced exploration of my research question. Historically, there has been divided thought as to whether the emic or etic viewpoint is given primacy; however, most ethnographers tend to use both perspectives to make sense of the phenomena of interest (Morse, 1994). Roper & Shapira (2000) cite Werner and Schoepfle's (1987) original work in stating, "The two views, side by side, produce a 'third dimension' that rounds out the ethnographic picture (p. 4)." By looking at my research from the immigrant, nurse and researcher viewpoints I feel that I can better understand and accurately describe the situations and behaviours that have been shared with me.

Rigour

The goal of qualitative research is to accurately represent the experiences of the study participants (Streubert Speziale & Rinaldi Carpenter, 2007). The study was assessed for rigor or 'trustworthiness' through Lincoln and Guba's (1985) qualitative technical elements of credibility, dependability, confirmability and transferability. They recommended specific strategies be used to attain

trustworthiness such as negative cases, peer debriefing, prolonged engagement and persistent observation, audit trails and member checks (Lincoln & Guba, 1985). Credibility includes ways the researcher increases the probability that credible findings are produced (Lincoln & Guba, 1985). One of the best ways to achieve credibility of findings is by prolonged engagement (Streubert Speziale & Rinaldi Carpenter, 2007). The semi-structured interviews were in-depth lasting between 60 – 90 minutes in length. Clarification of responses was sought throughout the conversational interviews, while persistent observation and maintaining a high level of attentiveness were also used during the prolonged engagement to convey the quality of this aspect of rigour. Member checking was not used to assess credibility as the interview data was de-contextualized and abstracted to produce a product in which the participant may not actually identify with herself. This may also be viewed as an enhancement of reliability. Dependability of results was sought through data triangulation of time, person, and space as proposed by Watson et al (2008). Participant interviews took place over a 1 year period and thus data was collected over an extended period of time and although not purposefully done to show dependability, congruence of findings over time should be considered. Space triangulation was achieved by obtaining participant interviews at three different hospital sites to look for multiple site consistencies and rule out across site variations (Watson et al, 2008). Person triangulation was achieved through recruiting participants of nursing skill mix (LPN & RN), varying experiential levels and varying educational

training backgrounds. Investigator triangulation using thesis advisor to check the researcher's work throughout the study process was also used to ensure dependability of data to help ensure more than one perspective was explored. The objective of confirmability is to clearly illustrate thought processes that led to the conclusions (Streubert Speziale & Rinaldi Carpenter, 2007). The researcher journal records sought to provide a clear audit trail in order to keep decision making transparent and the process confirmable. Memos were also kept within analyzed transcripts to keep questions and decisions close to the data. In as much as researchers produce transparency through an audit trail, Sandelowski (1998a) cautions researchers to contemplate the level of confirmability achieved as only the researcher that has collected the data and immersed in them can confirm the findings. Transferability means there is likelihood that the results have meaning to others (Streubert Speziale & Rinaldi Carpenter, 2007). Do the findings resonate with the reader? Interestingly, Lincoln & Guba (1985) state, "It is…not the naturalist's task to provide an *index of transferability*, it is his or her responsibility to provide the database that makes transferability judgment possible…" (p. 316). Also important were characteristics of the investigator, who must be responsive and adaptable to changing circumstances, holistic, having processional immediacy, sensitivity, and ability for clarification and summarization (Guba & Lincoln, 1981). Morse et al (2002) also ask us to consider that strategies for ensuring rigour must be built into the research process. Morse et al (2002) argue against post hoc evaluation of research rigour and encourage

the use of strategies such as investigator responsiveness, methodological coherence, sampling adequacy and saturation that motivate the researcher to correct the analysis and development of the study through a formative process.

Ethics

Ethics approval was sought from the University of Alberta's Health Ethics Review Panel B and Capital Health Ethics Review Board Committees. Informed consent is based on the principle of autonomy; in this case, for the individual to be able to make a voluntary decision to participate in a research study (Trimble & Fisher, 2006). The researcher is responsible for a clear explanation of the research study to potential participants including both positive and negative consequences associated with the research (Roper & Shapira, 2000). As a qualitative, ethnographic study, this research had minimal harmful effects which primarily were concerned with privacy or confidentiality (Roper & Shapira, 2000). The benefits of this study included sharing of participant knowledge with the greater community of nurses to help expand our cultural knowledge that may help improve overall care practices. No physical, psychological, emotional, or spiritual risks were anticipated with this study. Informed consents were obtained from participants prior to engaging in any data collection procedures. Participants were given the opportunity to withdraw from the study or modify terms of participation at anytime. The principle of non-maleficence or 'do no harm' was achieved by maintaining privacy. Privacy includes maintaining

confidentiality and anonymity (Morse, 1994). Confidentiality revolves around who has access to data (Morse, 1994). Confidentiality was upheld by ensuring information is kept secure in a locked office and will not be accessible to others. Only the researcher and thesis supervisor had access to research information and the transcriptionist was the only additional member to the team who had access to interview transcripts. Anonymity was kept by using codes on transcripts to identify participants. The transcriptionist had a signed confidentiality agreement as part of her contract for services. Permission was sought to use data in publications or conference presentations but it was reiterated to participants that confidentiality and anonymity will be maintained. As stated by Streubert Speziale and Rinaldi Carpenter (2007), "permission to use direct quotes must be acquired, and the researcher must be sure that examples of raw data do not reveal the participant's identity" (p.66). The principle of justice was upheld by ensuring a private environment was available to conduct interviews. Justice concerning the welfare of the participants was also upheld by maintaining a researcher role as opposed to a therapeutic role. The letter of consent stated that if concerns arose from the participants that required therapeutic measures, participants would be directed to the appropriate resources. For the purpose of ensuring an equitable and respectable relationship exists between the researcher and the participants the following ethical principles as referred to by Dearnley (2005) were also included: (1) mutual respect – understanding others' aims and interests, not damaging self-esteem,

and not being condescending; "(2) non-coercion and non-manipulation – not using force or threats or leading others to co-operate when it is against their interests; (3) support for democratic values and institutions – commitment to equality and liberty" (p.20).

Limitations

The limitations of this research study are inherent to the study design. The qualitative focused ethnography involves a participant group of twelve nurses purposively selected according to specific criteria. This is necessary to look for patterns in group features such as behaviours, thoughts, and attitudes yet limit the study to this specific subcultural group. Maternity services in Canada offer a wide range of antenatal to postpartum care through many different service providers but the research findings gleaned from this study come from acute care maternity nurses from Labour and Delivery as well as Postpartum units in three Albertan hospitals. The small sample size also means the interpretation of findings is to be regarded within the context of the study scope and may be limited in transferability. Care should be taken when interpreting findings even when thematic similarities are found to resonate in the work of others. The non-inclusion of the African immigrant/refugee women's voices is also a limitation of this study. The master's thesis level was limited in scope to pursue additional recruitment from the dimension of the African immigrant/refugee women. The single mode of data collection may also be seen

as a limitation as there are limited ways of triangulating data when only one method of data collection is used.

Conclusion

In the context of this study, the research methods chosen were felt to be appropriate with the methodology of focused ethnography. Consideration was given to each portion of the methods: setting, sample, recruitment, participants, data collection, reflexivity, ethics, rigour and limitations to ensure these elements were synonymous with the underpinnings of focused ethnography. Many academic resources were consulted in my journey of 'mapping' out methods for this research study yet the reality remains that neither words, nor expertise of another can completely create or define each individual process. Although there is a great deal of value in receiving the insight of experienced scholars and the historical foundations of research, there is also value in our 'daily study work' for it is there where the researcher makes the personal connection between the research experience and academy. The methods section affords the researcher the opportunity to better organize the design map; however, operational details involved in the research process are highly contextual, at times convoluted and completely dependent on situational circumstances. By sharing the design map of methods, the researcher is able to communicate with clarity, the significant 'daily study work' accomplished towards exploring research phenomena.

Chapter 5 – Data Analysis

As with other styles of qualitative research, ethnographic analysis uses inductive reasoning as the basic premise of how to approach data analysis. Ethnographic data analysis characteristically is a cyclical process between data collection and analysis moving from categories, themes, and eventual abstraction of shared behaviours and patterns of the group of interest. This is typical of inductive reasoning of qualitative research as referred to by Streubert Speziale & Rinaldi Carpenter (2007), which "is a process that starts with details of the experience and moves to a more general picture of the phenomenon of interest" (p.10). The descriptive analysis of focused ethnography will take complex segments of data and reduce them to component parts but will also show how these component parts fit together according to rules (Muecke, 1994). Ethnographic analysis uses the terms emic and etic accordingly in order to produce such results. The emic or insider's (participant's) views are analyzed to described what is happening and why. In this research study, semi-structured interviews with maternity nurse participants are the primary legitimated source of the emic perspective (Richards & Morse, 2007). The etic or outsider's (researcher's) perspective is the framework with which abstractions are made and theoretical explanations of reality are created. It is necessary to acknowledge both of these views as they are necessary to help the researcher effectively describe situations and behaviors of interest (Muecke, 1994). A description of focused ethnographic data analysis according to nurse

ethnographers, Roper & Shapira (2000), as the process of choice, will be given. The role of the qualitative software package of Atlas.ti6© as used in this research study will also be provided.

Description of Systematic Process

Semi-structured interviews were conducted with each maternity nurse participant. A digital audio voice recorder was used to record interviews which were uploaded onto the computer. The audio interviews were then burned to a compact disc and sent by secure courier service for transcription. Once the transcribed interviews were received back via secure courier service, they were re-checked by the researcher simultaneously with the audio recording for consistencies and corrections along with a review of field notes. The transcripts were then converted to rich text format (rtf) files in order to upload onto the qualitative software package of Atlas.ti6©for data management. The various aspects of data management used through Atlas.ti6© were data storage, retrieval, visual mapping and inventory/output functions of codes, code families and primary documents. Ethnographic data analysis was be carried out using steps as outlined by Roper & Shapira (2000) which include: (a) coding for descriptive labels; (b) sorting for patterns; (c) identification of outliers or negative cases; (d) generalizing: constructs and theories; and (e) memoing: reflective remarks. According to Swanson (2001), "coding is a very involved process and includes asking questions of the data, making constant comparisons

between incidents in the same interview or in different interviews, and naming as a category those codes that are alike" (p. 237). In ethnographic analysis, codes are used as tags or labels to assign meaning to descriptive or inferential segments which are words, phrases, sentences or paragraphs of interview text (Miles & Huberman, 1994). These meaningful units are contextually bound and embedded in the researcher's conceptual lens or etic perspective and therefore, the research is in constant awareness of reflexivity throughout the analysis process (Miles & Huberman, 1994). Initially, the coding process should categorize a broad range of phenomena so as not to constrain the search for meaningful data (Roper & Shapira, 2000). Displaying relationships and how they recur is the way in which focused ethnography 'sees' the data (Richards, 2005). Codes were given definitions using the code comment box to help elucidate assigned meanings as well as to create an output function that could generate code lists with definitions. Two hundred raw codes were created from the twelve interview transcripts (see Appendix B). Upon further transcript reviews, some of the codes were discarded and others were merged to produce a total of one hundred seventy six codes. Merged codes were created using the code family function; a sample of a code family and relationship mapping of codes using the examples of breastfeeding, characterization of African immigrant/refugeewomen, systemic ethnocultural challenges and nursing challenges is shown in Appendix O. The following basic domains are suggested by Roper & Shapira (2000) to facilitate the thoroughness in approach to coding data (see Figure 1).

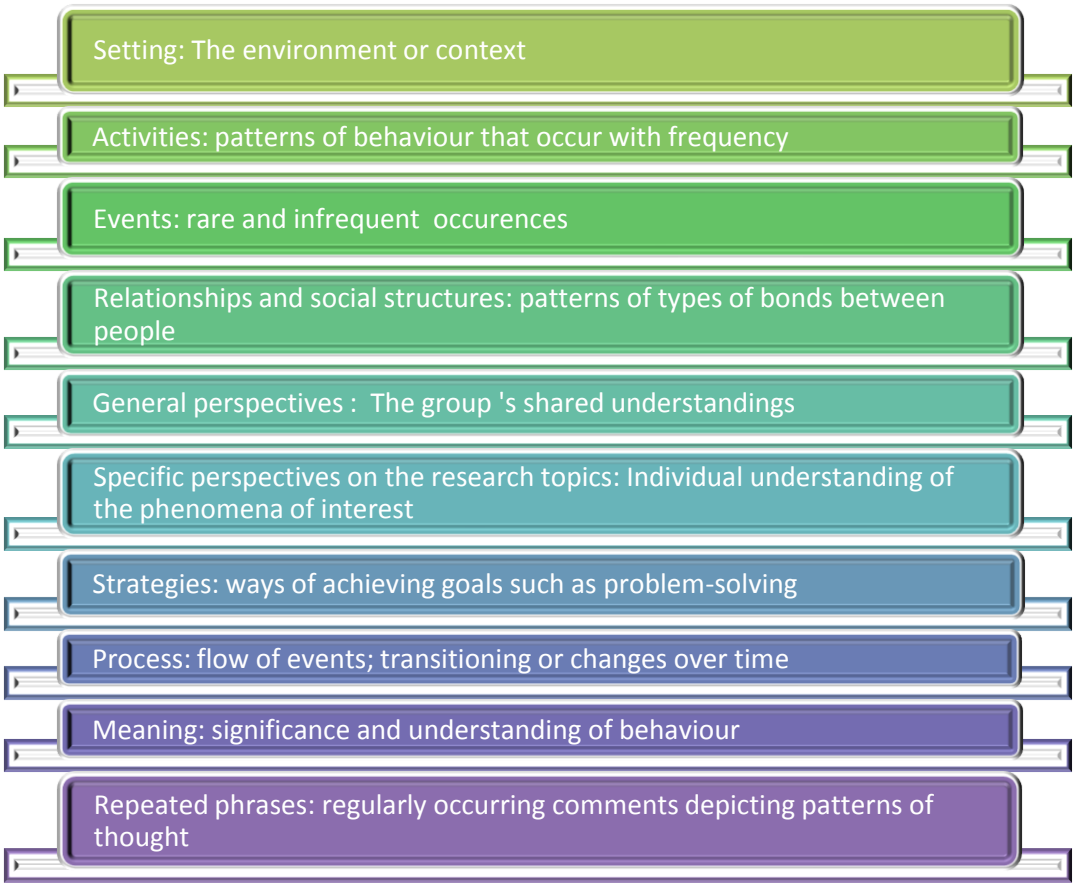

Figure 1. Dimensions to Facilitate Coding of Data

Coded data were examined for the relevance and significance to the research questions and are either kept or discarded accordingly.

Pattern sorting leads to the formation of themes and greater abstractions. Pattern categories may be like or unlike labels but fall under larger groupings that explain regularities in behaviours and beliefs. In this way, the researcher is able to form hunches or hypotheses with potential themes and

explore data further by using “if then” questions. Focused ethnography data analysis would start this process upon the first point of data collection, in this case, the first participant interview (Roper & Shapira, 2000). Consequently, the cyclical process between data collection and data analysis is initiated

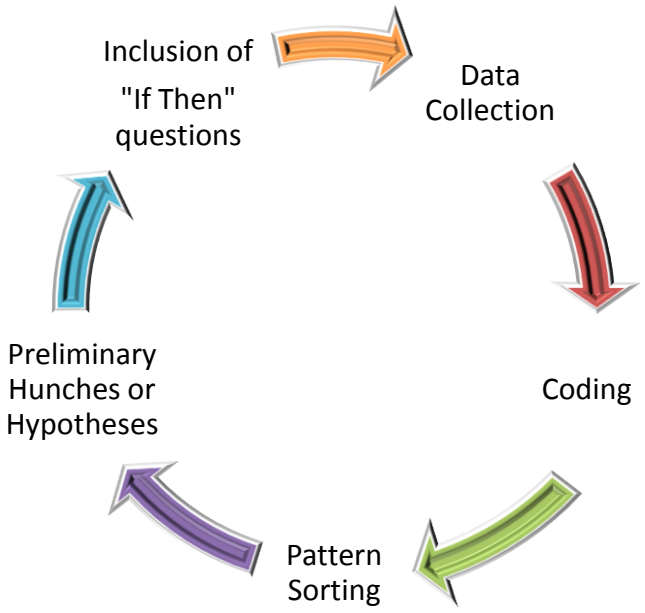

Figure 2. Preliminary Cyclical Process between Data Collection and Data Analysis

During pattern sorting, outliers or negative cases which are contrary to emerging patterns may appear. Identification of such negative cases can help revise data analysis and actually confirm emerging patterns in the data majority (Cohen & Crabtree, 2006; Roper & Shapira, 2000). It is important not to discard such outliers as they will help to better understand or explain the major data trends (Roper & Shapira, 2000). Pattern sorting was challenging as the

researcher searched for emergent themes by data emersion under the constancy of searching for answers to the research questions at hand. Attentiveness and reflection are necessary throughout this process in order to ensure themes are true to the narratives of the maternity nurses and not pre-determined or selectively chosen for a strategic fit. Interrogation of the data is necessary to 'see' with depth. Some questions Roper & Shapira (2000) suggest to ask during this process were:

> (a) Are the similarities enough alike to represent a true pattern? (b) Do the differences reflect extraordinary responses ("outliers"), or are there shared characteristics in the difference? We also asked ourselves about the patterns' relationships to already established concepts…We further compared these patterns to descriptions in the literature… (p. 99)

The interrogation of the data with constant re-emersion resulted in two thematic model changes before the final constructed results. My etic perspective as a nurse researcher guided me to ponder on my existing theoretical knowledge and philosophical stance such as transcultural nursing and its related concepts, Carper's (1978) ways of knowing, and post colonial feminism when interrogating themes. I am also cognizant of the emic perspectives of the maternity nurses and how data analysis captures and becomes the essence of their narratives.

Roper & Shapria (2000) talk about the 'generalizing' findings in the form of construct or theories about the cultural work of study, however, this is not to

be confused with generalizability or transferability of findings. Generalizing in this sense is meant to describe the activity of higher abstraction from the existent codes and themes. Emergent findings in the way of constructs and/or theories are built in ethnographic analysis which aims to develop an abstract network of the interrelated concepts from the emergent patterns found in the data (Roper & Shapira, 2000). This is where the researcher bridges the emic meanings or the participant views with the etic interpretation of those meanings and connects the themes with the proposed construct or theories. Constructs were generated from the data analysis in relation to this study. There are different ways to display relationships between codes, patterns/themes, and emergent findings. Roper & Shapira (2000) suggest the construction of a data matrix to discern specific patterns and their relationships between selected codes, patterns, and/or participant demographics and emerging themes. The various computer assisted software packages for qualitative research also have capabilities to show relationships between the different levels of analysis. Atlas.ti6© in particular can display the familial relationships between codes and themes.

Memoing included recording of descriptive and interpretive field notes, memo entries using Atlas.ti6© as well as the use of a personal reflective journal. Memos are ways of asking questions of the data or reflecting on ideas and insights in close relation to the data. Memoing is a place where emic and etic perspectives can intersect and be captured in closeness to the data. There is

significant value in this element of analysis as memos afford the researcher cues to deeper data mining during subsequent data collection and analysis which can later lead to theoretical understandings (Roper & Shapira, 2000).

Choosing a Computer Assisted Qualitative Data AnalysiS ©(CAQDAS) Package

Specialized software programs for qualitative research have been revolutionary in helping researchers manage the volumes of data produced from the research study. Software programs are meant to help code, retrieve and analyze data but do not provide the researcher with a methodological or analytic framework (Lewin's & Silver, 2007; Roper & Shapira, 2000). The researcher must supply codes that give meaning to the text and put forth the intuitive and intellectual energy to link patterns into concepts and relationships (Roper & Shapira, 2000). In this study, analysis was carried out with the aid of Atlas.ti6© software. Atlas.ti6© software will aid in the coding process to produce graphic representations of codes. Pattern sorting into themes was then accomplished by Atlas.ti6©. Storage and retrieval of data was also facilitated by the use of Atlas.ti6© and of great benefit in reducing the time intensive organization of data.

With the variety of options for software programs, the choice could have been quite difficult to make in regards to the 'best fit' for the research and the researcher. The choice of using Atlas.ti6© was made after the following informational searches: discussions with thesis supervisor, attendance at a

seminar by qualitative software experts held at the International Institute of Qualitative Methods (IIQM)'s Thinking Qualitatively Conference at University of Alberta, as well as conducting on-line and textbook reviews of software packages. The current software trend amongst qualitative researchers at the University of Alberta seems to be NVivo8©. As a novice researcher, Atlas.ti6©had the best 'user friendly' profile both visually and intuitively. The menu tabs were easy to understand and navigate with multiple ways of creating codes, memos and themes. Not only does Atlas.ti6© gives a holistic view of each transcript text with a right sided margin area for displaying codes, comments, and memos for on-screen viewing but also as an output option. This gives the researcher the opportunity to look at a hard copy of an entire transcript including codes and memos to conduct manual work as desired. NVivo8© does not have the capacity for whole transcript outputs. I found this feature worked well as a novice researcher in order to work through some preliminary coding and pattern/theme sorting before 'committing' to assigning meanings of units of analysis on the software program. My thesis supervisor also had worked with Atlas.ti5©and Atlas.ti6©which offered me close proximity to a field expert. She had also used NVivo7©and preferred to work with Atlas.ti6©for similar reasons that I have stated. The seminar on qualitative software during the *Thinking Qualitatively* conference provided by the (IIQM) gave some additional insights into the vast choice of software but software experts did not endorse any particular choice as choice should be made by each individual researcher

according to his or her research methodology and interrogative style. Following in the footsteps of Miles & Huberman (1994), Lewins & Silver (2007) provide the most up to date qualitative software comparison textbook and thus was used to provide the following comparison table between features of Atlas.ti5© and NVivo7© (see Table 3, p. 104). This is a closer comparison of software program features even though both software packages now offer updated versions Atlas.ti6© and NVivo8©.

Conclusion

In this chapter, rationale was provided for focused ethnographic analysis through the work of Roper & Shapira (2000). Synthesis of information on choice of software to aid in the management and analysis of data was also provided. Immersion into the data occurred using these analytical steps along with the use of the computer software of Atlas.ti6©. This type of data analysis is congruent with the qualitative focused ethnography methodology as it speaks to the naturalistic and inductive approach of qualitative research, the ability to view and deconstruct the emic and etic perspectives, and to thoughtfully and reflexively engage in interpretation and abstract representation of the raw data.

Table 3. Comparative Features of Atlas.ti5© and NVivo7©

Comparative Features of Atlas.ti5© and NVivo7©*

	Atlas.ti5©	NVivo7©
Data Preparation	Handles the greatest range of data types including multimedia formats due to the use of external database structure; sophisticated activation and embedding of objects with hyperlink to files but no direct internet hyperlinks	Supports less data types but offers active internet hyperlinks
Getting Started	Allows any combination of functions to be open together; more fluidity to switch between different objects and tasks External database means more planning & care when moving files, saving and backing up	Inability to see more than one List View at a time reduces movement between panes; lack of text link wrap gives a cramped appearance Easier to move files, save and back up since it is one file
Exploration and Text Level Work	Many different ways to annotate including attaching 'comments' to objects (codes, quotations, etc.) Memos can also be anchored to quotes with an interactive icon in margin display; retrieval of notes easier and more systematic Has word frequency tool Effective hyperlink- point-to-point jumping around at text level	Footnotes are hyperlinked to text and output can be generated later Does not have word frequency tool No within dataset hyperlink; requires more process to create textual linkage
Coding Schemes & Coding Frames	Non-hierarchical codes listing but shows code-document & code-code connections via Object Explorer Combining methods prevent duplication of coding schemes	Structurally hierarchical in terms of main codes listing Combining methods prevent duplication of coding schemes Most instant and useful

Comparative Features of Atlas.ti5© and NVivo7©*

	Atlas.ti5©	NVivo7©
		device for creating one large code
Coding Tasks	Drag and drop is very interactive and flexible with immediate visual of how codes are building; multiple code sorting methods and simple code structures add flexibility to assess progress and frequency Margin view helpful to see codes simultaneous as you code Able to group codes without changing coding schemes; simple to use code families and replicate the process for documents and memos	Not as easy to see coding procedures List Views will show code frequency but only Free Codes listing can be variably sorted Unique feature of code density stripe which provides an estimate of number of codes applied but stripes are printed on a separate page Good ability to easily create sets which can incorporate several different types of project items without changing coding scheme
Basic Retrieval of Coded Data	Simple ways to focus on parts of dataset without the use of search tools; easy filtering tool to aid this process Remain close to data as codes are retrieved in context Interactive and flexible margin view without same printout view Can view hyperlinks in the margin Tabular overviews of code lists, comments, memos but no interactivity with coded segments between data lists	Complex query required to retrieve coded passages Codes retrieved out of their source context Codes and data are printed on separate pages Margin view is less effective for viewing all codes but can filter by 'least' or 'most' coding Tabular overviews of code lists, comments, memos but no interactivity with coded segments between data lists
Managing Process and Interpretations by Writing	Same tools used for code and document	Memos can be created as a node which is unique to

Comparative Features of Atlas.ti5© and NVivo7©*

	Atlas.ti5©	NVivo7©
	management allows for full integration; export of memos into same file easily Easy contact with memo without moving away from the text	this software Treats memos as sources which can hide them away even when linked to project items; annotations are highlighted and listed separately
Mapping Ideas and Linking Concepts	Links that are created or changed are remembered across the project as a whole Allows for later retrieval of coded data based on code relationships both inside or outside a network Good graphic sense of code relationships	Can incrementally view layers to show the development of idea or theory Relationships can only be created in correspond List View not within model Equally good graphic sense of code relationships
Organizing Data	Use document families Can export information into MS Excel or SPSS	Uses case nodes, attributes and values Has more support for shortcuts to organize data where there is more than one respondent
Interrogating the Dataset	Search tools take practice to use comfortably Super code provides an easy way to rerun searches Lacks interactivity between tables and qualitative data Can export tabular information	Search tools take practice to use comfortably Can produce complex cross-tabulations of multiple codes, providing varied interactive frequency Can export tabular information

*Based on Lewins, A. & Silver, C. (2007). *Using software in research: A step-by-step guide.* Los Angeles, CA: Sage.

Chapter 6 – Findings

The results of exploring maternity nurses' knowledge and understandings in caring for immigrant/refugee women of African origin through ethnographic analysis are described in this section. This study sought to examine the front line application of cultural competence, awareness, sensitivity and most recently, cultural safety amongst maternity nurses as they cared for African immigrant/refugee women seeking labour, delivery and post-partum care in three Alberta hospitals. By exploring the everyday experiences of maternity nurse clinicians', insights were gained that identified barriers to care, gaps/differences in knowledge as well as strengths or successes in the provision of ethnocultural care. The setting and participants are described with key participant demographics in order to envision the grounding backdrop to the study findings. The following themes and sub-themes emerged from the data analysis of the semi-structured interviews:

- Building ways of Knowing
    - Learning from patient
    - Learning from others
    - Learning from self
- Negotiating Ethnocultural Encounters
    - Relational approach
    - Informative approach

    - Collaborative approach
- Challenges & Gaps/Differences
    - Nurse
    - Facility/Larger System
    - Patient

Each of the themes and sub-themes will be described and verbatim examples from chosen participants will be given to convey its essence. Outliers or negative case points will also be included according to the corresponding themes/sub-themes.

Setting and Participants

Maternity nurse participants were from three hospitals from large and mid-sized city centres in Alberta, Canada. Interviews were conducted before and during the centralization of health regions into the current amalgamated structure of Alberta Health Services over the years of 2009-2010. Macro-level changes (arrangement of organizational structures) were the most significant areas to be restructured, however, micro-level changes (budget and staffing reviews) were under consideration which caused increase tension and strain amongst health services staff at all levels until pending changes were finalized

and communicated.[3] A total of 12 participants were recruited for this study which is within the estimated sample size. The demographics collected from participants were self reported and included position title, numbers of years of experience, city and country of education, specialized nursing education, and evidence of transcultural education, country of origin, ethnicity and languages spoken (see Appendix N). Eleven of the maternity nurses were educated as registered nurses with diploma or baccalaureate training. Seven of the Registered Nurses (RN) had experience working Labour and Delivery but four registered nurses were cross trained to work Labour and Delivery as well as Post Partum units; unit specific work information was not captured through the demographic self report but came out through interviews. Three of the cross trained nurses were from the mid-sized city hospital. One nurse was a Licensed Practical Nurses (LPN) who worked exclusively on the Post Partum unit and had received additional baccalaureate education prior to her LPN training. Two of the interview participants were clinical nurse educators for their respective areas of Labour and Delivery and Post Partum. One clinical nurse manager was also interviewed. Years of maternity nursing experience ranged from 1 -37 years; one at <1 year, two at <5 years, two between 10-20 years, and seven at 25+ years. All but one nurse received her nursing education from a Canadian institution, the

[3] Some examples of financial cutback decisions affecting on floor nurses include the elimination of currently vacant positions, no hiring outside of employees outside of Alberta Health Services, no paid work day for attending professional development opportunities. Alberta Health Services is currently in labour relations discussions with the United Nurses of Alberta regarding the upcoming contract renewal.

exception being, the RN who received her midwifery and nursing training in the UK. Specialized nursing education included focused obstetrical courses that were reported to be taken by seven nurses. Concepts of transcultural nursing education were most evident in baccalaureate trained maternity nurses who had 5 or less years of maternity nurse experience. Nurses also had exposure to ethnocultural education through in hospital seminars, workshops, or presentations. Two nurses also reported the use of written materials such as textbooks and community resource publications to increase knowledge of various ethnocultural groups with which they were in frequent contact. Two foreign born nurses were amongst interview participants, one who identified as belonging to a minoritized group and the other of European origin. The rest of the ten nurses were Canadian born with two nurses belonging to different minoritized groups and the others were of European and British Isles heritage; three nurses reported ethnic identity solely as Canadian.

Building ways of knowing

This main theme captures the sources in which the maternity nurse participants used to build knowledge about African immigrant/refugee women. Insights were gained during their work with African immigrant/refugee women, from other hospital staff members as well as from their own personal experiences.

Learning from the patient. Maternity nurses drew from experiential interactions with African immigrant/refugee women to help gain practical knowledge and understandings. Learning from patients was the most significant way to gain knowledge and understanding as the majority of nurses did not feel they had much exposure and information to African immigrant/refugee women. The Labour and Delivery and Post Partum units were at most times running at full capacity. Maternity nurses found themselves seeking and gaining knowledge throughout their point of care experiences. In other words, maternity nurses' practical knowledge and understandings of their African immigrant/refugee patients were drawn from structured maternity nursing roles and responsibilities as guided by unit routines, policies and procedures. As nurses cared for their African immigrant or refugee maternity patients, they were able to highlight some unique areas of information specifically relating to cultural practices, beliefs or values. The majority of information maternity nurses gained from patients revolved around breastfeeding practices, food preferences, supportive networks, physician preference, labour and delivery options, countries of origin, and personal characteristics. As participant 7 suggested,

I think we're kind of going by the seat of our pants and I think because I have an interest in it, maybe I do a little more reading about it or something and even at that I don't do a whole lot of reading about it. I think I can learn more almost from the people themselves.

Participant 7 – RN of 37 years

As breastfeeding information is a significant element of maternity nurse teaching, there was large clustering of data around this aspect of care when maternity nurses were asked about unique differences seen amongst African immigrant/refugee women; the breastfeeding code family example displays 38 related quotes grouped under 8 codes (see Appendix N, Figure 3). Maternity nurses noted that African immigrant/refugee women did not prefer to breastfeed within the first one to two days post partum. Nurses experienced reluctance on the part of African immigrant/refugee women to initiate breastfeeding in the immediate post partum period as the women did not feel there is adequate breast milk available to nourish the baby. Maternity nurses also noted this particular belief about lack of breast milk and the inappropriateness of colostrum was also prevalent in other ethnocultural subgroups of Asian origin that by one participant were named as Chinese and Vietnamese. As participant 11 suggested,

Okay, like with breastfeeding. I was trying to get him [the husband] to understand, "breast feed the baby first every time before you give the bottle" because she had a lot of breast milk and they were saying, "no milk, no milk"…well there is but they don't believe it. We get that a lot, that's a big one.

Participant 11 – LPN of 33 years

Fulfilling roles and responsibilities means the maternity nurses are located within and guided by a dominant Western hierarchical system of care. Thus, the shared experiences of the maternity nurses are grounded from a specific point of reference; in this case, breastfeeding practices as structured by hospital based breastfeeding programs. The Western viewpoint for breastfeeding practices appeared to be the benchmark norm.

Maternity nurses also noted that African immigrant/refugee women naturally gravitated towards breastfeeding in a relaxed manner despite the temporary hesitancy for immediate post partum feeding. This seemed to be a positive view or strength of the African immigrant/refugee women whom in comparison to either the nurses' own other maternity women's ethnocultural

experiences. As participant 5 suggested,

> *They are better at it than we are. It's more natural, it's part of who they are and it's not complicated, as we make it. It's just part of what they do*.
>
> **Participant 5 – RN of 4 years**

The optimistic nature of such comments should be balanced with caution against over generalizing or 'essentializing' towards all African immigrant/refugee women as having an easier experience with breastfeeding. As an outlier example, one of the maternity nurses noted that African immigrant/refugee women who were multiparous were more attuned with breastfeeding than primiparous women and thus, attributing reasons for ease of breastfeeding outside of a generalized ethnocultural trait. The same maternity nurse also shared an experience with one of her African immigrant/refugee maternity patients in which the patient was engrossed in either using the cell phone or watching television while attempting to breastfeed. This example of not relaxing and attending solely to breastfeeding may resonate especially well with other ethnocultural subgroups particularly those well grounded in Western lifestyles.

There was also an underlying element of time tension related to the African women's 'time' orientation with maternity nurses' expectations that women would initiate breastfeeding in the immediate post partum period versus

bottle feeding or no feeding. The common discharge window time for the average maternity patient is 24-48 hours; thus, leaving only a small window of opportunity for patient care interactions, assessment, teaching and evaluating opportunities giving rise to such time pressures. Time pressures will be discussed in more depth under the theme of Challenges & Gaps but also add to perpetuating power differentials and achieving effective ethnocultural care.

Maternity nurses gave specific references to food preferences along expressed acceptance for in-hospital consumption of ethnic foods. Homemade food allowances were encouraged across ethno-cultural groups at each of the three hospitals labour and delivery and post partum units. There seemed to be a broad spectrum of acceptance from maternity nurses as to ethnoculturally specific food preferences although one nurse shared one incident of between patient tensions with the acceptance of ethnoculturally specific foods when eaten within a shared room setting. As participant 11 suggested,

> *If that makes them feel better then go ahead, have that and whatever you want. I mean that's the same with Hutterites…the Chinese bring in their hot soups, the Hutterites bring in their home made bread, you know whatever and it doesn't matter. Our girls bring in McDonalds, right. So it doesn't matter, whatever they want to eat they can bring in, especially for cultural…you know.*
>
> **Participant 11 - LPN of 33 years**

There was variation noted by the maternity nurses in the observed ways African immigrant/refugee women were supported by husbands, family or community members. Through eleven shared experiences, the majority of maternity nurses felt that African immigrant/refugee women were well supported by husbands, family or community friends. Maternity nurses shared descriptions of patients' rooms 'filled' with visitors during visiting hours. I am wondering about the maternity nurses' knowledge and conceptual gap of cultural safety. Are women coming to the hospital with support systems in response to not feeling culturally safe without these community members? For the nurses, this seemed to translate into attentive home support upon hospital discharge. Maternity nurses had minimal to no engagement with groups of visitors so it is difficult to ascertain whether large groups of visitors can accurately translate into attentive home support. There are assumptions that enough within nation-state similarities (e.g. Nigerian, Somali) existed that fostered a natural support system. Nurses shared experiences with African immigrant/refugee women who did not have any support systems during their hospital stay. Some of the nurses shared that the women had husbands who were either busy with work schedules or still in Africa. There were two instances of single women giving birth evidence by no partner recorded on admission record in which nurses ensured social workers and community health supports were notified for post discharge follow up. As

participant 7 suggested,

> *... 'when you go home do you have support, do you have people there to help you'...or 'are you drifting out in the wind by yourself'. Because having a baby and going home and having no support, I can't even imagine. But you know, and you can pick up even with the amount of visitors that they have because lots of times there would be 3 or 4 couples come in to see them and so hopefully they are there for them when they go home. But I think...I do believe that there's good support among each...like within their group. Like even if they're not getting it from us so to speak, I think that unless they were 9 months pregnant and just came to the Canada, then you might be in a little bit of trouble but I'm sure even then if you knew you were Nigerian and there was other Nigerian people here or Sudanese people or the Congo that I'm sure they would put you in touch with somebody.*
>
> **Participant 7 – RN of 37 years**

Maternity nurses' perceptions of African immigrant/refugee women's preferences surrounding labour and delivery as well as post partum care also included physician preference, pain control, delivery options and post partum mobility. The maternity nurses are key caregivers who have the most direct and constant contact with the African immigrant/refugee women. Maternity nurses shared that African immigrant/refugee patients preferred female physicians for

their labour and delivery experiences; some nurses made associations to feelings of modesty on the part of the woman and one cited Muslim tradition as the reason for this preference. Flexibility in accommodating such requests was dependent on time of delivery, with weekend and evening births being the most challenging times due to reduced physician pools outside of regular office hours. There were also fewer female physicians at the mid-sized facility and little to no likelihood of having interns due to the geographic location away from University teaching institutions and consequently the non-teaching status of the hospital. As participant 3 suggested,

> *...they are coming with a lot of support, do not want an epidural and don't want any of the extensive interventions. I have found for the most part a large number of ladies are very hesitant to have C-sections but they are very considerate and very willing to do anything that you suggest in terms of pain control positioning, all of those kinds of things that assist in the management of labour and such and support from that. I do know that a lot of them come from not good things that have happened to them in Africa.*
>
> **Participant 3 – RN of 30 years**

Maternity nurses felt that pain relief preferences of African immigrant/refugee women were less likely to be pharmacological interventions

including the use of epidural anesthesia. Variations did exist amongst maternity nurses with the types of pain relief options preferred by African immigrant/refugee women; non-pharmacological preferences included positioning, showers and support from friends and family. Maternity nurses shared that in some instances, African immigrant/refugee women were influenced either toward or away from Western medical options through their personal friendship networks. Three maternity nurses made specific references to husbands, family members or friends being directly involved in the decision making process for pain relief options. Collective decision - making was also experienced with regards to the non-preference for C-sections by African immigrant/refugee women in four maternity nurses. Maternity nurses shared their perception of the possibility of pre-migration traumatic experiences affecting the woman's non-preference towards invasive procedures such as epidural anesthesia and C-Sections that may indicate some level of maternity nurses' understandings of cultural awareness and cultural sensitivity.

The question of countries of origin was meant to initiate the interview conversation with the maternity nurse participants reflecting on the level of ethnoculturally specific information gained from their immigrant/refugee patients. Nine maternity nurses shared their recollection of the various countries of origin of their African immigrant/refugee patients. Maternity nurses recalled countries such as Sudan, Somalia, Ghana, Nigeria, Ethiopia, Sierra Leone, Rwanda, and Congo. Most maternity nurses engaged in patient conversation to

glean this information, however, included this information once known on admission or chart records. Language specific information was usually found on the admission record and was not pursued in direct conversation with the exception of three nurses who noted experiences of finding their African immigrant/refugee patients were from Francophone minority communities and two nurses who asked patients to confirm they spoke Swahili. Language specific data is the most recorded element of ethnoculturally specific data kept on each patient for the purposes of requesting interpretive services. The exploration of ethnocultural information did not go beyond countries of origin or languages spoken unless such elements were directly associated with aspects of maternity patient care (e.g. breastfeeding, pain control, delivery options, etc.). The lesser of extent of gleaning in-depth ethnoculturally specific information is related to the maternity nurses' purposeful extraction of information in order to assist with the fulfillment of role responsibilities and overall work expectations which also relates to time constraints.

The final point of learning from patients experienced by maternity nurses is in relation to the descriptions of the African immigrant/refugee woman's characteristic traits (see Appendix N, Figure 4). There was a consistent trend in the descriptions of character traits maternity nurses shared through their experiences Maternity nurses also shared perceptions using terms such as modesty, quiet, accepting of care, easygoing, passive, appreciating care, polite, kind, pleasant, considerate, shy, stoic, and non-disclosing. The contexts of the

terms were in regards to a variety of direct patient care experiences during labour, delivery and post partum care. What does quiet and the other related terms really mean? Silence does not mean acceptance. So I wonder if when we see passivity, stoicism, compliance, etc., have we truly discerned between acceptances related to true informed understanding, or have we thought about the possibility of power relations and the historical positioning of dominant cultures? When this characterization is further contextualized by the busy acute care hospital environment and language differences, and other ethnoculturally specific differences, the question of true discernment takes on even more significance. One of the limitations of this study was the analytical viewpoint from the maternity nurse not the African immigrant/refugee woman to corroborate and discern the existence of differences in character perceptions. My etic research perspective affords me the ability to compare and interrogate this characterization using my understanding of post colonial feminism and empirical findings such as those from Spitzer (2004) and Harper-Bulman McCourt (2002) who have noted immigrant women's power positioning as affecting their ability to establish truly equitable relationships with nurses. As

participant 3 suggested,

> *They have a very distinct separation between you as the nurse and them as the patient. They are very respectful and very considerate of your as a nurse with medical knowledge and are very accepting of care from you.*
>
> **Participant 3 – RN of 30 years**

Learning from others. Maternity nurses also acknowledge the use of other sources to gain knowledge and information that would facilitate their understanding and knowledge in caring for African immigrant/refugee women. Maternity nurses sought information from other staff members including social workers, other ethnoculturally diverse nurses, nurses who had more in-depth experience working with ethnospecific populations, and multicultural brokers. Seminars, workshops, and discussions were the modes of informal learning. The help of other staff members located within the hospital was sought because of their close proximity in time and space to when and where the maternity nurses needed to access their specialized abilities. Other factors to consider why maternity nurses sought to gain information in this way may be due to building of rapport, trust and collegiality with these staff members that offered them a comfortable venue for learning. Further examination of this approach to gaining information brings to question the varying perspectives and levels of information gained by hospital staff members as they themselves are not a homogenous

group. The knowledge and perspectives of multicultural brokers who themselves as immigrants are situated quite differently than a Canadian born social worker who has familiarity with working with immigrant populations. The same can also be said about gaining information from a foreign born minoritized nurse versus a Canadian born nurse who had volunteer work experience in an African country. The complex ethnocultural, social and professional locations of each staff member should be kept in consideration when attempting to gain insight into the lifeways of African immigrant/refugee women. As participant 9 suggested,

> *I've talked to her [multicultural broker]about….we have had discussions about handouts and the interpretation of some of the information and if we run out of handouts and if there's any other languages that she thinks might be beneficial to our specific area or teaching sheets that she really thinks are important. She's very helpful that way.*
>
> **Participant 9 – RN of 27 years**

Learning from self. Four maternity nurses who had personal experience in which they were able to immerse themselves in ethnocultural interactions demonstrated more depth of knowledge and understanding of African immigrant/refugee women and their families during their professional care experiences. Personal experiences included overseas travel to African countries

for all four maternity nurses as well as one volunteer experience at a local community refugee support agency, thereby gaining a direct ethnocultural immersion experience. The level of sensitivity and awareness and ability to engage their patients were at a different level than those maternity nurses who did not have such opportunities to directly engage in such ethnocultural experiences. A couple of questions arising from such examples include:

(a) What aspects of these experiences are transformative in gaining such knowledge and understanding?
(b) Are there other inherent characteristics of these maternity nurses that lend them towards gaining deeper understanding and knowledge regardless of such overseas immersion experiences?

Interestingly, the two maternity nurses who had less than five years experience since graduating from BScN programs were the only two who spoke of formal transcultural educational experiences within their nursing programs. One of the recent nursing graduates took additional university level courses on global health as well as a cultural immersion course and preceptorship that took her overseas for her nursing experiences. Despite the existence of transcultural nursing concepts for decades, the translation and communication of such concepts amongst these interview participants only came through the two recent graduate nurses. Concepts around cultural safety and acknowledgement

of power positioning also arose in conversation with the most recent nurse graduate. As participant 12 suggested,

> *…in my time spent in Ghana a big focus that we talked about was cultural safety which is pretty recent in the literature where the preface is I guess from the patient's perspective, the patient feels safe with you as their nurse from a different cultural background. So I want to make sure they feel safe with me and if there are issues going on at home that they feel safe if the opportunity arises for them to say something. I want to really develop that relationship and make sure that they feel they are valued and that they are safe with me and they are safe in the hospital.*
>
> **Participant 12 – RN for 8 months**

Perhaps maternity nurses having had these direct ethnoculturally specific immersion experiences have been afforded more tangible ways of learning that the hospital based experiences do not provide. As participant 7 suggested,

…we developed a friendship through priests from the Congo and hearing their stories and spending time with them, it just makes your eyes….the more people you meet, the more you see, the more you understand, you know that kind of thing.

Participant 7 - RN of 37 years

On the question of inherent characteristics, perhaps there is some 'catalyst' from within certain individuals that also predisposes them to be able to effectively engage in ethnocultural encounters. The nurse in the below example shares her passion for working with different groups of immigrant women. In the context of this particular nurse who communicated a high degree of ethnocultural engagement skills including understandings of cultural safety, the source of her inherent characteristics affords her the ability to place a significant value for social justice ideals involving immigrant women. As participant 12 suggested,

I have to say that it really holds a special place in my heart in working with women who are from a different country, whether it's an African country or the Middle East or from Latin America. It's one of my favorite things when someone says 'oh I don't think they speak much English' and I'm right there and I go "I'll go, I'll go, let me in'.

Participant 12 – RN of 8 months

An interesting outlier example of personal experience that afforded the nurse to have more ethnocultural depth of knowledge and understanding came through one of the minoritized nurses. This nurse was able to understand how her ethnocultural location positioned her to gain the tangible experiences necessary to more likely engage in effective ethnocultural interactions. This is a valuable insight to consider as there are many minoritized nurses working within the Canadian health care system whose own personal ethnocultural location can effectively facilitate ethnocultural care interactions. Identity and belonging or kinship within the various ethnoculturally diverse populations of Canada are strengths minoritized nurses bring to the hospital workplace which can positively affect ethnocultural interactions. As participant 1 suggested,

I don't know how much Caucasian nurses understand, you know, with my coming from the [place of origin] there are certain things we do alike. One of my best friends here, her husband is from Ethiopia so when we get talking, we could compare things…My hairdresser right now is from Ethiopia but the other one was from Nigeria so I've mixed a bit with them so I know the kinds of things to understand…and our customs in some ways are the same.

Participant 1 – RN of 26 years

Negotiating ethnocultural encounters

The theme of negotiating ethnocultural encounters describes the ways in which nurses responded to tailoring the care needs for African immigrant/refugee women. The different approaches to negotiating care encounters were grouped as sub-themes called relational, informative and collaborative. The relational approach describes ways in which nurses attempted to build a relational connection with the individual woman. The informative approach describes ways in which nurses used information in attempts to provide a basis for informed decision making. The collaborative approach describes ways in which nurses worked in tandem with other key staff members to help tailor care. A variety of factors exist to influence the choice of any of these approaches such as time and resource constraints, depth of ethnocultural

knowledge and understanding, availability of resources and creating a culturally safe environment but in most cases a combination of approaches was used by maternity nurses. Nurses, however, did share their overall desire to learn more about African immigrant women through their encounters; regardless of their level of knowledge and understanding there seemed to be a willingness to find learning opportunities.

Relational approach. Maternity nurses used different ways to create a relational connection with African immigrant/refugee women. Seven nurses shared particular behaviours to build a relationship with African immigrant/refugee women including attending, building trust, seeing the individual and being culturally flexible. Attending involves a commitment to thoughtful care and attention in which the maternity nurse is focused on the needs of the African immigrant/refugee woman in order to tailor care accordingly. Nurses were able to provide examples of such behaviour. The behaviours of attending often require taking time to do so in order to gain a deeper understanding of patient needs, to facilitate participation and decision making. Conversely, this can also be a source of tension for maternity nurses as time constraints are most often an everyday reality which challenge the ability to attend. As participant 7 suggested,

I'm still there, right and so I'm staying and I'm really a big believer in family-centered care and I'm a believer in giving reports on the patients that they can put input into…you know you're talking about them in front of them and saying this is so and so and she's, you know wherever and she would prefer that we didn't do this or she would prefer that we did this and so at least the patient knows that she's a part of it and her wishes are being [known] ….

Participant 7 – RN of 37 years

Creating a genuine connection also entails looking at each person as an individual and not a solely as a conglomerate of shared characteristics. One maternity nurse in particular was able to consistently explore the possibilities of individual uniqueness rather than engage in essentializing or culturalizing her care experiences with African immigrant/refugee women but also other subgroups of immigrant women. As participant 12 suggested,

...we are all individuals, we are all unique no matter if you are from an African country or if you are from Latin America or Middle East or whatever, everyone is individual in the way they care for their bodies and care for their babies and care for their family, so I want to treat them all as individuals regardless if I have 2 patients from Sudan or not. I mean they could be very similar, they could be very different.

Participant 12 – RN of 8 months

Cultural flexibility was demonstrated maternity nurses and involved acceptance of various aspects of the African immigrant women's ethnospecific care needs such as breastfeeding practices, food preferences, pain control and delivery preferences. Widespread acceptance of ethnoculturally unique practices was present once nurses understood why patients may engage in particular practices. However, this presents with potential for conflict when nurses do not have knowledge of ethnoculturally specific practices. Acceptance and equality hinge on the nurses' level of knowledge about the ethnocultural groups under their care; a problematic way of thinking as it presumes we can build a finite capacity of ethnocultural knowledge that will help satisfy our ability to understand the many lifeways of immigrant/refugee populations. It is important for nurses to understand the limitations of superficial 'fact file' bits of information as their best served approach in building a connection with

individuals. Once again, the 'fact file' approach creates essentialist and culturalist practices which perpetuate 'othering' or power play practices. As participant 9 suggested,

> *And when someone doesn't sort of fit your pattern, your culture, then it's like 'well what do I do now, now they have thrown a wrench in my day, now I have to adapt and I have to be innovative and think of something else'. So it does kind of throw you off but I think once you understand why, then it's not such a big deal and that they are not purposely doing this just to mess up your day.*
>
> **Participant 9 – RN of 11 years**

Informative approach. Maternity nurses gave particular examples of how they would inform African immigrant/refugee women in order to facilitate and/or influence care decision-making. The context of providing rationale came at times of informing African immigrant/refugee women about why immediate post partum breastfeeding was important, to explain types of pain control and for delivery options. In as much as maternity nurses self-perception was that of being respectful, they were not necessarily aware that points of rationale were well seated in Western medicine (e.g. breastfeeding practices and methods of pain control). In providing rationale for various aspects of maternity care decisions, the nurses also presumed autonomous decision making as the norm

mistakenly placed on their African immigrant/refugee patients. Newcomers navigating an unfamiliar health care system may look to the nurse and other health care professionals as the professional experts who are better positioned to make decisions on their behalf. The maternity nurses may also not recognize the value of collective decision making as a legitimate familial function amongst various ethnocultural groups. In fact, there are three instances where maternity nurses questioned the husband's authority in decision making all of which communicated levels of tension in the way maternity nurses witnessed the perceived removal of the woman from the direct decision making process. As participant 4 suggested,

> *That's something else to get used to…'I'm not talking to you hubby, I'm talking to her'. She asks you and then we go in circles. Which partly could, you know you want to blame you know the patriarchal culture but the other thing is she might not have a clue what I'm talking about. You have to ask him.*
>
> **Participant 4 – RN of 3 years**

Collaborative approach. The collaborative approach to negotiating ethnocultural encounters involved working with other individuals in attempts to tailor care needs for African immigrant/refugee women. Key multidisciplinary staff maternity nurses worked with included social workers, unit specific clinical

nurse educators, multicultural brokers, diverse hospital staff and community health nurses. The varying roles and disciplines acted to fulfill certain aspects of care and support but the key players ensuring ethnospecific care needs were incorporated were the multicultural brokers. The Multicultural Brokers Association is a community based agency which assists immigrant/refugee populations with various aspects of resettlement support. In the case of immigrant women, multicultural brokers ensure appropriate interpretive services are provided as needed, specific concerns are addressed and care is properly bridged into the community upon the woman's discharge from hospital. One of the hospital sites had a multicultural broker situated on the Post Partum unit. This provided a strategic placement of the broker whose services were readily utilized by the immigrant maternity patients and maternity nurses. As participant 11 suggested,

> *I would say that was a smart idea that the [hospital name's] administration had of having a multicultural broker as I think it does help the transition very well. They need that little extra to see how they are doing and to have them get used to the hospital experience.*
>
> **Participant 11 – LPN of 33 years**

Not only did maternity nurses learn from ethnoculturally diverse staff members, they also utilized their services for the purpose of tailoring care needs

for their African immigrant/refugee patients. The main use of other staff members was for their language skills. Interpretative skills were used in the labour room as well as for any extensive post partum teaching requiring a translator. Staff ranged from medical students to fellow nurses working on other maternity units, although the references all come from the larger hospital centres. Hospital size and geographic location within Alberta may influence the presence or absence of ethnoculturally diverse staff. The same strengths cited for the sub-theme of *learning from others* applies here as the *in situ* ethnoculturally diverse health care professionals provide a relatively quick access for maternity nurses along with some level of familiarity and possibly collegial connection. As participant 3 suggested,

it's a teaching hospital so there is a number of different people of different cultures that come in either as student interns, interns, residents, and nurses because it is very multicultural so we do try as much as possible to accommodate interpretation that way and if the nurse speaks the person's language or a resident or student intern to make sure they are with them as much as possible for interpretation. I don't know about the resources afterwards but there are nurses downstairs as well on our ante-partum unit, some of them actually speak a number of the different languages from Africa so we use them after a bit of time.

Participant 3 – RN of 30 years

Challenges & Difference

Maternity nurses were able to share experiences that also reflected challenges that occurred during their care encounters with African immigrant/refuge women. Challenges and gaps/differences in knowledge and understanding were noted at the nurse, patient, and facility or larger system level.

Nurse. Despite the maternity nurses' keenness and desire to draw from various sources to gain knowledge and understanding, moments of challenges and gaps/differences also emerged from the data (see Appendix N for details).

Maternity nurses' felt they do not have enough understanding and knowledge in caring for African immigrant/refugee women; having knowledge or lack thereof was thought to be tied to ability to care. Ethnocultural differences between nurses and their African immigrant/refugee patients were felt to have contributed to gaps in knowledge and understandings. Maternity nurses were looking for more information around ethnocultural practices of African immigrant/refugee women. Female circumcision was the least knowledgeable area for maternity nurses. Maternity nurses shared their lack of experience in understanding much of the information such as the varying degrees of circumcision, the ethnocultural reasons for the practice, and legal policy. Care decisions around labour and delivery are made by physicians and in most instances, maternity nurses stated decisions were made during the women's prenatal visits prior to hospital admission. When maternity nurses were asked about post partum care treatment, they did not know of any changes to care for women who had female circumcision previous to giving birth. No maternity nurses at any of the three sites knew of hospital recommendations, guidelines or protocols that existed in regards to standardized care for women who had female circumcision. There was one account of decision making to have a C-section that was also related to African immigrant/refugee women's psychological trauma, one account of a pre-hospital vaginal opening in preparation of imminent labour/birth, and the rest of the maternity nurses talked of African immigrant/refugee women attempting vaginal delivery as the

first choice of delivery. Maternity nurses expressed their views of the African immigrant/refugee women as being the subjugated women in their efforts to try and make sense of the practice of female circumcision. As participant 11 suggested,

> *I thought it was just the clitoris was removed'. She said, 'no', she had read that sometimes it's way more than that. And I said, 'oh, I didn't know that'. And I thought…to me this is mutilation and I said 'well, hopefully that goes down the tube'. That's one of those things that needs to go down the tube. It's torture…to me it's torture.*
>
> **Participant 11 – LPN of 33 years**

A few assumptions and generalities came through the maternity nurses' not knowing or understanding African immigrant/refugee women. In relation to assumptions and generalities, no maternity nurses made references to African immigrant women who were not Black Africans. No mention was given about White, East Indian or Arab Africans in the sharing of maternity experiences. Such lack of recognition of the diversity amongst African ethnocultural subgroups is also a demonstration of the 'othering' practices of 'culturalizing' or 'racializing'. The topic guide contained broad questions and used the term African origin so as not to make direct reference to any one ethnocultural sub-group, however, did

my line of questioning produce pointed responses or were responses inherently envisioned by the nurses to only refer to Black Africans?

There was also a lack of knowledge of community support services to help African immigrant/refugee women upon discharge. Maternity nurses were not aware of community support programs or agencies other than the standard Health Beginnings program in which public health nurses are required to make 1-2 home visits to assess mother and child. Maternity nurses specifically cited the resource of multi-cultural health brokers as bridging the gap between Healthy Beginnings and hospital care. Given the time constraints as explained in the proceeding section, awareness of community support systems is a way in which maternity nurses relied on continuity and sustainability of care.

Time constraints and commitment to fulfill tasks were also elements that created challenges for maternity nurses to provide care. Seven nurses shared experiences that demonstrated either time or task orientation to their points of care. In as much as this sub-theme is grouped under the individual nurse's challenge, this is actually also a facility/larger system challenge. Time and task orientations are directly link to the maternity nurse's ability to fulfill the expected work role. Two nurses also shared their frustration with time constraints in being able to provide satisfying care; care is reduced to ensuring basic tasks such are physiological needs are met. Time and task orientations significantly affect the maternity nurses' ability to communicate effectively with

African immigrant/refugee women when language difference exists. Time constraints and pressure to accomplish tasks left nurses with shared communication challenges. Three of the nurses actually estimated that it took 2 to 2.5 times longer to go through post partum teaching when interpreters were used to communicate. As participant 8 suggested,

> *Yes, she wasn't bleeding, yes her blood pressure was okay, yes the baby was content, but I didn't know how she was doing. It becomes very basic care, it's not very satisfying. You don't have a relationship.*
>
> **Participant 8 – RN of 31 years**

When language differences were found to exist, all of the maternity nurses sought help from husbands, family and friends to assist with interpretation. Professional interpreters were only sought if more complex concepts involving formally consented procedures such as epidural and C-section decisions were needed. Nurses had specific examples of the use of sign language in the forms of hand and facial gestures, vocal expressions (such as for pain), and props (breastfeeding) and use of touch were used to facilitate what the maternity nurses deemed basic communications. Examples of basic communications revolved around assessing level of pain, general status, teaching breastfeeding and bathing of babies. Maternity nurses articulated their measure of gauging whether women understood their gestures was through return

demonstration of learnings, assessing non-verbal gestures such as smiling, head nodding and eye contact coupled with intuitive knowledge of felt understanding.

Facility/Larger System. Maternity nurses felt a variety of facility level factors affected their ability to carry out effective care of their African immigrant/refugee patients. Obligations to carry out a set post partum teaching routine actually fails to take into account other aspects of the African immigrant/refugee woman's ability to cope such as ability to access health care resources, navigating her local environment to carry out daily living functions, as well as the presence or absence of financial or social support. Maternity nurses recognized the ease of mothering and strong coping skills for child caring but were not able to envision and subsequently assess a larger scope of challenges that may be present for the African immigrant/refugee patients upon discharge. There was consistent under-recognition of larger systemic discrimination as influencing everyday practice. As participant 11 suggested,

I'm sure they are very used to that and looking after children is very much a part of the woman's role so I think there would be less problems in that aspect of looking after a child. But that's most of our discharge teaching, it's very practical….how to look after the baby and how you look after yourself so you don't get infection basically. So I think there's really a little less with them because they are closer to the practical earthy side of like a little more in that regard anyway.

Participant 11 – LPN of 33 years

Maternity nurses reported other facility level challenges including lack of privacy, limited in-hospital educational opportunities, lack of diverse staff at certain sites, and lack of health literature to support aspects of post partum teaching and lack of access or quick access to interpretive services. Maternity nurses desired to see better patient room configurations that would allow for a greater sense of privacy related to the feelings of modesty and Muslim traditions seen in some of the African immigrant/refugee women. Lack of language appropriate health literature was shared by four maternity nurses and found to be helpful when giving patients take-home information. Interestingly, maternity nurses also noted that even French literature was difficult to access for their Francophone African immigrant/refugee women and their families. One of the on-site clinical educators had been struggling for several months prior to the

interview with trying to access reliable and standardized French literature resource for post partum teaching. As participant 9 suggested,

> *...trying to find some of the teaching sheets in the French language was very difficult so I thought, you know what I'm going to call the [*name of suburb] because over in that area in [name of suburb] there's [name of French educational institution], so I thought, 'okay that's a big French speaking community, they have got to have all these teaching sheets in French and they can probably just send everything via email, print it off, not a problem. ...I'm talking to an area in the city, a community that should probably be very very bilingual because everybody that lives around there, so I thought it shouldn't be a problem but I still have that problem. I still couldn't get what I wanted. I was shocked.*
>
> **Participant 9 – RN of 27 years**

Some maternity nurses specifically talked about using interpretive services situated on site to aid with interpretation. Two nurses at the mid-sized facility spoke of using mobile phones to call Health Link Alberta for interpretive services. The same services were also seen as difficult to coordinate into the nurses routine so the amount of utilizing interpretive services was dependent on the ease of access and the timely delivery of interpretive services. Only on two

occasions did maternity nurses question the difference in the level of understanding through the use of interpretive services versus sign language especially as it may relate to the unknowns of the *taken-for-granted* type language health care providers use specific to our hospital environment. As participant 8 suggested,

> *...so maybe they understand my words but do they understand what I meant. So that's an important piece… We use words and technology and concepts they may never have encountered.*
>
> **Participant 8 – RN of 27 years**

In previous themes, diverse staff was noted as a source of ethnospecific information as well as collaborators in helping maternity nurses negotiate encounters with African immigrant/refugee women. Conversely, the lack of diverse staff was seen by maternity nurses as being a drawback to the workplace support system to facilitate ethnocultural care encounters. Two of the nurses who shared this experience were from the mid-sized facility and one from a larger facility.

Maternity nurses talked of the lack of and large variation in ethnoculturally specific information captured on the prenatal and admission records. The facility records had no content areas on which this information could be captured. Nurses also mentioned the tension in 'keeping track of' and

taking time to capture ethnoculturally specific information as it would create conflict with gathering priority physiological information. Prenatal record keeping is usually a physician responsibility; however, maternity nurses seek information informally through the patient and family then share through shift report. The drawback with this system is that there is variation in information gathering as it is dependent on the maternity nurses' level of engagement with the woman and family and the value placed on capturing ethnoculturally specific information. As participant 5 suggested,

> *...even if we don't have documentation from the physician as to what her preferences are, we are going to ask questions and we are going to use the family members or whoever we need to use surrounding her support people in order to get some kind of background as to what her expectations are and what her fears are and what she really wants out of that birth experience.*
>
> **Participant 5 – RN for 21 years**

Patient. Maternity nurses were asked to contemplate the types of challenges they perceived African immigrant/refugee women experienced. The most commonly perceived challenge facing African immigrant/refugee women revolves around ethnocultural differences. As the nurses were learning from the patient, they shared experiences in the areas in which maternity nurses and

African immigrant/refugee women and their families differed: breastfeeding, pain control and delivery options. This is a patient challenge as the majority of maternity nurses interviewed perceived the lack of knowledge and understanding was on the part of the African immigrant/refugee woman. Maternity nurses shared their perceptions of witnessing fear in African immigrant/refugee women who were having a first time Canadian hospital experience.

Either subconsciously or consciously, the maternity nurses in this study were using Western medicine as the comparative norm as their gauge for lacking knowledge and understanding. The characterization of the women which indirectly emerged from the data analysis, as learned by the maternity nurses also poses challenges for patients. The perceived traits of quietness, compliance, and non-demanding may actually be the African immigrant woman's response to her feelings of racialization and discrimination that disable her from being an equal partner in care decision making. Perceived functional challenges for immigrant/refugee women included difficulty accessing prenatal care, social language difference, limited or no social support networks. As participant 2 suggested,

I guess the biggest barrier like the lack of understanding right? So you don't really know where they're coming from, what their afraid of and you don't… I think another thing is not knowing what they know, what they know they can access…

Participant 2- RN for 3 years

Language difference appeared most commonly as the challenge African immigrant/refugee women face. The majority of maternity nurses interviewed noted that women relied on husbands and other family and friends to interpret communications. Maternity nurses contemplated whether husbands were acting paternalistically or if women were in actual agreement with care decisions. Uncertainty in discerning the difference was due to language and ethnocultural difference. Maternity nurses felt that when the women had language difference she cannot communicate well enough to help the nurse accurately discern the level of healthy marital social dynamics. Maternity nurses viewed language difference as the springboard for further challenges such as accessing prenatal classes or other community supports, social isolation, lack of transportation, and inability to obtain work related to under-recognition of education. There were two outlier examples of African immigrant/refugee women who were able to converse exceptionally well in English and who the nurses thought to be of professional working status. These two maternity nurses shared very different experiences with these particular women as they were able to 'seamlessly'

navigate the hospital system, feel confident and capable to participating in care decisions.

The findings highlight the various ways in which maternity nurses experienced care encounters with African immigrant/refugee women. As noted through the data analysis and verbatim examples, maternity nurses displayed various levels of understanding and knowledge. Maternity nurses also used a variety of ways of building knowledge to help gain understanding such as through the patients, other hospital staff members, or themselves. Maternity nurses chose to approach their care encounters through attempting relational involvement with the patient, collaborating with other hospital staff, and using maternity nursing specific knowledge and expertise. Gaining knowledge and/or understanding was not without challenges. From the perspectives of the nurse, the facility or larger system, as well as the patient, challenges exist that make the achievement of ethnoculturally tailored care difficult.

Chapter 7 – Discussion

The dynamics of engaging in ethnocultural care encounters is complex. Findings showed some ways in which maternity nurses engaged in gaining ethnocultural knowledge and understanding of their African immigrant/refugee patients. Maternity nurses also shared the ways in which knowledge and understandings were applied as they proceeded to negotiate ethnocultural care encounters. There were many layers of personal and public meanings of interpretation that came into play associated with the ways ethnocultural knowledge and understanding was acquired, interpreted and applied. The interpretivistic methodological underpinnings of focused ethnography were an appropriate fit to explore the variety of expressions of maternity nurses care experiences. The flexibility of focused ethnography provided the opportunity to acknowledge the diversity of interplays between maternity nurses, patients and at the same time was able to weave together shared patterns of thought, interpretations and behaviours. The aims of this study were to gain insights into the everyday experiences of nurse clinicians in order to identify barriers to care, gaps in knowledge as well as strengths or successes in the provision of ethno-cultural care. This discussion section seeks to bridge the findings with relevant literature to add theoretical perspectives to the study findings. Each of the larger themes will be discussed in relation to epistemological underpinnings such as Carper's (1978) ways of knowing and feminist post colonialism as seen through Gustafson's (2005) critical cultural

perspective of transcultural nursing theory. The model of Menon's (2002) psychological health empowerment model and the concept of cultural safety will also be used to link findings theoretical constructs.

Addressing Challenges within Maternity Nurses' Ethnocultural Care Encounters

Some of the ways maternity nurses constructed knowledge and understanding were in keeping with Carper's (1978) descriptions of building knowledge as described in Chapter 3 Methodology. The thematic areas of learning from the patient, learning from others, and learning from self have elements of Carper's (1978), aesthetic, personal and moral ways of knowing. The themes of learning from patient, learning from others, and learning from self, by and large subscribe to the aesthetic ways of knowing where subjective expressions, interpretations and creative development of nursing care formed the basis of how maternity nurses engaged in ethnocultural care encounters. The everyday realities of front line clinical care afforded maternity nurses the organic experiences from which they could build knowledge. Maternity nurses are able to readily engage in such a pragmatic approach as it is essential in nature but it is not without some challenges.

One of the challenges comes with unguided interpretations of care experiences, in this case, ethnocultural care experiences. The characterization of the African immigrant/refugee women is an example of unguided interpretations. Within their care experiences, the majority of maternity nurses

perceived traits such as stoicism, shyness, quietness, compliance, appreciation of care, as commonly found amongst African immigrant/refugee women. This 'essentialized' interpretation of such perceived personal characteristics put maternity nurses in a dominant position of decision making. Maternity nurses in these instances were not able to discern between personal quality traits of the women versus the responsiveness of the women to the contextual situation. Gustafson's (2005) critical cultural perspective of transcultural nursing theory (TCN) provides a lens with which to further examine the possible influences of the characterizations. Gustafson's (2005) interrogation of TCN through a critical cultural perspective shows how the goal and processes of providing culturally competent care reinforce and institutionalize the dominant approach to care rather than transform the very social practices and relations it was meant to change. Gustafson's (2005) critique contributes to feminist post colonial dialogue which regards human identities as fluid, dynamic and deeply interconnected to social, political and ideological spheres. Therefore this critical cultural perspective challenges the distinct, bound categories of human difference; the consequences of which are different access to power, privilege, wealth, opportunity, and resources (Gustafson, 2005).

In referring back to the aesthetic based interpretation of the characterization of African immigrant/refugee women, the critical cultural perspective would question the maternity nurses' Westernized social location as the benchmark to assessing the responsive behaviours. The implicit legitimacy of

a Westernized social position as a politically neutral identity displaces the maternity nurse from acknowledging the wider systemic power imbalances also at play within the nurse-patient ethnocultural encounters. Gustafson (2005) also reflects on the deep rooted European Christian moral base of nursing as contributing to this subtle subjugation in which, "sensitivity, understanding, and empathy can stand in for being fair and being fairly represented" (p. 12). This was also apparent as maternity nurses spoke of female circumcision as being 'barbaric' or a form of 'torture' brought feelings of sympathy. The resulting product of the characterization of African immigrant/refugee women, therefore, may be thought of in terms of a subjective interpretation from the Westernized social location and influences of European Christian morals. As Gustafson (2005) states,

> Those of us in positions of power have the luxury of expressing tolerance and sensitivity for nondominant beliefs and practices. Those of us who are marginalized are expected to be satisfied with being tolerated or having our diversity celebrated rather than being able to expect fair treatment…and equitable access to healthcare as clients. (p.12)

The ensuing results are demonstrated in more attention and focus to concepts such as cultural awareness and cultural sensitivity as well as seeking a fixed skill based approach to care encounters. This also resulted in the under-recognition

of cultural safety or the larger power imbalances as playing a significant part of the nurse-patient relationship dynamic.

Aesthetic or subjective based interpretations of ethnocultural encounters can also affect the nurses' critical reflection and assessment skills. Even the well intentioned nurse may not be largely aware of the dominant systemic discourses influencing their perspectives and decision-making abilities; the consequences of which are the inability to engage in deeper critical reflection. Unguided interpretations become vulnerable to being 'essentialized' or 'culturalized' as described by Johnson et al (2004). Maternity nurses and nurses in general are taught to reflect on their individual practice and look for professional growth and development accordingly. For example, looking beyond the African immigrant/refugee woman's shyness, compliance and stoicism to discern more accurately the reason for such responsive behaviours could lead to greater understanding. Assessing physiological pain and decisions around pain control could be answered more precisely with deeper critical thinking. Do the behaviours of large amounts of visitors truly translate into adequate home support systems? In as much as African immigrant/refugee women appear to have a natural ease with mothering, is that enough to cope with motherhood in a new country?

Assessments and teachings around breastfeeding practices and delivery options are also areas subject to the same degradation of ethnocultural care.

When maternity nurses do not have sufficient evidence to support ethnospecific health practices, the expectation is to err on the safe side and encourage African immigrant/refugee women to partake in standardized hospital teachings in the woman's 'best interest', thus, pulling the woman into the "existing boundaries of Western healthcare" (p.13). The institutional roles and expectations of maternity nurses also make equal partnerships in care decision making with African immigrant/refugee women difficult. Maternity nurses perceive nonparticipation and compliance with care decision making to be related to lack of knowledge of the Canadian health care system and practices. The workload and roles expectations was manifested in the numerous accounts of time and task oriented examples where maternity nurses felt hard pressed to take time for an extended care decision making process that was especially necessary when language differences existed. The scenario then becomes skewed towards the maternity nurses assuming that their position of expertise within the deemed superior Western medical system as the primary remedy to assist their African immigrant/refugee patients, once again perpetuating the effects of systemic power dimensions.

Time stressed maternity nurses also expressed their reliance on community programs such as Health Beginnings to bridge care especially in light of the short length of hospital stay (24-48 hrs). The reliance on community programs to bridge care is not without its challenges as Spitzer (2004) noted that,

> Health care reform, with its focus on home and community care, has increased the burden on all women in their roles…however, the burden on immigrant and refugee women whose family support systems have been truncated has been especially severe. (p.496)

Although time and task orientations are influenced by institutional expectations, nurses should take care in using this as a rational to provide equal or less time allocation for care to all patients. Spitzer (2004) advises that immigrant/refugee patients actually need more time to achieve equitable treatment rather than less or equal to that of middle-class Euro-Canadians. This comes back to the TCN concept where culture ascribes multiple differences to everyone equally (Gustafson, 2005). The notion that everyone is struggling obscures the "operation of difference as a social mechanism of domination and subordination" (p. 8).

Another area of concern where deeper critical thinking and assessment is needed is with regards to social support networks. Maternity nurses by enlarge perceived abundant presence of social support networks for African immigrant/refugee women. Researchers have reported evidence to the contrary of such findings which should caution nurses to take heed of possible 'essentializing' or 'culturalizing' perspectives (Stewart, 2003; Lindsay, 2001). The relational presence of family and friends may also be a demonstration of

solidarity and the creation of an ethnocultural safe environment within the hospital environment in response to perceptions of power dimensions.

As this study did not look at the perceptions of care from the African immigrant/refugee women's point of view, Menon's (2002) psychological health empowerment model with implications for health care in multicultural communities is used to reflect on the notion of empowerment to ponder on decision making from an individual perspective. Empowerment within the health care system is not easily accomplished for many patients coming from diverse lifeways. However, Menon (2002) believes that minoritized individuals could be less health empowered psychologically compared to the majority population as reflected by disparities in health and underutilization of health services. Menon's (2002) psychological health empowerment model points out that patients trust health experts and institutions to determine what actions to take in the best interest of the patient, leaving limited to no choice for patients.

There are limits to what an individual can accomplish on their own thereby resulting in feelings of powerlessness (Menon, 2002). According to Menon (2002), the following relational elements should be present in order for patients to feel empowered: wishes and dignity are to be respected, full information is provided in a comprehensible manner, options are presented in a meaningful way, and choice is given whenever appropriate. There is difficulty meeting these conditions to create successful nurse-patient decision making

partnerships. On the individual level, African immigrant/refugee women may come with varying levels of English language proficiencies, varying levels of education, limited or no support and be influenced by a collectivistic style of decision making. On the institutional and systemic level dominant Western discourses and practices produce a social power imbalance creating responsive behaviours such as those manifested in the characterization of the African immigrant/refugee women that disrupt the possibility of an equitable nurse-patient care decision making partnership. Facility gaps such as limited access to interpretive services, lack of ethnoculturally diverse staff, and limited educational opportunities and resources to enhance ethnospecific care encounters are tangible examples from this study that demonstrate a larger system of exclusion and privilege influencing nursing care. This example strikes at the very heart of Essed's (1991) structural aspect of 'everyday racism' in which, "dominance and discrimination exists and is reproduced through access to and the allocation of resources" (Cortis & Law, 2005, p. 205). The end result of which influences nursing care and thus, reduced opportunities for health empowerment of African immigrant/refugee women.

Creating a connection with ethnoculturally diverse patients at an individual level is central to achieving effective ethnocultural care. Group representations of immigrants/refugees can grossly misrepresent how each individual manifests a health experience. In our bid to create awareness of systemic power differentials and discrimination of our ethnoculturally diverse

populations, we must also come back to our face-to-face encounters and begin to understand what is at stake for each of our patients according to their own life-worlds.

> *"…what is at stake for the patient; what the patient, at a deep level, stands to gain or lose… a direct and immediate appeal is made to the patient as an individual, not as a representative group."*
>
> (Kleinman & Benson, 2006, p. 1676)

Attempts to improve nurse-patient ethnocultural care encounters currently seem to be a one-sided affair. There is unequal onus on the nurse to look for ways to grow and develop greater skills to enhance care for ethnoculturally diverse patients. As Gustafson (2005) states, "…bias, discrimination, and prejudice are situated in the individual psyche or condemned as aberrant behavior whereas systemic racism is unreflectively expressed and unnamed" (p. 11). Maternity nurses and nurses in general cannot be left to their own devices to seek ways to grow and develop ethnocultural knowledge and understanding. Learnings of social location and messages such as equal treatment do not mean equitable treatment cannot be realized by unguided interpretations. Systemic engagement involving macro level structures such as education and health care institutions is necessary to achieve effective change.

de Leon Siantz & Meleis (2007) clearly articulate ways is which nursing education can take leadership to improve cultural competency, however, health care institutions are equally responsible to take charge of improvements. Health care institutional change will be a difficult challenge for the nursing profession as our sphere of leadership and political influence is minimal in this realm. Advancements in ethnocultural competencies will take multi-level nursing leadership initiatives and multidisciplinary partnerships to affect change.

Addressing Strengths within Maternity Nurses' Ethnocultural Encounters

Strengths of maternity nurses came through the ways of personal and moral knowing as defined by Carper (1978). Aspects of personal knowing that can allow nurses to achieve higher level understandings and knowledge attainment include comfort with ambiguity and patience for the purpose of creating authentic relationships and genuine nurse 'presence' (Carper, 1978).

Moral ways of knowing which require openness to different philosophic positions in order to discern what should be done in a given situation were also demonstrated by maternity nurses who were able to achieve genuine relationships with their African immigrant/refugee patients. Entertaining more fluid concepts of culture and human differences and include possibilities of heterogeneity on dimensions other than ethnocultural traits were ways in which maternity nurses demonstrated this venue of knowledge building.

Kleinman & Benson (2006) draw interesting parallels to personal and moral knowing from an anthropological ethnographic viewpoint which emphasizes engagement with people in their 'local world'. Kleinman & Benson (2006) believe that anthropologists and clinicians share the belief in 'primacy of experience' and therefore can empathize with the lived experience of patients; a result of intensive human engagement "with their foreignness, and understanding their religion, moral values, and every day practices" (p. 1674). Maternity nurses who displayed such qualities were able to experience a deeper level of engagement with their African immigrant/refugee patients. Empirical collection of outcomes was not part of this study design, however, maternity nurses offered qualitative observations of patient engagement. Lengthy and engaging conversations, smiles and laughter, and return families and visitors who made a point of greeting nurses were seen as signs of significant relationship building.

Interestingly maternity nurses who were best able to articulate deeper levels of engagement with their African immigrant/refugee patients attributed this ability to tangible learning from experiences abroad. The direct ethnocultural immersion experiences afforded them a more deeply sensitized understanding of the difference in social positioning of African immigrant/refugee women rather than simple rote knowledge of ethnocultural differences. Being embedded in the social lives of ethnoculturally diverse populations abroad allowed these maternity nurses higher comfort levels to engage in freer dialogue

with their African immigrant/refugee patients. Lipson & Desantis (2007) speak of strengths of nursing immersion experiences which can enhance the holistic view of the patient by increasing self awareness of health care preconceptions and the impact of personal values, beliefs, practices and behaviours on patient care. Overseas immersion experiences are not an economical option for many nursing students and clinicians but other options exist for deeper learning to occur, the key being well trained educators who can wholly address elements of effective ethnocultural care (Calvillo et al., 2009; Lipson & Desantis, 2007). For the maternity nurse who was the most recent graduate, experiences abroad were associated with university level nursing courses which kept her learnings in constant guidance by instructors and current interpretations ethnocultural concepts such as cultural safety. This was an added layer of reinforcement which pushed her critical reflection and thinking skills to higher levels of ethnocultural engagement as demonstrated by her narratives. This is of importance to note as immersion experiences, whether abroad or local, in themselves do not guarantee enhanced ethnocultural knowledge and understandings “unless student are encouraged to think critically by experienced and prepared faculty and preceptors" with explicit dialogue on practices of social exclusion and power dimensions between dominant and minoritized groups (Lipson & Desantis, 2007, p. 17S).

Minoritized nurses who participated in this study also used personal and moral ways of knowing in ways that demonstrated deeper level of knowledge

and understanding of their African immigrant/refugee patients. Their self-actualization of their own ethnoculturally different social location, comfort with ambiguity and patience for creating genuine presence was demonstrated through their narratives. Coming from different lifeways afforded the minoritized nurses different ways of thinking and acquiring knowledge which relates to the knowledge building venue of moral ways of knowing (Carper, 1978). This is important to acknowledge as traditional views of transcultural nursing are "often applied from a 'uni-ethnic' (white European) perspective' (Serrant-green, 2001, p.673). Ethnocultural diversity of health care professionals such as nurses may enhance critical thinking, assessments and ethnospecific care decision-making. The contributions of minoritized nurses to enriching the Canadian health care system's ability to more effectively engage in ethnoculturally diverse patient care is significant. The presence of ethnoculturally diverse staff helps to negate the neutral identity and social location of Westernized nurses and health systems and misrepresentation of our ethnoculturally diverse patient populations.

Accessing this vital human resource within the Canadian health care system is however, challenging. Jeans (2006) reported that less than ten percent of the nursing workforce is internationally educated. Reasons for such a diminutive proportion reflect barriers to licensure such as education and skills that do not meet provincial indicators for entry to practice requirements (Ogilvie et al., 2007). There is also a possibility of ethnospecific discrimination that may be subtly at play in preventing the inclusion of more diverse in-hospital staff

(Esses et al., 2007; Ogilvie et al., 2007, Ogilvie et al, 2000; Reitz & Sklar, 1997). As educational institutions and professional licensure bodies make advances in bridging the entry to practice ability of internationally educated nurses, so too, should employers in carefully examining practices of discrimination in order to promote better inclusion of diverse staff (Ogilvie, 2007; Esses, 2007).

There is, however, one caveat to the use of diverse staff to enhance ethnocultural care. In as much as the perspectives of ethnoculturally diverse staff can be of great benefit to enhancing clinical care experiences, caution needs to be taken that the ethnospecific views of minoritized nurses and other staff are not taken as a universal truths. We are in danger of homogenizing populations and denying the uniqueness at the individual level and the nurse's ability to retrieve more nuanced information (Serrant-Green, 2001). The expansion of ethnocultural understandings and knowledge must be viewed through a critical lens that considers the individual's unique experience.

The critical cultural perspectives on transcultural nursing theory were able to highlight areas which continue to challenge front line maternity nurses to engage effectively in ethnocultural care encounters. Traditional views of cultural competence and related concepts including but not limited to cultural awareness and cultural sensitivity are not enough to achieve effective ethnocultural care. Nursing scholars continue to advance cultural competence and related concepts through a variety of strategies including community based education, use of

imaginative literature, immersion experiences, and holistic integration of cultural concepts throughout all courses, and better representation of ethnoculturally diverse nursing students and faculty (Calvillo et al., 2009; de Leon Siantz & Meleis, 2007; Anderson et al., 2007; Lipson & Desantis, 2007; Newcomb et al., 2006; Serrant-Green, 2001). Ways of engaging our patients in relationships that acknowledge each individual in a more holistic sense will enhance our face-to-face understandings. The concept of cultural safety as it evolves to be a universal for all ethnoculturally diverse populations should also be considered as a viable addition in advancing effective ethnocultural care. Cultural safety as an explicit concept of critical cultural and post colonial feminist perspective is necessary to expand our focus on "issues of political economy, the historical process of colonization in Canada [and abroad], and the role of our sociopolitical landscape in shaping inequities" (Browne, 2005, p. 82). Examination of such discourses is necessary to equip nurses to overcome challenges in providing effective ethnocultural care. Multi-level and multidisciplinary partnerships are needed to help front line nurses' work towards success; a formidable and complex task, yet the momentum exists in beginning to understand.

Chapter 8- Conclusion

Findings from this study highlighted the challenges that can emerge from traditional views of cultural competence as narrow understandings of how to approach ethnocultural care encounters. The liberal standpoint of transcultural nursing theory, in the sense of under recognition of systemic power imbalances and discrimination, prevented maternity nurses from being equipped to accurately assess ethnocultural care encounters and discern appropriate care decision making on equitable grounds with African immigrant/refugee women. The unguided aesthetic interpretations of maternity nurses were inadvertent reflections of dominant Western societal discourses that have been institutionalized in our everyday social practices and infused into the Canadian health care system. Maternity nurses displayed a variety of levels of knowledge and understanding of their African immigrant/refugee patients. Threads of cultural concepts such as cultural awareness, cultural sensitivity, cultural desire and cultural safety were seen in the findings. All but one maternity nurse showed detailed awareness of the concept of cultural safety in either explicit or implicit terms, hence the under recognition of systemic or institutionalized discrimination. Challenges were seen not only at the individual maternity nurse's level but also at the systemic level and included limited access to interpretive services, a strong institutional focus on the biomedical perspective, time constraints, lack of diverse staff, and limited ethnocultural educational

opportunities. Findings of this study also showed strengths of the maternity nurses to grow and challenge such dominant discourses. Maternity nurses used a variety of ways of building knowledge such as aesthetic, personal and moral ways of knowing as described by Carper (1978). Although all nurses were engaged in aesthetic learning, maternity nurses who demonstrated personal and moral ways of knowing seemed to be the most successful in terms of achieving higher quality ethnocultural care encounters with their African immigrant/refugee patients. Maternity nurses interviewed for this study were highly skilled clinicians who showed a deep commitment to their professional practice. They possess the desire to continue to grow in their knowledge and understanding of not only African immigrant/refugee women but of ways to enhance ethnocultural care encounters for all newcomers. This study, from and Albertan-Canadian context, adds to the growing body of evidence pointing to the need to advocate for and promote greater critical analysis of mainstream thoughts on culture and ethnocultural differences. Insight from the findings into ways maternity nurses were building knowledge may help to build future cultural competence curriculum. In doing so, create awareness of how dominant social assumptions perpetuate misrepresentations relating to ethnocultural differences. The implications for policy, practice and education are as follows:

Implications for Policy

Policy changes are needed to influence systemic level of change. The research findings from this study have potential to influence policy by

- Demonstrating the need for hospital institutional policy to acknowledge facility gaps that promote practices of exclusion and power differentials such as limited interpretive services, lack of diverse staff including internationally educated nurses and the ethnospecific services of multicultural brokers, as well as limited educational opportunities for staff to enhance knowledge and understanding around ethnocultural care

Implications for Practice

Practice level change will help individual nurses grow and develop ethnocultural knowledge. The research findings from this study have potential to influence maternity nursing clinical practice by

- Insights gained into ways that maternity nurses build knowledge by aesthetic, personal, and moral ways of knowing may help to streamline clinical learning approaches to engaging in effective ethnocultural care encounters. Practical approaches should include creating dialogue with nurses that bridges aesthetic knowledge with personal and moral knowledge. Consideration should be given to include guided social immersion activities with various ethnocultural groups through an

interface with relevant immigrant community service agencies or a more convenient approach such as video vignettes

- Promoting maternity nurses' awareness raising of systemic discrimination that perpetuates power imbalances that play out at the nurse-patient level
- Promoting maternity nurses' deeper critical thinking and assessment skills which will in turn help to more accurately assess and interpret ethnocultural care encounters such as assessment of pain and pain control, engage in more equitable decision making around delivery options and other aspects of peri-natal care

Implications for Education

Nursing educational institutions can influence both systemic and individual level change. The research findings from this study have the potential to influence education by

- Encouraging the incorporation of critical cultural perspectives through explicit concepts such as cultural safety into nursing curricula and how the socio-political context and post-colonial consequences contribute to the inequitable relations between minoritized individuals and health care providers, thereby, giving consideration to both individual and systemic influences on ethnocultural learning and care

- Again, through describing knowledge building of the maternity nurses through Carper's (1978) ways of knowing, educational curricula can also consider structuring cultural competence curricula that appeal to the different ways nursing knowledge is gained

Implications for Research

- Further research into ways maternity nurses and/or other nurses learn through their ethnocultural encounters in the Canadian context is needed. Gaining sights into ways of building ethnocultural knowledge in a variety of settings and other subgroups of nurses deepen our understanding of how nurses engage ethnoculturally diverse patients as well as strengths and challenges they face in doing so
- Further research into maternity experiences which includes the narratives of the women as well as nurses would also be beneficial to capture a more holistic research view of this phenomenon
- Research should also include the roles of both in-hospital and community formal and informal social support systems for immigrant/refugee women in seeking health care needs

Conclusion

As a wealthy nation, Canada does offer its citizens many privileges such as universal health care, a democratic society, and multiculturalism. The

road to citizenry can be a very rocky one for many immigrants. The journeys and experiences for our ethnoculturally diverse patients and for maternity nurses differ and will always change through time. Time has also gifted maternity nurses with positive change in knowledge and understanding of immigration and health and of our relationships between groups. In fact, our changing profile of newcomers, such as our African immigrant/refugee women, has enriched our perspectives and added insight into our approach to immigrant health. Despite barriers of political ideologies, rhetoric of post colonialism, the constraints of multiculturalism or over-generalized health paradigms, Canada and our nursing profession have not remained static on issues of migrant health. Such is the case with the growing interest and infusion of critical cultural perspectives in mainstream nursing and health perspectives. There is enough reciprocity by formal and informal welfare state structures to support resettlement; demonstrated through structures such as CIC and Prairie Metropolis Centre. There are enough strands of embracing diversity that maintain momentum against the shortcomings of traditional views of culture; demonstrated through the development of cultural safety. There is enough insight into inadequacies of immigrant health paradigms to explore the needs for more depth and breadth of perspectives; demonstrated through the example of Menon's (2002) psychological health empowerment model. Perhaps it is a matter of degree that stops us from being held back from change; a degree of freedom that affords many of us to push boundaries of exclusion to farther distances imagined.

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Appendix A

Table 4: Search Strategy Results for Literature Review

CINAHL Plus with Full Text				
#	Query	Limiters/Expanders	Last Run Via	Results
S1	Immigrant Women	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	347
S2	Maternity Services	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	673
S3	(Maternity Services) and (S1 and S2)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S4	Refugee women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	98
S5	Refugee women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	98
S6	(Refugee women) and (S2 and S4)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S7	African immigrant women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	6
S8	(African immigrant women) and (S2 and S7)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0

S9	(African immigrant women) and (S2 and S7)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S10	Discrimination	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	10348
S11	(Discrimination) and (S1 and S2 and S10)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S12	(Discrimination) and (S1 and S2 and S10)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S13	(Discrimination) and (S1 and S2 and S10)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S14	(Discrimination) and (S1 and S2 and S10)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S15	Racialization	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	17
S16	(Racialization) and (S1 and S2 and S15)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S17	(Racialization) and (S1 and S2 and S15)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0

S18	S7 and S27 and S29 and S30	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S19	S7 and S18 and S27 and S29 and S30	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S20	Maternity and Discrimination	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	32
S21	(Maternity and Discrimination) and (S18 and S27)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S22	Health Care	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	180996
S23	(Health Care) and (S1 and S22)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	93
S24	(((Health Care) and (S1 and S22)) and Maternity) and (S23)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S25	Pregnancy and Childbirth	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	8919
S26	(Pregnancy and Childbirth) and (S1 and S25)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	13

S27	Maternity experiences	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	17
S28	(Maternity experiences) and (S1 and S27)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S29	(Maternity experiences) and (S1 and S27)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S30	Obstetrics	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	3353
S31	(Obstetrics) and (S1 and S30)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S32	((Obstetrics) and (S1 and S30)) and (S4 and S25)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S33	((Obstetrics) and (S1 and S30)) and (S4 and S25)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S34	Cultural competence	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	3728
S35	(Cultural competence) and (S2 and S34)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	2

S36	Cultural safety	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	224
S37	(Cultural safety) and (S2)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S38	S5 and S25	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S39	S7 and S25	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S40	Immigrant Women	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	347
S41	Maternity Services	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	673
S42	(Maternity Services) and (S40 and S41)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S43	Refugee women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	98
S44	Refugee women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	98

S45	(Refugee women) and (S41 and S43)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S46	African immigrant women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	6
S47	(African immigrant women) and (S41 and S46)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S48	(African immigrant women) and (S41 and S46)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	150177
S49	Discrimination	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	10348
S50	(Discrimination) and (S40 and S41 and S49)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S51	(Discrimination) and (S40 and S41 and S49)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	44564
S52	(Discrimination) and (S40 and S41 and S49)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S53	(Discrimination) and (S40 and S41 and S49)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	44564

S54	Racialization	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	17
S55	(Racialization) and (S40 and S41 and S54)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S56	(Racialization) and (S40 and S41 and S54)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	34482
S57	S46 and S27 and S29 and S30	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S58	S46 and S57 and S27 and S29 and S30	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S59	Maternity and Discrimination	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	32
S60	(Maternity and Discrimination) and (S57 and S27)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S61	Health Care	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	180996
S62	(Health Care) and (S40 and S61)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	93

S63	(((Health Care) and (S40 and S61)) and Maternity) and (S62)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S64	Pregnancy and Childbirth	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	8919
S65	(Pregnancy and Childbirth) and (S40 and S64)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	13
S66	Maternity experiences	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	17
S67	(Maternity experiences) and (S40 and S66)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S68	(Maternity experiences) and (S40 and S66)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	76694
S69	Obstetrics	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	3353
S70	(Obstetrics) and (S40 and S69)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S71	((Obstetrics) and (S40 and S69)) and (S43 and S64)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0

S72	((Obstetrics) and (S40 and S69)) and (S43 and S64)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	37760
S73	Cultural competence	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	3728
S74	(Cultural competence) and (S41 and S73)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	2
S75	Cultural safety	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	224
S76	(Cultural safety) and (S41)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S77	S44 and S64	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S78	S46 and S64	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S79	Immigrant Women and Maternity Services	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S80	Maternity Services and Immigrant Women	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1

S81	Maternity and Immigrant Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S82	Maternity and Minority Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	9
S83	Maternity and Othering	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S84	Maternity and Othering	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	4354
S85	Maternity and Discrimination	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	32
S86	(Maternity and Discrimination) and (S82 and S85)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S87	Maternity and Refugee Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S88	Maternity and Immigrant Women	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S89	Maternity and Immigrant Women	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5

S90	Immigrant Women and Health Care	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	94
S91	Maternity	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	3776
S92	(Maternity) and (S90 and S91)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S93	Pregnancy and Childbirth	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	8919
S94	Immigrant Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	361
S95	(Immigrant Women) and (S93 and S94)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	14
S96	Refugee Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S97	Refugee Women	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	107179
S98	Canadian Health Care	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	165

S99	(Canadian Health Care) and (S95 and S98)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S100	(Canadian Health Care) and (S95 and S98)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	905266
S101	Immigrant Women and Maternity Services	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S102	Maternity Services and Immigrant Women	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S103	Maternity and Immigrant Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S104	Maternity and Minority Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	9
S105	Maternity and Othering	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S106	Maternity and Othering	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	4354
S107	Maternity and Discrimination	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	32

S108	(Maternity and Discrimination) and (S104 and S107)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S109	Maternity and Refugee Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S110	Maternity and Immigrant Women	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S111	Maternity and Immigrant Women	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S112	Immigrant Women and Health Care	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	94
S113	Maternity	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	3776
S114	(Maternity) and (S112 and S113)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S115	Pregnancy and Childbirth	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	8919
S116	Immigrant Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	361

S117	(Immigrant Women) and (S115 and S116)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	14
S118	Refugee Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S119	Refugee Women	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	107179
S120	Canadian Health Care	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	165
S121	(Canadian Health Care) and (S117 and S120)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S122	(Canadian Health Care) and (S117 and S120)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	905266
S123	Immigrant Women and Maternity Services	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S124	Maternity Services and Immigrant Women	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S125	Maternity and Immigrant Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5

S126	Maternity and Minority Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	9
S127	Maternity and Othering	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S128	Maternity and Othering	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	4354
S129	Maternity and Discrimination	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	32
S130	(Maternity and Discrimination) and (S126 and S129)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S131	Maternity and Refugee Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S132	Maternity and Immigrant Women	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S133	Maternity and Immigrant Women	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S134	Immigrant Women and Health Care	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	94

S135	Maternity	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	3776
S136	(Maternity) and (S134 and S135)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S137	Pregnancy and Childbirth	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	8919
S138	Immigrant Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	361
S139	(Immigrant Women) and (S137 and S138)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	14
S140	Reefugee Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S141	Reefugee Women	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	107179
S142	Canadian Health Care	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	165
S143	(Canadian Health Care) and (S139 and S142)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0

S144	(Canadian Health Care) and (S139 and S142)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	905266
S145	Immigrant Women and Maternity Services	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S146	Maternity Services and Immigrant Women	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S147	Maternity and Immigrant Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S148	Maternity and Minority Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	9
S149	Maternity and Othering	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S150	Maternity and Othering	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	4354
S151	Maternity and Discrimination	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	32
S152	(Maternity and Discrimination) and (S148 and S151)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1

S153	Maternity and Refugee Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S154	Maternity and Immigrant Women	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S155	Maternity and Immigrant Women	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	5
S156	Immigrant Women and Health Care	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	94
S157	Maternity	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	3776
S158	(Maternity) and (S156 and S157)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	1
S159	Pregnancy and Childbirth	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	8919
S160	Immigrant Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	361
S161	(Immigrant Women) and (S159 and S160)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	14

S162	Reefugee Women	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S163	Reefugee Women	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	107179
S164	Canadian Health Care	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	165
S165	(Canadian Health Care) and (S161 and S164)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	0
S166	(Canadian Health Care) and (S161 and S164)	Search modes - SmartText Searching	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	905266
S167	Refugee	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	784
S168	(Refugee) and (S159 and S167)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	9
S169	((Refugee) and (S159 and S167)) and (S166 and S168)	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	9
S170	(Immigrant Women) and (S159 and S160)	Limiters - Publication Year from: 1990-2010 Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	13

S 1 7 1	((Refugee) and (S159 and S167)) and (S166 and S168)	Limiters - Publication Year from: 1990-2010; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - CINAHL Plus with Full Text	9

Ovid MEDLINE(R) 1950 to 2010			
#	Searches		Results
1	exp "Emigration and Immigration"/ or exp Pregnancy/	Limiters - English Language; Publication Year from: 1990-2010; Language: English Search modes - Boolean/Phrase	Interface - Ovid Search Screen - Advanced Search Database-MEDLINE 644930
2	limit 1 to (english language and yr="1990 - 2010")		284486
3	exp HIV Infections/ or exp Delivery, Obstetric/ or exp Pregnancy/ or exp Midwifery/ or exp Hospitals, Maternity/ or exp Postpartum Period/ or exp Adult/ or exp Maternal Health Services/ or exp Prenatal Care/		5073813
4	limit 3 to (english language and yr="1990 - 2010")		2721085
5	2 and 4		277554
6	exp "Emigrants and Immigrants"/		1630
7	limit 6 to (english language and yr="1990 - 2010")		1366
8	4 and 7		838
9	exp Canada/		96017
10	limit 9 to (english language and yr="1990 - 2010")		63112
11	8 and 10		74
12	(Pregnancy and Childbirth).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]		8297
13	limit 12 to (english language and yr="1990 - 2010")		4996
14	2 and 10 and 13		102
15	7 and 14		1
16	exp Women/		25610
17	limit 16 to (english language and yr="1990 - 2010")		15687
18	4 and 10 and 17		359
19	9 and 12 and 17		6

20	exp "Discrimination (Psychology)"/		14210
21	limit 20 to (english language and yr="1990 - 2010")		9193
22	17 and 21		10
23	13 and 22		0
24	exp Ethnic Groups/ or exp Prejudice/ or exp Health Services Accessibility/ or exp Healthcare Disparities/		161988
25	limit 24 to (english language and yr="1990 - 2010")		119697
26	13 and 17 and 25		9
27	9 and 26		2
28	exp Pregnancy/ or exp Refugees/ or exp "Emigration and Immigration"/		649035
29	limit 28 to (english language and yr="1990 - 2010")		287174
30	10 and 13 and 29		102
31	exp "Emigrants and Immigrants"/ or exp Africa/		142256
32	limit 31 to (english language and yr="1990 - 2010")		82058
33	10 and 13 and 32		4
34	exp "Emigration and Immigration"/ or exp Pregnancy/		644930
35	limit 34 to (english language and yr="1990 - 2010")		284486
36	exp HIV Infections/ or exp Delivery, Obstetric/ or exp Pregnancy/ or exp Midwifery/ or exp Hospitals, Maternity/ or exp Postpartum Period/ or exp Adult/ or exp Maternal Health Services/ or exp Prenatal Care/		5073813
37	limit 36 to (english language and yr="1990 - 2010")		2721085
38	35 and 37		277554
39	exp "Emigrants and Immigrants"/		1630
40	limit 39 to (english language and yr="1990 - 2010")		1366
41	37 and 40		838
42	exp Canada/		96017
43	limit 42 to (english language and yr="1990 - 2010")		63112
44	41 and 43		74

45	(Pregnancy and Childbirth).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]		8297
46	limit 45 to (english language and yr="1990 - 2010")		4996
47	35 and 43 and 46		102
48	40 and 47		1
49	exp Women/		25610
50	limit 49 to (english language and yr="1990 - 2010")		15687
51	37 and 43 and 50		359
52	42 and 45 and 50		6
53	exp "Discrimination (Psychology)"/		14210
54	limit 53 to (english language and yr="1990 - 2010")		9193
55	50 and 54		10
56	46 and 55		0
57	exp Ethnic Groups/ or exp Prejudice/ or exp Health Services Accessibility/ or exp Healthcare Disparities/		161988
58	limit 57 to (english language and yr="1990 - 2010")		119697
59	46 and 50 and 58		9
60	42 and 59		2
61	exp Pregnancy/ or exp Refugees/ or exp "Emigration and Immigration"/		649035
62	limit 61 to (english language and yr="1990 - 2010")		287174
63	43 and 46 and 62		102
64	exp "Emigrants and Immigrants"/ or exp Africa/		142256
65	limit 64 to (english language and yr="1990 - 2010")		82058
66	43 and 46 and 65		4
67	from 66 keep 1-4		4
68	from 67 keep 1-4		4
EMBASE 1996 to 2010			
#	Searches		Results
1	exp "Emigration and Immigration"/ or exp Pregnancy/		101408
2	limit 1 to (english language and yr="1990 - 2010")		89835

3	[limit 3 to (english language and yr="1990 - 2010")]		0
4	[limit 6 to (english language and yr="1990 - 2010")]		0
5	[limit 9 to (english language and yr="1990 - 2010")]		0
6	[limit 12 to (english language and yr="1990 - 2010")]		0
7	[limit 16 to (english language and yr="1990 - 2010")]		0
8	[limit 20 to (english language and yr="1990 - 2010")]		0
9	[limit 24 to (english language and yr="1990 - 2010")]		0
10	[limit 28 to (english language and yr="1990 - 2010")]		0
11	[limit 31 to (english language and yr="1990 - 2010")]		0
12	exp "Emigration and Immigration"/ or exp Pregnancy/		101408
13	limit 12 to (english language and yr="1990 - 2010")		89835
14	exp HIV Infections/ or exp Delivery, Obstetric/ or exp Pregnancy/ or exp Midwifery/ or exp Hospitals, Maternity/ or exp Postpartum Period/ or exp Adult/ or exp Maternal Health Services/ or exp Prenatal Care/		2613250
15	limit 14 to (english language and yr="1990 - 2010")		2314553
16	13 and 15		85670
17	exp "Emigrants and Immigrants"/		8188
18	limit 17 to (english language and yr="1990 - 2010")		7354
19	15 and 18		3189
20	exp Canada/		30291
21	limit 20 to (english language and yr="1990 - 2010")		29585
22	19 and 21		148
23	(Pregnancy and Childbirth).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name]		3933
24	limit 23 to (english language and yr="1990 - 2010")		3441

25	13 and 21 and 24		26
26	18 and 25		2
27	exp Women/		1931199
28	[limit 20 to (english language and yr="1990 - 2010")]		0
29	[limit 24 to (english language and yr="1990 - 2010")]		0
30	[limit 28 to (english language and yr="1990 - 2010")]		0
31	[limit 31 to (english language and yr="1990 - 2010")]		0
32	exp "Emigration and Immigration"/ or exp Pregnancy/		101408
33	limit 32 to (english language and yr="1990 - 2010")		89835
34	exp HIV Infections/ or exp Delivery, Obstetric/ or exp Pregnancy/ or exp Midwifery/ or exp Hospitals, Maternity/ or exp Postpartum Period/ or exp Adult/ or exp Maternal Health Services/ or exp Prenatal Care/		2613250
35	limit 34 to (english language and yr="1990 - 2010")		2314553
36	33 and 35		85670
37	exp "Emigrants and Immigrants"/		8188
38	limit 37 to (english language and yr="1990 - 2010")		7354
39	35 and 38		3189
40	exp Canada/		30291
41	limit 40 to (english language and yr="1990 - 2010")		29585
42	39 and 41		148
43	(Pregnancy and Childbirth).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name]		3933
44	limit 43 to (english language and yr="1990 - 2010")		3441
45	33 and 41 and 44		26
46	38 and 45		2
47	exp Women/		1931199
48	limit 47 to (english language and yr="1990 - 2010")		1773577
49	35 and 41 and 48		8387

50	40 and 43 and 48		23
51	exp "Discrimination (Psychology)"/		22382
52	limit 51 to (english language and yr="1990 - 2010")		21782
53	48 and 52		8015
54	44 and 53		0
55	exp Ethnic Groups/ or exp Prejudice/ or exp Health Services Accessibility/ or exp Healthcare Disparities/		719629
56	limit 55 to (english language and yr="1990 - 2010")		640243
57	44 and 48 and 56		480
58	40 and 57		7
59	exp Pregnancy/ or exp Refugees/ or exp "Emigration and Immigration"/		103089
60	limit 59 to (english language and yr="1990 - 2010")		91407
61	41 and 44 and 60		26
62	exp "Emigrants and Immigrants"/ or exp Africa/		62260
63	limit 62 to (english language and yr="1990 - 2010")		57563
64	41 and 44 and 63		2
65	from 64 keep 1-2		2
ProQuest Dissertations & Theses			
#	Query		Search Type Results
1	Immigrant Women Database: Dissertations & Theses: Full Text Look for terms in: Citation and abstract Publication type: All publication types		Advanced 581 results
2	(Immigrant Women) AND PDN(>1/1/1989) Database: Dissertations & Theses: Full Text Look for terms in: Citation and abstract Publication type: All publication types		Advanced 532 results
3	(Immigrant Women) AND (Maternity) AND PDN(>1/1/1989) Database: Dissertations & Theses: Full Text Look for terms in: Citation and abstract Publication type: All publication types		Advanced 2 results

4	(Immigrant Women) AND (Maternity) OR (Pregnancy) AND PDN(>1/1/1989) Database: Dissertations & Theses: Full Text Look for terms in: Citation and abstract Publication type: All publication types		Advanced 15 results
5	(African Immigrant Women) AND (Maternity) OR (Pregnancy) AND PDN(>1/1/1989) Database: Dissertations & Theses: Full Text Look for terms in: Citation and abstract Publication type: All publication types		Advanced 6 results
PsychInfo Searches			
#	Query		Search Type Results
1	exp "Emigration and Immigration"/ or exp Pregnancy/		Advanced 9974
2	limit 1 to (english language and yr="1990 - 2010")		Advanced 8805
3	[limit 3 to (english language and yr="1990 - 2010")]		Advanced 0
4	[limit 6 to (english language and yr="1990 - 2010")]		Advanced 0
5	[limit 9 to (english language and yr="1990 - 2010")]		Advanced 0
6	[limit 12 to (english language and yr="1990 - 2010")]		Advanced 0
7	[limit 16 to (english language and yr="1990 - 2010")]		Advanced 0
8	[limit 20 to (english language and yr="1990 - 2010")]		Advanced 0
9	[limit 24 to (english language and yr="1990 - 2010")]		Advanced 0
10	[limit 28 to (english language and yr="1990 - 2010")]		Advanced 0
11	[limit 31 to (english language and yr="1990 - 2010")]		Advanced 0
12	exp "Emigration and Immigration"/ or exp Pregnancy/		Advanced 9974
13	limit 12 to (english language and yr="1990 - 2010")		Advanced 8805

14	exp HIV Infections/ or exp Delivery, Obstetric/ or exp Pregnancy/ or exp Midwifery/ or exp Hospitals, Maternity/ or exp Postpartum Period/ or exp Adult/ or exp Maternal Health Services/ or exp Prenatal Care/		Advanced 10781
15	limit 14 to (english language and yr="1990 - 2010")		Advanced 9556
16	13 and 15		Advanced 8805
17	exp "Emigrants and Immigrants"/		Advanced 0
18	limit 17 to (english language and yr="1990 - 2010")		Advanced 0
19	15 and 18		Advanced 0
20	exp Canada/		Advanced 0
21	limit 20 to (english language and yr="1990 - 2010")		Advanced 0
22	19 and 21		Advanced 0
23	(Pregnancy and Childbirth).mp. [mp=title, abstract, heading word, table of contents, key concepts]		Advanced 960
24	limit 23 to (english language and yr="1990 - 2010")		Advanced 798
25	13 and 21 and 24		Advanced 0
26	18 and 25		Advanced 0
27	exp Women/		Advanced 69195
28	limit 20 to (english language and yr="1990 - 2010")		Advanced 0
29	limit 24 to (english language and yr="1990 - 2010")		Advanced 798
30	limit 28 to (english language and yr="1990 - 2010")		Advanced 0
31	[limit 31 to (english language and yr="1990 - 2010")]		Advanced 0
32	exp "Emigration and Immigration"/ or exp Pregnancy/		Advanced 9974
33	limit 32 to (english language and yr="1990 - 2010")		Advanced 8805

34	exp HIV Infections/ or exp Delivery, Obstetric/ or exp Pregnancy/ or exp Midwifery/ or exp Hospitals, Maternity/ or exp Postpartum Period/ or exp Adult/ or exp Maternal Health Services/ or exp Prenatal Care/		Advanced 10781
35	limit 34 to (english language and yr="1990 - 2010")		Advanced 9556
36	33 and 35		Advanced 8805
37	exp "Emigrants and Immigrants"/		Advanced 0
38	limit 37 to (english language and yr="1990 - 2010")		Advanced 0
39	35 and 38		Advanced 0
40	exp Canada/		Advanced 0
41	limit 40 to (english language and yr="1990 - 2010")		Advanced 0
42	39 and 41		Advanced 0
43	(Pregnancy and Childbirth).mp. [mp=title, abstract, heading word, table of contents, key concepts]		Advanced 960
44	limit 43 to (english language and yr="1990 - 2010")		Advanced 798
45	33 and 41 and 44		Advanced 0
46	38 and 45		Advanced 0
47	exp Women/		Advanced 69195
48	limit 47 to (english language and yr="1990 - 2010")		Advanced 60497
49	35 and 41 and 48		Advanced 0
50	40 and 43 and 48		Advanced 0
51	exp "Discrimination (Psychology)"/		Advanced 0
52	limit 51 to (english language and yr="1990 - 2010")		Advanced 0
53	48 and 52		Advanced 0
54	44 and 53		Advanced 0

55	exp Ethnic Groups/ or exp Prejudice/ or exp Health Services Accessibility/ or exp Healthcare Disparities/		Advanced 56573
56	limit 55 to (english language and yr="1990 - 2010")		Advanced 52360
57	44 and 48 and 56		Advanced 18
58	40 and 57		Advanced 0
59	exp Pregnancy/ or exp Refugees/ or exp "Emigration and Immigration"/		Advanced 12432
60	limit 59 to (english language and yr="1990 - 2010")		Advanced 11006
61	41 and 44 and 60		Advanced 0
62	exp "Emigrants and Immigrants"/ or exp Africa/		Advanced 0
63	limit 62 to (english language and yr="1990 - 2010")		Advanced 0
64	41 and 44 and 63		Advanced 0
65	[from 64 keep 1-2]		Advanced 0
SCOPUS			
1	TITLE-ABS-KEY(immigrant women)		3913
2	TITLE-ABS-KEY(immigrant women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011		3551
3	(TITLE-ABS-KEY(immigrant women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011) AND (maternity)		128
4	(TITLE-ABS-KEY(immigrant women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011) AND ((maternity)) AND (canada)		28
5	TITLE-ABS-KEY(refugee women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011		1049
6	(TITLE-ABS-KEY(refugee women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011) AND (maternity)		36
7	(TITLE-ABS-KEY(refugee women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011) AND ((maternity)) AND (canada)		5
8	TITLE-ABS-KEY(immigrant minority women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011		257

9	(TITLE-ABS-KEY(immigrant minority women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011) AND (maternity)		9
10	(TITLE-ABS-KEY(immigrant minority women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011) AND ((maternity)) AND (canada)		2
11	TITLE-ABS-KEY(discrimination) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011		115841
12	TITLE-ABS-KEY(racialization) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011		333
13	(TITLE-ABS-KEY(immigrant minority women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011) AND (TITLE-ABS-KEY(discrimination) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011)		13
14	(TITLE-ABS-KEY(immigrant minority women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011) AND (TITLE-ABS-KEY(racialization) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011)		2
15	TITLE-ABS-KEY(pregnancy AND childbirth) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011		11148
16	(TITLE-ABS-KEY(immigrant minority women) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011) AND (TITLE-ABS-KEY(pregnancy AND childbirth) AND PUBYEAR AFT 1989 AND PUBYEAR BEF 2011)		4
Global Health Searches			
#	Query		Search Type Results
1	exp "Emigration and Immigration"/ or exp Pregnancy/		Advanced 28840
2	limit 1 to (english language and yr="1990 - 2010")		Advanced 21343
3	[limit 3 to (english language and yr="1990 - 2010")]		Advanced 0
4	[limit 6 to (english language and yr="1990 - 2010")]		Advanced 0
5	[limit 9 to (english language and yr="1990 - 2010")]		Advanced 0

6	[limit 12 to (english language and yr="1990 - 2010")]		Advanced 0
7	[limit 16 to (english language and yr="1990 - 2010")]		Advanced 0
8	[limit 20 to (english language and yr="1990 - 2010")]		Advanced 0
9	[limit 24 to (english language and yr="1990 - 2010")]		Advanced 0
10	[limit 28 to (english language and yr="1990 - 2010")]		Advanced 0
11	[limit 31 to (english language and yr="1990 - 2010")]		Advanced 0
12	exp "Emigration and Immigration"/ or exp Pregnancy/		Advanced 28840
13	limit 12 to (english language and yr="1990 - 2010")		Advanced 21343
14	exp HIV Infections/ or exp Delivery, Obstetric/ or exp Pregnancy/ or exp Midwifery/ or exp Hospitals, Maternity/ or exp Postpartum Period/ or exp Adult/ or exp Maternal Health Services/ or exp Prenatal Care/		Advanced 101111
15	limit 14 to (english language and yr="1990 - 2010")		Advanced 81834
16	13 and 15		Advanced 21343
17	exp "Emigrants and Immigrants"/		Advanced 0
18	limit 17 to (english language and yr="1990 - 2010")		Advanced 0
19	15 and 18		Advanced 0
20	exp Canada/		Advanced 18253
21	limit 20 to (english language and yr="1990 - 2010")		Advanced 14580
22	19 and 21		Advanced 0
23	(Pregnancy and Childbirth).mp. [mp=abstract, title, original title, broad terms, heading words]		Advanced 1849
24	limit 23 to (english language and yr="1990 - 2010")		Advanced 1530
25	13 and 21 and 24		Advanced 25
26	18 and 25		Advanced 0

27	exp Women/		Advanced 72427
28	limit 20 to (english language and yr="1990 - 2010")		Advanced 14580
29	limit 24 to (english language and yr="1990 - 2010")		Advanced 1530
30	limit 28 to (english language and yr="1990 - 2010")		Advanced 14580
31	[limit 31 to (english language and yr="1990 - 2010")]		Advanced 0
32	exp "Emigration and Immigration"/ or exp Pregnancy/		Advanced 28840
33	limit 32 to (english language and yr="1990 - 2010")		Advanced 21343
34	exp HIV Infections/ or exp Delivery, Obstetric/ or exp Pregnancy/ or exp Midwifery/ or exp Hospitals, Maternity/ or exp Postpartum Period/ or exp Adult/ or exp Maternal Health Services/ or exp Prenatal Care/		Advanced 101111
35	limit 34 to (english language and yr="1990 - 2010")		Advanced 81834
36	33 and 35		Advanced 21343
37	exp "Emigrants and Immigrants"/		Advanced 0
38	limit 37 to (english language and yr="1990 - 2010")		Advanced 0
39	35 and 38		Advanced 0
40	exp Canada/		Advanced 18253
41	limit 40 to (english language and yr="1990 - 2010")		Advanced 14580
42	39 and 41		Advanced 0
43	(Pregnancy and Childbirth).mp. [mp=abstract, title, original title, broad terms, heading words]		Advanced 1849
44	limit 43 to (english language and yr="1990 - 2010")		Advanced 1530
45	33 and 41 and 44		Advanced 25
46	38 and 45		Advanced 0
47	exp Women/		Advanced 72427

48	limit 47 to (english language and yr="1990 - 2010")		Advanced 62324
49	35 and 41 and 48		Advanced 396
50	40 and 43 and 48		Advanced 22
51	exp "Discrimination (Psychology)"/		Advanced 0
52	limit 51 to (english language and yr="1990 - 2010")		Advanced 0
53	48 and 52		Advanced 0
54	44 and 53		Advanced 0
55	exp Ethnic Groups/ or exp Prejudice/ or exp Health Services Accessibility/ or exp Healthcare Disparities/		Advanced 19058
56	limit 55 to (english language and yr="1990 - 2010")		Advanced 17484
57	44 and 48 and 56		Advanced 62
58	40 and 57		Advanced 3
59	exp Pregnancy/ or exp Refugees/ or exp "Emigration and Immigration"/		Advanced 30015
60	limit 59 to (english language and yr="1990 - 2010")		Advanced 22279
61	41 and 44 and 60		Advanced 25
62	exp "Emigrants and Immigrants"/ or exp Africa/		Advanced 85972
63	limit 62 to (english language and yr="1990 - 2010")		Advanced 57688
64	41 and 44 and 63		Advanced 0
65	[from 64 keep 1-2]		Advanced 0
Web of Science® – with Conference Proceedings			
Set			Results
1	Topic=(Immigrant Women) AND Author=(Maternity) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years		0
2	Topic=(Immigrant Women) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years		1950

3	Topic=(Immigrant Women) Refined by: Topic=(Pregnancy and Childbirth) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years		13
4	Topic=(Immigrant Women) Refined by: Topic=(Pregnancy and Childbirth) AND Topic=(Maternity Experiences) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years		2
5	Topic=(African Women) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		14344
6	Topic=(African Women) Refined by: Topic=(Immigrant women) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		132
7	Topic=(African Women) Refined by: Topic=(Immigrant women) AND Topic=(Maternity) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		4
8	Topic=(Minority Women) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		4770
9	Topic=(Minority Women) Refined by: Topic=(Pregnancy and Childbirth) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		18
10	Topic=(Discrimination) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		95302
11	#10 AND #9 Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		1
12	#10 AND #7 Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		0
13	#10 AND #4 Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		0
14	Topic=(Racialization) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		310

15	#14 AND #1 Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		0
16	#14 AND #7 Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		0
17	Topic=(Pregnancy) Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		>100,000
18	#17 AND #2 Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		158
19	#18 AND #5 Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=1990-2010		13
Google Internet Search			
#	Query	Limiters/Expanders	Search Type Results
1	African Immigrant Women Pregnancy OR Maternity OR Childbirth site:.edu.	English; 1990 – 2010; site:.edu	Database- Google Advanced 39
Hand searching key journals			
#	Authors	Country of Research	Journal Results
1	Chalmers, B. & Hashi, K., Somali women's birth experiences in Canada after earlier female genital mutilation	Canada; 2000	*Birth 27*(4), pp. 227-234 1
Scanning references for key articles			
#	Authors	Country of Research	Journal Results
2	Small, R., Gagnon, A., Gissler, M., Zeitlin, J., Bennis, M., Glazier, R. H., Haelterman, E., Martens, G., McDermott, S., Urquia, M., Vangen, S.	Canada (+ multi-country); 2008	*British Journal of Obstetrics and Gynecology 115,* pp. 1630-1640 1
3	Gagnon, A. J., Zimbeck, M., Zeitlin, J., ROAM Collaboration	Canada; 2009	*Social Science & Medicine* 1
4	Spitzer, D.	Canada; 2004	*Medical Anthropology* 1

Appendix B

Table 5. Output of raw code list generated from Atlas.ti6©

Code List with Definitions
Code: Acknowledgement of Ethnocultural Difference **Created: 24/02/2010 16:45:58 by Super** **Modified: 24/02/2010 17:11:53** **Quotations: 1** **"Nurse acknowledges and accepts ethnocultural differences"**
Code: Acknowledgement of Expertise **Created: 29/07/2009 00:39:58 by Super** **Modified: 24/02/2010 21:44:55** **Quotations: 1** **"Patient is acknowledging the expertise of the nurse"**
Code: Appreciative of Care **Created: 23/02/2010 12:35:25 by Super** **Modified: 24/02/2010 19:11:01** **Quotations: 2** **"Appreciative of care - expressing gratitude for nursing services"**
Code: Assumptions-Generalities **Created: 16/12/2009 22:38:59 by Super** **Modified: 26/02/2010 10:01:22** **Quotations: 7** **"Statements of assumptions and essentializing generalities"**
Code: Attempt to Negotiate Ethno-Cultural Encounter **Created: 16/12/2009 22:35:30 by Super** **Modified: 26/02/2010 14:40:58** **Quotations: 18** **"Various ways in which nurses attempt to problem solve ethnocultural interactions. These are the situations in which the nurse is having difficulty understanding but still attempts to reason through the situation with flexibility and reorients her thinking to allow or accept another's viewpoint, in this case, ethnocultural viewpoint."**

Code List with Definitions
Code: Attentiveness-Nurse **Created: 29/07/2009 00:16:30 by Super** **Modified: 24/02/2010 21:48:29** **Quotations: 6** **"The nurse creates moments of attending with patients in ways to foster relational connections"**
Code: Breastfeeding **Created: 28/07/2009 23:18:04 by Super** **Modified: 24/02/2010 21:49:27** **Families (1): Breastfeeding** **Quotations: 1** **"Talking about breastfeeding differences amongst African women as compared to the nurses"**
Code: Breastfeeding- Multiparous Versus Primiparous **Created: 28/07/2009 23:55:53 by Super** **Modified: 24/02/2010 21:50:34** **Families (1): Breastfeeding** **Quotations: 1** **"Feeling of difference in comfort level with breastfeeding for multparous women as compared with primiparous women"**
Code: Breastfeeding Beliefs **Created: 28/07/2009 23:19:26 by Super** **Modified: 24/02/2010 21:50:53** **Quotations: 1** **"Specific beliefs about breastfeeding"**
Code: Breastfeeding Beliefs - Nurse **Created: 29/07/2009 00:00:26 by Super** **Modified: 25/02/2010 21:18:50** **Families (1): Breastfeeding** **Quotations: 13** **"The nurse's beliefs on breastfeeding"**

Code List with Definitions
Code: Breastfeeding Beliefs - Nurse/Cultural Comparison **Created: 29/07/2009 00:13:01 by Super** **Modified: 24/02/2010 21:51:56** **Quotations: 3** **"Nurse comparing differing breastfeeding beliefs between African women and those of another culture"**
Code: Breastfeeding Beliefs - Nurse/Reconciling Personal **Created: 29/07/2009 00:14:43 by Super** **Modified: 24/02/2010 21:52:38** **Quotations: 3** **"Nurse's reconciling their own beliefs and accepting those of the woman's as being equally important"**
Code: Breastfeeding Beliefs - Obstetrician **Created: 29/07/2009 00:20:41 by Super** **Modified: 24/02/2010 21:53:00** **Quotations: 1** **"Varying views of obstetrician in regards to breastfeeding"**
Code: Breastfeeding Beliefs - Patient **Created: 29/07/2009 00:17:47 by Super** **Modified: 25/02/2010 21:19:38** **Quotations: 7** **"Perceptions of the immigrant woman's breastfeeding beliefs"**
Code: Breastfeeding Support **Created: 28/07/2009 23:20:17 by Super** **Modified: 25/02/2010 21:18:27** **Quotations: 2** **"Nursing belief of support needed to encourage early breastfeeding in African women"**
Code: Building Trust **Created: 28/07/2009 23:26:44 by Super** **Modified: 26/02/2010 15:25:48** **Quotations: 4** **"Ways in which the nurse builds a trusting relationship with the woman"**

Code List with Definitions
Code: C-Section - Hesitant **Created: 16/12/2009 21:54:49 by Super** **Modified: 24/02/2010 16:38:07** **Quotations: 1** **"Hesitancy to undergo a c-section"**
Code: Challenges of translating health literature **Created: 24/02/2010 19:21:45 by Super** **Modified: 24/02/2010 19:33:02** **Quotations: 2** **"Describing difficulty with accessing language specific (in this case, French) health literature"**
Code: Childcare support **Created: 16/12/2009 23:39:22 by Super** **Modified: 24/02/2010 21:56:00** **Quotations: 1** **"Perceived barrier of childcare support"**
Code: Communication on Pain Relief -Level of support **Created: 23/02/2010 12:08:18 by Super** **Modified: 23/02/2010 21:44:15** **Quotations: 2** **"The amount of requested pain relief support asked for by immigrant African women is associated with the level of community support. Nurse perception is that preference is given not to use many Western oriented pain relief options such as epidurals."**
Code: Communication on Pain Relief Options **Created: 16/12/2009 20:56:06 by Super** **Modified: 25/02/2010 15:54:12** **Quotations: 4** **"Nurse perception that immigrant women are not accepting of western medicine in terms of pain control interventions"**

Code List with Definitions
Code: Community Agency - Create a Resource Link **Created: 16/12/2009 23:54:11 by Super** **Modified: 25/02/2010 16:19:40** **Quotations: 6** **"Creating a resource link to community agencies"**
Code: Community Resource Awareness **Created: 16/12/2009 21:29:41 by Super** **Modified: 26/02/2010 10:07:18** **Quotations: 10** **"Awareness of community resources that assist immigrant women"**
Code: Community Resource Awareness - Patient **Created: 16/12/2009 21:58:40 by Super** **Modified: 23/02/2010 21:37:41** **Quotations: 4** **"Nurse perception of the immigrant women's awareness of community resource and their ability to utilize them appropriately"**
Code: Community Resources - Importance of Linkage **Created: 25/02/2010 16:21:44 by Super** **Modified: 26/02/2010 16:10:29** **Quotations: 4** **"Nurse perception of the importance of linkage to postpartum community resource such as Health Beginnings to ensure continuity of care and an extended vantage point to assess the well-being of women"**
Code: Community Resources Lack of Awareness by Acute Care Nurses **Created: 16/12/2009 21:30:58 by Super** **Modified: 26/02/2010 15:46:21** **Quotations: 7** **"Lack of knowledge on the nurses' part of community resources available to immigrant women"**
Code: Community Support - More Resources **Created: 16/12/2009 21:18:46 by Super** **Modified: 26/02/2010 16:32:46** **Quotations: 3** **"Thoughts that more community resources are necessary"**

Code List with Definitions
Code: Community Support - Uncertain **Created: 16/12/2009 21:09:32 by Super** **Modified: 24/02/2010 21:57:46** **Quotations: 2** **"Nurse uncertainty of community support services"**
Code: Compliant - Not Demanding **Created: 16/12/2009 21:56:51 by Super** **Modified: 23/02/2010 21:22:17** **Quotations: 2** **"Nurse-Perceived characteristic of compliance in immigrant women"**
Code: Consistent Pre-Natal Care **Created: 23/02/2010 15:36:02 by Super** **Modified: 23/02/2010 21:24:01** **Quotations: 1** **"Nurse perception that immigrant women are seeking prenatal care"**
Code: Countries of Origin **Created: 28/07/2009 23:22:21 by Super** **Modified: 26/02/2010 14:32:08** **Quotations: 15** **"Asking the nurses for knowledge of countries of origin to gauge the amount of nurse initiated ethnospecific discussions take place and how much interest there is to obtain such information."**
Code: Creating a Connection **Created: 29/07/2009 00:05:00 by Super** **Modified: 25/02/2010 20:54:16** **Quotations: 4** **"Ways in which nurses reach out on an individual level to create a genuine connection with the immigrant woman"**
Code: Creating a Connection - Seeing the Individual **Created: 26/02/2010 14:18:51 by Super** **Modified: 26/02/2010 15:26:04** **Quotations: 4** **"The nurse makes a connection with the patient by using an individual approach"**

Code List with Definitions
Code: Creating a Connection with African Nursing Colleague **Created: 17/12/2009 08:05:38 by Super** **Modified: 24/02/2010 22:00:20** **Quotations: 1** **"Ways in which nurses reach out on an individual level to create a genuine connection with the African nursing colleague"**
Code: Cross Cultural Comparison **Created: 29/07/2009 00:13:45 by Super** **Modified: 26/02/2010 09:27:01** **Quotations: 7** **"Cross cultural comparisons of maternity experiences to help identify similarities and differences"**
Code: Cultural Barriers - Food **Created: 05/08/2009 22:23:39 by Super** **Modified: 24/02/2010 22:00:56** **Quotations: 0** **"Any cultural impasse related to food preferences"**
Code: Cultural Safety Gap-Difference in Environment **Created: 16/12/2009 21:11:57 by Super** **Modified: 26/02/2010 16:36:20** **Quotations: 5** **"This nurse acknowledges the greater systemic hospital environment that contributes to a gap for our ethnoculturally diverse newcomers to understand a 'Canadian' health care experience."**
Code: Decision Making by Husband **Created: 16/12/2009 22:04:44 by Super** **Modified: 24/02/2010 22:08:46** **Quotations: 2** **"Nurse tension with husband's decision making role"**
Code: Delivery Option - Trauma **Created: 23/02/2010 15:47:02 by Super** **Modified: 23/02/2010 21:18:40** **Quotations: 1** **"C-section as a delivery option for women who have had traumatic experiences"**

Code List with Definitions
Code: Desire for more Knowledge **Created: 16/12/2009 23:15:38 by Super** **Modified: 24/02/2010 22:09:34** **Quotations: 5** **"Nurse desire for more ethnocultural knowledge"**
Code: Desire for more Knowledge and Understanding **Created: 24/02/2010 16:27:03 by Super** **Modified: 26/02/2010 12:01:45** **Quotations: 4** **"Nurse desire for more ethnocultural knowledge and understanding"**
Code: Desire to Create Connection **Created: 16/12/2009 21:27:32 by Super** **Modified: 17/12/2009 08:48:02** **Quotations: 2** **"Despite stated gaps, there is a desire to try and create a caring environment"**
Code: Detailed Description of Nurse-Patient Conversation **Created: 25/02/2010 20:43:18 by Super** **Modified: 25/02/2010 20:43:18** **Quotations: 1** **"A detailed description of a nurse-patient conversation indicating high level of relational engagement"**
Code: Difficulty Accessing French Health Literature **Created: 24/02/2010 19:25:08 by Super** **Modified: 24/02/2010 19:25:48** **Quotations: 1** **"When attempting to access French health literature even in Eastern Canada, this nurse had a great deal of difficulty."**
Code: Distinct Separation **Created: 23/02/2010 12:37:39 by Super** **Modified: 23/02/2010 21:30:24** **Quotations: 1** **"Nurse perception of distinct separation or gap between the nurse and African immigrant women - a feeling of difference"**

Code List with Definitions
Code: Drawback of Professional Translator Service **Created: 17/12/2009 00:28:20 by Super** **Modified: 24/02/2010 22:10:50** **Quotations: 1** **"Drawback of impersonal feeling in using phone-in interpretive services"**
Code: Easygoing - Not Demanding **Created: 16/12/2009 14:58:12 by Super** **Modified: 24/02/2010 22:11:20** **Quotations: 1** **"Characterization of African immigrant woman as easygoing"**
Code: Empathizing **Created: 26/02/2010 11:48:03 by Super** **Modified: 26/02/2010 15:39:16** **Quotations: 2** **"Seeking to understand another's viewpoint"**
Code: Ethno-Cultural - Communication Response **Created: 28/07/2009 23:13:11 by Super** **Modified: 16/12/2009 20:10:27** **Quotations: 2** **"Attempting to describe participant's degree of specific cultural knowledge, in this case, ability to understand heterogeneous groups within Africa."**
Code: Ethno-Cultural Barrier - Difference in Culture **Created: 05/08/2009 22:27:17 by Super** **Modified: 26/02/2010 12:02:44** **Quotations: 7** **"Difference in cultural origins as being the barrier to better ethnocultural understanding"**
Code: Ethno-Cultural Barrier - Traditional Customs **Created: 05/08/2009 22:31:41 by Super** **Modified: 24/02/2010 22:13:17** **Quotations: 2** **"Impasse in understanding traditional customs"**

Code List with Definitions
Code: Ethno-cultural Challenge-Domestic Conflict **Created: 17/12/2009 01:00:22 by Super** **Modified: 24/02/2010 22:14:25** **Quotations: 2** **"Nurse perception of domestic violence as being an ethnocultural challenge for African women with whom they have had care experiences"**
Code: Ethno-Cultural Challenges - Caucasian **Created: 29/07/2009 00:52:54 by Super** **Modified: 24/02/2010 22:15:02** **Quotations: 1** **"Ethnocultural challenges with Caucasian maternity patients"**
Code: Ethno-Cultural Data- Prenatal Record **Created: 05/08/2009 22:12:51 by Super** **Modified: 25/02/2010 16:14:12** **Quotations: 9** **"No cultural data on prenatal or admission record - verbal reports between nurses."**
Code: Ethno-Cultural Data- Prenatal/Admission Record **Created: 24/02/2010 19:39:24 by Super** **Modified: 26/02/2010 15:37:55** **Quotations: 5** **"References to elements of ethnocultural data present (or not) on the prenatal or admission record"**
Code: Ethno-Cultural Data - Comparison **Created: 05/08/2009 22:13:35 by Super** **Modified: 24/02/2010 22:16:23** **Quotations: 1** **"Comparison of how ethnocultural data is collected on other unit(s)"**
Code: Ethno-Cultural Data - Relative Importance **Created: 05/08/2009 22:15:37 by Super** **Modified: 16/12/2009 20:30:39** **Quotations: 2** **"The participant agrees on the need for obtaining cultural data but also trying to weigh importance of this info with other important medical information, hence the term 'relative importance'."**

Code List with Definitions
Code: Ethno-Cultural Flexibility **Created: 28/07/2009 23:31:02 by Super** **Modified: 23/02/2010 21:23:21** **Quotations: 5** **"Nurse's ability to look another ethno-cultural point of view and accommodate ethnocultural expressions."**
Code: Ethno-Cultural Specificity **Created: 16/12/2009 14:27:51 by Super** **Modified: 25/02/2010 21:23:59** **Quotations: 1** **"Observation of ethnospecific customs"**
Code: Ethno-Cultural Strength - Supportive Network **Created: 29/07/2009 00:25:58 by Super** **Modified: 25/02/2010 16:35:02** **Quotations: 7** **"Supportive networks as being a strength for African immmigrant women"**
Code: Ethnocultural Barrier- Paternalism **Created: 24/02/2010 15:28:33 by Super** **Modified: 24/02/2010 22:08:01** **Quotations: 2** **"Health care providers having difficulty with accepting the immigrant woman's decision to defer decision making to husband."**
Code: Ethnocultural Barrier- Refusing Delivery Option **Created: 24/02/2010 15:26:28 by Super** **Modified: 25/02/2010 14:50:41** **Quotations: 2** **"Impasse or difference between women/husband/family and health care providers in terms of accepting delivery options such as c-section"**
Code: Ethnocultural Barrier-Lack of Knowledge **Created: 16/12/2009 20:47:43 by Super** **Modified: 26/02/2010 15:14:34** **Quotations: 7** **"Lack of knowledge on the nurse's part as being a barrier to ethnocultural understanding"**

Code List with Definitions
Code: Ethnocultural Challenge - Economics and Housing **Created: 25/02/2010 16:35:45 by Super** **Modified: 26/02/2010 16:08:23** **Quotations: 3** **"References to economics & housing as being a challenge to immigrant populations"**
Code: Ethnocultural Challenge - Paperwork **Created: 26/02/2010 15:41:54 by Super** **Modified: 26/02/2010 15:43:32** **Quotations: 1** **"Paperwork involved in maternity services can be seen as a barrier in the case of having to understand copious amounts of English written information required to process birthing records."**
Code: Ethnocultural Data- Physiological Disposition **Created: 17/12/2009 01:43:08 by Super** **Modified: 24/02/2010 22:18:31** **Quotations: 1** **"physiological risks seen as prevalent in African women"**
Code: Ethnocultural Data-Reluctance to Disclose **Created: 16/12/2009 22:45:13 by Super** **Modified: 24/02/2010 22:19:17** **Quotations: 1** **"Reluctance of African immigrant women to disclose certain personal health information"**
Code: Ethnocultural Data - Nurse Initiated **Created: 16/12/2009 20:31:51 by Super** **Modified: 26/02/2010 15:32:09** **Quotations: 8** **"Self-directed need to learn more about her patients from an ethno-cultural viewpoint."**

Code List with Definitions
Code: Ethnocultural Encounters-Awareness Raising Experience **Created: 17/12/2009 07:38:05 by Super** **Modified: 17/12/2009 07:43:19** **Quotations: 3** **"Emergence of broader perspectives on ethno-cultural diversity and depth of Africans as a result of her son's work experience."**
Code: Ethnocultural Knowledge - Depth and Breadth **Created: 26/02/2010 14:34:21 by Super** **Modified: 26/02/2010 14:36:10** **Quotations: 1** **"Indication of deeper ethnocultural knowledge as demonstrated in conversation in which the nurse is able to observe more refined variations between patients and does not make generalizations or assumptions"**
Code: Ethnocultural Nursing - Affinity for Understanding Ethnospecific Care **Created: 26/02/2010 14:22:08 by Super** **Modified: 26/02/2010 15:38:20** **Quotations: 4** **"The nurse's inherent ability to create relationships with those from another ethnocultural background."**
Code: Ethnocultural Nursing - Importance of Educational Opportunities **Created: 26/02/2010 16:46:21 by Super** **Modified: 26/02/2010 16:48:13** **Quotations: 1** **"Realizing the importance of ongoing educational opportunities in nursing programs in efforts to develop, enhance and sustain & validate ethnocultural nursing care."**
Code: Experiential Learning - Nurse **Created: 29/07/2009 01:12:08 by Super** **Modified: 26/02/2010 14:41:37** **Quotations: 8** **"Gaining ethnocultural knowledge and flexibility through experiential learning"**

Code List with Definitions
Code: Experiential Resource - Patient Preferences **Created: 29/07/2009 01:29:22 by Super** **Modified: 24/02/2010 22:19:47** **Quotations: 1** **"Nurse experiential learning about patient preferences"**
Code: Facility Barrier- No Overnight Accommodation for Family Member Support **Created: 24/02/2010 16:02:25 by Super** **Modified: 24/02/2010 22:20:57** **Quotations: 1** **"No overnight accommodation in hospital facility for family member who can assist in the care of the woman"**
Code: Facility Environment- High Acuity level **Created: 24/02/2010 16:08:11 by Super** **Modified: 24/02/2010 16:09:06** **Quotations: 1** **"Description of types of high risk pregnancies are referred to this facility conveys the sense of high acuity level and high work load"**
Code: Facility Resource-Female Physician **Created: 16/12/2009 23:30:39 by Super** **Modified: 24/02/2010 22:24:09** **Quotations: 1** **"Facility resource of having female physicians has been helpful for women of various cultures who prefer female health care providers"**
Code: Facility Resource-Transportation Assistance **Created: 24/02/2010 15:51:14 by Super** **Modified: 24/02/2010 22:22:25** **Quotations: 1** **"The facility's ability to provide assistance with transportation for immigrants"**
Code: Facility Resource - Lack of Diverse Staff **Created: 16/12/2009 23:41:09 by Super** **Modified: 25/02/2010 14:18:58** **Quotations: 1** **"Lack of ethnoculturally diverse staff is seen as a facility resource constraint"**

Code List with Definitions
Code: Facility Resource - Use of Other Disciplines **Created: 26/02/2010 09:51:48 by Super** **Modified: 26/02/2010 09:52:34** **Quotations: 1** **"Collaborating with other disciplines to support the care of maternity patients"**
Code: Facility Resources **Created: 05/08/2009 21:37:29 by Super** **Modified: 24/02/2010 15:33:37** **Quotations: 8** **"Small size of unit compared to patient demand"**
Code: Facility Resources- Lack of Awareness **Created: 16/12/2009 23:17:34 by Super** **Modified: 24/02/2010 22:23:17** **Quotations: 5** **"Lack of awareness by nurses of facility resources to assist them with ethnocultural care"**
Code: Facility Resources - Interpretive Services **Created: 29/07/2009 01:26:20 by Super** **Modified: 26/02/2010 15:02:35** **Quotations: 5** **"Acknowledgement of interpretive services as a hospital facility resource"**
Code: Facility Resources - Privacy **Created: 05/08/2009 22:06:02 by Super** **Modified: 24/02/2010 22:23:37** **Quotations: 5** **"Lack of privacy as a resource constraint"**
Code: Female Circumcision **Created: 16/12/2009 22:20:39 by Super** **Modified: 26/02/2010 15:24:15** **Quotations: 12** **"Comments surrounding female circumcision"**

Code List with Definitions
Code: Female Circumcision- Resources **Created: 24/02/2010 15:36:17 by Super** **Modified: 24/02/2010 15:36:47** **Quotations: 1** **"Seminar from sexual health unit on female circumcision."**
Code: Female Circumcision - Value of Delivering in Canada **Created: 26/02/2010 09:05:53 by Super** **Modified: 26/02/2010 09:07:00** **Quotations: 1** **"Nurse perception of the value of delivering a baby in Canada for women who have previously undergone female circumcision"**
Code: Female Circumcision - No Policy **Created: 29/07/2009 01:25:28 by Super** **Modified: 26/02/2010 15:24:25** **Quotations: 9** **"No hospital policy or guidelines pertaining to the care of women with female circumcision during labour and delivery"**
Code: Female Physician Preference **Created: 16/12/2009 22:25:59 by Super** **Modified: 24/02/2010 22:24:09** **Quotations: 3**
Code: Financial Barrier **Created: 17/12/2009 00:59:29 by Super** **Modified: 24/02/2010 22:24:54** **Quotations: 1** **"Financial constraints as being a barrier to seeking antenatal care"**
Code: First Hospital Experience **Created: 16/12/2009 20:13:14 by Super** **Modified: 24/02/2010 22:25:17** **Quotations: 5** **"First hospital experience in Canada"**

Code List with Definitions
Code: Food Preference **Created: 28/07/2009 23:29:31 by Super** **Modified: 26/02/2010 10:10:26** **Quotations: 8** **"Description of food preferences by African immigrant women"**
Code: Food Preference - Conflict **Created: 16/12/2009 20:57:51 by Super** **Modified: 24/02/2010 22:26:37** **Quotations: 1** **"Conflict situation when accommodating food preference"**
Code: Francophone Africans **Created: 17/12/2009 01:17:45 by Super** **Modified: 26/02/2010 15:39:58** **Quotations: 8** **"Particular reference to Francophone Africans - do nurses experience or have knowledge with this perspective?"**
Code: Gauging the Need for Professional Interpreter **Created: 24/02/2010 17:03:43 by Super** **Modified: 25/02/2010 10:47:06** **Quotations: 1** **"How the nurse decides when a professional interpreter is required"**
Code: High Level Critical Assessment Skills **Created: 26/02/2010 14:57:08 by Super** **Modified: 26/02/2010 15:04:04** **Quotations: 2** **"This is an example of high level critical assessment skills, using detailed observations to help assess a situation in which language difference exists. Despite language difference, the nurse is able to look at non-verbal gestures between husband and wife to help gauge comfort levels and understanding."**
Code: Higher Education of African Immigrants **Created: 25/02/2010 16:09:47 by Super** **Modified: 25/02/2010 16:36:36** **Quotations: 2**

Code List with Definitions
Code: HIV Status **Created: 16/12/2009 21:57:39 by Super** **Modified: 25/02/2010 10:48:16** **Quotations: 0** **"Unique experiences with HIV maternity patients"**
Code: HIV/AIDS **Created: 29/07/2009 01:22:54 by Super** **Modified: 26/02/2010 09:42:30** **Quotations: 2** **"Unique experiences with HIV maternity patients"**
Code: Husband - Unable to Support **Created: 17/12/2009 07:59:29 by Super** **Modified: 17/12/2009 08:00:41** **Quotations: 1** **"Work commitments kept this husband from attending to his laboring wife."**
Code: I've seen that most of them ha.. **Created: 25/02/2010 16:07:44 by Super** **Modified: 25/02/2010 16:07:49** **Quotations: 0**
Code: Identification of historical background **Created: 23/02/2010 12:10:30 by Super** **Modified: 23/02/2010 21:48:59** **Quotations: 1** **"Nurse initiated probing in regards to historical background."**
Code: Informal Networking - Creating Resource Links **Created: 17/12/2009 00:43:54 by Super** **Modified: 25/02/2010 10:56:25** **Quotations: 1** **"Informal networking to create resource links for ethnocultural support"**

Code List with Definitions
Code: Lack of Accessibility for Prenatal Classes **Created: 16/12/2009 21:08:22 by Super** **Modified: 26/02/2010 16:09:30** **Quotations: 2** **"Nurse perception of lack of access for African women to attend prenatal classes"**
Code: Lack of Prenatal Care **Created: 29/07/2009 01:18:59 by Super** **Modified: 25/02/2010 10:58:20** **Quotations: 2** **"Nurse perception of minimal prenatal care amongst immigrant African women"**
Code: Language-Ability to Communicate **Created: 29/07/2009 00:42:51 by Super** **Modified: 25/02/2010 11:01:24** **Quotations: 4** **"Ability of immigrant African women to communicate verbally well"**
Code: Language Barrier- Gauging Understanding **Created: 24/02/2010 19:00:04 by Super** **Modified: 26/02/2010 14:53:53** **Quotations: 5** **"How the nurse feels that the woman understands her communication despite the presence of language barrier."**
Code: Language Barrier-Negative Case **Created: 16/12/2009 23:00:59 by Super** **Modified: 25/02/2010 15:51:13** **Quotations: 1** **"Nurse perception that African immigrant women speak better English than Whites"**
Code: Language Barrier-Nurse **Created: 28/07/2009 23:42:29 by Super** **Modified: 23/02/2010 21:39:15** **Quotations: 4** **"Nurses are unable to speak language of patient's mother tongue"**

Code List with Definitions
Code: Language Barrier-Patient **Created: 28/07/2009 23:43:10 by Super** **Modified: 26/02/2010 14:37:31** **Quotations: 13** **"Patient's inability to verbally communicate"**
Code: Language Barrier - Distinction **Created: 28/07/2009 23:58:29 by Super** **Modified: 25/02/2010 12:31:32** **Quotations: 1** **"Language barrier creating a distinction or separation between the nurse and patient"**
Code: Language Barrier - More Time **Created: 16/12/2009 20:49:54 by Super** **Modified: 25/02/2010 16:17:12** **Quotations: 3** **"Language barrier associated with more nursing time to carry out care needs"**
Code: Language Barrier - None **Created: 25/02/2010 15:49:31 by Super** **Modified: 25/02/2010 15:51:30** **Quotations: 1** **"No language barrier for African immigrant women as seen by nurse"**
Code: Language Barrier - Tension in Not Understanding **Created: 24/02/2010 19:34:07 by Super** **Modified: 24/02/2010 19:34:41** **Quotations: 1** **"The nurse is unsatisfied with not understanding what is being said between the husband and wife"**
Code: Language Barrier - Urgent Situation **Created: 17/12/2009 01:16:44 by Super** **Modified: 25/02/2010 13:04:00** **Quotations: 1** **"Option for interpreter in an urgent situation - usually family"**

Code List with Definitions
Code: Language Interpretation-Nil **Created: 28/07/2009 23:50:31 by Super** **Modified: 25/02/2010 13:04:38** **Quotations: 2** **"No use of formal or professional interpreter"**
Code: Limited Language Specificity-Nurse **Created: 28/07/2009 23:48:29 by Super** **Modified: 25/02/2010 13:05:07** **Quotations: 1** **"limited English language skills"**
Code: Lower Education of African Immigrants **Created: 26/02/2010 09:39:30 by Super** **Modified: 26/02/2010 09:40:53** **Quotations: 1** **"Observation of perceived lower education of African immigrants"**
Code: Modesty **Created: 28/07/2009 23:24:45 by Super** **Modified: 25/02/2010 13:05:42** **Quotations: 4** **"References to modesty on the part of African immigrant women"**
Code: Multiculturalism - National Identity **Created: 26/02/2010 09:47:21 by Super** **Modified: 26/02/2010 09:47:57** **Quotations: 1** **"References to multiculturalism and Canadian national identity"**
Code: Muslim Tradition **Created: 16/12/2009 22:59:59 by Super** **Modified: 25/02/2010 13:06:18** **Quotations: 1** **"Reference to specific practice related to Muslim religion"**

Code List with Definitions
Code: Need More Time **Created: 16/12/2009 20:18:39 by Super** **Modified: 25/02/2010 13:07:23** **Quotations: 2** **"Nurses desire or recognize the need for more time to spend with patients due to language barrier or ethnocultural differences"**
Code: Nice, Pleasant, Kind **Created: 25/02/2010 20:35:23 by Super** **Modified: 25/02/2010 20:36:53** **Quotations: 1** **"Characterization of African immigrant women as nice, pleasant and kind"**
Code: Nurse Conflict with Task Orientation **Created: 24/02/2010 18:55:49 by Super** **Modified: 25/02/2010 14:20:47** **Quotations: 2** **"Nurse expressing tension in fulfilling tasks as a constraint to achieving more depth and quality of care"**
Code: Nurse Initiated versus Patient Initiated Care **Created: 16/12/2009 14:50:45 by Super** **Modified: 25/02/2010 14:21:47** **Quotations: 0** **"Nurses are initiating decision making around aspects of care with no or minimal collaboration with African immigrant women"**
Code: Nurse Initiated versus Patient Initiated Care **Created: 16/12/2009 20:12:26 by Super** **Modified: 25/02/2010 14:22:08** **Quotations: 2** **"Nurses are initiating decision making around aspects of care with no or minimal collaboration with African immigrant women"**
Code: Nurse Perception- positive **Created: 23/02/2010 12:42:07 by Super** **Modified: 23/02/2010 21:28:07** **Quotations: 1** **"Positive perception of African immigrant women"**

Code List with Definitions
Code: Nursing Education- Lack of Ethnocultural Knowledge **Created: 24/02/2010 16:32:19 by Super** **Modified: 24/02/2010 16:33:13** **Quotations: 1** **"Nurse observation of lack of ethnocultural knowledge amongst nurses"**
Code: Nursing Education - Decreasing Ethnocultural Tensions **Created: 24/02/2010 18:46:47 by Super** **Modified: 24/02/2010 18:49:12** **Quotations: 2** **"Nurse feels that through more ethnocultural education, nurses will gain a better understanding of another's culture providing them will explanations for ethnospecific expressions thereby reducing tensions and frustrations"**
Code: Nursing Perception of Immigrant Challenges **Created: 17/12/2009 08:31:49 by Super** **Modified: 24/02/2010 16:57:56** **Quotations: 2** **"Empathy and sensitivity of challenges faced by immigrant women upon coming to a new country"**
Code: Nursing Routine-Time Orientation **Created: 29/07/2009 00:35:43 by Super** **Modified: 25/02/2010 14:24:06** **Quotations: 3** **"References that convey the value of time oriented nursing routines"**
Code: Nursing Routine - Task Orientation **Created: 29/07/2009 00:37:18 by Super** **Modified: 25/02/2010 14:24:15** **Quotations: 4** **"References that convey the value of task oriented nursing routines"**
Code: Nursing Routine - Time & Task Orientation **Created: 29/07/2009 00:43:55 by Super** **Modified: 26/02/2010 16:34:46** **Quotations: 13** **"References that convey the value of time & task oriented nursing routines"**

Code List with Definitions
Code: Passive - Not Demanding **Created: 16/12/2009 21:01:43 by Super** **Modified: 25/02/2010 14:24:52** **Quotations: 1** **"Characterization of African immigrant women as passive, not demanding"**
Code: Patient Appreciation of Care **Created: 16/12/2009 22:12:37 by Super** **Modified: 25/02/2010 14:25:24** **Quotations: 2** **"Characterization of African immigrant women as being appreciative of care"**
Code: Patient Teaching - Husband Present **Created: 29/07/2009 00:47:35 by Super** **Modified: 25/02/2010 14:26:03** **Quotations: 1** **"Preference to conduct patient teaching in the presence of the husband who can communicate in English"**
Code: Polite-Considerate-Acceptance of Care **Created: 16/12/2009 21:56:08 by Super** **Modified: 25/02/2010 14:26:57** **Quotations: 0** **"Characterization of African immigrant women as being polite, considerate and acceptance of care as it is delivered by nursing staff"**
Code: Positive Affirmation and Validation of Understanding **Created: 24/02/2010 19:04:42 by Super** **Modified: 25/02/2010 14:34:50** **Quotations: 2** **"Gestures made by the patient and/or family to indicate satisfaction with interaction- indication of positive outcome"**
Code: Postpartum Mobility - Nurse Beliefs **Created: 29/07/2009 01:00:05 by Super** **Modified: 25/02/2010 14:30:34** **Quotations: 3** **"Nurse beliefs and values of postpartum mobility"**

Code List with Definitions
Code: Postpartum Mobility - Patient Beliefs **Created: 29/07/2009 00:58:15 by Super** **Modified: 25/02/2010 14:31:09** **Quotations: 1** **"Patient beliefs and the value of postpartum mobility"**
Code: Postpartum Teaching **Created: 26/02/2010 10:00:37 by Super** **Modified: 26/02/2010 10:00:52** **Quotations: 1** **"Description of postpartum teaching elements"**
Code: Providing Rationale **Created: 15/03/2010 10:55:44 by Super** **Modified: 19/03/2010 14:11:24** **Quotations: 10** **“Nurse providing rationale to African immigrant women about various health practices/teachings”**
Code: Quiet - Nondisclosure **Created: 23/02/2010 12:14:10 by Super** **Modified: 23/02/2010 21:48:16** **Quotations: 1** **"Nurse perception of immigrant women's characteristic of quietness and non-disclosure of causal reason for HIV status perhaps related to a traumatic incident."**
Code: Quiet - Not Demanding **Created: 16/12/2009 20:11:53 by Super** **Modified: 23/02/2010 21:50:46** **Quotations: 5** **"Nurse perception of immigrant women as being quiet"**
Code: Recent Immigrants **Created: 23/02/2010 12:42:50 by Super** **Modified: 23/02/2010 21:27:49** **Quotations: 1** **"Nurse perception that most African immigrant women are recent arrivals to Canada"**

Code List with Definitions
Code: Reciprocal Satisfaction-Patient **Created: 28/07/2009 23:46:52 by Super** **Modified: 25/02/2010 14:34:52** **Quotations: 1** **"The expression of patient satisfaction as returned to the nurse"**
Code: Recognizing Value of Immigrant Contributions **Created: 26/02/2010 15:21:05 by Super** **Modified: 26/02/2010 15:22:32** **Quotations: 1** **"Recognition of varied viewpoints from immigrant populations as a valuable contribution to our workforce"**
Code: Relationship Gap **Created: 24/02/2010 16:29:24 by Super** **Modified: 24/02/2010 16:30:08** **Quotations: 1** **"Nurse senses a relationship gap in her encounters with African immigrant women"**
Code: Reluctance for Peri-care **Created: 23/02/2010 12:41:29 by Super** **Modified: 23/02/2010 21:28:40** **Quotations: 1** **"Reluctance to let nurse assist with peri-care post delivery"**
Code: Resettlement Challenge **Created: 23/02/2010 12:18:04 by Super** **Modified: 26/02/2010 16:07:59** **Quotations: 4** **"Language barrier as a resettlement challenge for the immigrant women"**
Code: Resettlement Challenge - Refugee Status **Created: 26/02/2010 09:40:17 by Super** **Modified: 26/02/2010 09:41:22** **Quotations: 1** **"Refugee status as being a challenge to resettling within Canada"**

Code List with Definitions
Code: Resettlement Challenge - Transportation **Created: 24/02/2010 15:48:32 by Super** **Modified: 26/02/2010 15:44:45** **Quotations: 2** **"Transportation as a resettlement challenge"**
Code: Resettlement Challenge - Under Recognition of Educational Status **Created: 26/02/2010 15:19:16 by Super** **Modified: 26/02/2010 15:20:13** **Quotations: 1** **"The under recognition of educational status of many immigrants leads to challenges in resettlement as job or career advancement prospects are minimal to non-existent."**
Code: Resource-Multicultural Broker **Created: 24/02/2010 16:53:52 by Super** **Modified: 26/02/2010 10:08:35** **Quotations: 6** **"Acknowledgement of multicultural broker as a resource for nurses to facilitate care for immigrant women"**
Code: Resource-Seminars by Multicultural Brokers **Created: 24/02/2010 17:09:49 by Super** **Modified: 26/02/2010 16:40:23** **Quotations: 3** **"Acknowledgement of multicultural brokers as an educational resource"**
Code: Resources- Female physicians **Created: 24/02/2010 16:21:37 by Super** **Modified: 25/02/2010 14:36:34** **Quotations: 1** **"Female physicians as a positive ethnocultural facility resource for immigrant women"**
Code: Resources- Historical Development of Multicultural Resources **Created: 24/02/2010 15:42:55 by Super** **Modified: 24/02/2010 15:43:43** **Quotations: 1** **"Nurse talking about the change in facility to include more multicultural resources"**

Code List with Definitions
Code: Resources- Learning From the Experience of Others **Created: 24/02/2010 15:40:24 by Super** **Modified: 26/02/2010 09:56:19** **Quotations: 2** **"Taking opportunities to learn from the ethnocultural interaction experiences of others to help sensitize oneself in their own practice"**
Code: Resources- Minimal use of midwifery **Created: 24/02/2010 16:23:03 by Super** **Modified: 25/02/2010 14:38:05** **Quotations: 1** **"A facility deficit as there is minimal use of midwifery in the hospital setting"**
Code: Resources - Diverse Hospital Staff **Created: 23/02/2010 12:26:16 by Super** **Modified: 26/02/2010 11:44:08** **Quotations: 6** **"Acknowledgement of using ethnoculturally diverse staff members as resources for care"**
Code: Resources - Language Specific Health Literature **Created: 23/02/2010 12:24:34 by Super** **Modified: 26/02/2010 10:14:40** **Quotations: 5** **"Using language specific health literature to help explain certain procedures"**
Code: Resources - Transcultural Books **Created: 23/02/2010 12:25:11 by Super** **Modified: 24/02/2010 15:35:01** **Quotations: 2** **"Acknowledgement of transcultural books as a facility resource"**
Code: Respectful and Accepting **Created: 23/02/2010 12:38:18 by Super** **Modified: 23/02/2010 21:29:31** **Quotations: 1** **"Nurse perception of African immigrant women as respectful and accepting"**

Code List with Definitions
Code: Satisfaction in Caring **Created: 28/07/2009 23:45:16 by Super** **Modified: 25/02/2010 14:39:17** **Quotations: 1** **"Nurse satisfaction in meeting care needs of ethnoculturally diverse patients"**
Code: Service Improvement- Interpretive Services **Created: 24/02/2010 19:42:03 by Super** **Modified: 26/02/2010 11:52:03** **Quotations: 3** **"Suggestions for improvement in the service delivery of interpretive services"**
Code: Service Improvement - Educational or Awareness Raising Opportunities **Created: 26/02/2010 15:28:04 by Super** **Modified: 26/02/2010 16:44:19** **Quotations: 2** **"Desire for more educational opportunities that raise awareness on ethnocultural issues in relation to clinical practice"**
Code: Service Improvement - Health Literature **Created: 26/02/2010 11:50:07 by Super** **Modified: 26/02/2010 11:50:54** **Quotations: 1** **"Desire for more health literature specific to languages of African immigrant communities"**
Code: Shy **Created: 23/02/2010 12:36:16 by Super** **Modified: 23/02/2010 21:34:21** **Quotations: 1** **"Nurse perception that the woman is shy"**
Code: Sign Language Preference **Created: 29/07/2009 01:27:40 by Super** **Modified: 25/02/2010 14:40:35** **Quotations: 2** **"Nurse preference to use sign language to communicate basic information to African immigrant women"**

Code List with Definitions
Code: Sign Language Versus Translation **Created: 29/07/2009 01:11:06 by Super** **Modified: 24/02/2010 17:02:19** **Quotations: 2** **"An approach to communication when language barrier exists is to use sign language visualization, and picture drawing."**
Code: Single Mom **Created: 29/07/2009 01:20:59 by Super** **Modified: 25/02/2010 14:41:05** **Quotations: 1** **"Reference to profile of an African immigrant woman being a single mom"**
Code: Stoic **Created: 16/12/2009 22:16:57 by Super** **Modified: 23/02/2010 21:27:15** **Quotations: 4** **"Nurse perceived patient characteristic of stoicism"**
Code: Suggestion - Antenatal Care **Created: 05/08/2009 22:28:53 by Super** **Modified: 25/02/2010 14:41:36** **Quotations: 1** **"Service improvement suggestion for more antenatal care for African immigrant women"**
Code: Supportive Network - Family Members **Created: 16/12/2009 21:50:56 by Super** **Modified: 25/02/2010 15:48:33** **Quotations: 5** **"Family members as being a supportive network for African immigrant women"**
Code: Supportive Network - Friends **Created: 29/07/2009 01:20:05 by Super** **Modified: 25/02/2010 14:42:54** **Quotations: 5** **"The use of friends as the primary supportive network for African immigrant women"**

Code List with Definitions
Code: Supportive Network - Husband **Created: 29/07/2009 00:45:17 by Super** **Modified: 25/02/2010 14:42:50** **Quotations: 3** **"The use of husband as the primary supportive network for African immigrant women"**
Code: Supportive Network - Minimal **Created: 26/02/2010 09:20:28 by Super** **Modified: 26/02/2010 09:26:38** **Quotations: 1**
Code: Supportive Network - None **Created: 29/07/2009 01:21:26 by Super** **Modified: 26/02/2010 09:19:10** **Quotations: 6** **"No supportive network for African immigrant women"**
Code: Supportive Network - Variations **Created: 24/02/2010 19:49:29 by Super** **Modified: 26/02/2010 14:14:57** **Quotations: 2** **"Nurse observations of various types of supportive networks for African immigrant women"**
Code: Systemic Regulations **Created: 28/07/2009 23:33:50 by Super** **Modified: 25/02/2010 14:44:30** **Quotations: 1** **"Facility regulation of not eating post C-section"**
Code: Transcultural Nursing Education - Formal **Created: 16/12/2009 20:42:33 by Super** **Modified: 25/02/2010 14:45:12** **Quotations: 3** **"Description or reference to formal ethnocultural nursing education"**

Code List with Definitions
Code: Transcultural Nursing Education - Informal **Created: 16/12/2009 20:43:06 by Super** **Modified: 25/02/2010 16:05:59** **Quotations: 7** **"Reference to informal ethnocultural nursing education"**
Code: Transcultural Nursing Education - Maternity Specific Resources **Created: 16/12/2009 21:20:18 by Super** **Modified: 25/02/2010 14:45:52** **Quotations: 3** **"Reference to maternity specific transcultural nursing education"**
Code: Transformative Experience **Created: 14/03/2010 20:43:23 by Super** **Modified: 15/03/2010 14:11:45** **Quotations: 6** **"A type of experience that lends itself to changing the nurses outlook and sensitivity towards ethnoculturally diverse patients"**
Code: Translator Preference **Created: 29/07/2009 01:27:15 by Super** **Modified: 25/02/2010 14:51:41** **Quotations: 2** **"How nurses reason through when to call for professional interpretive services"**
Code: Understanding Sign Language-Patient **Created: 29/07/2009 01:15:17 by Super** **Modified: 25/02/2010 14:52:08** **Quotations: 1** **"Reference to patient understanding the nurse's use of sign language"**
Code: Use of Sign Language **Created: 28/07/2009 23:38:23 by Super** **Modified: 26/02/2010 09:15:15** **Quotations: 9** **"References to nurses using sign language to communicate when there is a language difference between nurse and patient"**

Code List with Definitions
Code: Use of Sign Language-Props **Created: 29/07/2009 01:07:32 by Super** **Modified: 25/02/2010 14:55:00** **Quotations: 3** **"References to nurses using sign language props to communicate when there is a language difference between nurse and patient"**
Code: Use of Sign Language-Touch **Created: 29/07/2009 01:08:06 by Super** **Modified: 25/02/2010 14:55:15** **Quotations: 2** **"References to nurses using sign language touch to communicate when there is a language difference between nurse and patient"**
Code: Use of Sign Language - Facial Expression **Created: 29/07/2009 01:04:26 by Super** **Modified: 25/02/2010 21:08:27** **Quotations: 6** **"References to nurses using sign language facial expressions to communicate when there is a language difference between nurse and patient"**
Code: Use of Sign Language - Sound **Created: 29/07/2009 01:09:33 by Super** **Modified: 25/02/2010 21:07:47** **Quotations: 4** **"References to nurses using sign language sound to communicate when there is a language difference between nurse and patient"**
Code: Use of Translator-Husband **Created: 28/07/2009 23:40:34 by Super** **Modified: 26/02/2010 10:15:30** **Quotations: 6** **"Use of husband as an interpreter to communicate with women"**
Code: Use of Translator - Friend **Created: 29/07/2009 00:03:27 by Super** **Modified: 26/02/2010 09:20:02** **Quotations: 5** **"Using a friend for interpretation needs"**

Code List with Definitions
Code: Use of Translator - Husband or Other **Created: 29/07/2009 00:10:43 by Super** **Modified: 26/02/2010 15:00:51** **Quotations: 6** **"Use of husband or other informal community member for interpretive services"**
Code: Use of Translator - Length of Time **Created: 29/07/2009 00:22:30 by Super** **Modified: 25/02/2010 14:56:24** **Quotations: 2** **"Acknowledging the greater length of time needed to carry out patient communication when an interpreter is used"**
Code: Use of Translator – Professional **Created: 16/12/2009 23:56:04 by Super** **Modified: 25/02/2010 15:58:36** **Quotations: 5** **"Use of professional interpretive services"**

Appendix C

Ethics Document 1: Introductory information letter as it appeared using University letterhead stationary

Exploring Understandings and/or Knowledge of Maternity Nurses in Caring for Refugee Women of African Origin

To the Maternity Nurses of the Royal Alexandra Hospital,

Hello and thank you for your time and interest! My name is A. Shireen Bell. I am a Masters of Nursing student at the University of Alberta. I am interested in interviewing maternity nurses in regards to your knowledge and understanding of caring for refugee women of African origin.

The purpose of this study is to find out about the knowledge you have with respect to the specific ethnocultural groups that fall under the term refugee women of African origin. I am interested in finding out what specific needs unique to these women you have found and how such knowledge and understandings influence your care practices.

Learning from your experiences and conversations will be helpful to guide and support nurses to incorporate a culturally sensitive approach to care and health focus into their everyday practice and ultimately a culturally safe environment in the context of the Alberta/Canadian community.

The end goal or purpose of gaining such insights would be to provide maternity nurses with a richer understanding of refugee women of African origin in order to ensure that through the application of effective, culturally congruent care healthy maternal outcomes are achieved.

Interviewing will take place in January and February of 2009. Nurses will be interviewed individually and each interview will take approximately 60 – 90 minutes. Information will be kept confidential and secure and your names and the hospital name will be kept out of any published information. I will ensure a private area at the Royal Alexandra Hospital is available for the interview. If you prefer an alternate location to the hospital site, I will make the necessary arrangements to provide you with another private location. I have three days a week that are very flexible to coordinate meeting times that are most convenient for you.

I look forward to your responses and to working with you in the near future. If you are interested, please fill out the information reply sheet and I will contact you and make arrangements to participate in this research study. If you have further questions or concerns, please do not hesitate to call or contact me using the contact information shown below. Thank you for your time and consideration.

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Appendix D

Ethics Document 2: Contact information indicating participation interest or non-interest as it appears using University letterhead stationary (Reason for non-participation was not used for documentation, only to assess for alternative recruitment strategies)

Study Title: Exploring Understandings and/or Knowledge of Maternity Nurses in Caring for Refugee Women of African Origin

My name is _____

☐ I would like to participate in your research study.

Please contact me by:

Phone: _____

Email:_____

Other: _____

☐ I am not interested in participating in your research study.
Please state briefly reasons why.

Appendix E

Ethics Document 3: Recruitment poster as it appeared using University letterhead stationary and posted in staff lounge and hospital newsletters

What is the name of this study?

EXPLORING UNDERSTANDINGS AND/OR KNOWLEDGE OF MATERNITY NURSES IN CARING FOR REFUGEE WOMEN OF AFRICAN ORIGIN

Who are the people the researchers would like to participate in this study?

Who is conducting the study?

Investigators:

Dr. Gina Higginbottom PhD,MA, Postgradip, B/A (Hons), RN, RM, RHV and

A. Shireen Bell RN, BScN, Masters of Nursing Student,

From

University of Alberta

***Maternity Nurses interested in participating can fill out the application form along with contact information and place in the drop**

Thank you for your time and interest!

We look forward to hearing from you!

Appendix F

Ethics Document 4: Information portion of consent form read with interested participant prospects using University letterhead stationary

Exploring Understandings and/or Knowledge of Maternity Nurses in Caring for Refugee Women of African Origin

Annalita Shireen Bell, Masters of Nursing Student, University of Alberta

Background: Alberta is one of the four top provinces which receive immigrants/refugees from African countries. Royal Alexandra Hospital is located in an area which services many of these newcomers including providing maternity services. Studies have shown there are a variety of challenges for maternity nurses in caring for refugee women of African origin yet very little Canadian research exists on immigrant/refugee women and health care providers' experiences. Multi-level government initiatives speak of the need to include integration of health services to help with resettlement of newcomers.

Purpose: You are being asked to participate in a research study which involves being interviewed regarding your knowledge and understanding of refugee women of African origin and their maternity needs. The objectives of this research include describing your experiences in caring for refugee women of African origin, understanding the depth and breadth of your cultural knowledge, identifying barriers and challenges you face in providing care, as well as identifying barriers and challenges you feel refugee women face in seeking care. Understanding how you care for these women will help us work towards adapting nursing practice for such cultural encounters across the Albertan/Canadian context.

Procedures: *Participating in this study will involve:*

a) One 60 – 90 minute interview

b) The interview will be done in a conversation style with some specific questions about your knowledge and understanding of your care practices for refugee women from Africa. The interview will be recorded, with your consent, using a digital audio recording device (voice only, no video). You will have a choice to meet in a private location within Royal Alexandra Hospital or a different private off-site location to ensure your privacy and confidentiality.

Possible Benefits: The possible benefits to you for participating in this study are that you may include:

- Sharing your knowledge with the greater community of nurses to help expand our need to grow in cultural knowledge

- Creating an awareness of how you practice may help with identifying strengths (ways that work) and challenges (ways that do not work) that may help improve overall care practices

Possible Risks: No physical, mental, emotional or spiritual risks are anticipated with this study. If any of the above events occur during the course of the interview, suggestions for help will be provided.

Confidentiality: Personal records relating to this study will be kept confidential. Any research data collected about you during this study will not identify you by name, only by your initials and a coded number. Your name will not be disclosed outside the research team. Any report published as a result of this study will not identify you by name.

The only personal information collected in this study that is required is your name and contact information. Under the Alberta Health Information Act, asking for name and contact information from research participants does require your formal approval. Although we have access to your information you provide, you will be given a pseudonym or alternate name in the research report.

Voluntary Participation: *You are free to withdraw from the research study at any time If any knowledge gained from this or any other study becomes available which could influence your decision to continue in the study, you will be promptly informed.*

Reimbursement of Expenses: Staff interviews will be conducted at the hospital where staff parking is available. If you prefer to meet away from the facility site, parking expenses will be reimbursed to a maximum of $10.00 per participant. Due to the flexibility in scheduling interviews, expense reimbursements for child care or meals are not necessary for this research study.

Contact Names and Telephone Numbers:

If you have concerns about your rights as a study participant, you may contact the Health Ethics Research Board (HREB) at 403-492-0302. This office has no affiliation with the study investigators.

Please contact any of the individuals identified below if you have any questions or concerns:

A. Shireen Bell, Master of Nursing Student *403-302-4477 (24 hrs)* Telephone Number

Dr. Gina Higginbottom, Thesis Supervisor *780-492-6761* Telephone Number

*Investigators must provide a phone number which can access an investigator or co-investigator 24 hours per day.

Appendix G

Ethics Document 5: Signatory portion of consent form using University letterhead stationary

Title of Project: ***Exploring Understandings and/or Knowledge of Maternity Nurses in Caring for Refugee Women of African Origin***

A. Shireen Bell, Master of Nursing Student Phone Number(s):

Part 2 (to be completed by the research subject):

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without affecting your future medical care?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your records, including personally identifiable health information?	☐	☐
Do you want the investigator(s) to inform your family doctor that you are participating in this research study? If so, give his/her name _____	☐	☐

Who explained this study to you? _____

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Subject _____

(Printed Name) _____

Date:_____

Signature of Witness _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee _____ Date _____

Appendix H

Ethics Document 6: Participant demographic form as it appears using University letterhead stationary

Demographic Information Sheet

Please print the information as requested below. This document will be kept secure and confidential. No names will be mentioned in written reports, presentations, or discussions both published and unpublished.

Name	
Position Title	
Number of years of nursing experience	
City and Country of nursing education	
Country of origin	
Ethnicity	
Languages spoken	

Appendix I

Ethics Document 7: Interview topic guide used for semi-structure interviews

Interview Topic Guide: **Exploring Understandings and/or Knowledge of Maternity Nurses in Caring for Refugee Women of African Origin**

Semi-structured interview questions are used in this focused ethnography to illicit responses from participant surrounding the main research question. The majority of questions will be open ended but framed with specific direction. The interview is conversation style which makes it difficult to list specific questions, however, the following questions and the topic areas will provide the basis for the interview.

Gaining an experiential perspective from participants

- Looking for positive and negative experiences, and/or strengths and challenges unique to any ethnic group under this broader term African origin
- Can you tell me about your experience in caring for refugee women of African origin?

Exploring depth of cultural knowledge

- Looking for depth and breadth of cultural knowledge
- How much information regarding refugee women of African origin have they acquired? Ask for examples and from what resources from which knowledge was gained.
- Are nurses able to distinguish the different ethnocultural groups stemming from Africa they have encountered?
- What information have you acquired in regards to refugee women of African origin?

Comparative question technique to explore care practices

- Looking for similarities and difference in care practice approaches
- Seeking information on how nurses tailor care practices according to the unique needs of their maternity patients and to see if ethnocultural contexts play into decision making
- How is your practice with refugee women of African origin any different than with other maternity clients?

Perception of health care barriers/challenges for refugee women

- Exploring the nurses' awareness of difficulties refugee women have in seeking and receiving maternity care
- Looking for identification/orientation of perceived barriers such as systemic (facility policy &/or procedure), staff (ethnocultural or experiential knowledge base), or patient/family (language, communication, customs, beliefs) or other
- In your opinion, what barriers, if any, do refugee women of African origin experience in seeking maternity care?

Exploring potential service improvement areas

- Providing opportunity to provide solutions, offer contributions, to highlight areas of service improvement
- Looking for either facility, staff, or patient oriented views or other
- In what ways can maternity services be improved for refugee women of African origin?

Appendix J

Ethical Approval Document 1: University of Alberta Health Research Ethics Board (HREB) Panel B approval letter to conduct research study

Health Research Ethics Board

413 Heritage Medical Research Centre
University of Alberta, Edmonton, Alberta T6G 2S2
p.780.492.0532 HREB Panel B
p.780.492.0532 HREB Panel C
p.780.492.0429
p.780.492.0429
f.780.492.7800

HEALTH RESEARCH ETHICS APPROVAL FORM

Date: November 2008

Name of Principal Investigator(s): Gina Higginbottom

Organization: U of A

Department: Nursing

Project Title: Exploring Understandings and/or Knowledge of Maternity Nurses in Caring for Refugee Women of African Origins

The Health Research Ethics Board has reviewed the protocol involved in this project and has been found to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the subject information letter and consent form.

The approval for the study as presented is valid for one year. It may be extended following completion of the yearly report form. Any proposed changes to the study must be submitted to the Health Research Ethics Board for approval. Written notification must be sent to the HREB when the project is complete or terminated.

Special Comments:

Dr. Glenn Griener, PhD.
Chair of the Health Research Ethics Board
(B: Health Research)

NOV 2 6 2008
Date of Approval Release

File Number #B101108

UNIVERSITY OF ALBERTA

Capital Health

CARITAS HEALTH GROUP

Appendix K

Ethics Approval Document 2: Facility specific administrative approval to recruit maternity nurses at first hospital site

Alberta Health Services

Regional Research Administration
Northern Alberta Clinical Trials and Research Centre
1800 College Plaza
8215 - 112 Street NW
Edmonton, AB T6G 2C8

ADMINISTRATIVE APPROVAL FOR PROPOSED RESEARCH

Operational Approvals:
RAH - Site Approval
RAH - Women's Health

Protocol Number:
Protocol Acronym:
Protocol Title:
Exploring Understandings and/or Knowledge of Maternity Nurses in Caring for Refugee Women of African Origin

Principal Investigator: Dr. Cina Higginbottom
Faculty: Nursing
Department:
Division:

Research Locations:
Royal Alexandra Hospital

Funding Source: Prairie Metropolis Centre
CRO:
Funding Type: Grant
O/H Rate - GST: 0% - 0%
Oracle Account:
Legacy Account:

Comments:

Regional Research Admin File:	6550
Ethics File# and/or HERO File#:	B-101108
Ethics Approval Date:	Nov 26, 2008
Contract Finalized Date:	
Project Approval Date:	Jan 29, 2009
Approval Printed:	Jan 29, 2009

Carlos Miranda
Regional Research Administration
Copy to Finance and Administration

Appendix L

Ethics Approval Document 3: Facility specific administrative approval to recruit maternity nurses at second hospital site

Research & Evaluation, Knowledge Management
Wetaskiwin Hospital & Care Centre
6910 – 47 Street
Wetaskiwin, AB T9A 3N2

Phone: 780-361-4390
Fax: 780-361-4107

June 15, 2009

Dr. Gina Higginbottom
Faculty of Nursing
University of Alberta
Room 6-30B, University Terrace
8303 – 112 St.
EDMONTON AB T6G 2T4
E-mail: gmg.higginbottom@ualberta.ca

Dear Dr. Higginbottom:

RE: **Exploring Understandings and/or Knowledge of Maternity Nurses in Caring for Refugee Women of African Origin (Research ID#260)**

Thank you for submitting an application regarding the above project for review by the Alberta Health Services – David Thompson area (AHS-DT area) Research Committee. This will confirm that we have granted institutional approval for this project, and that AHS-DT area has granted approval under Sections 53 and 54 of the *Health Information Act* and AHS-DT area policies IT-VII-10 and IT-VII-11.

Enclosed, please find a one-page Letter of Understanding which outlines the conditions for the conduct of the research. We ask that you sign this agreement and return to us within two weeks of receipt. We will send you a copy of the signed agreement for your records.

Once our office receives the signed agreement back, we will let Unit 25 know that all requirements have been met. Please work with Sandi Sebastian in Unit 25 to coordinate your request. Sandi can be contacted at (403) 343-4825 or email lsebastian@dthr.ab.ca

Please accept my and the committee's best wishes for success with your project.

Sincerely,

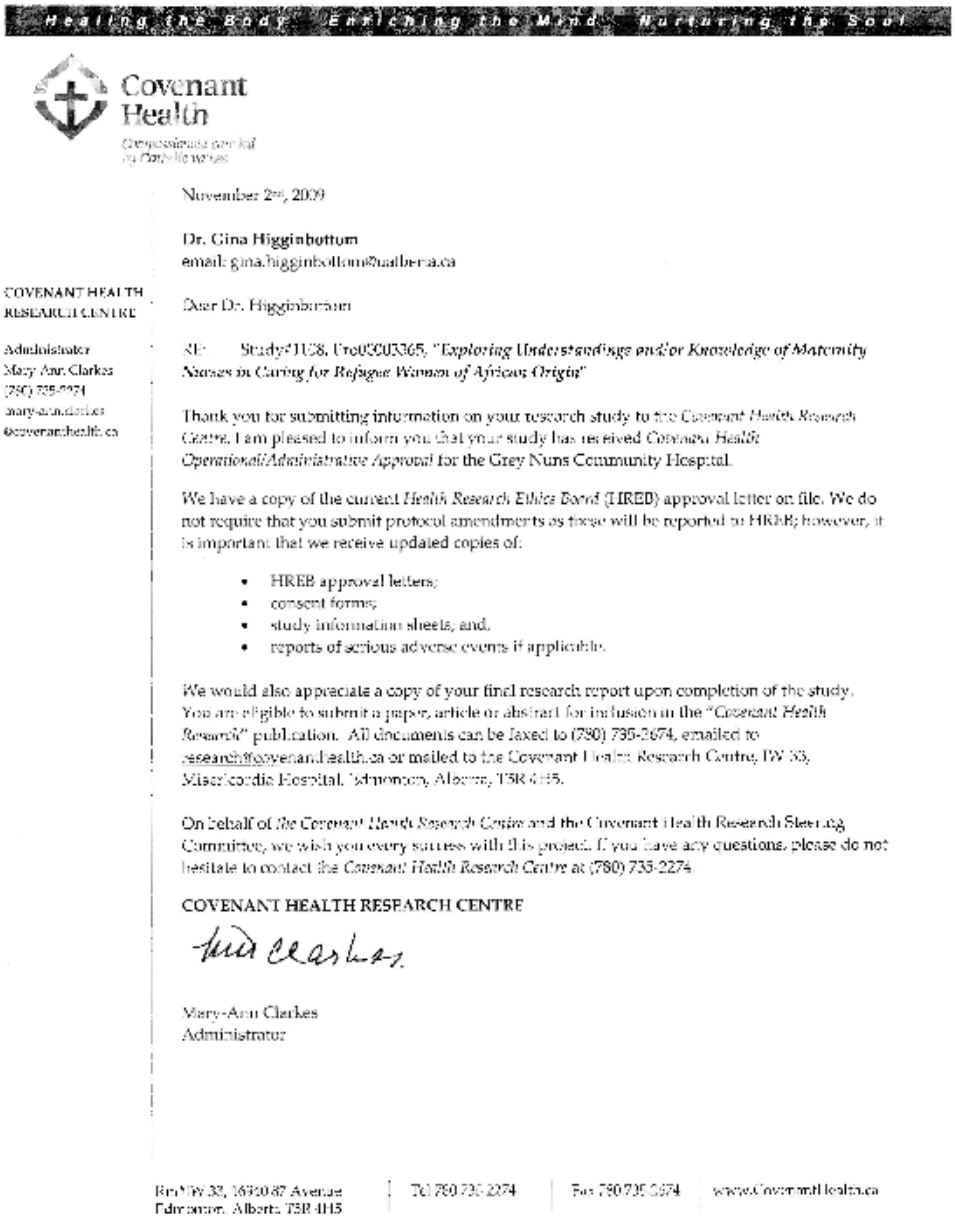
Lorraine Thiessen
Research Committee Chair

Enclosure: Letter of Understanding

cc: MAC
Research File
Annahla Shireen Bell, Study Coordinator, abell@ualberta.ca
Sophia Christofordakis, Research & Evaluation Officer
Sandi Sebastian, Acute Care Manager, Unit 25

Appendix M

Ethics Approval Document 4: Facility specific administrative approval to recruit maternity nurses at third hospital site



Healing the Body · Enriching the Mind · Nurturing the Soul

Covenant Health

Compassionate care led by Catholic values

November 2nd, 2009

Dr. Gina Higginbottom
email: gina.higginbottom@ualberta.ca

COVENANT HEALTH RESEARCH CENTRE

Administrator
Mary Ann Clarkes
(780) 735-2274
mary-ann.clarkes@covenanthealth.ca

Dear Dr. Higginbottom

RE: Study#1108, Pro00003365, *"Exploring Understandings and/or Knowledge of Maternity Nurses in Caring for Refugee Women of African Origin"*

Thank you for submitting information on your research study to the *Covenant Health Research Centre*. I am pleased to inform you that your study has received *Covenant Health Operational/Administrative Approval* for the Grey Nuns Community Hospital.

We have a copy of the current *Health Research Ethics Board* (HREB) approval letter on file. We do not require that you submit protocol amendments as these will be reported to HREB; however, it is important that we receive updated copies of:

- HREB approval letters;
- consent forms;
- study information sheets; and,
- reports of serious adverse events if applicable.

We would also appreciate a copy of your final research report upon completion of the study. You are eligible to submit a paper, article or abstract for inclusion in the *"Covenant Health Research"* publication. All documents can be faxed to (780) 735-2674, emailed to research@covenanthealth.ca or mailed to the Covenant Health Research Centre, FW 30, Misericordia Hospital, Edmonton, Alberta, T5R 4H5.

On behalf of *the Covenant Health Research Centre* and the Covenant Health Research Steering Committee, we wish you every success with this project. If you have any questions, please do not hesitate to contact the *Covenant Health Research Centre* at (780) 735-2274.

COVENANT HEALTH RESEARCH CENTRE

Mary-Ann Clarkes
Administrator

FW 30, 16940 87 Avenue
Edmonton, Alberta T5R 4H5 | Tel 780 735 2274 | Fax 780 735 2674 | www.CovenantHealth.ca

Appendix N

Table 6. Participant Demographic Information

Position Title	Number of years of nursing experience	City and Country of nursing education	Specialized nursing education	Transcultural nursing education	Country of origin	Ethnicity	Languages spoken
RN	26 years	SRN – London, England NUA Canada	SCM – Glasgow, Scotland RMN – London, England	-	Grenada, West Indes	Black	English
RN	4 years	Edmonton, AB Diploma 2003 BScN 2006	None – areas of nursing: medicine, surgery float, postpartum, community health visitation	None	The Netherlands	Dutch	Dutch, English
RN	30	Edmonton, Canada	None	Two in hospital education seminars; one on culture and death & dying and the other on FGM	Canada	Ukranian-Canadian	English, Ukranian
RN	3	Edmonton, Canada	Obstetrical Nursing	During my degree	Canada	Irish/Scottish	English
RN-Acute Care Manager	19	Calgary, Canada	Obstetrics	None	Canada	Caucasian Canadian	English
CNE	21	Diploma: Antigonish, Nova Scotia, Canada Post RN: Halifax, Nova Scotia	Obstetrical	None	Canada	British/Scottish	English
RN	37	Charlottetown, Prince Edward Island, Canada	More Obstetrical	None	Canada	Scottish	English
RN (BScN)	31	Edmonton, Canada	None	None	Canada	Canadian	English, some Swahili
CNE, Diploma	27	Edmonton, Alberta, Canada	None	None	Canada	Canadian	English
RN; U of A Nursing clinical	11	Alberta, Canada	Obstetrics	Informal through experience	Canada	Punjabi Canadian	English, Punjabi

tutor							
LPN	33	Prince George, British Columbia	Obstetrics, Breastfeeding Education	None but BA in Anthropology	USA	Norwegian	English
RN	>1 year	Red Deer, Alberta, Canada		Global Health Perspectives college course; Honduras Cultural Immersion Course; 4th year nursing preceptorship in Ghana	Canada	Canadian	English

Appendix O

Visual Display of Codes and Code Families with Relationship Maps

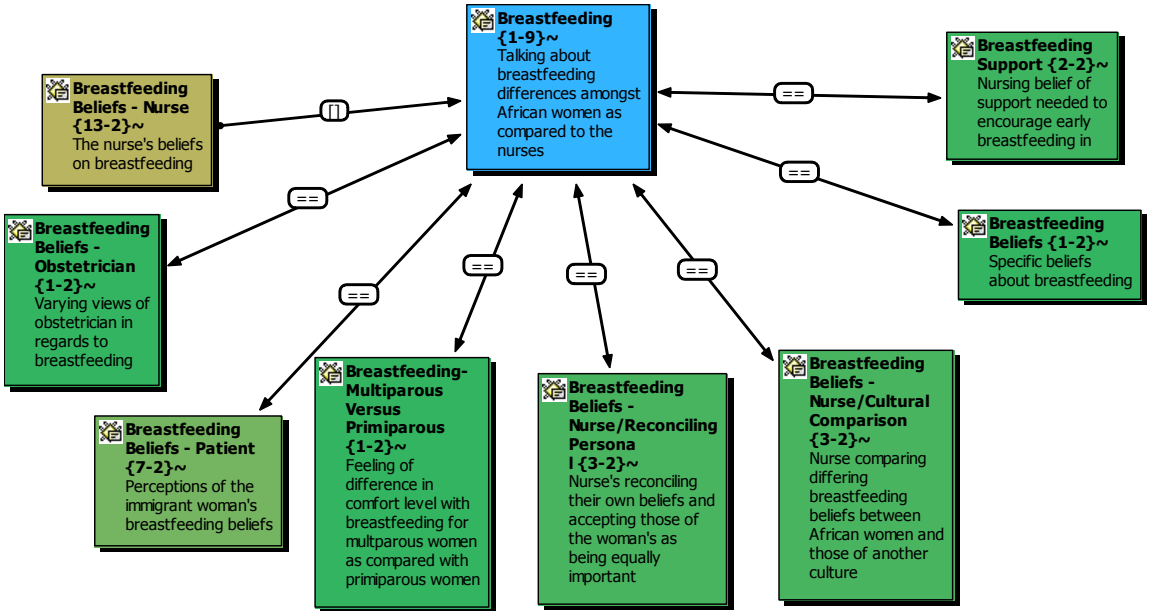


Figure 3. Atlas.ti6© Example – Breastfeeding

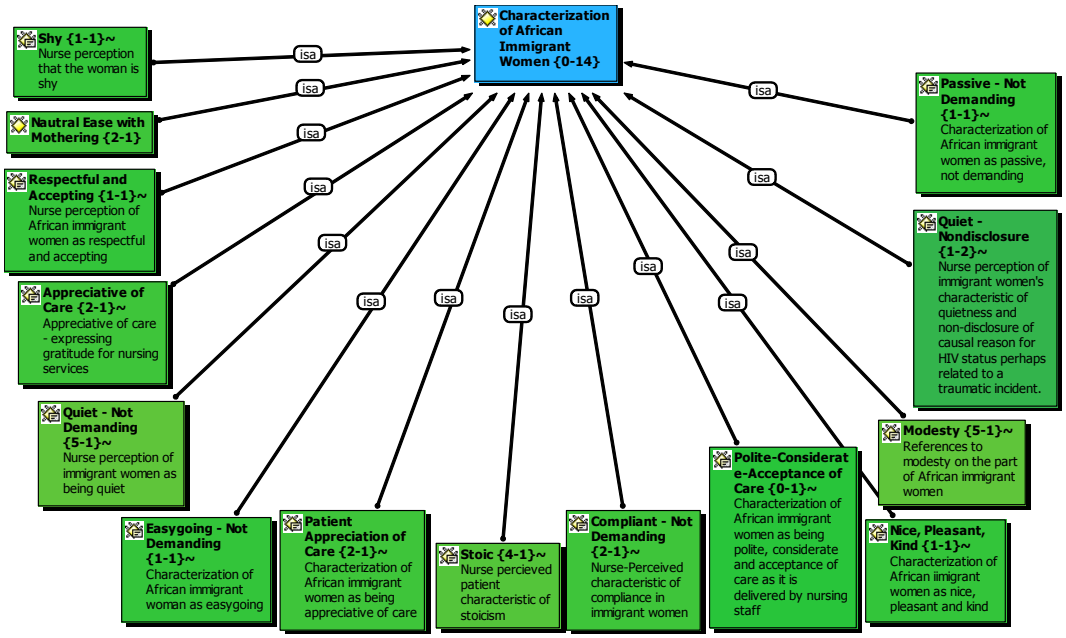


Figure 4. Atlas.ti6© Example - Patient Characterization

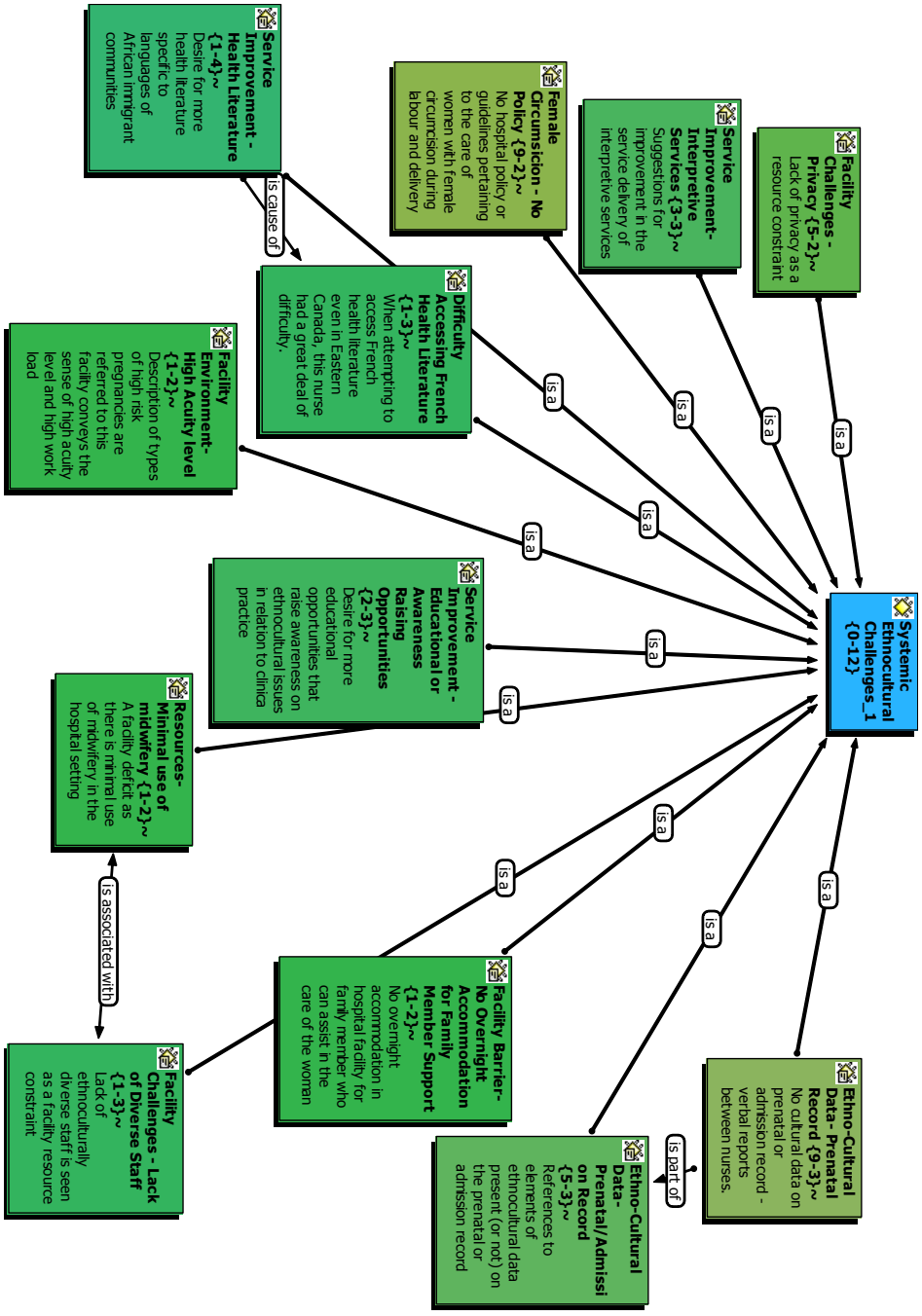


Figure 5. Atlas.ti6© Example - Systemic Ethnocultural Challenges

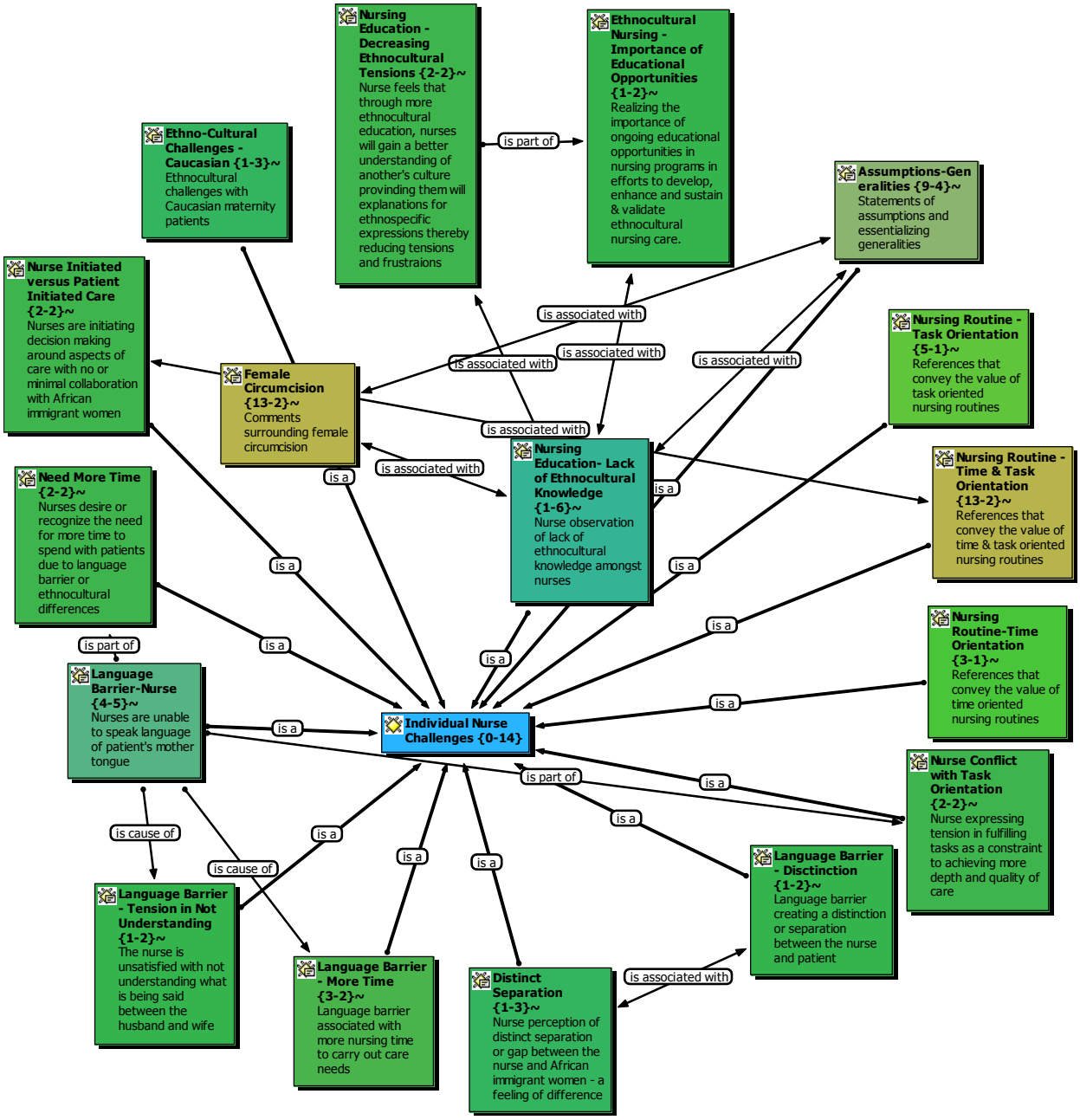


Figure 6. Atlas.ti6© Example - Nurse Challenges