Promoting Culturally Competent Perinatal Care Practices Among Nurses and other Health Care Providers who Work with South Asian Women

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Abstract

This project was conducted to explore the literature related to culturally competent care with the goal of developing an education program to help perinatal nurses and other health care providers reflect on their daily practice for providing culturally competent care to South Asian women and incorporate the important components of culturally competent care. Leininger’s Theory of Cultural Care Diversity and Universality provides a theoretical lens which can guide perinatal nurses and other health care providers in their work with women from diverse cultures. Based on the literature review on culturally competent care and my own knowledge and experiences working with this population, I have developed a one day culturally competent care workshop utilizing multiple teaching and learning strategies to deliver the workshop content. The ultimate goal is to help perinatal nurses and other health care providers become culturally competent when providing care for this population. This project will make a positive contribution to nursing by inviting perinatal health care nurses and other health care providers to reflect on their practices, identify their own values and beliefs, increase their cultural knowledge and skills, and generate positive attitudes when providing Culturally Competent Care for South Asian women.
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Introduction

To care for someone, I must know who I am
To care for someone, I must know who the other is
To care for someone, I must be able to
Bridge the gap between myself and the other (Anderson, 1987, p. 10)

Background Information

I have been working on the maternity unit at Abbotsford Regional Hospital and Cancer Centre (ARHCC) for more than 10 years holding different positions such as a Registered Nurse (R.N.), Patient Care Coordinator (P.C.C.), and Clinical Nurse Educator (C.N.E.). During my experience, I have witnessed South Asian women going through emergency situations without proper communication with their health care providers due to language barriers. The health care professionals also get frustrated as they do not have proper resources/tools and knowledge to address the cultural, religious, and traditional needs of their South Asian patients. My colleagues, physicians, social workers, and dieticians often ask me many “why” and “how” questions such as ‘why do South Asian women like to stay in bed?’, ‘why do they have many visitors?’, ‘why don’t they breast feed soon after delivery?’, ‘why don’t they go for prenatal classes?’, ‘why do they like to give baby something sweet after birth before initial breast or bottle feeding?’, ‘why don’t they eat meat?’, ‘why don’t we have this information in South Asian language?’, and ‘where and how can I learn about their cultural, religious, and traditional practices?’ , ‘what do I need to provide Culturally Competent Care (CCC) to South Asian women ?’, ‘where and how can I obtain the necessary knowledge?’ The perinatal care providers working in my hospital setting seem to lack the knowledge, skills, and the resources needed to provide culturally competent care.
Purpose of the project

The purpose of this project is to review literature on culturally competent perinatal care and identify strategies and approaches for educating perinatal nurses and other health care providers who work with South Asian women.

Objectives of the project

- To review literature on culturally competent perinatal care with the view to identifying teaching strategies and educational approaches
- To develop a one day educational workshop to help perinatal nurses and other health care providers learn about culturally competent care.
- To assist perinatal nurses and other health care providers reflect on their daily practices and how they might incorporate culturally competent care.

South Asian Population

According to Statistics Canada, 19.8% of the people living in Canada in 2006 were foreign-born (Statistics Canada, 2009). British Columbia (B.C) has the largest visible minority population which includes 11.9% South Asians (B.C Vital Statistics, 2000). In B.C ethnicity is not recorded on hospitals admission records as patients have the right to provide this personal information or not. To estimate the number of South Asian women having babies in my setting I reviewed patients’ names as I am familiar with South Asian names. The expected proportion of South Asian women giving birth at ARHCC and SMH (Surrey Memorial Hospital) was estimated from two randomly selected months of patient census of each year of 2008 and 2009. One percent of the names were Muslim and it was not clear whether or not these women were of South Asian descent, so these patients were not included in the estimates.
Based on this small sample of our hospitals’ health records, I was able to estimate that about one third (33%) of women who deliver on the maternity unit in Abbotsford are South Asian (Health Records, ARH, 2008, 2009). At SMH, about 42% of the women who deliver on the birthing unit are from this cultural/ethnic group (Health Records, SMH, 2008, 2009). Therefore, South Asian women account for a large proportion of maternity patients in both of these maternity care facilities. South Asian women and their families emigrate from South Asian countries that include Bangladesh, India, Pakistan, Nepal, and Sri Lanka (Gopalan, 1996). Punjabi women, who practice the Sikh religion, and have emigrated from Punjab, India form the largest group of South Asian women delivering in both of these hospitals located in the Fraser Valley (Health Records, ARH & SMH).

Despite the large number of South Asian women utilizing perinatal health care services in these hospitals, the Fraser Health Authority (FHA) does not offer any cross cultural education for perinatal health care providers. There is also a shortage of nurses or other maternity care providers who have a South Asian heritage and would be more familiar with the implications of cultural practices for the delivery of culturally relevant maternity care. In addition, there are no guidelines or policies related to Culturally Competent Care (CCC) available for perinatal health care nurses. Interpreter services and appropriate health education material are also not readily available. As a result, perinatal nurses and other health care providers face many challenges in providing Culturally Competent Care (CCC) to their South Asian patients. Let’s start with the meaning of culturally competent care or cultural competence.

Culturally Competent Care or Cultural Competency

Leininger (1999) describes Culturally Competent Care (CCC) as care that is sensitive and meaningful to the patients and fits well with their cultural beliefs and values. Culturally
Competent Care (CCC) consists of actions that identify, respect, and promote the cultural uniqueness of each individual (Kearns & Dyck, 1996). These important actions are enhanced by continuing education for nurses and other health care providers (Mixer, 2008).

Cultural competence is not just about understanding client cultural values, but also about understanding our own limitations; valuing diversity; and managing the potential dynamics of systemic bias, racism, prejudice, and exclusion within client-health provider relationships. Discussions of cultural dynamics need to include consideration of ways in which culture intersects with issues of power and equity. In other words, clinical cultural competence can be redefined as the ability to provide care with a client-centered orientation that both reflects the client’s cultural values and beliefs and recognizes the impact of marginalization in healthcare and responses. (Srivastava, 2007, p. 20)

Cultural competence is an educative process that involves developing self-awareness, learning to appreciate difference, valuing cultural practices other than one’s own, and acting flexibly in ways that accommodate these values (Lester, 1998). Meleis and Im (1999) describe Culturally Competent Care (CCC) as sensitivity to the differences individuals may have in their experiences and responses due to their socioeconomic conditions, ethnicity, sexual orientation, and cultural background. Similarly, “in the area of maternal-child nursing practice, possessing cultural competence means that the nurse is sensitive to the sociocultural context of women and children in the provision of holistic care” (Callister, 2005, p. 381). I believe Culturally Competent Care (CCC) is a continuing process of learning and understanding about myself and others around me. I need to have a desire and openness to initiate this important process. I am the one who starts this process. I am the one who needs to be aware of personal biases and values so that I can learn respectfully from and with other people.
According to Health Canada (2001) culturally competent care is the “provision of health care that responds effectively to the needs of patients and their families, recognizing the racial, cultural, linguistic, educational, and socio-economic backgrounds within the community” (p.229). Health care professionals often ask a few questions about cultural variables such as race, religion, beliefs and values when providing care to culturally diverse populations (Stephenson, 1999). Furthermore, the language of culturally competent, safe, sensitive, appropriate care is used frequently and interchangeably but the policies and procedures that guide health care professionals do not always support practices that incorporate this important discourse.

In B.C maternity units and perinatal health care providers follow guidelines developed by the British Columbia Perinatal Health Program (BCPHP, 2007) for assessing, planning and implementing care for women in the prenatal (during pregnancy), intranatal (during labour and delivery) and postnatal (after delivery of the baby) periods. But these BCPHP guidelines do not provide any clear directions about providing Culturally Competent Care (CCC). Additionally, many health care providers do not receive very much education about culturally competent care in their pre-registration or undergraduate education (Stephenson, 1999). There is no formal transcultural education available within Fraser Health Authority with the special focus on South Asian women’s experiences of perinatal health. Also, there are many ideologies that shape how perinatal health services are delivered.

Culturally competent care is a complex concept that includes attitudes such as cultural sensitivity or openness to learning, knowledge such as how to provide culturally competent care, and skills such as how to use an interpreter or how to assess the degree of acculturation. I think that knowledge about cultures and openness to learning about diverse cultures creates positive attitudes.
Important Components of Cultural Competence

In order to provide Culturally Competent Care (CCC) healthcare providers who have cultural knowledge and skills, access to appropriate resources, and culturally sensitive attitudes, are required (Srivastava, 2007, p. 75; Health Canada, 2001; CNA Position Statement, 2008). Health care providers also need to be culturally, linguistically, professionally and spiritually competent to provide culturally competent care (Shah, 2004). Further, there is a need to develop standards for the provision of Culturally Competent Care (CCC) as well as ongoing education and training for perinatal nurses, administrative staff, and other health care provider to address the needs of South Asian women. Educational programs such as cultural workshops, seminars, and conferences can provide health care providers with additional cultural knowledge and skills (Chin, 2000; Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Curtis, Dreachslin, & Sinioris, 2007; Campesino, 2008; Callister, 2005).

According to Campesino (2008), “new and innovative educational approaches are required to prepare a work force that responds to the diverse needs of people from a wide variety of cultural backgrounds, languages, and worldviews” (p. 298). Furthermore, there is a need to integrate community and hospital services, Western and Eastern approaches in patients’ care to ensure culturally competent care (Chin, 2000). Betancourt and colleagues (2003) suggest a framework that involves organizational, structural, and clinical cultural competence interventions to eliminate racial disparities in health and the health care system. For example, it is important to recruit and retain diversity and minority employees, as well as to reduce language barriers via interpreter services. There is also a need to develop national standards for the educational preparation of health care professionals to provide culturally and linguistically appropriate health services (Campinha-Bacote, 2006).
Moreover, health care organizations should promote and support the attitudes, behaviours, knowledge, and skills necessary for staff to work respectfully and effectively with patients, families, and communities, as well as each other, in a culturally diverse work environment (Shah, 2004). Additionally, an increased knowledge about other cultures closes the gaps that are developed by socially constructed differences that exist between health care providers and recipients on the basis of culture, race and ethnicity (Campesino, 2008).

Cultural Knowledge

Cultural knowledge is a process of seeking and obtaining a sound educational base about diverse cultures (Campinha-Bacote, 2003). Cultural knowledge can help caregivers avoid cultural imposition and ethnocentrism, or the belief that one’s own ways are superior (Callister, 2005). Further, cultural knowledge enhances health care providers’ self-awareness (Purnell, 2002). Nurses and other health care providers will be able to appreciate the diversity of our society with cultural knowledge and understanding of multicultural nursing (Spector, 2004). Willis (1999) states that it is impossible to know all languages and cultures but as transcultural nursing practitioners, we must continually expand our knowledge base to know more about diverse cultures (Leininger, 2002). Knowledge about other cultures’ values, beliefs, lifestyles, care needs, and health practices help nurses to make meaningful decisions with their patients (Leininger, 2007; Rorie, Paine, & Barger, 1996).

Baldonado, Beymer, Barnes, Starsiak, Nemivant & Anonas-Ternate (1998) conducted research using a convenience sample of 767 registered nurses and nursing students to examine their transcultural practices. These researchers used the Transcultural and International Nursing Knowledge Inventory (TINKI) questionnaire that included open and closed ended questions. Their study found that neither nurses nor students reported confidence in their ability to provide
care to culturally diverse populations. However, participants of their study felt that “their beliefs about transcultural nursing were influenced by being with people of other cultures, their own personal values, and education” (p. 15). I will be drawing upon Baldonado et al.’s study for some examples of what nurses had to say about culturally competent care throughout this project. One nurse wrote about the lack of cultural knowledge:

To me, the biggest problem is the compliance on the nurse’ part, to accept differences and allow differences within reason of well being of the patient. More than once on shift reports, nurses have criticized patients and families for differences rather than conveying understanding and accepting differences (Baldonado et al., p.20)

*Cultural Skills*

Cultural skills are the ability to gather important cultural data about the patient’s condition, perform assessment in a culturally sensitive manner, and make a mutually acceptable plan of care (Campinha-Bacote, 2003). Cultural assessment is a systematic examination of individuals, families, groups, and communities about their cultural values and beliefs and intervening accordingly (Leininger, 2001). Cultural skills can be enhanced by the integration of the intellectual qualities of discernment, practical knowledge, and cautiousness (Campinha-Bacote, 2002).

*Cultural Attitudes*

Nurses and other health care providers must be willing to develop the knowledge and understanding of multicultural nursing and to support women who choose to follow their personal traditional, religious, and cultural values and beliefs (Spector, 2004). Perinatal health care nurses can show their openness to learning about South Asian women by asking some
simple question about such things as dietary practices, family members’ roles, breastfeeding practices, and other cultural, traditional or religious beliefs.

_Cultural Encounter_

Cultural encounter is the opportunity that encourages health care providers to directly engage in face-to-face interactions with clients from diverse backgrounds (Campinha-Bacote, 2003). Negative encounters from health care providers such as personal biases and stereotyping can affect South Asian women’s decision to utilize perinatal health care services. Health care encounters involve bringing three worlds together: the culture of the women and her family, the culture of health care providers and the culture of the health care system (Spector, 2004). Cultural encounters also involve an assessment of patient’s the linguistic needs.

Formally trained interpreters may be necessary to facilitate communication during assessment and care planning, including the process of ensuring informed consent. Sometimes family members and friends who interpret are not familiar with medical terminology which can lead to inaccurate information and misunderstanding when developing the plan of care (Woollett, & Dosanjh-Matwala, 1990). Further, some South Asian women do not feel comfortable sharing sensitive information, such as about breastfeeding, vaginal bleeding, and reproductive issues through a family member and/or a male interpreter (Kim-Goodwin, 2003; Mahat, 1998). Therefore, it is important to make plans for communication and use appropriate interpreter services (Mattson, 2006).

_Cultural Awareness_

Cultural awareness is the self-examination and in-depth exploration of one’s own cultural and professional background (Campinha-Bacote, 2003; Papadopoulos & Lees, 2002). This process involves the recognition of personal assumptions and biases about diverse cultures. Lack
of awareness of these assumptions can cause health care professionals to impose their individual beliefs, values, and patterns of behaviour on a person from another culture (Leininger, 2002). Another nurse participant said: “Overall, I have to put aside my beliefs and opinions and realize that whatever facilitates care and well being of patients is what is needed to be utilized in patient care” (Baldonado et al., 1998, p.21).

Understanding one’s own cultural values and beliefs as well as the culture of others is essential if nursing care is to be appropriate and effective for the patients, families, and communities (Spector, 2002; Health Canada, 2001). Moreover, a health care provider will approach any given situation based on his/her own individual, professional, and cultural perspective. For example, a health care provider who has had cultural understanding of his/her patients can approach certain situations differently and in a more culturally appropriate way.

**Cultural Desire**

Cultural desire is defined as the nurse’s motivation to “want to” engage in the process of becoming culturally competent not the “have to” (Campinha-Bacote, 2003). Cultural desire includes a genuine passion and commitment to being flexible, open to others, building upon similarities and having a willingness to learn from others (Campinha-Bacote, 2002). Humility is a key factor in addressing one’s cultural desire. Caring and love, sacrifice, social justice, compassion, and ‘sacred encounters’ are the building block of cultural desire (Campinha-Bacote, 2008). “Cultural humility is a quality of seeing the greatness in others and coming into the realization of the dignity and worth of others” (Campinha-Bacote, 2008, p. 28). The desire to respect patients’ cultural values and beliefs results in positive health outcomes (Leininger, 2002). According to Campinha-Bacote, cultural desire can be ‘caught’ from co workers, educators who model cultural desire, and diverse guest speakers. I believe that it can also be taught in
continuing professional education settings by providing opportunities for participants to reflect on their practices and by sharing stories about cultural care from their experience, role playing, case studies and a variety of other approaches to learning.

Why Culturally Competent Care

Glenn (1999) believes effective Culturally Competent Care (CCC) depends upon establishing understanding that respects differences in values and beliefs, and thus differences in response to the multiplicity of patient’s/client’s needs. Health care professionals are ethically obligated to understand the relationships among health, illness, and well-being within social, historical, political, and religious contexts and provide care accordingly (Anderson, 2004). The Canadian Nurse Association’s (CNA) Code of Ethics for Registered Nurses (2008) also clearly states that “there are broad aspects of social justice that are associated with health and well being and that ethical nursing practice addresses. Nurses should endeavour, as much as possible, individually and collectively, to advocate for and work towards eliminating social inequities” (p.20).

Moreover, nurses are professionally and legally obligated to provide their clients with safe, competent and ethical care (CRNBC, Practice Standards, 2009). Culturally Competent Care (CCC) contributes to better health outcomes as well as increases satisfaction of clients, families, communities and health care providers (Mahat, 1998; Campinha-Bacote, 2002; Fisher, Bowman, & Thomas, 2003). Also, CCC may result in cost savings because of shorter hospital stays and more timely patient discharges (Office of Minority Health, 2001). Health care providers who lack the knowledge, skills and resources to competently address cultural differences may affect women’s and families’ experiences of optimal maternity care (Spector, 2002).
Ideologies that influence Culturally Competent Care

An ideology is a set of interrelated ideas, values, beliefs, and attitudes characteristic of a societal group or community (Brown, 2001). According to McDonald and McIntyre (2002), ideologies are the foundations that create our world, shape our thinking and limit/control our actions and choices. Cultural ideology is defined by Arnaults (2009) as the health related values and beliefs of cultural groups about what is good, bad, right, wrong, useful and/or harmful during certain ailments. These ideologies have direct or indirect impact on the health care system as well as on health care recipients and providers (Schott & Henley, 1996) in all areas of health care, including maternal child health.

Many ideologies such as personal choice, medical or expert domination, racial characteristics, communication, inequity, power, gender and hierarchy are prevalent in maternity care settings. Health care plans are dominated by medical and nursing staff. In other words, women are frequently told about the plan of care instead of asked to participate in their care plans. An inability to communicate between the patient and health care team members is cited as one of the major problems encountered by both parties (patients/families and health care providers) in the health care system (Anderson, 2004). The health care provider often assumes that the patient is accepting the care plan by nodding or not questioning the health provider. This assumption is a special concern for with South Asian women (Woollet & Dosanjh-Matwala, 1990).

The ideologies such as medical or expert domination, race, inequity, and communication also influence the Canadian health care system by silencing the voices of minority groups such as Aboriginals and South Asians women (Brown & Syme, 2002). Racine (2002) clearly states that racist remarks and cultural judgements have demoralizing effects on people’s health and
social integration. For example, discourses or assumptions heard frequently in perinatal care include: “South Asian women never come prepared for labour and delivery”, “East Indian women always have relatives to take care of them”, and “South Asians do not like moving in the post partum period.” These generalized and judgemental statements if heard by a South-Asian woman, who communicates well in English, can leave that woman with the wrong perception about health care professionals. She may feel that she is being stereotyped or judged and thus be less willing/able to engage in the conversations in the same way she could have before hearing the above statements. Anderson (1990) cautions health care professionals that these ideologies give rise to inequalities by diverting our attention away from social, economic and political structures and practices.

Barriers to the Provision of Culturally Competent Care

Public services are underutilized by the minority population due to language barriers and other barriers in access to health services (Racine, 2002). Further, due to the inability to understand each other, it is common for the patients, families and their health care providers to become frustrated (Mahat, 1998; Kim-Goodwin, 2003). As a result, limited assessment and treatment compromise quality health care (Fisher et al. 2003; Health Canada, 2001). Lack of cultural sensitivity by health care providers is another barrier to receiving Culturally Competent Care (CCC). Moreover, as discussed previously, perinatal health care providers need to identify and critically reflect on their own values and beliefs in order to provide CCC.

Teal and Street (2009) also write that self-awareness is important in providing CCC because a self-aware physician or health care provider can comprehend his or her responses to or expectations of a patient, evaluate the extent to which personally held biases might influence the circumstances, and endeavour to prevent inequities. One nurse in the study previously cited
reflected, “as I learn more about other cultures, I realize how my actions can be perceived as unhelpful when I thought I was helping. It was my own ignorance” (Baldonado et al. 1998, p. 20).

Lack of cultural competency training as well as continuing education for the perinatal health care providers is also a barrier in CCC. Moreover, there is a shortage of diverse leadership, medical, nursing and other health care providers such as social workers, and dieticians (Betancourt et al., 2003) who have the basic knowledge about South Asian women’s cultural, religious, and traditional beliefs and practices. Lack of guidelines or policies that guide perinatal nurses is another barrier in the provision of CCC. Interpreter services and appropriate health education materials are also not always available in some settings.

Ethical Considerations and Culturally Competent Care

Nurses are encouraged to engage in active reflection and dialogue around ethical challenges and moral distress. Self reflection empowers nurses to be architects of their own ethical knowing and everyday ethics (Canadian Nurses Association, 2002). It is important to reflect on nursing practices including identifying ethical dilemmas when providing Culturally Competent Care (CCC). Further, health care providers need to remember that each person has dignity, values, and beliefs, needs a sense of belonging, and contributes to supportive families, friendship and diverse communities (Health Canada, 2001). It is the task and responsibility of health care providers to recognize, respect, and respond appropriately to these cultural variables (Leininger, 2007; Clegg, 2003).

Theoretical Approaches

*Cultural Care Theories*
A number of nursing theorists have provided us with different models of Culturally Competent Care. The main purpose of these theories is to illuminate research, minimize the gaps in knowledge, and guide health care providers and educators in the provision of culturally competent care (Douglas, 2002). The following section will examine the contributions of the following models and theories:

- Capinha-Bacote’s Model of Cultural Competence.
- Giger and Davidhizar Transcultural Assessment Model.
- The Purnell Model for Cultural Competence.
- Spector’s Model of Cultural Diversity.
- Leininger’s Theory of Culture Care Diversity and Universality.

**Capinha-Bacote’s Model of Cultural Competence.**

Campinha-Bacote views cultural competence as an ongoing process in which health care professionals continuously strive to achieve the ability and availability to work effectively within the cultural context of patient, family and community (Campinha-Bacote, 2006). This model requires nurses to see themselves as becoming culturally competent rather than being culturally competent by integrating “cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire” in their practice (Campinha-Bacote, 2002, p. 181). Thus, this model focuses on the health care providers rather than on the patients. One may argue about the focus of this model because according to some other cultural care theories such as Leininger’s (2005), the main focus of nursing practice should be the patients and their families. This model can be used in several health care areas such as clinical practice, research, education, administration and policy development (Campinha-Bacote). However, this model is still in its infancy which calls for further research in order to demonstrate its usefulness for guiding nurses.
who provide perinatal care to South Asian women. I have drawn on this model quite a bit in this project especially for the required components for nurses and other health care professionals in the provision of culturally competent care.

*Giger and Davidhizar Transcultural Assessment Model.*

This model was developed by Giger and Davidhizar in 1988 for undergraduate nursing programmes to facilitate nursing students in assessing and providing care to culturally diverse patients (Giger & Davidhizar, 2002). The Giger and Davidhizar model suggests that each individual is unique and should be assessed and treated individually based on six cultural phenomena: communication, space, social organization, time, environment control and biological variations (Giger & Davidhizar, 1999). According to Giger and Davidhizar, culture is “a patterned behavioural response that develops over times as a result of imprinting the mind through social and religious structures and intellectual and artistic manifestations.” (p. 187). This model focuses on the individual rather than on the family and community as a whole. Additional investigation by various researchers, including Giger and Strickland, will explore biological and inherited differences between individuals. This model has never been used for South Asian women and will require further research for its usefulness for this population. This model’s six cultural phenomena are certainly important for assessing and treating individuals of diverse populations.

*The Purnell Model for Cultural Competence.*

This model was developed in 1998 by Larry Purnell for nursing students to use as a clinical assessment tool (Purnell, 2002). The Purnell model is based on twelve cultural domains: overview/heritage, communication, family role and organization, workforce issues, biocultural ecology, high-risk behaviours, nutrition, pregnancy and childbearing practices, death rituals,
spirituality, health care practice, and health care practitioners. These domains are intertwined and are not meant to be used individually (Purnell). The model has been used by health care providers including nurses, physicians, and occupational therapists in practice, education, and research (Purnell & Paulanka, 2003). For example, it has been used by physicians and nurses in Panama as an assessment guide to record accounts of native values, beliefs and cultural practices (Purnell). Much like Campinha-Bacote’s model, the Purnell Model is still in its infancy. Continued use over time, testing, and research will determine the value and significance of the model to health care providers in the future. The Purnell Model’s twelve domains can easily be integrated in perinatal health for South Asian women.

*Spector’s Model of Cultural Diversity.*

The Model of Cultural Diversity was developed by Rachel Spector in 1983. The purpose of this model is to increase the awareness of the dimensions and complexities involved in delivering nursing and health care to people from diverse cultural background (Spector, 2004). The model is based on the work of Estes and Zitzow’s theory of Heritage Consistency, or health traditions, and cultural phenomena affecting health (Spector, 1995). In this model, health is considered a complex, interrelated phenomenon in which body, mind, and spirit need to be taken care of in order to maintain, protect, and restore health (Spector). The assumption of Spector’s theory is that physicians, nurses, and other health care professionals believe in the norms of their own distinctive “culture of providers” about health and illness and interacting with a patient from a contradictory health and illness perspectives that can result in a conflict (Spector, 2002). Some may criticize the model for its focus on the health care providers rather than on the patients, families, and communities. To my knowledge, the model has not been used with diverse populations in perinatal health.
Leininger’s Theory of Culture Care Diversity and Universality.

Leininger was the first nurse theorist to introduce cultural care theory to the discipline of nursing, in the mid-1950s (Leininger, 2002). Drawing upon anthropology and ethnography, her theory remains one of the oldest, most comprehensive, and most holistic theories to generate knowledge of diverse and similar cultural practices throughout the world (Leininger, 2001). This theory focuses on providing human and culturally based nursing care so that nurses have a better understanding of cultural differences when caring for patients and their families from diverse cultural backgrounds (Leininger). This theoretical approach to providing culturally based nursing care has been extensively studied with better patient outcomes in health, healing, illness, and death (Leininger & McFarland, 2002). The theory also embraces the importance of discovery from the people’s (emic) way of knowing about realities and truths of human conditions in health, illness, and death and gives credibility to the professional nurses’ (etic) way of knowing (Leininger, 2005). The theory is also unique in its incorporation of social structure factors such as “religion, economics, education, technology, politics, kinship, ethno-history, environment, language, and generic and professional care factors” (Leininger & McFarland, p. 78). Further, the theory hypothesizes that culturally congruent care is essential for human well being, growth, health, and healing process as well as for the promotion of individual and family health (Leininger).

Leininger (2002) envisions three major modes of action and decision making that can be used to provide culturally congruent care: cultural care preservation and/or maintenance, culture care accommodation and/or negotiation, and cultural care restructuring or repatterning (Leininger, 2005). These three major modes are discussed later in this project. Moreover, Leininger (2001) explains the three phases of transcultural nursing knowledge and use: cultural
awareness, use of theories to guide research and explain transcultural nursing phenomena, and use of knowledge in practice for culturally congruent care.

For this project, Leininger’s Theory of Culture Care Diversity and Universality will provide the theoretical underpinnings for the program developed (Leininger, 2005). The Sunrise Model (see Appendix A) serves as a cognitive map for the discovery of holistic data and visualizing the totality of influences within one’s own cultural world (Leininger, 2001). The Sunrise Model presents different factors such as educational, economic, political, kinship and social, religious and philosophical, technological factors that need to be considered to arrive at a holistic approach. This model can be used at individual, family, institutional and community levels as a guide for providing care to diverse populations (Leininger). The theory provides a body of theory-based research knowledge and teaching content on transcultural nursing for undergraduate and graduate curricula, and continuing education (Leininger & McFarland, 2002). The theory also urges nurses and other health care providers to keep the patients/clients in the centre of care and view them within their context. This theory has been used for nursing research, clinical practice, institutional policies, and guidelines and educational programs worldwide and proven to be useful.

Leininger’s Model will be useful for my educational program development because I can incorporate the Sunrise Model (Appendix A) to help perinatal nurses and other health care providers understand the range of factors needed for assessing South Asian women’s health needs and for planning care in the perinatal area. Leininger and McFarland (2002) also proposed that nursing education in the 21st century must become ‘transculturally grounded’ by considering the phenomena of student, educator, and client care values, beliefs and practices. There have been no studies conducted to discover these phenomena related to teaching culture care. I will be
able to provide “emic” knowledge to the participants of the culturally competent care workshop based on my personal experience of being a part of South Asian population along with information from my literature review. This will help perinatal nurses and other health care providers to understand the similarities and differences between their clients’ and their own interpretation of some clinical situations.

Socioeconomic and cultural factors greatly influence the choices that individuals make (Zierler & Kreiger, 1997; Leininger & McFarland, 2002). Therefore, it is important to find out who our patients are, where are they coming from, what kind of social support, education, and resources they have available. Postcolonial and feminist theories will also be used to examine the provision of Culturally Competent Care (CCC) from different perspectives. Since culture cannot be isolated from the broader social context, a postcolonial approach provides an analytic lens for examining the degree to which nursing research and practice reinforce colonialism through our everyday practices (Anderson, 2004). Postcolonial feminism also encourages us to critically assess the effects of race, gender, class, and other ideologies on health, find the root causes of problems, and close the gap between theory and practice by producing transformative knowledge.

Professional Development for Promoting Culturally Competent Care

A one day culturally competent care workshop will be held (see Appendix B). This educational workshop will provide perinatal nurses and other maternity care providers with the opportunity to learn more about culturally competent care and will be one of the initial steps towards providing culturally competent care for South Asian women in my work setting.
Approaches to Teaching and Learning

The theoretical underpinnings of constructivism are used for approaches to learning and teaching. Young and Maxwell (2007) write, “Constructivism holds that learning is a process of meaning making or knowledge building in which learners integrate new knowledge into a pre-existing network or understanding (p.9). Further, knowledge is constructed socially by interacting with teachers and colleagues and by making meaning from what is already known (Colliver, 2002; Schaeitzer & Stephenson, 2008; Young & Maxwell). Learners are motivated to critically reflect and construct upon their foundational knowledge (Banning, 2005).

This learning theory challenges the traditional model of learning where students are viewed as empty vessels and the instructor is an expert (Young & Maxwell, 2007, p. 8). Constructivism also facilitates the development and application of critical thinking. It promotes creativity in learning and teaching process. Moreover, it extends learners’ understanding of clinical reasoning, teaching and learning strategies, and collaboration with external and internal stakeholders in program development and modification (Banning, 2005).

Educators must remember that every student is unique (Hanson & Stenvig, 2008) and brings something special to the classroom. As Michelangelo wrote (cited in Zander and Zander, p. 26) “Inside every block of stone or marble dwells a beautiful statue; one need only remove the excess material to reveal the work of art within”. Also, every individual has his or her own learning style such as visual, auditory, kinaesthetic and tactile (Hanson & Stenvig). It is imperative for educators to know about the learners as well as about the ways they learn (Mikol, 2006). The teacher needs to ask himself/herself- who are the learners? What do they bring to the learning situation? What are their learning needs? How might their learning needs be met? Therefore, it is important for the educators to disseminate information by various methods to
fulfil the needs of each student (Banning, 2005). Moreover, utilization of a variety of teaching learning strategies help students to advance their critical thinking and decision making skills (Vigeant, Lefebvre, & Reidy 2008; Wilgis & McConnell, 2008). Young, Maxwell, Paterson and Wolff (2007) describe some of the student-centered teaching techniques such as case study, role playing, storytelling, critical reflection journals, problem based learning, context- based learning, and mind mapping.

I will use multiple strategies to deliver the workshop content such as power point presentation and lecture, as well student-centered teaching techniques, for example role playing, group discussions, case scenarios, storytelling, and game playing. I will also use humour to keep participants connected with the workshop content and activities. Korobkin (1988) suggests that a sense of humour in teaching motivates student to pay attention, retain information, and engage in class discussion in a positive way. However, Struthers (1994) cautions that humour sometimes can leave students wondering whether the teacher was delivering the content seriously or amusingly. Therefore, it is important to present humour clearly and in a non-threatening way.

**Strategies**

*Lecture and Power Point Presentation.*

I will integrate various teaching and learning strategies in a lecture and power point presentation. As Oermann (2004) states “By interspersing active learning within the lecture, teachers can present essential content, synthesized from multiple sources, and also provide for involvement in the learning process” (p. 3). The content of the workshop includes: cultural, religious, and traditional values and beliefs of South Asian women (see Appendix C), Capinha-Bacote’s Model of Cultural Competence, Leininger’s Theory of Culture Care Diversity and Universality, the use of Sunrise Enabler, Modes of Actions and Decisions, important components
of culturally competent care and strategies for providing culturally competent care to South Asian women (see Appendix D). This content will be delivered via lecture and power point presentation.

Power point presentation will give me an opportunity to explain the content as well as maintain the learners’ attention by including photographs and cartoons. This method will also give me some flexibility in the pace at which I can move through the content material. For example, if the information is generating considerable discussion I can linger, or conversely, if the information is deemed already known then I can move quickly, providing a brief refresher. Furthermore, participants will receive a copy of the power point presentation slides and will be able to make notes on the same handouts. Another reason of using power point presentation is that based on my personal experience majority of the learners enjoy power point presentation despite their age differences.

Collaborative Learning.

Collaborative learning has become an essential component of teaching and learning in health and social care (Clark, Miers, Pollard, & Thomas, 2007). It allows health care providers to learn from and with each other. Collaborative learning can be made possible (Zander & Zander, 2000) by educators through working together with students and learning from each other. This approach to teaching and learning also promotes mutual respect, supportive relationships between facilitator and learners, and diminishes hierarchies that exist in the traditional teaching settings (Ironside, 2001). Group discussion activities, case studies, and case stories are some examples of collaborative learn that I will be using in one day culturally competent care workshop (see Appendix E, F and G).
I believe that every participant brings his/her unique strengths to any classroom or learning session based on their ethnicity, education, knowledge, and experience. In the culturally competent care workshop, the participants will be multidisciplinary team members such as perinatal nurses, public health nurse, physicians, obstetricians, and social workers who will bring wisdom to the workshop by sharing their knowledge, expertise, and stories from their personal clinical experience. This will help me to tailor teaching/learning activities of the workshop to fit the participants’ needs, interest, and priorities.

*Group Discussions.*

Group discussion activities create the opportunity to work with people from diverse backgrounds which increases understanding and tolerance about each other (Yearwood, Brown, & Karlik, 2002). Mikol (2006) emphasizes that small group discussions engage participants in communicative dialogue. This approach also leads to flexibility, openness to learners’ ideas as well as the opportunities to share stories from their experience (Zimmerman, McQueen, & Guy, 2007). Therefore, it provides participants with empowerment by boosting their critical consciousness and problem solving skills (Opalinski, 2006; Ironside, 2001).

In my culturally competent care workshop, I am going to provide participants with the opportunity to share stories from their clinical experiences with culturally competent care. I am going to use this activity as an icebreaker that will help me to assess participants’ previous knowledge about culturally competent care as well as to develop rapport and create a non-threatening learning environment. Group discussion will also provide opportunities for participants and educator to explore the case together and come up with the care plan using Leininger’s Sunrise Enabler. I will be able to use the story in Appendix E or from my own experience. Participants will be asked to pay special attention to the role played by lived
experience in their personal stories and how the experience affected learners’ emotions and feelings.

*Case Study and Talk Aloud.*

Case study approach is a type of problem-based and collaborative learning. It promotes critical thinking because the case study does not offer actual answers or solutions to the presented situation. Case studies “encourage students to work through problem situations, generate hypotheses, and test these hypotheses against relevant literature and personal experiences within the context of a caring framework” (Chen & Lin, 2003, p. 138). This approach offers learners the opportunity to discuss real-life situations, make conceptual linkages, and illustrate how concepts are applied in health care setting in a safe environment (Andrews & Boyle, 2002).

The case scenarios and case studies will assist participants to think critically and apply their learning to the clinical setting and solve clinical problems (Young et al., 2007). In the workshop, I will use a case study (see Appendix F) and divide participants into groups that will focus on each of the cultural and social structure dimensions of Leininger’s Sunrise Model (Appendix A). For instance, one group will work on family dynamics, another will focus on social factors and so on. Each group will make a care plan using available resources such as interpreter services for language barriers and educational material about breastfeeding and then one member from each group will present the plan to the whole group. Learners can present their solutions by role playing if they choose. Role playing help participants to become aware of their own values and beliefs (Graham, & Richardson, 2008).

A talk aloud or think aloud approach can be combined with both case studies and case stories. Banning (2005) states, “The main concept of the think aloud approach is to gain access to
student’s thought processes when investigating an important subject” (p.10). In the culturally competent care workshop, I will use this strategy in talking about a case study (see Appendix G) out loud and asking some specific questions related to the problem such as: what are the issues with this situation and what strategies could I use to solve them? How does socio-political status influence South Asian women’s health in perinatal area? Have you ever experienced or witnessed inequity and discrimination in providing care to South Asian women? How? What did you want to do about it?

Critical Thinking Questioning.

Critical thinking questioning also known as purposeful questioning and co-creating dialogue to activate learners to think rather absorb the dumped information from the educator/s (Randell, Tate & Lougheed, 2007). Critical thinking questioning also elucidates participants’ experience and aids them to open up possibilities based on their experience (Tanner, 2005; Yorks & Sharoff, 2001). Critical thinking questions can be directing, refocusing, prompting, eliciting, and re-eliciting (Wolff, 2007) such as: What is the main issue? What further information do you need? What else could have done? What is the rationale for using this knowledge? Which nursing theory are you using? What kind of resources would you need? In the workshop, I will use the case study (see Appendix F) and ask these critical thinking questions. Critical thinking questioning will also be used throughout the workshop to stimulate discussion and trigger critical thinking.

In the beginning and end of the one day workshop, participants will be given a set of self assessment questions (see Appendix H) to answer by reflecting on their daily practice. They will also be able to evaluate their own learning from the one day workshop by answering the same questions at the end of the workshop.
Role Playing and Game Playing.

Role playing, game playing and other forms of simulation, promote problem solving, decision making, team work and patient care skills. These strategies allow learners to link theory to practice in a non-threatening and controlled atmosphere (Comer, 2005). I will use role playing approaches in the one day workshop. For example, one participant will be the primary care nurse of a patient who is a new immigrant, does not speak English, and would like to have only female health care providers for her care. Her other cultural beliefs are: bottle feeding baby for first two days until her breast milk comes in, resting in bed for 42 days postpartum, and eating particular foods that aid her recovery. Another participant will act as the patient described above and rest of the participants will observe. Post scenario debriefing, where everyone will participate, will provide the opportunity for discussion about the decisions that the primary care nurse made in providing culturally competent care. Participants will be asked to recognize cultural differences and respond sensitively to the situation. As a result, these simulation activities will promote cultural awareness of the participants.

I will also incorporate a game of self awareness in which each participant will write at least one personal assumption about South Asian culture on a piece of paper and put it in a hat. Then I will pick one piece of paper and read the written assumption and will discuss how that assumption can become an obstacle in providing culturally competent care to South Asian childbearing women. A Fish bowl game (see Appendix I) will also be used as an activity in the one day culturally care workshop. Game playing and awards will keep participants motivated during the workshop. Incentives (such as Tim Horton/Starbucks gift cards, a hat, a laptop carrier, a picture frame, a watch etc.) will encourage learners to get their answers correct in order to receive awards.
Leininger’s Three Modes of Action and Decision.

Culture care preservation/maintenance refers to assistive, facilitative, and supportive actions and decisions that help clients to retain their relevant care values in maintaining or improving their health (Leininger, 1999). This does not mean that the perinatal health care nurses and other health care providers have to agree with women’s practices but it means making effort to find, acknowledge, and integrate the values that are important to the woman into the care plan (Srivastava, 2007). I have designed a learning activity (Appendix J) that can help perinatal nurses and maternity care providers understand these concepts. For example, a South Asian woman does not want her baby’s hair to be combed after the first bath because she believes that combing baby’s hair can cause cradle cap. This patient’s cultural value can easily be incorporated in the care plan. In the one day workshop, I will also use a case study to help participants learn about culture care preservation (see Appendix G).

Culture care accommodation/negotiation refers to assistive, supportive and facilitative actions and decisions that help people of one culture adapt to or negotiate with others to maintain or improve patients’ health (Leininger, 2005). Using an interpreter to ensure that woman is able to participate in her care plan or allowing family members to be part of the care could be part of negotiation. Negotiation means “balancing of competing priorities and occurs when there are differences between the clients and the health care provider’s preferences and the health care provider feel strongly that his or her medical interventions are essential to client’s care”. Another example would be a South Asian woman who is reluctant to have intravenous oxytocin but would like to use home remedies for her post partum haemorrhage. In this situation, the perinatal nurse can negotiate with her to continue with the home remedy and her prescribed medication as
long as they are compatible. A case study (see Appendix F) will also be used to discuss this mode of action and decision making.

Culture care repatterning/restructuring refers to actions and decisions that help clients to change or modify their life ways for a new and beneficial healthcare pattern (Leininger). For example, a South Asian woman is reluctant to get out of bed 6-7 hours after her caesarean section because she believes that bed rest will hasten her recovery from the changes of pregnancy and childbirth. The questions that I will ask participants- how can you modify her practice so that she could benefit from early ambulation? What would you need to support your actions? How would you make her understand the benefits of early ambulation without undermining her beliefs? I will also use an activity (Appendix J) to facilitate understanding of repatterning/restructuring.

Utilization of Leininger’s Sunrise Enabler in Perinatal Health.

As mentioned earlier, Leininger’s Sunrise Model (Appendix A) presents different factors such as educational, economic, political, kinship and social, religious and philosophical, technological factors that need to be considered to arrive at a holistic approach for providing culturally competent care to South Asian women. Not all the factors stated in the Sunrise Model are pertinent during prenatal, intranatal, and postnatal health or can be assessed by a busy perinatal nurse.

In the literature review, I have not noticed any technological factors that perinatal nurses and other health care providers need to consider in providing culturally competent care to South Asian women. In religious and philosophical factors, prayers were used by women and families. Baptised Sikh women wear 5 Ks which I have described in Appendix C (Dhari, Patel, Fryer, Dhari, Bilku, & Bains, 1997; Choudhry, 1997; Grewal, Bhagat, & Balneaves, 2008). Religious
restrictions in food selection are important for South Asian women. For example, Hindu and Sikh women are usually vegetarian (Henley, 1981; Getrad, R., Jhutti-Johal, Gill & Sheikh, 2005) and Muslim women consume “halal food” or food that does not originate from a pig or does not contain alcohol (Reitmanova & Gustafson, 2008). Therefore, perinatal nurses and health care providers are required to explore religious factors with South Asian women.

With regard to kinship and social factors, Dhari et al. (1997) and Fisher et al. (2003) consider South Asian women may be new to the in-laws’ family, and new to Canada. They may have minimal social support, minimal sexual and prenatal education, be going through multiple transitions, so may feel isolated (Choudhry, 1997). On the other hand, some South Asian women may have ample support from their extended family members and may have attended prenatal classes. Therefore, it is important for a perinatal nurse to assess the degree of acculturation of individual woman.

In cultural and life way factors, hot and cold foods are consumed at certain stages of pregnancy, labour, and post partum period to maintain balance in the body (Dhari et al.; Grewal et al., 2008). In the postpartum period, many South Asian women rest from 13-42 days to recover from the changes that they experience in pregnancy and childbirth (Choudhry; Lynam, Gurm, & Dhari, 2000; Grewal et al.). Extended family members are the major support during pregnancy, labour, and postpartum period (Grewal et al.). However, some women do not have this support system so the nurse should not make assumptions about the availability of family support (Lynam et al.).

Colostrum is considered old, stale, and pus like substance that is difficult to digest for the baby (Dhari et al. & Choudhry). Hence, kinship and social factors need to be assessed by
perinatal health care providers. I have not found much discussion of political, legal, and economic factors in the literature that are significant for South Asian women in perinatal health. However, based on my personal experience and Anderson’s (2004) work, it is important to note “…that suffering, health and well-being are woven into the fabric of socio-historical-political context, and as health care professionals we have a moral responsibility to be mindful of this context” (p. 239). I have witnessed some women who were planning to go back to work within 3-4 weeks after the childbirth because they were planning to sponsor their parents and siblings from their home countries. In order to show that they would be able to provide financial support to their parents and siblings when they live in Canada, these women were required to return to work. Sometimes, South Asian women send their toddlers back home to grandparents so that both husband and wife would be able to work, earn and save money to sponsor their parents and buy a house. Also, some South Asian women migrate to Canada as refugees so it is important to know their past history and support them accordingly. Educational factors include the inability to communicate with perinatal health care providers. It is critical for the perinatal health care providers to recognize and respond to the needs of South Asian women but we should not assume that all South Asian women have similar needs. It is important to understand the similarities and differences within the culture to fulfill the needs of each individual woman and her family.

Summary and Reflections

*What I have learned from this project*

I have expanded my knowledge by doing this project. In the initial stage, I believed that I knew a lot about culturally competent care and South Asian women because I belong to this ethnic group. By doing this project, I gained a deeper knowledge and understanding about
various cultural care theorists, theories, components of culturally competent care, and approaches to teaching and learning. There is an overwhelming amount of literature about culturally competent care in general health areas but I was surprised to find so little literature about culturally competent care in perinatal health with the focus on South Asian women.

**Recommendations for Nurse Educators**

Educators have the responsibility to teach students information, develop competencies, professional values, and an understanding of the nursing role, in a caring, humanistic manner that will facilitate safe, effective practice (Diekelmann, 2005; Zhang, 2008). Nurse educators can make the provision of culturally competent care possible so that South Asian women feel respected and understood. Nurses can provide an environment for care which maintains/supports South Asian women’s religious, cultural, traditional and dietary needs (Clegg, 2003). Further, educational programs may help perinatal nurses and other health care providers to challenge their own assumptions, biases, and develop understanding of cultural, religious and traditional values and beliefs of South Asian women. The effectiveness of such educational programs that are relevant and specific to perinatal care have received little study so evaluating the impact of professional education on the provision of culturally competent care warrants future research.

In Fraser Health, there is also a need to recruit more perinatal nurses and other health care professionals that mirror the cultural and ethnic diversity of South Asian population. On-going dialogue between community leaders and health care boards about what is happening in the community and how health care providers can also better meet the needs of South Asian women can have a positive impact on health authorities, patients and communities (Browne-Krimsley, 2004). Nurse educators also need to encourage nurses and other health care providers to use a variety of methods to collect health information from South Asian women and their families by
utilizing available resources. Translated educational materials should also be available in South Asian languages for patients’ and family members and interpreter services in South Asian languages should be more readily available.

Questions for Further Research

Further research can focus on the effectiveness of educational programs using qualitative or quantitative approaches. The appropriateness of the program can be evaluated by interviewing South Asian women who have utilized the perinatal services. One focus of the questions could be on clients’ satisfaction and to what extent their cultural/religious/traditional beliefs were met. Additional questions could include: What difference did the care or health teaching make in terms of self/baby care or quality of life? Were the health care professionals knowledgeable of women’s cultural, traditional and religious beliefs?

Phenomenological approaches to enhance understanding of the meaning of women’s perinatal experiences through dialogue with South Asian women may also be helpful. This approach would need in-depth interviews with open-ended questions with South Asian women who have experienced the perinatal services and will help us further understand the importance of cultural/traditional values from the participants’ perspective (Polit & Beck, 2008, p.227). Finlay (2003) calls phenomenology a journey of discovery where the researcher sets out in a spirit of adventure, not knowing where he or she will end up and open to the opportunity of encountering the new world. Here are some possible research questions:

- What is the perinatal experience of South Asian women during (prenatal, intranatal, postnatal period) their stay in this maternity care setting?
- How do South Asian women express their traditional/cultural/religious practices and beliefs during childbearing/perinatal period?
• How do nurses provide culturally competent care to South Asian women?

• What is the lived experience of perinatal nurses who provide culturally competent care to South Asian women?

• What effects do the work environment and health care delivery systems have on the provision of culturally competent care?

• What are the effects of culturally competent care educational programs on perinatal health care nurses’ and other health care providers’ cultural awareness, attitude, skills, knowledge, and patients’ outcomes?

Conclusion

In this project, I have reviewed literature on culturally competent care and identified strategies and educational approaches to learning and teaching. The literature review shows that South Asian women hold distinctive cultural, traditional and religious beliefs and values that require perinatal nurses and other health care providers to examine their practices and consider ways to fulfill their unique needs. However, perinatal nurses and other health care providers should not assume that the differences stated in the literature review apply to all South Asian women. Therefore, it is important to inquire from each woman about her beliefs, values and cultural practices and plan care accordingly.

I have developed a culturally competent care workshop that would be beneficial for the perinatal health care nurses and other health care providers who provide care to South Asian women. The information provided in this project as well as the workshop will help perinatal health care nurses and other health care providers to incorporate the important components of culturally competent care and reflect on their daily practice for providing culturally competent care to this population. Leininger’s Theory of Cultural Care Diversity and Universality provides
a theoretical lens through which perinatal nurses and other health care providers can utilize the three major modes of action and decision in providing culturally competent care to South Asian women. The information in this project is by no means deemed complete. It may be modified in the future for the same or different learners as well as for another population of women and families.

Perinatal nurses and other health care providers are in a perfect position to make childbearing a positive, memorable, health promoting experience by providing Culturally Competent Care (CCC) to women and their families.
References


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APPENDIX A
The Sunrise Model

APPENDIX B
Culturally Competent Care Workshop Plan

The purpose of this culturally competent care workshop is to address some of the issues that are identified in the project and to help ensure the provision of Culturally Competent Care (CCC) to South Asian women in maternity care settings.

The goal of this ten hour workshop is to increase the knowledge, positive attitudes and skills of perinatal nurses and healthcare professionals when providing CCC to South Asian women utilizing multiple educational strategies. This educational workshop will enable perinatal health care providers to:

- Learn about culturally competent care and its importance in perinatal health
- Reflect on their daily practices and how they might incorporate culturally competent care.
- Understand cultural, religious, and traditional beliefs and practices of South Asian women and its importance in perinatal health
- Demonstrate the ability to assess, plan, deliver and evaluate CCC interventions using “Leininger’s Sunrise Model”

The expected learners of this educational workshop are multidisciplinary health care team members; perinatal nurses, public health nurses, midwives, physicians, obstetricians, paediatricians, social workers, and dieticians who work in the perinatal area. I will invite the participants to attend this workshop by using multiple methods such as- emailing, placing a poster in the staff lunch and report room, providing information in staff and obstetric meeting, faxing a poster of invitation to physicians’ offices, public health units, and maternity units of other hospitals within the Fraser Health. The interested participants will be able to register for this workshop on the Fraser Health intranet.
This culturally competent care workshop is a full day (7 hour) educational session which can be delivered in different ways. Some workshops will be scheduled on weekdays and some on the weekends to accommodate nurses who work shifts. At the end of the session, participants will be requested to complete an evaluation form (see Appendix K) to assess the effectiveness of this educational workshop asking for constructive feedback.

**Teaching Plan for Delivering Workshop Content**

<table>
<thead>
<tr>
<th>Content</th>
<th>Learning Activity</th>
<th>Estimate Time Spent</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>The mnemonic “ASKED” Handout Appendix H</td>
<td>Self Reflection</td>
<td>10 minutes</td>
<td>Self assessment by asking 5 simple questions</td>
</tr>
<tr>
<td>Introduction</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Assessment, what is already known to learners</td>
<td></td>
<td></td>
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<tr>
<td>Icebreaker - anyone wants to share a story related to CCC with the focus on South Asian women, Collaborative Learning Appendix E</td>
<td>40 minutes</td>
<td>will build on from what is known to learners, will develop rapport, will create non threatening environment Promotes mutual respect, supportive relationships between facilitator and learners, and diminishes hierarchies</td>
<td></td>
</tr>
<tr>
<td>Literature review- Summary of culturally competent care, issues, ideologies, beliefs/practices of South Asian women (Appendix C)</td>
<td>Lecture and Power point presentation</td>
<td>40 minutes</td>
<td>Will get learners’ attention To deliver factual information regarding cultural differences including differences within the culture Cultural knowledge: help nurses to make meaningful decisions Avoid cultural imposition and</td>
</tr>
<tr>
<td>Activity</td>
<td>Description</td>
<td>Duration</td>
<td>Benefits</td>
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| Leininger’s Theory of Culture Care Diversity and Universality and Capinha-Bacote’s Model of Cultural Competence | Lecture and Power Point Presentation | 60 minutes | Learners will gain knowledge of these cultural care theories that I have used in this project.
To keep participants motivated, connected. |
| Application of contents to practice by active learning | Case scenarios in groups: Appendix F and G | 60 minutes | Learners will be able to verbalize culturally appropriate approach.
Will help participants to develop the ability to gather important cultural data and make a mutually acceptable plan of care (Cultural skills).
Will show perinatal health care providers’ openness to learning about South Asian women (cultural attitude).
Provide access to participants’ thought process. |
| Group Discussion: Use of Appendix D | | 20 minutes | |
| Talk Aloud: Appendix H | | 10 minutes | |
| Gain ‘emic’ knowledge | Share my personal experience as a South Asian patient on maternity unit | 60 Minutes | Discovery from people’s way of knowing. |
| | | | ethnocentrism
Enhances health care providers’ self-awareness.
References in the handouts will help participants to access original resources and literature about CCC. |
<table>
<thead>
<tr>
<th>Activity/Session</th>
<th>Description</th>
<th>Duration</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Share information from the literature</td>
<td>Role Playing</td>
<td></td>
<td>Cultural encounter-opportunity that encourages face to face interaction with diverse client, culture of the woman+culture of the health care providers+culture of the health care system</td>
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<tr>
<td>Role Playing</td>
<td>Share a joke任何人都 can share a joke</td>
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<tr>
<td>Questioning/questions from learners</td>
<td>Game Playing</td>
<td>30 minute</td>
<td>Evaluation of gained knowledge</td>
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<tr>
<td>Game Playing</td>
<td>Fish Bowl Questions</td>
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<td>Assimilate content in their daily practice</td>
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<tr>
<td>Awards</td>
<td>Whoever participate in fish bowl question will be able to put his/her name in the draw box</td>
<td>15 minutes</td>
<td>Incentives will encourage learning</td>
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<tr>
<td>Self-Examination (Cultural awareness)</td>
<td>Game playing- write at least one personal bias about South Asian women and put it in the hat</td>
<td>60 minutes</td>
<td>Recognition of personal biases about South Asian culture</td>
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<td></td>
<td>Getting out of the box</td>
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<td>Recognition of three modes of action and decision in providing culturally competent care</td>
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<td></td>
<td>Using Appendix J</td>
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<tr>
<td>The mnemonic “ASKED” Handout</td>
<td>Self Reflection/evaluation, It’s time to laugh again</td>
<td>15 minutes</td>
<td>Any questions?</td>
</tr>
<tr>
<td>Appendix H</td>
<td>Appendix K</td>
<td></td>
<td>Self evaluation</td>
</tr>
<tr>
<td>Workshop Evaluation</td>
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<td>To assess effectiveness</td>
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<td>Indication for improvement of future CCC workshop/s</td>
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</table>
APPENDIX C (Handout)

**Cultural, Religious, and Traditional Beliefs of South Asian Women**

Cultural beliefs, and traditional practices during pregnancy, labour and postpartum period have a major affect on women’s perinatal experience (Choudhry, 1997). But within each culture, are imbedded a range of practices and beliefs. Therefore, perinatal nurses should never assume that all South Asian are the same as this results in stereotyping and a lack of appreciation for the uniqueness of the life circumstances of individual women and families.

Nurses need to be aware that some health practices can become health issues in pregnancy. For example, dietary choices of eating certain foods to facilitate pregnancy and being vegetarian can result in a lack of important nutrients and cause undernourishment, low birth weight babies, and neural tube defects (Dhari, Patel, Fryer, Dhari, Bilku & Bains, 1997). Choudhry states that in South Asian cultures pregnancy is considered a “hot” state and cold foods such as milk, yogurt, buttermilk, rice, banana, green leafy vegetables, fresh fruits, wheat and coconut are recommended by the elderly women to maintain balance between hot and cold. According to Choudhry hot foods are meat, eggs, fish, clarified butter, beans, pulses, lentils, eggplants, onion, garlic, papaya, dates, alcohol, coffee, tea, ginger and chillies. Grewal and colleagues (2008) discussed the similar beliefs about the consumption of cold foods for continuation of the pregnancy and hot foods at the end of the third trimester to induce labour. Moreover, eating hot foods in the postpartum period is encouraged since it helps clean the uterus, promote breast milk supply, alleviate backache, and avert weakness and ailments in later life.

Dhari and colleagues (1997) discuss the importance of understanding that South Asian pregnant women might be going through multiple transitions as new immigrants. These can include being new family members in their in-laws families by arranged marriages, being new to the Western world, facing language barrier, and lacking social support as well as the important
knowledge of pregnancy related changes and available resources. Dhari et al. further conclude that these women may go through a tremendous amount of stress due to their lack of knowledge of various medical procedures. Fisher, Bowman, and Thomas (2003) also discovered that South Asian woman have scarce knowledge about sexuality, contraceptives, childbirth process, postnatal, and baby care as well as lack of fluency in English language. These researchers identified that sexual health is not discussed either at school or home. As a result, pregnancy, labour and childbirth can be a frightening experience for this population (Grewal et al, 2008; Dhari et al; Hayes, 1995). Being a virgin, the ability to please husband and family members, and to carry out home responsibilities are some of the valued qualities of young Indian women in their culture (Fisher et al.).

As stated above language barriers is another issue identified in the literature (Dhari et al., 1997). South Asian women may feel uncomfortable asking questions and expressing their health concerns, and may not understand the messages from health care providers. Language barriers can further cause frustration for both patients and health care providers (Dhari et al.; Lynam, Gurm & Dhari, 2000).

Rest is considered important for maternal health right after delivery and in the postpartum period; this rest period varies from 13-40 days (Choudhry, 1997; Lynam et al., 2000; Grewal et al. 2008). During this rest period mothers are not expected to perform any house chores such as cooking or cleaning. The extended family members and or husbands ensure that women get appropriate rest to recover from the changes that were acquired from childbearing (Grewal et al.). Occasionally, this mandatory rest can cause some conflict between patients, family members and health care providers if the health care professionals are unaware of this traditional practice (Hayes, 1995). Lynam et al. (2000) conclude that women of the extended family or female
friends are the major source of support and education regarding pregnancy, labour and delivery for the South Asian women. Husbands may play a similar role in case members of the extended family are not available (Grewal et al., 2008). It is important for the health care providers to assess social support and refer these women to appropriate resources if they lack social support (Dhari et al., 1997; Lynam et al.).

Breastfeeding is believed to be God’s gift for South Asian women. However, colostrum is considered hot, old, stale, insufficient and a pus-like substance which can be difficult to digest and unsafe for the newborn baby (Dhari et al. 1997; Choudhry, 1997). Choudhry also concludes that breastfeeding initiation depends on the women’s education and socioeconomic level. Withholding colostrum does not mean that mothers do not want to breastfeed but rather that formula is believed to be healthier than colostrum. Another tradition that can interfere with breastfeeding is that the members of the extended family and community visit mother and baby in the hospital as well as at home (Dhari et al.; Choudhry; Grewal et al., 2008). However, once breastfeeding is established, babies are fed on demand which continues until mothers feel that the milk supply is sufficient, get pregnant, or decide to wean (Choudhry). Grewal et al. (2008) found that women used prayers to create positive energy, a peaceful environment, and to wish for having a male infant. Women and their families also visited the temple on their way home from the hospital for a baby’s naming ceremony.

Sikh and Hindu women eat chapattis (homemade bread) as the main cereal staple, clarified butter as core source of fat, lentils as the core source of protein, dairy products such as buttermilk, paneer, cooked and raw vegetables, curry and fresh fruits (Henley, 1981). Baptised Sikh (who have gone through a special religious ceremony and wear 5 Ks – they are Kesh-long uncut hair, Kangha-a wooden comb to keep hair tidy, Kirpan-a sword, Kacha-are trousers worn
by both male and female, *Kara*- a bracelet worn on the right wrist. Moreover, Baptised men and women do not consume meat, fish, or eggs which can cause anaemia during pregnancy (Gatrad, R., Jhutti-Johal, Gill & Sheikh, 2005). Even many non-baptised Sikh women conserve the religious faith in their families (Choudhry, 1998) and refrain from meat, eggs, and fish even if their spouses consume meat.

South Asian women hold distinctive cultural, traditional and religious beliefs, values and practices which perinatal health care professionals need to understand to provide CCC. Care providers working with South Asian women need to remember that every childbearing woman is unique and that cultural knowledge must be tailored to the particular situation. Perinatal nurses and other health providers need to consider each woman’s beliefs, values, health practices and life circumstances in order to provide culturally competent care for South Asian women.

References


APPENDIX D (Handout)

ASK, ASK and ASK ABOUT........

- Traditional beliefs such as role of hot and cold foods
- Important dietary practices for pre, intra and post natal period
- Group practices and beliefs
- Family members’ roles such as husband, mother-in-law, sister, sister-in-law
- Breast feeding, skin-to-skin, co-bedding practices
- Woman’s and her family’s fear regarding an unfamiliar heath care setting
- If woman or any family member has any question/s

STRATEGIES FOR CCC DELIVERY

- Explain your rational and reasons for suggestions, for example importance of colostrums
- Use formal interpreter to breakdown communication barriers
- Provide educational material in woman’s native language and be available to answer questions
- Integrate woman’s native treatments as long as they are not interfering with her recovery, for example- South Asian women do not like drinking ice water in post partum period but to maintain fluid intake, let them drink warm or tap water or juice that is sitting at room temperature
- Understand the dimensions of culture and enlist the family caretakers and others
- Move to a holistic approach and build on women’s strengths
- Reflect on your practices and change your ethnocentric attitudes
- Demonstrate respect for sociocultural diversity of women, their newborns, and families

References


APPENDIX E
Mrs. Brar’s Story

I was both excited and afraid to have my first baby. I was young, and new to Canada. There was no one from my family here and my husband was a truck driver. But my lady friend, who had been living in Canada for many years, was very helpful. One day, my tummy was sore. My lady friend took me to maternity triage.

I am surrounded by many people; I guess they are doctors and nurses. They are telling me something but I do not understand a word. I think something is really wrong. More and more people are coming with different machines. I understood the word- ultrasound. One nurse examined me down below and left me uncovered. I really want them to cover me up, but don’t know how to ask. Don’t they understand that I am a Baptised Sikh (the Sikhs who have been through a special ceremony) and should not put my special shorts away from my body. One of them in a white coat told me something about my baby. I turned my head towards my lady friend so that she could help me to understand what he was saying. My lady said, “They could not find baby’s heart beat.....the baby is dead. They will give you some medication tomorrow and deliver your baby.”

Next day, they induced me. It was a saddest day of my life.....I was lonely.........My dead Baby Boy was delivered without his father’s presence. It was an extremely difficult time for me and my friend. Nurses and doctors were very nice; they gave a memory box with my baby’s pictures, foot prints, little blue outfit and some hair. My husband came 3-4 hours after our baby’s birth. A social worker and an interpreter came to talk to us. After spending some time our deceased son, we looked through the memory box and were devastated that a lock of hair was cut for the memory box but we were not planning to cut our child’s hair as cutting hair is against one of the religious practices of a Baptized Sikh.
A: Using Leininger’s (2001) Sunrise Enabler Explain:

- Which social structure factors were overlooked in this Mrs. Brar’s case?
- Which ideology or ideologies are prominent in this situation?
- What are the barriers in providing culturally competent care to Mrs. Brar?
- Are we as perinatal health care providers equipped in providing Culturally Competent Care to a Sikh woman and her family?
- What could have done to preserve this patient’s and family’s cultural and religious values, avoid distress and ensure culturally competent care?
- What kind of thoughts/emotions are you having after reading Mrs. Brar’s story?

B: Using Leininger’s Sunrise Enabler make a culturally appropriate care plan for Mrs. Brar.

C: Is the lack of attention to woman’s privacy related to power inequities between health care providers and patients? Why or why not?
APPENDIX F
Case Study 1

A 24 year-old, 22 weeks gestation, South Asian woman presented to perinatal triage with her husband with the chief complaint of abdomen pain and nausea and vomiting. The nurse reviews her chart before attending this patient. The nurse noticed that this woman’s chart was flagged as she is a new immigrant, underweight, does not have health insurance, is unemployed, lives with her husband, and does not eat proper food. The nurse sighs and rolls her eyes, and enters the room to collect initial assessment information.

Nurse: (enter the room, looking through the chart) “Why are you here?”

Woman: (lying on the stretcher holding on to her abdomen) “My tummy hurts and I throw up when I move.”

Nurse: (sighs) “How long have you been sick?”

Woman: “For 4 weeks but it is worse today. It almost went away since I start drinking boiled water with cloves as my mother told me.”

Nurse: (rolls eyes) “Well, those home remedies can make things worse, do you know that? You should have gone to you family doctor or come to the hospital right away.”

Woman: “I don’t have insurance. I do not have money to pay for the clinic visit and pills. I was trying to fix the problem myself so that I wouldn’t have to pay for the visit. Why can’t I use the home remedies if they work.”

Nurse: “All right.” (Walks out of the room still looking through the chart)

Then the nurse gives report to the physician: “The patient will not be compliant as she has been using home remedies and believes they have been working for her hyperemesis. There is no way she will get her prescription filled because she does not have health insurance. She also is a challenging authority; I’m not sure how well she will listen to you.”
Consider the following:

- Potential and actual barriers to communication
- Issues relative to cultural desire
- Issues relative to cultural awareness
- Implications of cultural knowledge as it relates to self care
- The impact of cultural skill on the outcome of care
- The impact of cultural encounters on the outcome of care
- What kind of questions the primary nurse should have asked about health insurance and other resources of financial support?
- How are the socio political determinants of health (poverty, unemployment, inequity, discrimination etc.) affecting this woman’s well being?
- How can you repattern/ reframe your and your patient’s actions and decisions?
APPENDIX G
Case Study 2

A 21 year-old Muslim women, 34 weeks gestation, presented to maternity triage with the complaint of vaginal bleeding and watery discharge. After assessment, you have contacted the male physician who is covering her primary care provider. The plan is to do sterile speculum on the women to assess her bleeding and diagnosis the preterm rupture of membranes. But your patient’s religion does not permit her to have this procedure done by a male health provider.

Questions:

- How would you accommodate her religious needs without jeopardizing this woman’s and her unborn baby’s health needs?
- What would you do if there is no female physician available?
APPENDIX H (Handout)
The mnemonic “ASKED”

The perinatal nurses and other health care providers can ask themselves the following questions:

**Awareness:** Am I aware of my biases and prejudices toward South Asian women as well as existence of racism in health care?

**Skill:** Do I have the skill of conducting a cultural assessment with South Asian women?

**Knowledge:** Am I knowledgeable about health related beliefs, practices, and cultural values; disease incidence and prevalence; and treatment efficacy among South Asian women?

**Encounters:** Do I seek out face-to-face encounters with South Asian women?

**Desire:** Do I really “want to” become culturally competent with South Asian women in perinatal health?

(Campinha-Bacote, 2002, p.187)

Reference

*Fish Bowl Questions

Each of the questions from the following list will be written on individual piece of paper and put in a fish bowl. Any participant can pick one question and answer. Participant can consult someone from the audience for help to answer the selected question correctly. Once participant comes up with the correct answer, he or she will be able to put his/her name in the prize draw box.

1. Approximately what % of women, who deliver at ARH, is Punjabi speaking? (33%)
2. What kind of family structure do majority of Punjabi speaking women come from? (Extended)
3. Where do Punjabi speaking women go to get the first letter of the baby’s name? (Sikh Temple)
4. How many days do Punjabi speaking women usually rest after the delivery? (13-40 days)
5. What kind of food do Punjabi speaking women usually eat after delivery? (Vegetarian)
6. What kind of food is prohibited in Muslim culture? (Pork)
APPENDIX J

Is it *Cultural Care Preservation/Maintenance, *Cultural Care Accommodation/Negotiation, or *Cultural Care Repatterning/Restructuring?

1. My patient wanted to bottle feed her baby for first two days of her because she believes that colostrums is old, stale, and not enough for the baby and her real milk does not come until 3rd day of postpartum. She breast fed her first child for two year and I really wanted her to start breast feeding right after her baby was born. I did some teaching about the benefits of colostrums, and the amount her baby is going to need for the first and day of his/her age. She changed her plan and decided to initiate breastfeeding right after her baby was born.

2. My patient wished to give her baby couple of drops of “Holy Water” that her husband retrieved from the temple and perform prayers for five minutes. I was glad that I was able to accommodate their wish as both mother and baby were stable and I was able to leave them alone for a few minutes.

3. My patient did not like the hospital food. I encouraged the family to bring healthy food from home. My patient and her family were happy about that.

4. I was the primary care nurse of a South Asian woman on her second day of post caesarean section. After helping her to the bathroom, I encouraged her to brush her teeth. But she told me that brushing can cause gum bleeding and wanted to leave it until the next day. I discussed the importance of mouth care and offered her mouth wash instead of tooth brush.

*Culture care preservation or maintenance refers to assistive, facilitative, and supportive actions and decisions that help clients to retain their relevant care values so they can maintain or improve their health (Leininger, 1999).

*Culture care accommodation refers to assistive, supportive and facilitative actions and decisions that help women maintain or improve their health (Leininger, 2005).

*Culture care repatterning or restructuring refers to actions and decisions that help clients to change or modify their life ways for a new and beneficial healthcare pattern (Leininger).
## APPENDIX K

### Workshop Evaluation

<table>
<thead>
<tr>
<th>Session Rating ✓ OR X</th>
<th>Poor 1</th>
<th>Fair 2</th>
<th>Good 3</th>
<th>Very Good 4</th>
<th>Excellent 5</th>
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<td>1. Overall evaluation</td>
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<td>2. The content was clear</td>
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<td>3. Format was clear</td>
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<td>4. Handouts were relevant</td>
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<td>5. Teaching style</td>
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<td>6. Instructor was-</td>
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<td>• Articulate</td>
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<td>• Professional</td>
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7. What I found most interesting......

8. One thing I liked about culturally competent care workshop............

9. One thing I did NOT like about competent care workshop.............

10. Improvement/s that I would like to see in the future.............