PERCEIVED CULTURAL SENSITIVITY AMONG PUBLIC HEALTH NURSES

by

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ABSTRACT

Studies on culture are important because we live in an increasingly diverse society. This study explores, from an interpretist perspective, the experiences of public health nurses in working with a culturally diverse community. Ten nurses and ten community workers from two public health departments were recruited by convenience sampling. Through semi-structured interviews the meaning of cultural sensitivity is explored from the perspectives of both nurses and community workers.

For both groups, cultural sensitivity means: a) knowing the historical background of the client; b) incorporating the clients current health practices with the health education offered by the public health departments and; c) demonstrating behavior that is acceptable to the particular culture of the individual with whom one is interacting.

Findings suggest that the priority of the nurses is in performing their roles to the best of their abilities. This role includes appearing to be culturally sensitive as a means to achieving an end. This method of capturing the attention of the audience in order to ensure compliance to their health education is governed by their accountability to their employer, the public health departments. The thesis concludes with consideration of the implications of these findings for practice and research.
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The focus of this study is on the cultural awareness of health professionals in the field of public health. This study explored the sensitivity and appreciation of the health professional to cultural diversity for three reasons: 1) Canada is a rapidly growing multicultural society; increased immigration from non-European nations means that this society has evolved into a culturally pluralistic one (Masi, 1995); 2) Public health involves working with an ethnoculturally diverse community, in particular, recent immigrants and refugees; 3) Awareness of cultural diversity means being able to work more effectively and successfully in all areas of health care. In this context, sensitivity means culturally aware practice that requires an ability to postpone departmental and professional priorities in order to be able to view services from the perspective of the client (Devore & Schlesinger, 1987).

This definition notwithstanding, I chose to let health professionals and community members

\(^1\)The term ethno-cultural combines both ethnicity and culture. Ethnicity:"Primary characteristics include common geographic origin, language and religion...ethnicity also describes a sense of community transmitted over generations by families" (Mensah, 1994, p.35).

Culture: Refers to a shared way of life among a group of people, this includes: "language, concepts, beliefs and values, symbols, structures, institutions and patterns of behavior" (Masi, Mensah & McLeod, 1995, p.7). One's culture may differ from one's ethnicity or race. For more on culture see Geertz (1973).
define what cultural sensitivity meant to them. This study aimed at explaining what cultural sensitivity meant to health professionals, from the point of view of those professionals, and ways in which they believed they were culturally sensitive. This study also aimed at explaining what cultural sensitivity meant to community members and explored ways in which they determined whether a health professional was being culturally sensitive. The perspectives of nurses and community workers was then compared for similarities and differences.

Background to Multicultural Awareness
This study is about cultural awareness in a multi-cultural society. Therefore, I believe it appropriate to provide the reader with a brief outline of three multiculturalism perspectives and a discussion of multiculturalism at the level of government policy. The intent herein is to provide the reader with some insight into the journey of multicultural policy creation to this point in time and also to set a context for my findings.

Multicultural Perspectives
Multiculturalism is a word that tends to elicit viewpoints ranging from support of cultural hegemony to cries of racism. There are a number of interpretations and definitions as to the meaning of multiculturalism or ethno-cultural diversity, as it will be referred to in this study. It is useful therefore, that a brief explanation be offered which serves to delineate the progression in thought, and perhaps, in action, of the ways in which advocates of multiculturalism approach the topic.
Conservative/Corporate Multiculturalists

According to McLaren, to conservative multi-culturalists or corporate multi-culturalists "...ethnic groups are 'add on' to the dominant culture" of the 'host' country (McLaren, 1994, p.49). It begs the question of how groups in power justify their position as non-ethnics, how they say "their traits and qualities are correct while the corresponding qualities are ethnic" (McLaren, 1994, p.59). Conservative multi-culturalism claims that everyone has an equal opportunity and can all reap the benefits which this society has to offer, but it fails to add that to do so one must become "deracinated, denuded and culturally stripped" (McLaren, 1994: p.49).

Critical/Resistance Multiculturalists

Liberal and conservative multiculturalists claim that justice exists, it just needs to be rationed out equally; critical or resistance multiculturalists, however, see lack of equality as a systemic problem, therefore, changes are needed within the structure. Justice needs to be continually struggled for, it does not exist just because laws exist. The answer, they say, lies in recognizing and changing the dominance of the ideas and customs of mainstream culture (McLaren, 1994). According to critical multiculturalists, when diversity ceases to be an important issue one would hope that it is because awareness and sensitivity to cultural diversity has been absorbed and internalized by all (become natural); and not because it has acquired a negative connotation and ridicule, "treated as either marginal or too hot to handle" (Stiehm, 1994, p.151).
Left Liberal Multiculturalists

The left liberal multicultural view supports my position on cultural diversity. It recognizes that equality smothers cultural difference (McLaren, 1994). To treat equitably means that we ought to recognize and acknowledge cultural differences and to be sensitive to the variations that exist. However, the left liberal perspective locates meaning in experience, in that only the native can speak with authority about that culture (McLaren, 1994). The shortcoming of this perspective is that one has to show one's identity papers before one can speak authentically about an issue. Locating meaning in experience negates, by implication, academic expertise and acquired sensitivity of others to multicultural issues.

History of Multiculturalism in Canada

Policies on multiculturalism exist at the federal and provincial levels. Major corporations/institutions are in various stages of creating policies which speak to issues of culturally diverse employees and populations. In spite of this, and even though there has been an increase in interest and research in cultural diversity over the past few years, the struggle for recognition continues (Goldberg, 1994). It is in this light that I deem it necessary to provide a brief account of the development of multicultural policy in Canada.

Canada's bi-lingual and bi-cultural policies were designed for the French and English only (Freisen, 1993; Kallen, 1988). Many groups felt left out. Consequently, initiated by the Ukrainians, other ethnic groups collaborated and produced book four of the Report of the Royal Commission on Bilingualism and Biculturalism entitled: "The Cultural Contribution of the
Other Ethnic Groups" (Kallen, 1988, p.237). In this document are recommendations for multiculturalism and multilingualism. The government at the time, headed by Pierre Elliot Trudeau, rejected the idea of multilingualism but suggested instead a multicultural policy within a bi-lingual framework (Freisen, 1993). The federal government's policy statement on multiculturalism sets out four objectives:

1) The Government of Canada will support all of Canada's cultures and will seek to assist, resources permitting, the development of those cultural groups which have demonstrated a desire and effort to continue to develop, a capacity to grow and contribute to Canada, as well as a clear need for assistance;  
2) The Government will assist members of all cultural groups to overcome cultural barriers to full participation in Canadian society;  
3) The government will promote interchange among all Canadian cultural groups in the interest of national unity; and  
4) The Government will continue to assist immigrants to acquire at least one of Canada's official languages in order to become full participants in Canadian society. (Freisen, 1993; Kallen, 1988).

Visible minorities claim that the policy does not place enough emphasis on combating racial discrimination. The problem with the multicultural policy lies in the fact that "...it says nothing and does nothing about existing racial and ethnic inequality in Canada...the long term effects of structural racism...and the visual absence of representation among Canada's elites of visible minorities is nowhere addressed in the multicultural policy statement" (Kallen, 1988, p.244).

Summary

Due to rapid and increasing immigration into Canada there is a need to examine cultural perspectives in health (Masi, Mensah & McLeod, 1995). We have seen that not only has the word multicultural changed to ethno-cultural diversity, in flight from an acquired negative connotation, but the meaning itself is wide and varied with much ambiguity. The last thirty
years has seen a great deal of activity in terms of policy creation aimed at encouraging national unity and equity for all Canadian residents. It is evident, however, that a great deal of work still needs to be done in terms of achieving equality for all, as well as, addressing the problems of systemic racism. Implicit in this study is the question of whether efforts to raise consciousness has had any impact at the level of public health nurses in terms of awareness and sensitivity toward cultural diversity.
CHAPTER 2
LITERATURE REVIEW

The relevance of this study lies in the fact that much research is needed in the area of ethno-cultural diversity (Masi 1995). Studies on culture continue to be important because we live in an increasingly diverse society. According to statistics, no one ethnic group dominates, in terms of numbers (Masi, Mensah & McLeod, 1995). The purpose of this chapter is to present literature that explored the relationships and interactions between health care professionals and their clients. The literature will be discussed according to the following themes: a) culturally appropriate and culturally sensitive health care; b) ethnicity and culture; c) culturally sensitive professional development training for nurses; and d) Berger and Luckman’s social construction of reality.

Definition of Culturally Appropriate and Culturally Sensitive Health Care

There are as many definitions of culture as there are cultural researchers. Tyler succeeded in capturing quite succinctly the essence of the meaning of culture as: "That complex whole which includes knowledge, belief, art, morals, laws, customs and any other capabilities and habits acquired by man as a member of society" (Tyler in Habayeb, 1995, p.224). One's ethnicity was defined not just by the country of origin but also the geographic location and shared history. Integral in the definition was the recognition that ethnicity is a continued tradition from the past (Rempusheski, 1989). In direct contrast, cultural diversity can be
described as a lack of homogeneity or sameness (Habayeb, 1995). There are countless definitions of health, what one culture considers abnormal, another culture may consider a way of life. It is virtually impossible for health professionals to have in-depth knowledge of all cultures. In light of that, it behooves health care professionals to take into account the ethno-cultural background of their clients. Awareness of their own ethno-cultural biases in their practice is important because: "Culturally aware practice requires an ability to suspend agency and professional priorities in order to be able to view services from the perspective of the client" (Devore & Schlesinger, 1987, p.137).

For the purpose of this study, culturally appropriate healthcare is defined as providing services in the language of the person and being sensitive to the traditional culture, particularly in terms of health beliefs, patterns of communication between individuals, knowledge of living conditions and life circumstances. Culturally appropriate and culturally sensitive healthcare include cultural and racial sensitivity and awareness, regardless of one's own culture (Mensah,1995). "We will have achieved really good and sensitive care when we get to the point where so called mainstream services are all multicultural" (Lechky, 1992, p.2221).

Recognizing Cultural Differences

As revealed in the literature, members of various ethno-cultural communities expressed concern regarding health professionals' lack of understanding of ethno-cultural communities (Waxler-Morrison, Anderson, & Richardson, 1990). Some communities expressed feelings of discrimination and racism, which they encountered in dealing with health professionals
(Waxler-Morrison, et al., 1990). Others expressed concern that they were treated as though they were all the same; which is an example of ethnic stereotyping. In contrast, health professionals maintained that they treated everyone fairly and justly by virtue of the fact that they treated all ethno-cultural communities the same (Waxler-Morrison et al, 1990). However, treating everyone the same is not equivalent to treating everyone equitably. According to Masi (1993), it is necessary to recognize difference in order to respond appropriately. Health professionals often expressed frustration with ethno-cultural communities, particularly in relation to non-compliance and a lack of interest in health related/health promotion endeavours (Waxler-Morrison et al, 1990). Implicit in this is the seeming lack of cultural knowledge on the part of health professionals.

**Ethnocentricity**

Knowledge of a culture is not always enough. There needs to be awareness of one's culture and awareness of one's biases (Eliason & Macy, 1992). Even researchers, who explored the area of cultural sensitivity, inadvertently demonstrated their own biases in writing about their findings. For example, in Hay's (1994) conclusion of his study, he reminded the reader that his research is from the perspective of the Natives, and therefore, may not be reality. The word Native is used in the literature to refer to Canadian Aboriginal people. The point of interest is not so much in the findings of the study but rather in the implication of his words. One is left to wonder whether Hay really meant that the native viewpoint is not reality, because, as he stated, reality is the Euro-Canadian perspective. Educators of multiculturalism ought to examine and confront their own feelings of ethnocentrism or intolerance before they attempt
to raise the consciousness of others (Freisen, 1993).

The key to delivering good health-care and health information is the examination of perceived biases of healthcare professionals (Klienman, Eisenberg & Good, 1978). Although professional staff claimed awareness and sensitivity to cultural variations, ethnic biases and stereotypes surfaced in delivery of care (Rempusheski, 1989). For example, Green (1995) reported that social workers insisted they understood their clients and that they had insight into their clients' needs and their actions. However, the social workers revealed that they did not understand the reasons why their clients demonstrated certain behaviors. When their (native) clients differed in behavior from the expectations of the social workers, the latter assumed that either the natives were not socialized properly, or they did not know how to express themselves as the social workers did (Green, 1995).

Not to be socialized properly meant one is not socialized in the ways of the mainstream culture, consequently, negating the socialization practices of native culture. Another example, of the difference in socialization, was the notion that White time and Indian time differed significantly in meaning (Green, 1995). For the social workers, when Indians (natives) did not adhere to White time meaning “on time”, they were on Indian time, which meant anything but the arranged time. Usually it meant being late for an appointment. Perhaps the recognition of time, that is, whether a culture is past, present or future oriented, may reveal a greater understanding on the part of healthcare professionals and may assist in determining how clients respond to treatments, suggestions, planning and so forth (Giger and Davidhizar, 1990).
According to Secundy and Sundstrom (1995), doctors often saw difference as deviant or bad. For example, the good patient/client was one who obeyed the orders of the doctor whereas the bad or deviant patient/client was one who would not submit to the prescribed treatment plan. The bad patient/client may have had religious or cultural reasons for refusing to participate in a treatment plan (Secundy & Sundstrom, 1995). Subsequently, the refusal to participate was interpreted as non-compliance. This, however, did not seem to be given much consideration by doctors as the patient was still labeled difficult or bad.

Hay (1994) found that Natives rejected medical therapy based on the way they perceived healthcare professionals behaving towards them. He found a great deal of misinterpretation of the behavior of Natives on the part of doctors due to a lack of knowledge of Native culture. For example, Hay (1994) found that some physicians chastised mothers for not taking care of their children and for not bringing them in early enough for treatment. The physicians did not seem to consider the reasons why the children were not brought in for medical treatment, instead, they labeled the mothers as non-compliant.

There were a number of reasons for non-compliance, which included, but were not limited to the fact that: a) parents may not have been able to afford bus fare; b) alternate forms of transportation may not have been available; and c) the belief of taking an already sick child out into the cold air was seen in the Native culture as tantamount to ineptitude as a mother (Hay, 1994). The fact that many Natives did not accept North American medicine led healthcare professionals to think about their clients as indifferent and non-compliant (McRae, 1994).
Waldram's (1994) study on Natives revealed that Euro-Canadian staff treated their own kind better than they treated Natives.

A frequent theme stressed in the literature was the need for health professionals to know the meaning behind the practices/actions/behaviors of their clients in order to fully understand their client population. It was evident that health professionals may not understand the norms/actions/behaviors of their clients (Chalander, 1995; Hoeman, 1989). Professional staff were urged to recognize the cultural variations, listen to the life stories of their clients and see the person as an individual (Pfeifer, 1995; Shubin, 1980). In addition, recognition and utilization of scientific and traditional healing practices may serve to strengthen the therapeutic relationship between health professionals and clients (McRae, 1994).

**Communication**

It is often not clear why individuals behave in certain ways. It is important, therefore, that healthcare professionals are knowledgeable regarding cultural norms, habits and behaviors of their client population in order to provide safe and efficient healthcare (Francis et al, 1989, Waxler-Momkon, 1990). One of the problems is that health professionals tended not to listen to their clients (Lechky, 1992). This in itself is unfortunate because cooperation in treatment is highest when communication between nurse and patient exists, when they share a common language, and there is respect for one another's goals in the therapeutic relationship (Anderson, 1987). To communicate more effectively, Grossman and Taylor (1995) suggested that it is necessary to pay attention to non-verbal clues and subtle nuances of expression for both the
client and healthcare provider.

Another concern found in the literature was that both nurse and client often cited communication in language as a frustrating problem (Giger & Davidhizar, 1990). Translation is a common problem with makeshift solutions that are less than desirable. Family members are often utilized as interpreters and this may place an added and unnecessary stress on family relationships, as in the case of a little girl who was asked to tell her mom that her unborn baby died in utero (Haffner, 1992). In addition, there is the possibility of the wrong information being provided when family members are used as interpreters. For example, in the case previously mentioned the daughter said she conveyed the doctor's information to her mother when in fact she did not (Haffner, 1992). Evidenced herein is that healthcare professionals have less control on sharing information when using an interpreter. Healthcare providers claimed that there was a great need for professional, reliable and effective interpreters to be available to them (Haffner, 1992; Meghani-Wise, 1996).

**Ethnicity and Culture**

Health professionals were of the opinion that they treated everyone equally (Masi, 1995). While this may be so, it is necessary for health professionals to have insight into cultural variances that may exist. Ethnicity and culture are often used interchangeably (Anderson, Morrison, Richardson, Herbert & Murphy, 1990), however, this does not necessarily mean that individuals who share the same ethnic background share the same culture. For example, the Caribbean consists of a group of islands, home to people of all races. Each island boasts its
own unique culture. To limit Caribbeans to one people/one culture is a major infraction upon recognition of cultural diversity.

Caribbeans easily adapt to the system here in Canada due to the history of the British rule and cultural diversity experienced on their own islands. However, they speak with a particular accent and for that are often deemed to be slow and unable to comprehend (Glasgow & Adaskin, 1990). Although urbanized and educated, many Caribbeans regardless of their socio-economic status, use herbal or bush medicine in combination with western medicine (Glasgow & Adaskin, 1990; Spector, 1991). There are a few medical conditions in North America that are not regarded as illness in the Caribbean. For example, alcoholism is common in the Caribbean but is not defined as a disease which needs treatment (Glasgow & Adaskin, 1990) and mental illness is frequently thought to be possession of the body by a sprit (Spector, 1991).

Interpretation of verbal language and body language may make communication difficult (Rosenbaum, 1995), but what about clothing? What does traditional clothing mean to health professionals? Some people who appear to be traditional will be quite knowledgeable regarding North American customs. For example, the wearing of a sari is no indication that the wearer does not understand Western ways nor does it mean that she will follow her own traditional medical practices. Indeed, her tradition may be that of the main stream North American culture. The opposite also applies to the one who dresses in western garments and speaks fluent English but does not necessarily adhere to North American custom (Anderson et al, 1990).
The practice of infibulation was not only unacceptable to nurses but also found to be abhorrent to Western society in general (Council Report, 1995; Meniru, 1994; Mustafa, 1966). Infibulation, which refers to female genital mutilation, has not been confined to African Muslims. It is also performed by Jews and indigenous religions in Africa (Meniru, 1994; Mustafa, 1966). There was a great deal of judgement on the part of health professionals towards those who practice infibulation (Shorten, 1995). A greater understanding, by way of education (Council Report, 1995), of the issues, rites, and symbolism that surrounds this practice is essential. Overall, it is important that health professionals need to be able to distinguish between what is morally unacceptable and legally unacceptable within the context of human rights in Canada (Masi, 1995). In order to deal with this controversial issue, it may be prudent for health professionals to recognize the difference between what is morally right (based on their own cultural and/or religious values) and what the law deems to be right (or wrong). Female genital mutilation may be an immoral practice to some, however, the fact remains that it is an unlawful practice in Canada and must not be condoned.

People share values, traditions, and experiences within ethnic groups. But there is also widespread diversity within those same groups (Anderson et al, 1993) and between generations in that group (New & Watson, 1983; Rosenbaum, 1995). It must be noted that even when ethnicity is the same, factors such as class, religion, age, and gender play a part in making a difference (Anderson, 1994). Cultural awareness/cultural sensitivity implies knowledge and understanding of the norms and customs of other groups, which vary from one's own (Meghani-Wise, 1996). The literature revealed that there is a great deal of misunderstanding and ethno-
centrism on the part of health professionals, regardless of their own ethno-cultural heritage (Hoeman, 1989; Masi, 1995; Rempusheski, 1989).

Culturally Sensitive Professional Development/Training

The lack of sensitivity on the part of healthcare professionals and problem/concerns in communicating with clients has been previously discussed. A possible reason may be because multicultural education is limited and is "too white, too middle class and too exclusive" (Eliason & Macy, 1992, p.32). Stereotyping occurs due to a lack of knowledge. The frequency with which stereotyping surfaced among healthcare professionals is a cause for concern (Papadoupoulos, Tilki, & Alleyne, 1994). Health professionals were urged to recognize the power of stereotyping and to be aware of their part in it (Pfeifer, 1995). Leninger's (1984) study of nursing students and stereotypes found that the students, who were middle class females, had very stereotypical responses such as welfare mothers were poor, lazy and black and Native Americans were alcoholics, poor, wore feathers and leather. Nursing programs included some multicultural topics but for the most part it was inadequate (Papadoupoulos et al, 1994), due to the fact that medical and nursing practitioners and faculty were white, middle class and rarely had multicultural training (Leninger 1984; Shubin, 1980).

The following quote succinctly articulated a vision in cultural education for healthcare professionals.

"The goal of the ethno sensitive or ethno competent approach is to create or recreate programs and organizations that will be more responsive and responsible to the culture of minority groups. Training for cultural competence and the delivery of ethnic sensitive service requires understanding of one's own personal attributes and values,
gaining knowledge about the culture of different groups and developing skills for cross-cultural work" (Gutierrez, 1992, p.326 quoted in Inglehart & Becerra, 1995, p.206).

It is necessary to appreciate that health professionals are usually from the main stream culture (New & Watson, 1983). Those from ethno-racial groups, other than main stream, are from upper and middle class and may be removed from their patients’ beliefs. In North America, health professionals are socialized into their profession regardless of ethno-cultural background (New & Watson, 1983). The more educated they are, the further away they become from their own ethno-cultural origins, in terms of understanding their belief systems. Ethnocultural education and training promotes an understanding of diverse lifestyles, beliefs and values (Papadopoulos et al, 1994), which healthcare professionals were encouraged to use to guide their practice (Leninger, 1984). As well as the necessity for cross-cultural training, more effort is needed to recruit, develop and retain ethno-cultural professional staff (Habayeb, 1994; Spicer, Ripple, Louie, Baj & Keating, 1994).

**Cultural Awareness Education/Training**

It seems that healthcare professionals were not given the advantage of cultural education. Therefore they often learned on the job. This section explores various methods of gleaning cultural knowledge other than formal education.

A study at Imperial Oil nicely captured the consequences that a lack of cultural understanding can have on people (Kapel, 1994). The study found that Asian employees, though hard working and technically competent, received performance appraisals that stated they lacked
leadership and communication skills. Insightfully, this company hired an expert on cultural diversity to assist in reducing the cultural misunderstandings. During the training process non-Asian employees discovered that Asians tended to be constrained in the presence of authority and that it was deemed impolite, by Asians, to say no to one in authority (Kapel, 1994). This training served to shed light on behaviors of Asians that elicited many interpretations, most of which tended to be negative.

Sharma’s study of settlement workers showed that workers gain and develop valuable, irreplaceable experience on the job in terms of cross-cultural sensitivity. This experience was difficult to train (Sharma, Ervin & Meintel, 1991). Sharma suggested, however, that in order to better serve the population, it may be more beneficial to formally educate doctors, nurses, and counselors in cross-cultural sensitivity, in addition to the experience gained on the job (Frideres, 1988; Sharma et al, 1991). Green (1995) claimed that while lectures and role-plays have their place, they were no substitute for learning in the field (Green, 1995). Connaught Laboratories, however, expounded the merits of in-house awareness-training for its employees (Kapel, 1994). Lum and Korenman (1994), offered a suggestion in that students ought to evaluate their own perceived preparedness and needs in terms of cultural awareness courses and training. The literature was wide and varied as to the most appropriate method for accruing cultural knowledge.

Culture and Deviance

The purpose of introducing the topic of deviance is to draw attention to how easily diversity
could be interpreted as deviance, simply because cultural norms differ. Universally, behavior, which does not conform to one's knowledge of the world is labeled as deviant. Behavior in and of itself, however, is not deviant. A behavior is only deviant if it is contrary to social norms as we understand them.

It is interesting to note that there are almost no behaviors or practices that have been automatically labeled deviant across all societies. For example, in Canada, infibulation is considered to be deviant behavior, whereas, in many African countries not practicing infibulation is considered to be deviant. Social perspective guides what label is placed on a behavior, practice or norm. "If we accept that behaviors are not automatically deviant, it follows that the creation of rules for behavior creates deviance. Society, not individuals, makes deviance...deviance therefore, is a social label" (Clark & Robboy, 1988, p.300). The literature cautioned that health professionals need to be aware of and exercise discretion in their labeling of norms, practices and customs that differ from mainstream culture. For a witty and thought provoking account of the strange habits and rituals of mainstream culture, see Miner, (1988).

Social Construction of Reality

In reviewing the literature it seems that the way in which health professionals interpret the actions/behaviors of others is a socially constructed process. Health professionals do not instinctively know and understand those who are not of their culture. What is known of other cultures is based on social relationships. According to Berger and Luckman (1967), humans construct their own reality and are constructed themselves by the reality that they participate
The social world was characterized as: "Society is a human product. Society is an objective reality. Man is a social product" (Berger & Luckman, 1967, p.58). In other words, our cultural norms, habits and customs were created by us and therefore become the way it is - the way the world functions. We function within that world, we are then created (and re-created) by that world. The individual member of society: "Simultaneously externalizes his own being into the social world and externalizes it as an objective reality...to be in society is to participate in its dialect" (Berger & Luckman, 1967, p.119).

This is not to say that individuals are free to construct any reality they choose, in fact, in reading Schutz we get the impression that individuals are "constrained, sometimes even controlled by the norms and values of society" (Ritzer, 1988, p.191). According to Schutz, people construct reality within the confines of a constraining social world. "People are constrained by social forces and people are able and are sometimes forced to overcome these constraints" (Schutz in Ritzer, 1988, p.330).

Berger and Luckman discussed socialization as primary and secondary. They defined primary socialization as the complete immersion into objective society and secondary socialization as the "internalization of institution based subworlds...the acquisition of role-specific knowledge" (Berger & Luckman,1967, p.127). Secondary socialization requires the use of language specific to that role, such as implicit understanding, interpretation and behaviors, in keeping with the norms of that situation. For example, when we learn a new language we think about
what we want to say in our language and then translate it into the new language. Eventually, we become intimate with the once new language, we learn to think in the new language making translation unnecessary. These moments of externalization, objectification and internalization occur simultaneously rather than temporally.

It seems that in order to play one's role it is necessary to have an awareness of society at large. Awareness of society is gathered through one's own socialization. To function competently and comfortably in a role, it is necessary to be intimately connected to the outside forces and influences on that role (Berger & Luckman, 1967). According to Berger and Kellner, the way in which we arrive at constructions of what is going on around us is by using ready-made typifications and by validating these typifications through discussions and interactions with other people. They then go on to say that:

"Because most events are ambiguous and could be interpreted in a number of ways, we turn to others to validate our use of the culture's typifications. If those whose opinions are important to us do not seem to share our matching of the typification to the event, we may redefine the event, drawing on other categories or meanings (other typifications) from our culture to explain it....our actions and sentiments toward the event will be aligned with the actions and sentiments of others" (Berger & Kellner 1964 in Clark & Robboy, 1988, p.352).

In relationship with others who are not intimate or close friends, the relationships are most likely to grow progressively more impersonal and stereotypical (Ritzer, 1988). The phenomenological analysis of the social structuring of reality is seen in the work of Schutz (in Ritzer, 1988), who claimed that, from very early on in life the individual continually reviews and revises his worldview. This reality is validated, deconstructed and reconstructed through conversation and association with others. Relating my own study to the work of Berger and
Luckman (1967), I examined the relationships and associations of the nurses in terms of how their views on culture are formed.

Summary

The three most common themes that emerged in review of the literature were:

a) ethnocentricity on the part of healthcare professionals; b) problems in communication; and c) a seeming lack of cultural knowledge possessed by healthcare professionals. In review of the literature there seemed to be a dearth of research which examined perspectives of both healthcare professionals and their clients, in terms of their experiences and impressions of each other. In light of that, the primary research question in this thesis asked: How do public health nurses experience working with individuals from a variety of cultures?

The first objective was to show whether public health nurses saw themselves as adequately prepared to work with a culturally diverse community. For example, a) what did public health nurses identify as some of the main issues/problems they seemed to be facing in working with a varied ethno-cultural community? b) How did public health nurses demonstrate cultural sensitivity? and c) By what criteria did public health nurses determine whether or not they were culturally sensitive? A second objective was to examine whether the community believed that public health nurses were sensitive to ethno-cultural differences of the community in which they worked. For example, by what criteria did the community\(^1\) assess/evaluate the sensitivity

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\(^1\) In this context, Community means the clientele/customer of the nurse. The community worker is also considered to be a client or customer of the nurse. The role of the community worker will be described more fully in the following chapter.
of public health nurses to ethno-cultural diversity?

In chapter six, Berger and Luckman's (1966) social construction theory was utilized to provide a fuller understanding of the experiences of healthcare professionals in their construction of cultural sensitivity.
CHAPTER 3

METHODOLOGY

In this chapter I will outline the research process of my thesis. Firstly, I will discuss the perspective from which I conducted the study and also my rationale for the chosen methodology. Following that, I will then describe the participants. A brief discussion on ethics and problems in qualitative research, as they relate to my study, will ensue. This will be followed by a detailed account of data collection and the analysis process I used. Limitations of the study will then be introduced and the chapter will conclude with a personal disclosure.

Background to Research Methodology

The researcher's world view in great part determines the methodology chosen for conducting research. A brief comment of three worldviews - positivism, idealism and realism will set the stage for my worldview and methodology of choice. Positivists take the stand that science is value free, and in addition, that the social world is observable and measurable (Wilson, 1983). "Positivists place great emphasis on making their concepts precise, unanimous and context free. We do not need to know who is using them or on what occasion they are used in order to grasp their meaning" (Wilson, 1983,p.119).

Unlike the positivists, the idealist "is not basing his judgement on a limited set of specifiable features of the behavior and the occasion. Rather, he must depend on the context as he sees it
being relevant, a context which is infinite in its zones of relevance" (Wilson, 1983, p.119). To
the idealist, the notion of role may pre-exist, however, the role itself is flexible - changing and
growing during the encounter. Idealists take the stand that the social world is ever changing and
meaning is derived from the significance of the circumstance in each interaction.

In keeping with the idealist or interpretive world view and the intent of this study (exploring
the experiences of individuals) utilization of qualitative methodology was appropriate for this
research project. Henderson, Sampselle, Mayes, & Oakley (1992) found that although we live
in a pluralistic (multicultural) society current research paradigms do not reflect the multi-
cultural nature of society. Ethnocentrism¹ is deeply embedded in our own assumptions. Our
beliefs and values are shaped by our own culture and it is difficult to appreciate that the beliefs
and values of other cultures are just as valuable to them as ours is to us (Henderson et al,1992).

In the past, other groups have been marginalized in research. For example, prior to the women's
movement, research, which was carried out on men, was commonly generalized to women. The
fact that both physical and psychological research and research instruments were first tested on
the dominant white male population to study populations such as the North American natives
is also notable (Anderson, 1992). Literature has shown that instruments which were intended
for use on the North American population were not transferable to ethno-cultural groups
(Schwab, Meyer & Merrell, 1994). Choosing a qualitative approach with open ended, semi-

¹Ethnocentrism is the belief that our own culture is normative.
structured interviews also addressed the concern of conducting a study of one cultural group with instruments intended for another cultural group.

Rationale for Methodology

As previously stated, I chose qualitative methodology because it is in keeping with the idealist/interpretive perspective. Epistemologically, qualitative research was the most appropriate approach to this study because the aim was to describe the meaning of cultural sensitivity from the perspective of those who were interviewed (Bryman, 1993). In addition, the qualitative approach assumes multiple perspectives and layers of reality (Burns, 1989). A definition of reality, however, with its multiple influences, remains elusive to me. Due to its very nature, I can only define and know my own reality. I acknowledge, however, that it is possible to record one given reality. That reality occurs in the moment when information is presented to me by one individual at one point in time.

This research focused primarily on the perceptions of public health nurses and to a lesser degree on the experiences of community workers. Since this is an interpretive research study it was appropriate to utilize qualitative methods, such as semi-structured interviewing, to explore the everyday life experiences of the participants. With this method I examined meaning, motive, intention, emotion and feelings as these were experienced (Patton, 1990) by nurses and community workers in order to gain an in-depth understanding of their experiences in interacting with each other.
Problems in Qualitative Research as it Relates to my Study

There are a number of inherent problems in qualitative research and therefore it was necessary for me to identify and address potential problems as they relate to my study.

(a) There was a risk of my view being colored by 'going native' (Bryman, 1993), that is, identifying myself too closely with either the health professionals or the community members. In response to that, as a researcher I must be alert for signs of unintentional bias. For example, there must be self-awareness. I must also recognize my own philosophy and principles that guide my practice as a nurse and as a person of a particular ethno-cultural origin (please see my personal disclosure at the end of this chapter).

(b) My findings cannot be generalized beyond this study. Findings from this study pertain only to the individuals in the study and within the time frame and the environment of the study.

(c) The notion of replication may be problematic (Haase & Myers, 1988). Any researcher attempting to duplicate findings must locate my study in its specified time frame, setting, participants and so forth.

(d) The use of community workers as spokespersons for their communities may have its own set of concerns, such as the question as to whether they are qualified to speak for their community.

Participants

Decision for Choosing a Community Worker to Represent the Community

My decision to choose community workers to represent community members was based on the wide and varied interactions of the community workers both with nurses and with individuals
in the community. Originally I had intended to interview community members who were currently utilizing the services of public health nurses. This seemed to be limiting in that clients of the nurses had interactions with only one nurse and therefore could not articulate their experiences in dealing with public health nurses. Their impressions would have been based on interactions with only one nurse per community member. Community workers, however, interacted with many public health nurses as well as a great many community members. Community workers often participated in home visits, assisted with group facilitation and supervised by nurses organized various projects with their communities. These activities made community workers a logical choice for recruitment as members of a culturally diverse community.

**Process for Choosing Participants**

The goal of this study was to understand how nurses experienced working with a culturally diverse community. A total of twenty interviews were conducted, ten nurses and ten community workers from two public health departments were recruited. This number was deemed to be adequate by experts in the field (my thesis committee members) for this type of study. It is also in keeping with grounded theory research. In grounded theory, sampling occurs until no new information emerges with regard to a particular category (Strauss & Corbin, 1990).

**Non-probability Sampling**

The participants in this study were chosen by utilizing non-probability, convenience sampling (Singleton, Straits, Straits & McAllister, 1993). Probability sampling involves a process of
randomly selecting participants. Random in this context means that every person in the study population had an equal chance of being included in the sample. Non-probability sampling means participants were selected in other than random ways (Singleton et al, 1993). There are a number of inherent weaknesses in non-probability sampling, for example, investigator bias in choice of participants. For the purposes of this study, however, it was quite appropriate as long as I remained mindful of the potential for bias. Non-Probability sampling is recommended when there are a very small number of participants such as my study (Singleton et al, 1993). Convenience sampling involves selecting a number of participants who are conveniently available. According to Singleton et al (1993), if generalizability is not a concern then convenience sampling is appropriate.

Recruitment

I utilized the aid of Divisional Directors of two public health departments in Toronto in my selection of nurse participants. The two sites were chosen for the wide range of ethno-cultural groups in their respective catchment areas and for their geographic proximity to my residence. To gain the assistance of the Divisional Directors I firstly presented the proposal of my study. I then requested that they in turn inform the nursing staff of the study and convey to the nurses that I would assure them anonymity and confidentiality. The nurses were given my phone number and instructed to contact me directly if interested in participating in the study.

The study began when a total of ten nurses contacted me. The first five nurses who contacted me from each public health department were interviewed. Upon completion of each nurse
interview I asked that the nurses inform community workers with whom they work or have worked with in the past of the study. The nurses were asked to give the community workers my telephone number and request that they contact me if interested in the study. The nurses were then instructed to convey that I would assure them (the community workers) anonymity and confidentiality.

The recruitment of community workers proved to be more challenging than I had originally anticipated. The first five who contacted me from each public health department were interviewed. Over the course of a four week period I received calls from six community workers. I asked the nurses to repeat their requests to community workers with whom they interacted, this met with small success. Following that request I received calls from two potential candidates who were subsequently recruited. Those two participants were asked to contact two of their colleagues. This completed the sample size of the ten needed for the study.

Criteria for Selection of Community Workers

Community workers were all required to be English speaking. It was necessary for each to have had a close working relationship with more than three nurses. This was necessary in order to qualify to speak about their experiences with public health nurses. It had the added benefit of protecting the identity of the nurses. I also required that the community workers received, at some point in their adult lives, the services of a public health nurse (i.e. must previously have been a client/customer of the nurse). Fortunately for me the first ten community workers fit the required criteria.
Description of Participants

Nurses

Nurse participants were all married females and ranged in age from thirty to fifty-six years old. The ethno-cultural backgrounds varied, consisting of a mixture of Canadians from British and European backgrounds and Asians. The nurses who were born outside Canada have lived here for most of their lives. The nurse's length of employment at the public health departments ranged from six to twenty years. All the nurses held at least one under-graduate degree while some held a Master's degree.

Community workers

In this study, community workers were cast in the role of customers/clients of the public health nurses. The community workers worked closely with the nurse in the provision of services to their community members, and they were also part of that community. These workers functioned as advocates of the community and were informal leaders within the small group sphere\(^2\). Community workers were at one time clients of the nurses either personally or in association, for example a mother or a sister of the community workers may have been a client prior to them becoming community workers. Community workers and/or their family members in this study were not necessarily clients of the nurses in this study.

Community workers were members of the community that they served. For example, the

\(^2\) small group sphere means: the immediate world of the groups that came together for a purpose such as New Beginnings or subsidized day-care and so forth
community workers in the Caribbean community were themselves from the Caribbean, in the African community they were African and so forth. Community worker participants were all female; some married, and ranged in age from twenty to fifty-four years. The ethno-cultural back-grounds varied, consisting of Africans, Afro-Caribbean, South Asians, and one European. All the community workers were born outside of Canada. The length of time in Canada varied greatly and ranged from twenty-five years to as little as five years. Employment and/or involvement with the public health departments ranged from two years to ten years. The highest level of education achieved varied a great deal among participants from primary school to post-graduate levels, the latter of which were obtained in their countries of origin. Two of the ten community workers held post graduate degrees.

Since most of the community workers employed by the public health departments were from visible minority groups, the sample reflected this. The community workers were paid a very small wage by various community groups. One worker referred to herself as a volunteer because as she stated "the wage is an allowance". In this capacity they were employed to work with the public health nurses as bridge workers. In other words, they bridge the gap between the community and the nurses. In chapter five I will elaborate on the meaning and the responsibilities of bridge workers.

Ethics

Methods for Obtaining Consent

Participants were informed of the study and the interview process during an initial telephone
contact when anonymity and confidentiality was assured. At the interview, prior to beginning the process, a consent form was given and explained to each participant. It was stressed to each participant that she may withdraw consent at any time during the study and confidentiality of name and any information received from the participant will be maintained (please see appendix A for information sheet and consent form).

**Maintenance of Anonymity and Confidentiality**

Anonymity was maintained by the use of codes in place of names. Interview transcripts and memos did not identify participants by name. The names attached to quotes in chapters four and five are made up and bear no resemblance to the real people. In the write-up, the location of the research is listed as Southern Ontario so that participants cannot be identified. All consent forms and data, which may identify a participant, are locked up in a place to which access is limited to myself. In a final endeavour to ensure that anonymity was maintained, the nurses were offered their interview transcripts to review. Two nurses initially showed interest in reviewing their interview transcript, however, only one nurse took the opportunity to actually review and comment on her transcript. The changes she made entailed deleting information/words that may identify her. In no way did these revisions affect the findings of the study.

**Statement of Expected Benefits to Participants**

I explained to each participant that they may or may not benefit directly from the study. Benefits to participants will be reliant on each public health department for the utilization of
results in terms of policy creation and implementation. Nurse participants may use information gleaned from the community participants to adjust, as they deemed necessary, their interactive processes with community members. Staff from other health departments may benefit, as results will be made available upon request. The community may benefit should results be utilized (by the public health departments) to adjust policy, if necessary, for professional development of staff re: cultural awareness and/or any other information generated by the study.

Data Collection

According to Lincoln and Guba (1985), the only truth is the lived experiences of others. In order to obtain quality data and to know what is going on with others the researcher must enter their world (Bryman, 1993; Lincoln & Guba, 1985). I was interested in the lived experiences of the nurses and community workers, therefore, in order to capture the experiences of these participants I believes that in-depth interviewing was the best method for collecting data. Thick description (rich detail) provides a holistic understanding of the interviewee's point of view (Patton, 1997). This in-depth interviewing has been called a conversation with a purpose (Berg, 1995, p.29; Kahn & Cannel, 1957, p.149 in Marshall & Rossman, 1995, p.80). Another reason why in-depth interviewing was preferred for this study was because the oral tradition is an important part of many ethno-cultural groups (Chavez & Oetting, 1995). For this reason too, Martinez, Bedore and Ludwig (1994) suggested that it may be more beneficial to utilize open-ended rather than close-ended questions.
The Interviews

According to Patton (1987, p.109) "interviewing allows the evaluator to enter another person's world, to understand that person's perspective". In order to explore the lived experiences of nurses and community members I conducted semi-structured interviews with probe questions. The interview began with general questions then followed an interview guide as the interview progressed, during which time I took care to allow the participants' views to unfold, guiding only if off topic. The interview guide was used to ensure that the same questions were asked of all participants. The guide also served as a checklist to ensure that all relevant topics were covered. Probe questions were used to clarify a statement and/or to encourage more detail from the story (please see appendix B for samples of the interview guides).

Interviews lasted one to one and one half-hours. The participants decided the venue where each of the interviews occurred. Of the nurses, one interview took place in the food court section of a mall, another at her home; the remaining eight took place at the workplace. Of the community workers, one interview began in a coffee shop but because of the noise level we moved to my car (as suggested by the interviewee). Four interviews occurred at their respective homes and all others at the workplace.

During an interview, it is very difficult to listen, ask pertinent questions and take useful notes all at the same time. In light of this, and with permission of the participants, a tape recorder was used and notes taken. Field notes recorded such elements as clothing of the interviewee, age, ethno-cultural orientation, body language, a description of the environment where the
interview took place, my impression of the interview process and so forth. Immediately following the interview, when the interviewee had left, I listened to the tape in order to ensure all information had been recorded (tape recorders have been known to malfunction). At this time I also took the opportunity to reflect on the interview as well as make notes of my impressions regarding the interview process.

Truth Value

Perhaps the most challenging part of this whole process was in knowing whether the participant was telling the truth. There were a number of ways to check truth validity but it was necessary for me to first ask a few questions. Were there any ulterior motives that might have encouraged the interviewee to modify his/her story? Did the interviewee have reason to want to be seen in a good light? Was there a desire to please the interviewer for any reason? To check the truth-value I asked myself whether the account of the interviewee sounded plausible. Did the interviewee have conflicting stories/accounts? It is important to keep in mind, however, that distortion of a perspective may only be in the mind of the interviewer, in this case, myself. For as Thomas and Swaine succinctly stated: “It is not important whether or not the interpretation is correct – if men define situations as real, they are real in their consequences” (Thomas & Swaine, 1928, p.572 in Berg, 1995).

Transcription

The interview tapes were transcribed word for word by three experienced transcribers. Three transcribers were needed, as the first two transcribers became ill following the completion of
a few tapes. Careful comparison of tapes and hard copy ensured that data had not been compromised during the transcription process. Tapes were numbered in order to maintain the anonymity and confidentiality of the participants.

Data Analysis

There are a number of qualitative research methods such as phenomenology, ethnography, life histories, and grounded theory. As previously mentioned, I utilized the constant comparative method, also known as grounded theory. The method chosen relies as much on the research question as it does on the researcher herself. Some researchers believe that data should not be analyzed but presented as is, with as little of the researcher's observation or opinions as possible. In other words, allow the data to speak for itself. Others (such as myself) present their findings with their own interpretive comments interspersed in long descriptive passages of quotes from interviews and field notes. This type of narrative gives a description of what the world is like to the participant. The words of the researcher lend a somewhat detached conceptualization of that reality (Strauss & Corbin, 1990; Strauss, 1987). The question as to how detached a researcher can actually be, having spent a significant amount of time in lengthy discussions about lived experiences, remains to be seen. The challenge for me is to recognise that I am a part of the data, a participant in the process of data collection. In recognizing and acknowledging my contribution to the interview process a somewhat detached view may indeed be possible.
Coding

The nurse interviews were analyzed before those of the community workers. Coding was done by reading all the interviews in search of main themes. The first reading of the interviews allowed me to have a general understanding of the role of the nurse and the community worker and the relationship to each other and to the community as described by the participants. The initial reading also enabled me to ask questions of the data. These questions allowed the process of open coding\(^3\) to begin. Here I was able to discover, name, and categorize events.

In order to fully explicate the steps that I outlined in the previous paragraph I will walk the reader through the process. Beginning with the first interview transcription I read through the transcription looking for the gist of the content. Following this I looked at each paragraph and attached a preliminary code to it. For example, if the paragraph was about spanking, then spanking became the code and I assigned a number to that code for easy retrieval at a later date. Utilizing my computer and the cut and paste method I grouped together all paragraphs and or sentences that had the same code.

I went through each interview following this procedure allowing coded information from previous interviews to inform the coding of the current interview under analysis. New information discovered in subsequent interviews was coded and named as new codes. I then returned to the previous interviews in the event that the new information had been stated but

\(^3\)Open coding is the process of breaking down, examining, comparing, conceptualizing and categorizing data (Strauss & Corbin, 1990).
had not been obvious to me. Utilizing my field notes I examined in detail the relationship of the coded data to interview, that is, to the environment, to the education and experience of the interviewee and any other information I could think of. I looked at each code or category with an eye toward similarities and differences between interviews and interviewees. I looked for the relationship to what was said before and after a particular statement/issue surfaces.

Following the procedure for initial coding, each coded category was collapsed and grouped together with similar categories. For example, "women who do not go out of the home without their husbands" was grouped with "birth control decisions are made by the husbands" under a heading titled "husband is boss". This process continued until four or five categories remained. Continuing with the example above, a final category of male dominance emerged from the previously mentioned categories.

Rigor and Validity in Qualitative Research

Rigor and validity in qualitative research is extremely important at every stage of the research process. Rigor means that each step of the research process is scrutinized carefully and critically (Ratcliffe & Gonzalez-del-Valle, 1988). Following the interview I reviewed my notes and any vagueness was checked with the participant for clarification. This was also a critical time for reflection in terms of my impressions of the interview. For example, I asked myself: How did my style and approach affect the interview? How did the participant react to the interview? Did the venue have any effect on the interviewee or on me?
The risk of personal bias in qualitative research makes it imperative that the researcher takes great care in minimizing influences. I gave careful consideration to capturing the flavour of the interviews as close as possible. During the interviews I took extensive notes describing the environment, attire of both parties, the mood of the interview, interviewer and interviewee and so forth. Participants were given the opportunity to review and comment on the transcript of their interview in order to clarify that the typed words conveyed the meaning of what was said in the interview. One participant accepted the offer to personally review and comment on her transcript. Subsequently, I carefully reviewed and deleted identifying words/statements from the remaining interviews. During the interviews and analysis of data I was mindful of personal and/or professional biases which could arise.

Criteria of Soundness (Trustworthiness of the Project)

Lincoln and Guba (1985) suggested four constructs to ensure trustworthiness of the project: credibility, transferability\(^4\), dependability and confirmability (in Marshall & Rossman, 1995). Lincoln and Guba suggested that credibility rather than external validity (in the quantitative sense) should be the criterion against which the truth value of qualitative research be measured (in Sandelowski, 1986). In keeping with Sandelowski then, I presented my data so that it faithfully adhered to the experiences (as told to me) of the nurses and community workers and can be immediately recognized as trustworthy by those who experienced it and by other researchers.

\(^4\)Transferability or external validity is a weakness of a qualitative approach. I would not have used this methodology had external validity been my goal.
It was also recommended that data be presented so that other researchers would also recognize
the experience when confronted with it, having only read about it in a study (Sandelowski, 
1986).

Another way to enhance the value of qualitative research is for researchers to describe and
interpret their own behaviour and influence in relation to the behaviour and experience of
participants, to see themselves as subjects in their own study (Sandelowski, 1986). Throughout
the interview process and indeed throughout the study the notion of self-awareness has very
much been in the forefront of my mind.

Will another researcher be able to confirm my findings? Inherent in the goal of reliability is the
value of repeatability (Sandelowski, 1986). In order for another researcher to follow the
decision trail used by me, I kept notes and a journal that recorded each design decision and the
rationale behind it so that others can inspect procedures and protocols. I also kept all data in
retrievable form and easily available should the findings be challenged or should someone else
wish to analyze the data.

Limitations of the Study

Limitations are an inherent part of any research project. Limitations of this study include but
are certainly not confined to the following:

(a) Although the methods I utilized were appropriate for this study results cannot be generalized
to other health departments (this is addressed in greater detail earlier on in this chapter).

The findings are applicable to only those participants in the study at the point in time when
they were interviewed. Nevertheless, it is hoped that this study will provide health professionals from other public health department with insights into their relationships with the multicultural community in their catchment area.

(b) Another possible limitation is in the method by which the participants were selected. Those nurses who came forward may quite conceivably have felt pressured to do so, by their divisional directors.

(c) Nurses may have responded with very positive statements regarding their relationships with the community for a number of reasons. The reasons for their responses could include: fear of retribution at work (especially in light of the existing tough employment/unemployment market); giving responses they thought the interviewer wanted to hear; and/or the desire to appear to have an excellent relationship with the multicultural community.

(d) The community workers were predominantly of African origin. A possible limitation is that the nurse participants did not include a nurse of African origin. This limitation may have shed another light on the findings in terms of experiences of both nurses and community workers.

(e) The venue for interviews varied. In retrospect, the workplace may not have been the most appropriate place to conduct interviews due to the risk of being overheard. There may have been an added caution in terms of freedom of expression on the part of nurses.

(f) Researcher bias is acknowledged as inevitable in any research project. In spite of the effort made to reduce bias as much as possible, it inadvertently remains. In the entire process of this study, every effort has been made to limit researcher bias. In spite of these potential
limitations, I believe I have captured what culturally sensitive behaviour means to those who participated in this study.

Summary
This study was from the idealist/interpretive perspective which utilized a grounded theory approach to data collection and analysis. Participants consisted of public health nurses and community workers who were all chosen by non-probability, convenience sampling. The collection of data involved the utilization of semi-structured interviews with probe questions. A qualitative approach to data analysis was taken.

Personal Disclosure
An important element to qualitative research is a brief account of the researcher herself. So here is my story. My grandparents migrated to the Caribbean from India in the early part of this century. I was born in Trinidad but left at an early age with my parents to reside in Canada. My high-school education was somewhat fragmented due to the fact that I attended three schools in three different countries (Trinidad, England and Canada) in five years. I obtained my registered nursing diploma in northern England then returned to Canada where I practised as a registered nurse (in a hospital environment). I believe it is important to point out that as a child I attended boarding school in England and as a student nurse in Northern England I was one of only two foreign nurses in the hospital. Not only were we the only visible minorities, we were the only two non-English or Scottish students. My values since the age of eleven years
reflected those of the dominant culture of England.

Perhaps it is evident at this point that the potential for personal and professional biases are vast. I left the country of my birth at an early age. This has made it possible to remove myself consciously or unconsciously (perhaps both) from identifying too closely with my birth culture or in fact with any one culture. Yet, I find that I will conveniently identify with a particular culture as suits the occasion and my purpose. For example, when I am in the presence of Caribbeans I may lay claim to being one of them, with someone from northern England I may do the same. There were moments in this study when I identified with the nurses and other moments when I identified with the community workers. There were a number of times during the course of this study when I recognized the need to step back from the interview and analysis and evaluate my part in the process. The danger of going native was significant enough to warrant exploration.

As a result of my personal and professional observations and experiences cultural sensitivity has been a topic of much interest and concern to me. During my career path I observed an increase (in recent years) in clients from various ethnic and religious back-grounds. I observed the frustrations of clients whose needs (interpreter services and dietary/religious are some examples) were not met for a variety of reasons. I also observed the frustrations of staff in trying to meet the needs of an increasing culturally diverse population. During this time I was also very much aware of my intolerance for nursing staff who displayed little or no sensitivity
nor understanding of the norms, habits and customs of those from cultures different from their own. Throughout this study I remained very much aware that I could have easily transferred those feelings to public health nurse participants. I can only hope I was successful in limiting my biases.

I am unsure why I chose this particular topic or population for study but I will venture some guesses. Perhaps it was due to the fact that I am a registered nurse that I chose to isolate this professional group for study. Perhaps I hoped to acquire greater insight into the norms and expectations of various cultural groups and with that enhanced understanding, develop the ability to more fully meet the needs of the patients/clients. Perhaps it was because I had a need to find data that may have indicated that health professionals (nurses) do have some understanding of cultural variations and that the existence of enthno-centrism is minimal in at least one area of healthcare.
CHAPTER 4

NURSES PERSPECTIVE ON CULTURAL SENSITIVITY

In this chapter, I will document the public health nurses’ accounts of their experiences in working with a culturally diverse community. Demographics of the nursing and community population have already been outlined in the methodology chapter. The chapter will begin with an outline of where and how nurses acquired their knowledge and expertise on cultural sensitivity and will then explore opportunities for professional development within the public health departments. The challenges and issues of working with culturally diverse groups, as identified by the nurses, as well as a description of the ways in which they deal with these challenges will follow. During the interviews, nurses reflected on culture and articulated that in order to deal with cultural issues/challenges one must be culturally sensitive. In the latter part of this chapter nurses explained what cultural sensitivity meant to them. Nurses described the ways in which they believed they demonstrated cultural sensitivity, as well as the criteria they used to determine whether or not they were being culturally sensitive.

Acquiring Expertise

When asked how they acquired their expertise in working with a culturally diverse population the responses identified three ways: experience, reading and inservices. Many of the nurses stated that when they first began working as public health nurses they had no idea how to be culturally sensitive. Experience seemed to be the number one means for acquiring knowledge
about various cultures and by interacting and asking questions. Often, by making many mistakes they came to understand what it meant to be culturally sensitive and insensitive. A great deal of time was spent reading and having discussions with their colleagues about various issues that occurred in the course of their day. Frequently, observation of clients would assist in the acquisition of knowledge. This occurred mostly by comparing how one person or group responded in a situation versus another.

The nurses all went to university in Canada and most had their master's yet all stated that courses on culture were few and far between. There may have been sociology and maybe an anthropology course in their program that gave them a little knowledge of the meaning of culture, which however, was only a textbook meaning. They felt that nothing could have prepared them for the real world of diverse cultures.

"We jumped in with both feet...I don't believe we had that much preparation other than knowing from training...we got a little bit" (Carrie, p.13).

Three of the ten nurses were born outside of Canada and two were of a visible minority group. These three nurses maintained that it was their own personal experiences which they believed gave them that added sensitivity.

"I guess it's because it is my own culture to begin with that I know. I'm extra sensitive to them because when I first came over here, I guess I know about this through when I was young, you know, how hard it is for them to learn English and to adjust to, you know, the Canadian environment" (Denise, p.21).

The remaining seven nurses believed that their acquisition of knowledge was achieved by their extensive experience as public health nurses over the years. They said that a great deal of their information came from peers both in the department and out in the community.
There was expressed amusement from two nurses in relation to the use of the library for the purpose of acquiring knowledge about various cultures. One nurse said that she once needed some information about an issue that occurred but by the time she figured out how to use the library system the issue had been resolved. Another said that she needed articles for a project she was doing but by the time she received the articles the project was over.

**Inservices**

Although there were many complaints about the insufficiency of education on cultural diversity within the public health department, every nurse seemed to feel the need to defend the department by explaining the reasons for the lack of inservices, even if it was only speculation on their part.

"As far as education put on by the department - well none of that happens now, there's just no money for that anymore" (Barbara, p.10).

Inservice education in this context means education sessions such as formal presentations and lunch and learn sessions which were offered by the public health departments. According to all the public health nurses inservices offered by the public health units were "few and far between". Some nurses denied there ever being any inservices that were offered by the department. There were some inconsistencies among the nurses regarding what the department offered in terms of education for employees. Five of the nurses claimed that there had been inservice education at one time or another. The other five claimed that there were no inservices and to their knowledge there never have been. Of those who claimed there were inservices none were able to take advantage of the opportunity and also added that they did not believe that the inservices were on culture and cultural issues.
Apparently, time was allotted for staff to attend in-services\(^1\) but, for the most part, nurses found it very inconvenient to attend because there was no one to cover their caseload. The consensus was that they would rather spend the time they had with their clients. Inservices usually occurred away from the nurses' catchment area so that travelling was also an issue for them. Inservices lasted about one hour and the nurses perceived that the time it took to get to inservices was simply not worth the effort; the cost in time was too great. One nurse commented that lunch and learn sessions were also a waste of time because everyone chewed loudly and rattled garbage bags making it impossible for her to hear the speakers.

It seemed that years ago there were frequent inservices on cultural diversity but over the years for one reason or another those inservices have become a rarity. Many of the nurses cited a lack of funding as the reason for the scant inservicing. Some of the nurses felt that because there was such a low turnover of nursing staff that inservices were redundant and that was perhaps why the department discontinued cultural inservices. Barbara stated that even though she had been with the department many years she recently moved to a new catchment area. She would have liked some education about the various cultural groups of her new catchment area but the health department offer nothing.

"I am newly transferred here. They gave me a brief orientation - they only talk about the geographic delineation and nothing about ethnic culture" (Barbara, p.23).

Many of the nurses articulated a need for education on cultural diversity, cultural issues etc and

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\(^1\) Inservices in general, not necessarily on cultural topics.
felt this ought to be offered by the public health departments. They did, however, state that in order for them to attend, sessions had to be accessible to them geographically and must be in an environment conducive to learning (not lunch and learn for example).

Summary

It seemed that, in general, there was little to no professional development for staff at the level of the public health department, regarding cultural diversity. What little there was appeared to be poorly communicated to staff. Cultural expertise was mostly acquired by years of experience as a public health nurse. Some reading and discussion with peers augmented the acquisition of knowledge.

Working with a Culturally Diverse Community

The ten nurses who were interviewed for this study expressed mixed experiences in working with a culturally diverse community. Many benefits were articulated which included descriptions such as fun, rewarding, job satisfaction and being fortunate enough to be afforded the milieu to glean a better understanding of people. During the interviews it became apparent that these nurses displayed a great deal of enthusiasm when discussing challenges and issues of working with a culturally diverse peoples. They were more articulate in describing situations and examples of the challenges they faced than in describing examples of benefits.
Challenges/Issues in Working with a Culturally Diverse Community

Public health nurses defined challenges as situations, events, practices and habits which they did not understand or which they believed threaten or were in direct opposition to what they deemed to be right and true. For example, nurses identified that they felt frustrated due to: a) the language barrier; b) male dominance/female subservience; c) child abuse such as female genital mutilation and coin rubbing\(^2\) and d) the attitude and lifestyle of black Jamaican people. These, they listed as the main or most frequent challenges they seemed to be facing.

Language Barrier

Issues relating to the perceived lack of parenting skills were frequently mentioned throughout the interviews. Nurses expressed great frustration at the lack of parenting skills of their clients. This, combined with the language barrier, made communication of these and any other skills especially difficult. For example:

"We try to teach them as much as we can because I think lack of knowledge how to take care of a new-born...even going to buy baby food they don't know because some of them don't know how to read the can...they were adding too much water...the baby keeps crying because the baby is hungry" (Carrie, p.3).

The baby cried continuously because the parents did not understand the instructions on the container of baby food and therefore added too much water. The fact that the baby was crying from hunger is perhaps quite accurate, however, there were other reasons the milk may have

\(^2\)Coin rubbing, also known as "scratching the wind", is used for various ailments such as headache, stomach ache, colds etc. Coin rubbing involves rubbing the affected area of the body with a coin or back of a spoon that is intended to relieve symptoms. This procedure leaves a reddened area or bruising on the skin and has often been mistaken for evidence of child abuse (Waxler-Morrison et al, 1993).
been watered down. It may have been an attempt to economize without realizing the impact of their actions on baby.

The nurses all agreed that a lack of information brochures in the language of the client was another source of frustration to both the nurse and the client. Some nurses used sign language, others used pictorials but still felt the information they gave was inadequate. Several nurses who utilized translators found them to be less than satisfactory. For example, in a parenting group one parent may speak English well enough to be able to translate to and for the rest of the group, however, this had its own share of problems according to the nurses. It seemed that the nurses were uncomfortable with the fact that they were not privy to all that transpired between their clients. According to Amy, she wanted to be sure the correct information was being conveyed but she had no way of knowing that. She had no control of the situation because she did not speak the language of her clients and was therefore dependent on a translator.

"I was there observing and there was another nurse conducting the group and she would say something and a community parent would translate it and the group would go chatter, chatter, chatter, chatter for ten minutes and there would be a sentence come back through the translator to us and we'd go - what went on for the last ten minutes?" (Amy, p.7).

During the interview with Amy she expressed disdain for individuals who have resided in Canada for a number of years but were unable to speak English. Another issue around translators or interpreters arose when a male translated for a female. Due to his worldview, the concern of the nurse was that he might have interpreted her words rather than give a verbatim translation (Elsie, p.4). This could potentially have posed its own problems.
Male Dominance/Female Subservience

Another challenge the public health nurses seemed to be facing was the male as authority figure in the household and the seeming lack of respect for his female partner. In the following quotation a mother tried to encourage her son to eat at the table rather than walk around the room while eating his supper. The father suggested to the mother that perhaps their son ought to be able to eat wherever he wished. Amy interpreted this as a contradiction and justified her feelings of indignation by articulating that her group moms often discussed their children and behaviors associated with them in the hope that they would receive some support or education around child-rearing.

“One of the issues had to do with discipline, the mothers didn't feel that the fathers encouraged the children to be respectful...they're giving the kid mixed messages, they're not teaching the child to respect the mother as well as the father. It was very obvious that he was going to be taught to respect the father but the father is then pooh-poohing what the mother said which teaches the child disrespect” (Amy, p.7).

According to several of the nurses it was quite challenging for them when they visited a woman in her home without the presence of the husband. She often asked them to return at another time or to wait until the husband got home before giving any information.

“I just visited a family and I was telling her all kinds, giving her a lot of resources and all that...and she say - wait 'til husband come home...and that's when I think that's the challenge...the man is the patriarch you know, their king, and they have to ask the man for things. And so, that's the chall, that's the difference between our culture and theirs” (Denise, p.12).

Although the issue of male dominance existed in North American families, the nurses did not articulate this. Some of the nurses felt that the issue of male dominance was not confined to
the culture of the man, but rather, was extended to any woman, even to public health nurses. Adele felt the husbands of her female clients would not accept information from her only because she is a woman.

"Some men in other cultures would not listen to you because you're a woman and we're not going to listen to you" (Adele, p.9).

Child Abuse

When asked about challenges they face, the topic of female circumcision (infibulation) surfaced as one of the most challenging and least understood practice. By their own admission they considered the practice to be abusive in nature. The nurses acknowledged their lack of understanding of the practice and therefore would rather discuss the subject only if their clients introduced the topic first.

"There are some things I won't touch...I won't touch that because I can't...I will not touch genital mutilation for example, I will not touch that one with a ten-foot pole. I will not discuss it even unless, unless a woman brings it up" (Adele, p.8).

The nurses, for the most part, stated that they tried to understand the reasons for female genital mutilation, however, the next two quotes captured the feelings of most nurses. It was clear that the nurses felt this was a form of child abuse.

"I have very strong views on what is happening with children and we know that most of these are children who are nine, ten years old who are being mutilated" (Denise, p.10).

"That type of thing hits home because it's a very difficult issue for me because personally I guess being a woman it's sort of, it seems really awful to me" (Cindy, p.12).

Referring to this practice as mutilation demonstrated abhorrence of the practice. Infibulation
was controversial only to those who did not practice it. It became controversial to those who practised it as a result of the antagonistic response from other cultures to the practice of female genital mutilation.

Another practice, which arose in conversation quite frequently, was called scratching the wind. Even though the nurses seemed to be quite knowledgeable about this subject and spoke about this practice being on the decline, they continued to refer to it as child abuse. Some found it too incredulous to believe that anyone thought that this practice had healing properties.

**One Group, Many Challenges**

When the nurses were asked about challenges with any groups in particular the response was unanimous; the black Jamaican group of people were the most challenging to deal with. Frequent themes that surfaced consisted of: a seeming lack of respect for authority, hostility, a lack of compliance with Canadian rules and regulations and teen pregnancies. The nurses felt that the two main reasons for these problems were: a) gender bias existed in the way boys and girls were socialized and; b) lack of parental guidance. The general impression of the nurses seemed to be that the boys were afforded a freedom unknown to the girls. According to the nurses, the unfair restrictions to the girls resulted in their sneaking around and subsequent pregnancies.

"There's very little teaching of discipline or self-reliance or responsibility to the boys. And yet the girls are reined in very much so to the point that the epidemic of teen pregnancies and so on comes from - you can't bring your friends home so you're going to meet them outside somewhere" (Amy, p.11).
A number of the nurses discussed at length the predicament of single mothers migrating from Jamaica in order to create a better life for her kids. The nurses acknowledged that these mother's often held two jobs, which occupied all of their time. The children remained at home alone, unsupervised and eventually got into trouble with the law. The nurses also expressed a great deal of frustration with the missing father syndrome. Their impression was that the male in this culture was a drifter, not dependable financially or otherwise and was of no support to the female. The nurses also indicated that it was not clear to them why the women allowed this behavior.

Summary

According to public health nurses, working with a culturally diverse population was a challenge in itself. Within each cultural group there were also challenges unique to that group. Some groups were more challenging to deal with than others in terms of belief and practices. How then did nurses respond to these challenges? The next section of this chapter focuses on how nurses met the challenges by constructing, for themselves, what it meant to be culturally sensitive and then by behaving in a manner that demonstrated cultural sensitivity.

The Meaning of Cultural Sensitivity

In light of the aforementioned and other challenges faced by the nurses, how then were they able to move beyond the obstacles they perceived in order to fulfil their role? How did they impart their knowledge to the clients or more importantly, by what means did they persuade the
clients to listen to them? According to the nurses, to better serve the client it was imperative that they conveyed their sensitivity to the cultural beliefs/norms and practices of their clients. To them this involved a number of steps. The nurses maintained that in order to work effectively with the community they needed to understand their clients. Based on their training and expertise these nurses indicated that the most important variable in providing health care in a culturally diverse milieu was the need to establish trust between the provider and the consumer. What was meant by trust? To the nurses this meant that the clients believed the nurses would not violate them in their beliefs or practices, that they (the clients) would feel physically safe, that the nurse would not threaten the authority of the male nor upset the social values of their family or culture in any way. Although nurses described several methods to accomplish this, the majority clearly stated that efforts needed to be made to gain an understanding of both the political and historical context from which the clients' culture was derived, as well as, the clients' cultural affiliation.

**Historical Background of the Client**

Nurses in this study were very eloquent in illustrating their appreciation for the historical background of the clients. Several of the nurses claimed that the place of origin had a strong influence on the perspective of the individual. The perception was that this knowledge and awareness allowed them to be culturally sensitive in the delivery of health care.

Everyone came to Canada with firm beliefs and traditions, some came from politically stable
environments while others came here in flight for their lives. According to the nurses, it was in the appreciation of environmental differences that cultural sensitivity was built. In the next two quotes Brenda articulated her understanding of cultural values, norms, practices and expectations. She explained that those who had difficulty trusting others came from war torn countries themselves. For example, the stability of Italy versus the upheaval in war torn South America:

"I think it's the cultural milieu that they come from. We're talking about cultural values and cultural expectations. You have the ...Canadian whose parents have come here and, as immigrants, as young immigrants and established themselves with the European values that came after the war. Many of them came for a better life. I'm not saying that they had nothing to lose when they left but they came from a culture that was very established in cultural values and norms and rituals were very set and they were steeped in history and steeped in religious tradition. And they just transplanted that here. And it's evolved and it's changed but it's still, it's still very strong traditions that are here and the value system is very strongly entrenched" (Brenda, p.6).

"I'm just saying that Latin American Catholics have come from a country where their culture was totally devastated. They...left with a culture, history and tradition. These kids from Nicaragua, from Guatemala, their whole culture, their whole mores, their whole value system has been destroyed as well, the parents who have come over here, they are not just victims, they are victims of torture, some of their parents may be criminals too, they're running, hiding from whoever might be ready to kill them, they...never had that, these people have come away with a survival. The Colombians are a different story, some of these people will have connected to the drug lords over there, some of these people are escaping the drug lords, so you're not going to find out about history, their family history or their background." (Brenda, p.7/8).

Elsie discussed the historical reality of her clients and the importance of establishing trust in order to be effective in her work. She articulated that due to the absolute power of the government and the devastation faced by many of her clients in relation to those in authority, a great deal of effort and sensitivity was required, on her part, in order to gain their trust.
"They don't always directly show it, but there may be an element where they might not trust. They have been through a lot of turmoil you know, okay, what's this person going to do. Are they actually Public Health or are they, you know, coming to take my children away. So, getting beyond that. I usually appear friendly with them and just kind of approach it, you know, not in a pushy kind of a manner or forceful manner I found that they've been pretty receptive" (Elsie, p.5).

Often interpreters were required to translate for the client to the nurse. In the following quote, the nurse acknowledged her awareness of the impact a stranger of the same culture may have on her client. She stated that instead of assuming whether it was acceptable to take a stranger into the home, she first asked the client if it would be a comfortable situation for him and would he permit this person to enter his home.

"Some of the people who come here don't want people from their own country because it would be dangerous. They're not too sure whether or not that other person would turn them in. And so they would prefer to have a Canadian there visiting. Before I introduce someone from their own culture I would say would you feel safe? Does this name sound okay to you? I would always check that out with them ... I think their safety is the most important thing for me" (Anita, p.8).

Anita felt that she needed someone who could bridge the gap between her culture and her clients' culture. She insisted that she needed to tread carefully in dealing with her clients. According to her, upon meeting her clients one of the first things she did was to focus on their history, their story. She felt that if she displayed an interest in learning about her clients' background then trust developed between them. Anita believed that she was culturally sensitive, however, she appeared to me as quite apprehensive in her interactions with people of other cultures.

"There are certain topics I know I need a Cultural Bridge. I would not just march right in and say things. And being aware of their body language as well knowing when they're upset with something or expressing my self in a way that is not offensive to
them. I'm very, very careful, very, very careful in my communication with them. First of all I want to know about them first and their country and what their experiences are" (Anita, p.17).

In the following quote we see that an understanding for the Jamaican way of being was gleaned by looking into the historical background. The nurse explained that these were not bad kids, rather, it was the severed relationship with one's home, friends and the familiar and transplantation in an unfamiliar environment, that was responsible for the acting out that was so often seen among Black Jamaican kids.

"Mother has come over here trying to establish a life, calls the kid over, maybe the child was 10, 13, 8, 14 and you're tearing this kid away from a life in Jamaica and this kid is very angry and lashing out and there is a lot of conflict and anger management that they have to deal with. So many times the need that the nurse can provide is beyond the scope of what she can provide, she can only refer them to another resource or community agency" (Brenda, p.10).

Summary

According to the nurses in this study, understanding the historical context of a client's perspective was vitally important for establishing trust. A recognition of the fact that history affects behavior enabled the nurses to present themselves in a way conducive to acceptance by the client. This in turn made it more probable that clients may be receptive to whatever message the nurse was conveying. For these nurses, it was the development of trust that determined their success in being able to promote healthy living to their clients.

The Cultural Affiliation of the Client

How was trust established? Nurses learned very quickly that if they did not respond positively
to the cultural affiliation of a group in terms of beliefs, norms and practices then just as quickly they would be shut out. This next section deals with the way in which nurses felt they incorporated the clients current practice with their own teachings.

Male Dominance/Female Subservience

All the nurses identified that the situation where the "man of the house...and the husband as boss" idea existed was not an ideal situation as far as they were concerned. According to Amy she felt the need to be careful lest her advice jeopardize the relationship between husband and wife. The following quote was a result of a discussion between a mother, father and nurse. The mother previously informed the nurse that when she attempted to discipline their child her husband intervened and allowed the child to have his way. The example she gave focused on an endeavour to have the child sit at the table for his meal rather than walk around the home while eating. The father insisted the child be allowed to wander about if he wished. Amy, the public health nurse, pleaded ignorance to the norms of the client's culture. She stated her aim was to first request clarification that what she considered to be common practice in her own culture was also the norm in her clients' culture.

"So I listened to this whole discussion as much as I could make out of it and I finally pleaded ignorance to their cultural norms. But, I said, in your culture is respect for the parent a value? Oh yes, a respect for both parents is a value" (Amy, p.7).

Another example of male domination was in the area of birth control:

"Certain types of birth control means you may have to touch your own genitalia in order to use that birth control and so they would never consider that...it might upset the husband because his knowledge might not be what it could be around birth control and he might be fearful of it..." (Adele, p.9).
Adele believed that the male was more of a hindrance than a help to any interactions between his wife and the nurse. It was, however, imperative to have the male present when such delicate subjects were being discussed. She pointed out the necessity of having a clear understanding of his knowledge and of the ideas and practices regarding birth control in the culture so as not to upset the husband/wife relationship and also to ensure they understood and complied with her teachings.

The Degree of Harm - Bathing

According to the nurses, the client's cultural practice must always be utilized in the teaching. The nurses maintained that if the practices of their clients were not shown to be valued then all the teaching in the world was not going to help - because they won't accept it. Carrie discovered ways to connect the cultural practices of her clients to her instructions. She stated there were practices that were not considered to be best practice by the standards of health professionals but the nurses found ways to work with these. Carrie claimed that she took into consideration the degree to which the practice was harmful when she gave suggestions for alternate practice; she was always careful to include the client's own beliefs and norms into her explanations. In terms of bathing and nutrition practices, some cultures believed that bathing following the birth of a child was detrimental to the health of the mom:

"I think we respect their practices and you know it's not detrimental there could be infection down below if you don't wash. Then they say well they'll just sit in the sitz-bath they don't take a shower. That's fine. We kind of modify in some ways to show them that they need to keep that area clean and washed and if they can modify some of the ways it's fine...." (Carrie, p.7).
Some cultures, if not all, have particular beliefs and practices following childbirth. Several nurses found these practices to be challenging. Ellen articulated quite nicely:

"Post-natally with Chinese culture, they have a number of customs that you know that crop up that we have to deal with and you have to find a way of educating them and a whole lot of openness to maybe changing their ways. Not that we want them to change their ways" (Ellen, p.7).

**Nutrition**

There were also beliefs regarding the intake of food following childbirth. The consumption of meat was curtailed without added protein in any other form.

"They should be eating properly so that they can have better milk for the baby or they believe they shouldn't eat chicken or beef or something because it's not good for you right after birth - we just teach them but... we feel we need to respect how they were brought up. It's not going to really be that serious as long as they are trying to eat other things, we tell them to eat a more balanced diet than just drinking soup" (Carrie p.6).

Cindy stated, she always tried to work within the cultural practices of her clients. She and the client first discussed what a normal diet for that family was comprised of, then she offered some alternatives for healthier eating, being careful not to make too many changes nor negative statements about the current diet.

"When we are teaching nutrition we don't say follow the Canadian Food Guide, what if that culture does not eat meat so that would not be appropriate. We teach nutrition around what they already eat. We work with the practical part, that's what I call appropriate" (Cindy, p.9).

**Summary**

The nurses articulated a necessity for ongoing development of the relationship between client and health professional. Relationship building was done by being sensitive to the cultural
noms, beliefs and practices of the clients. According to the nurses, sensitivity was conveyed by blending their beliefs with those of the clients when imparting any knowledge to the clients. It seemed, quite naturally, that all the nurses believed that they demonstrated cultural sensitivity toward their clients.

**Respect for Culture of Client**

To these public health nurses it was not enough to simply be aware of a client's political and historical background, nor was it enough to have knowledge of the client's cultural affiliation in terms of norms, beliefs and practices. According to the nurses, being culturally sensitive meant demonstrating behaviour that was acceptable to the particular culture of the individual with whom one was interacting; it meant behaving in such a way so as not to offend or alienate oneself, being mindful that one was a guest in other people's homes and respecting the home owner and the home. These nurses felt that if they behaved in a manner that showed respect for the culture of the client then there was a greater likelihood that trust would develop between them.

As Donna stated below, some practices that were considered to be the norm in Canada may be quite offensive to someone not of Canadian culture. Nurses, therefore, had to be aware of what these practices entailed. It was necessary for a nurse to be more than knowledgeable about a client's cultural practices, for example, during home visits the nurse must adhere to certain practices if she wanted to be heard by the client. To the Jews, Friday to Saturday was
considered to be a holy time, the Sabbath:

"When you're dealing with the Jewish culture for example you would never go visit them on Friday after sundown. You would have to be careful about even some of the foods that you would bring into that home. You have to study certain cultures practices so that you can understand them and try to work within that...you can offend a client with some of the things that you say or do..." (Donna, p. 16).

Some cultures were very generous and the sharing of food was a gesture of warmth and welcome. To refuse their food was to show disrespect.

"If you go into a house and they offer you something to drink or something to eat and you refuse that could sometimes be very offensive if you're a guest in their home and you refuse their hospitality" (Donna, p. 15).

Denise talked about her respect for culture and rituals, her respect for difference. She told how she established trust and rapport by sampling food (showing respect). She felt that accepting hospitality in this way showed a willingness and an openness to learning about the culture. This way, she claimed, there was more openness on the part of the client to hearing what she had to say.

"If you go into a place and they serve funny eggs I think that's part of the sensitivity. I try different kinds of food because of the community that I am involved with. Once you taste them you show them I'm accepting your culture. I'm learning about the culture and it makes it easier for me to go into the education part. They would more likely open up to me. If you don't do that they won't accept you" (Denise, p. 24).

Cindy stated that some practices were cultural and other practices were universal. She claimed that she demonstrated respect by explaining what was considered to be safe practice rather than by enforcing it. Enforcing meant the act of removing the pillow while telling the mother it was wrong practice, rather than explaining why it was not desirable practice in terms of the danger it posed to the baby. For example:

"I know pillows can be a cultural thing to certain cultures, if they love having pillows
in the crib - I say that's a really nice pillow, it's beautiful but did you know that this sometimes is associated with the baby suffocating and research has shown that it's dangerous to have this in here? And then you go back the next time and it's still there. And so then I would tell them again. As I said before pillows can be dangerous it's probably safer if you take the pillow out. And that's the strongest I get. I've heard of some people actually removing it. I think that's disrespectful because I don't want people in my house removing things, right?"
(Cindy, p22).

Conflicting Demands

Donna was concerned about the potential interpretation of split loyalties as in this case where the community itself was in disharmony over a situation. In terms of school agenda, Donna discussed respect for the parents values but at the same time allowed for the needs of the kids to be met, to be able to respond to their search for information. She felt she straddled a delicate topic and that this was how she demonstrated sensitivity to all involved, the parents, the school and the kids.

"I allow the kids to decide what they want to hear. Schools make the decision what to teach. There is a specific curriculum that I follow from the Metro Separate School Board which says that I can teach this and that but I can't talk about things like masturbation and I can't talk about abortion or I can't talk about condoms. They have the questions and when they ask me a question, I do not shy away from it. I do not bring it up but often the kids do, they have these incredible questions...I try to acknowledge their value system and their belief system and then I try to work within those parameters. People have different beliefs, you know" (Donna, p.9).

Infibulation

All the nurses felt that they were constantly having to put their own biases aside. In discussing infibulation, Elsie believed that she demonstrated an understanding, non-judgemental attitude and she coped with difference and accepted differences. She stated that she struggled with her
own biases and rationalized to herself that infibulation was a personal issue and she must not impose her views. Her final word was that although these were not her views and in fact she opposed infibulation, it was necessary to respect her clients way of doing things.

"It's a tricky one because I guess you're coming at it from a position that you may not agree with it, you don't want that bias to come across to the client. You don't know, they may have not even agree with it but it was imposed upon them as part of something and they had to go along with it. ...in Canada there's going to be all different things and some of them I'm going to agree with and some of them I'm not. I've just never really felt it was up to me to tell them that or really to impose my views" (Elsie, p.9/10) To Denise, sensitive means: "that you really have to respect that culture. Despite that I don't like FGM I have to respect that culture's rituals" (Denise, p.24).

Summary

These public health nurses seemed to be aware that there were many different interpretations and worldviews. The nurses articulated a desire in working with the clients to educate them in a way that complimented rather than violated their beliefs. In order to accomplish this the nurses expressed the importance of first knowing and understanding the historical context of the client. Based on this knowledge, they stated it was then possible to adjust their approach accordingly. The nurses seemed to be aware that utilization of the clients own beliefs, norms and practices elicited compliance to the nurses agenda (agenda being whatever the nurse's job was that day, whether it was to teach, inform or advocate for). Nurses felt that behaving in a manner that conveyed respect for the cultural norms of the client meant that they gained the trust of the client and therefore a greater likelihood of being heard. How then did these nurses learn to be culturally sensitive?
Determining When One is Culturally Sensitive

What criteria did nurses utilize in order to know when they were being culturally sensitive/insensitive? Many were aware of when they were being sensitive because their experience informed them when a behavior or a certain way of being was acceptable or not acceptable. From peers they gleaned more knowledge and information on the norms and practices of various cultures. Most of these peers were of the main stream culture themselves and gathered their information from experience. Nurses relied on their own knowledge, which was obtained in various ways, for defining the meaning of cultural sensitivity. All the nurses, however, stated that feedback from the community told them when they were being sensitive/insensitive.

Elsie stated that in schools there was a lack of trust among black Jamaican kids but by persevering she built up trust. For example, she held lunch time displays on various topics such as AIDS, sexually transmitted diseases and contraception. At first no one came to her but her reputation slowly increased as someone who they could trust, this was evident in the fact that the students began to access her.

"When you hear 'hey miss, I'd like to come and talk to you', then you know you've made it" (Elsie, p. 10).

With the first nations people Adele stated she felt like:

"I belong to the race of the oppressor" (Adele, p. 9). In the beginning there was no trust but "I have to work a little harder to getting trust built up between us and being seen as an advocate...when they start coming to me I know I'm doing a good job" (Adele, p. 10).
Summary

Nurses expressed both empathy and frustration in dealing with a culturally diverse population. Empathy for the fact that their clients came from a traumatic background or from a less than satisfactory environment and continued to live in a less than satisfactory environment through no fault of their own. Nurses admitted to stereotyping and acknowledged that they often needed to examine their own biases. There were times when apprehension existed and the challenge was in doing their job without alienating the client.

Cultural Background of Nurse

Nurses were asked to share their thoughts on the public health nurses' culture in relation to the community. Only one nurse believed it to be advantageous to have another nurse, from the same culture as the community members, with her when she held education sessions on controversial topics such as infibulation.

"I think instead of me talking to them, first of all, they won't understand, they will say, you don't understand, you don't feel it....but with her being there to talk to them about it they will more likely understand" (Donna, p.23).

On further probing, Donna stated that the clients did not tell her they did not understand, but rather, it was her own perception and comfort level from which she drew her conclusions. Interestingly, Amy told of a colleague who had many challenges in dealing with clients of the same culture as herself. They accused her of betraying the cultural values.

"She is accused sometimes as being a second class Muslim because she challenges the practice of FGM" (Amy, p. 13. Nurses referred to female genital mutilation as FGM).
Amy commented that individuals from her own culture, white anglo-saxon, adhered to practices they learned from their grandmas even though those practices were questionable.

"I deal with people who come from east coast Canada who say 'my mother raised everybody on a carnation milk formula that she made herself and we all survived'... or they'll listen to the girl next door who says 'give the kid applesauce at three weeks old' but they won't listen to me" (Amy, p. 18).

For Brenda the challenge was in separating her own cultural values from professional ones. The community members also had certain expectations of their own cultural group members, which Brenda acknowledged was sometimes difficult for her.

"It's a double-edged sword because I know exactly where they are coming from when they are talking to me... they see me as an 'in' into the system...I've had to do a lot of soul-searching in my practice...but that resolves through experience and falling back on my professional standards" (Brenda, p. 15).

Ellen's perception was that a same culture nurse may be more easily accepted by the community than a nurse of a different culture.

"The client is accepting of us coming in but sees us as the system... whereas a nurse of the same culture can sometimes be perceived as the system being more approachable and understandable because she straddles the division between the department and community" (Ellen, p. 15).

Cindy, herself a visible minority, stated that nurses from the same culture as their clients may take things for granted and may not capture the needs of the client.

"I work with my own population and I think it is better to stay away from them. Sometimes a person from another culture would understand more, they would take the time, they wouldn't take anything for granted" (Cindy, p. 9).

Denise, also of a visible minority group, offered another perspective in that a nurse of the same culture can zero right into the client's problem and that would make it easier for her in terms of time constraints. She did, however, say it was sometimes very challenging in terms of
knowing what the clients were feeling about a situation. She had to instinctively guess because her male clients for example acquiesced to everything.

"Even the men, they never say no... they might say no to another person not of their culture... they are very polite" (Denise, p.4).

As Denise articulated, the language barrier made it difficult for clients, so someone who spoke the language definitely had an advantage. Initially, a nurse of the same culture was accepted simply because she spoke the same language and looked like them.

"My community is easier because I have the same face as them... the trust and bond is there... the other one, you have to work harder" (Denise, p.10).

Elsie told of a time when she felt that her cultural background was initially a barrier with a particular minority group but in time she was able to break through that barrier and develop a relationship. She claimed that it was her experience initially which the community members accepted. At first, community members accepted a nurse based on sameness, however, it was the personality of the nurse that determined how the relationship developed.

"I think it is more of a personality thing... somebody of the right culture but the wrong attitude is not going to work either... the other thing is, if they're a nurse from a different education bracket they've removed themselves from the culture and no longer understand the lower socio-economic groups" (Elsie, p.15).

Summary

All the nurses believed that it may initially be advantageous (for the nurse) to be of the same culture as the community she served but in the long term it held no benefit. Rather than culture it was more a matter of personality which determined how the relationship progressed. The nurses highlighted a number of factors that may have determined the outcome of the nurse-
client relationship. For example, the nurses level of education played a part, the socio-economic status and even the geographic area of origin area all served to play a part.
CHAPTER 5
COMMUNITY WORKERS PERSPECTIVE ON CULTURAL SENSITIVITY

The experiences of public health nurses were explored in chapter four. Similarly, this chapter explores the perspectives of community workers in relation to the cultural sensitivity of the nurse. Here it is revealed that some nurses may not be as knowledgeable about the cultural norms and practices as the community worker would like them to be. However, it seemed that for the most part (according to the community workers) nurses were sensitive to cultural norms and practices. The nurse was perceived, by community workers, to be culturally sensitive when she demonstrated specific behaviors.

There were a few misgivings (on the part of community workers) regarding the sensitivity of the nurses to cultural issues. Two community workers seemed to have more negative than positive comments about nurses. Another two workers touched on a small area where nurses performed in a less than satisfactory manner. There were also some concerns that community participation in topic selection (during community education programs e.g. New Beginnings) either did not exist or existed minimally. Four of the workers pointed out that it was a matter of interpretation that determined one’s impression of the overall performance of a nurse. Two of the ten workers had only positive comments to make about public health nurses. Generally, it seemed that most of the community workers were satisfied with most of the nurses.
Culturally Sensitive Nurses

Interestingly, community workers identified similar themes as did the nurses for conveying sensitivity to various cultures: a) To the community workers it was important that the nurse had an understanding of the countries from which their clients originated in terms of the political and social histories of those countries; b) Community workers stated that it was not a good idea to teach new ways without incorporating the beliefs and practices of the culture with whom they interacted; and c) In the process of performing one’s duties it was important to convey respect for the norms, beliefs and practices of each culture.

Appreciation for the Historical Background and Lived Experiences of Clients

An understanding of the stresses and traumas were very important to the clients, according to the community workers. It seemed, to the community workers, that a few nurses lacked awareness or perhaps comprehension of what it meant to escape from social and political upheaval, while others were very knowledgeable and caring about the clients’ history.

“When people first arrive they’re under a lot of stress, they’re in a new country, they don’t speak the language, they don’t have any friends, they left their families behind. So just handling all that pressure, learning English, trying to find a job, trying to adapt to a new country, their children going to school, all these problems that’s the area I would consider them to be exceptionally knowledgeable and presenting useful information” (Chandra, p.17).

In the following quote, Bo stated that clients often complained that nurses did not understand them and that nurses ought to know about various cultures. Bo agreed that some nurses did not know the history or the customs of various cultures and others did. She stated that those who complained the most were of the African countries and tended to be what she termed
complainers. Bo justified her label by stating that those particular clients did not want to adjust to Canada but they wanted everyone to adjust to their culture. Bo was originally from India.

"Like Somalian people or Srilankan. They have some ritual culture like they, when somebody come to home they offer some food, tea or something. If they don’t accept very gladly or happily they mind it. He doesn’t like me. Why? And um, other things like new born baby. They have some ritual things or religious purpose, they have something. So Public Health Nurse doesn’t understand that. Yeah, some things like giving special water to the new born baby, so this is the conflict you know. So we have to understand that their cultural background when you go to some family you have to understand first their background” (Bo, p.5).

In the following two instances the nurse demonstrated a knowledge and sensitivity toward culture and cultural values. It was important in abusive husband/wife relationships that nurses not inadvertently make life more difficult for the woman. An appreciation for a client’s background in terms of family dynamics was very important in cementing the nurse/client relationship.

"There was this woman who couldn’t speak English and she needed a doctor and the nurse found her a doctor from her culture. Then there was this other one, her husband was very abusive to her. She came here and the nurse tried to help the woman living in that situation. The nurse was careful because she knows that she could make it worse for that woman if her husband found out, so she was very sensitive to the culture. The woman was from the Ukraine” (Betty, p.4).

Clients may have traumatic backgrounds and therefore prefer interacting with a nurse rather than with a doctor. Women felt more comfortable speaking to a female rather than to a doctor who more often than not was male. The perception was that the nurse also has more time to spend with them for whatever reason.

"They’d rather talk to the nurse than to the doctor. I don’t know why. A lot of these women have been abused as children or they have bad experiences with men and the doctor is a man, maybe that’s why. The doctor is higher too. He is educated and maybe
they feel intimidated” (Betty, p.7).

**Explanations Utilizing Cultural Beliefs, Norms and Practices**

It was necessary for nurses to be receptive to all kinds of customs. This community worker viewed nurses as open-minded.

“Many of the clients if they have a headache, know? They don’t like to take Tylenol, they prefer to put like a potato, know? Stuff like that, know? So sometimes they prefer to use their own method. But I find the nurse, they er, they very open-mind to that, know? They let you use potato and tell you to use Tylenol too” (Erin, p.2).

**Parenting**

It was well understood by community workers that the nurse was an authority on her subject matter. In this light, Bo presented clients as vulnerable from an emotional perspective. The nurse was perceived as sensitive when she acknowledged their experience as parents and took into consideration the cultural aspects of the population she was addressing. The nurse had to demonstrate caution with the information she gave to the community. An innocent comment made from lack of knowledge about her clients could create insecurity. For example, a client may leave the class believing she was not a good mother based on what the nurse stated. Earlier in the interview Bo expressed some misgivings regarding the nurses’ abilities in this area.

“The parenting group it went well. I think they see her as an authority and she knows how to raise a better child, so every thing she tell them will be, you know, the law, or, that’s the way we do things here. ... Here is a very poor neighbourhood and people are trying to be better parents, trying to keep their kids you know, out of trouble. And when they come to parenting groups they are very - which makes me very nervous because they are very receptive to everything you say so I try to make sure I say the appropriate thing and take into consideration where they are in their life and er what’s important for them’ (Bo, p.15).
Nutrition

In teaching nutrition the story of this community worker supported the nurses’ statements that they considered the eating habits of the clients. Arika said that nurses simply cannot introduce the Canadian Food Guide and expect it to be followed. It was reported that nurses personalized the class by working with the clients. Together they incorporated their teachings with the eating habits of the particular family. These classes were also a hands on experience so that clients got a chance to see and taste the dishes thereby finding out if this was something they wished to serve to their families.

“When the nurse gives a lecture on nutrition she points out that she knows that everyone is from a different culture and all eat differently and some of these things may not apply, but that this is the Canadian Food Guide, this is what is recommended, and then they sort of take it from there. This is so that no one gets offended. Most of the clients have children who are going to school and they sort of want to fit in. They are preparing lunches for them and they sort of want to be part of the group. They are preparing things from their culture but they are also preparing things that are Canadian” (Arika, p.2).

Diane liked when the nurse utilized visual aids (in the form of posters) to assist in discussion. These posters served another purpose; it showed the clients that the foods of their own cultures were not unfamiliar to the nurses’ culture, in that, nurses did indeed possess some knowledge about their customs. This offered some credibility to the nurses and their teachings.

“One nurse for example was going to talk about nutrition and she brought this beautiful poster of foods from around the world. And she was trying to adapt it to the Canada Food Guide. So she was using the foods people eat and trying to tie it in to the Canada Food Guide” (Diane, p.15).

The clients felt that something was known about their culture when visual aids were brought
in that related to them. There was a sense of the personal, of belonging. This in turn meant that information was processed by the clients, instead of shrugged off as unrelated to their reality. As one worker articulated:

"When they are doing groups and they bring in dolls, they try to bring in dolls that are not the white dolls. Bring in a black doll or er you know, a minority doll. It's a little touch that makes a big difference, people feel more comfortable" (Erin, p.7)

**Respect for Cultural Norms**

Diane and Anita were very impressed with public health nurses. They claimed that some nurses were quite attuned to their clients' needs and treated them with respect by helping them in a way that did not undermine their sense of self, while others did not seem to have that sensitivity.

"In the past we are very lucky. We had a, a nurse and she happened to be a wonderful nurse I don't know she was there er, er a black woman and she related very well with our participants. She used to spend lots of time, she had her own desk, and she always, you know, she would go after information in different languages, she would have a display of materials for the new mothers. And again, with the cut-backs you are not able to, and this nurse, she retired so they send another one to replace her but she's staying less in the program..., it's not the same even around cultural issues and dealing with a mixed er population" (Diane, p.11).

Erin said that clients liked the nurses and were happy with them. Her perception was that nurses tried to communicate with their clients. The perception was that nurses did not hold themselves to be more important than the clients. It seemed that they were interested in their clients and seemed to enjoy their work. Erin claimed that when nurses made an effort to be culturally sensitive then any faux pas would be over-looked.

"The clients they like when the nurse visit, know? Maybe because they are old people and they eager to learn more. They laugh a lot. The nurse, she tries, know?" (Erin, p.17).
Near Christmas time a party was usually held with the joint effort of the nurse, the community worker and the class they were teaching. Many from the group may not be Christians so the nurses suggested that this not be called a Christmas party out of respect for those non-Christians. The community workers believed that nurses are culturally sensitive when they take into consideration the feelings of all the various cultures in their program.

“We call it like a multicultural celebration or something, you know. Just to end the year. So I find that the nurses in that sense are sensible because, not sensible, I mean what’s the word you use?... You can’t celebrate one and not celebrate the others because you know you’ll make the people feel that theirs is not important. So we don’t celebrate any like you know it would be difficult to celebrate any of them so we just call it a multicultural day” (Anita, p.6).

In the next example the nurse is aware that these students were learning English, she therefore adjusted her teaching style to fit the group. The community worker stated that this behavior was considerate and the nurse showed respect to the clients by adjusting her teaching to the level of the group without making them feel as though they were not smart.

“If it was a level one class then it would be really difficult because they only know hi, bye, my name is.... So with the level 2 and level 3 basically the nurse speaks very slowly, explain things and asks a lot of questions and then the teachers help out. If they seem confused, if they don’t understand things she basically try to give them more examples. We are there for support” (Chandra, p.9).

According to all the community workers, some nurses connected with the clients and others did not. Those who showed an interest in the clients, the ones who mingle, are the ones who seemed to be comfortable in the environment. The nurse in the following quote was, according to Eva, respectful of the clients’ customs and practices and was herself willing to participate in their cultural habits. The nurse who visited the Center, taught her class and promptly left the
Center did not have the same level of relatedness as her colleague. Eva was not happy with most of the nurses she had been in contact with because, as she stated, they were not sensitive.

Had they behaved as the South Asian nurse in the following example they would have been accepted.

“One nurse I worked with which was south Asian she er was completely different from the rest. She just went in there, she was comfortable, the community was mostly Somalians and er er she’s Moslem too and um, and you know um, they just connected with her. And me who was not a Moslem didn’t feel out of place, you know, and even though I couldn’t relate to their lang er their religion, she er, was there and er she was very sensitive ... It’s her mannerisms, how she talks to people, looking at them, et, um could go down on the floor, could hold their hand, you know, that is sensitivity. It’s not the person who sits there and just answers questions, you know, and when it’s over, you’re gone. This nurse, she sits with them and even when the allotted time is up she is still with them answering questions. There are some nurses who will just go, they come with their agenda and that’s it, they go” (Eva, p.5).

In the next situation the nurse persisted with this family until she finally managed to meet with them. Carol felt that the nurse was respectful of the family’s cultural norms by accommodating them, by meeting them on their terms.

“I did see in situation there was a family simply refused to go search for nutritional things. And when the nurse asked them to go to their house to see their fridge or so food cupboards they refused, the family refused. Finally they accepted to get the, the nurse will talk to them but on neutral ground, not their home. So the nurse spoke with them and took them to the supermarket to show the things she was recommending for them but they refused to let the nurse to go home to see their home or to see where they are cooking or something like thetas” (Carol, p.11).

It was interesting to note that what was part of the nurse's role was often considered to be "extra" by clients.

“We had one nurse who did community resources and she went out to recreation centers and brought us all kinds of pamphlets about different things in different languages, she made photo copies, she was really amazing. I didn’t expect her to do so much and this wasn’t a topic on the list to be presented. This was something that was extra” (Chandra,
While discussing issues surrounding infibulation Carol stated that when nurses treated their clients with respect i.e. when an effort was made to find out more about certain cultural practices (instead of dismissing those practices as wrong), then those nurses were considered to be culturally sensitive.

"Some nurses they have that cultural sensitivity they would look for a worker who would explain to them, to the family and they would get information through you or through somebody within the community. Sometimes certain nurses they have, they don’t appreciate cultural things and they don’t feel they need to know this information or want to know” (Carol, p.14).

Below, the community worker referred a time when she was a client of the public health nurse. She said that the nurse sometimes unknowingly made a statement that is contrary to that cultures beliefs and practices. She was rather sweet and protective of the nurse’s feelings.

“If they do we just keep quiet. We don’t want to hurt their feelings. They don’t mean bad things, They try, so we make them happy (Arika, p.10). ... We don’t tell the nurses what we don’t follow. We say yes, yes, We don’t want to hurt their feelings nuh. They try so hard to help us” (Arika, p.3). ... The nurses from our own culture understand too much about the culture, they are good no. But all the nurses are the same, they all know a lot about the culture but they have to teach something a certain way, no. It is not their fault. They know my culture well and they teach the good things from my culture but it is not their fault that I don’t follow everything, they try, no. Everybody thinks the nurses good, no. Only those with language problem have difficulty. But we have interpreters for those people nuh, and some of us can translate, no” (Arika, p.15).

For the most part nurses were perceived as sensitive when they showed an interest in finding out about the culture. Diane stated that by showing an interest in learning about the culture, nurses exhibit respect for that culture.

“...We have a lot of different nurses, the one visiting the program is always the same nurse. To tell you the truth we are not very happy with her. We will try bringing her in to our staff meetings and see how it works, if it doesn’t then we will, you know, request
to have another nurse. We work with different nurses and I would say that most of them are sensitive, and if they are not knowledgeable they at least show an interest in learning about that culture. But the odd one doesn't show any interest. This is the way it is, this is the way we do things here" (Diane, p.19).

Summary

It would seem that recognition of cultural variation was the main theme in determining whether a nurse was culturally sensitive. An important criteria used by the community for determining cultural sensitivity on the part of their nurse was when they observed that the nurse lacked knowledge about various cultures but showed a willingness to learn.

Culturally Insensitive Nurses

It was of interest to note that nurses believed themselves to be culturally sensitive, but according to community workers, nurses frequently behaved in a manner contrary to a culture’s beliefs and practices. It was apparently recognized and accepted by the community that nurses have an agenda of teaching health from a Canadian perspective. A lack of knowledge, however, was not enough to label a nurse insensitive. This labelling occurred when a nurse showed little interest in learning about the culture.

In the following section very sensitive issues were explored. The characteristics of what constitutes a culturally insensitive nurse, from the perspective of the community workers, are outlined. Of the community workers interviewed four had positive feelings toward nurses, three had both negative and positive things to say and three are entirely negative. The following
quote allows us to appreciate the responsibility felt by the community worker toward the community.

"Some nurses know that they're intimidating, they do it, it depends on the nurse (Eva, p.13). ... I felt intimidated by nurses, I had to work on myself ... I saw to it that if the participants were not getting what they wanted to get I had to step up and say so you know, because I represent them you know, and when I am debriefing with you I'm really saying what they are saying to me or feeling" (Eva, p.17)

Lack of Understanding of Social, Political and Historical Context of Clients

Eva claimed that most nurses did not understand various cultures, they complained about anything that did not meet their standard of living. There seemed to be no acknowledgement or appreciation for different lifestyles, no understanding that there were those in society who were less fortunate than the main stream culture. Eva perceived nurses as insensitive and lacking in knowledge. A variety of examples were offered to substantiate this claim: either the nurse did not appear real; her words seemed to "come from her mouth not from heart"; she complained too much; or there was a readily observed social gap between the nurse and the clients. For example:

"When a nurse comes into a community and yes, it’s low income, and complains about the dirt, complains about the space, everything and anything....but complaining and not doing anything about it. Like for example, at this one site we have a little room to run the program but the garbage smells outside. It’s summer and it smells, there’s nothing we can do about it but she’s going to complain about it. ‘It stinks, she says, the room is always dirty, there’s roaches...’ She’s one that couldn’t relate to people and um, you have participants who come to me and say does she like us and, you know” (Eva, p.16).

The next quote suggests a lack of understanding regarding the social and historical context from which the client has emerged. "My baby’s father” is a commonly used phrase among Jamaicans
and well known to most who work with this population yet the nurse denied knowledge of the meaning of the phrase. The nurse in question had worked with the same population on a number of occasions yet seemed to have little understanding of her clientele. The feedback about this particular nurse was that she placed herself above the client. The term baby's father is a phrase used among Jamaicans women in particular when referring to her husband or boyfriend if he is her offspring's biological father.

“A participant will come in and say ‘my baby father’ he’s this, he’s that. What’s a baby father, what er, she just doesn’t understand it, she can’t understand the concept of it. She thinks it is so weird, why can’t the woman say her partner or her husband or something like that” (Eva, p.18).

The following quote suggested that, by itself, clothing or partaking of food did not make one culturally sensitive, nor did it deceive anyone into thinking that it was so. Here again was another example of lack of knowledge about the social, religious and historical aspects of the client.

“Oh, you have Somalis who have kids one after the other. You’ll hear the comment at the end of the session ‘don’t they know about birth control’, one after the other! Because you as a worker understand their culture, understand a little bit about their culture, this is how they do this, you know, they have babies a year apart or two years apart, this is part of their culture, or their religion, so you understand and are a bit more sensitive to them. Not to criticize it but to help it. Maybe they never learned what kind of birth control doesn’t go against their religion. Another thing, there’s one that she, every-time we have a party she wears an African gown, she has one African gown, but she’s never touched a baby!” (Eva, p.24).

Lack of Appreciation of Cultural Norms, Customs, and Practices

According to Diane, there was a gap in the relationship between the clients and nurses because nurses were condescending and therefore insensitive toward the clients. Diane claimed
throughout the interview that nurses did not seem to appreciate or respect the cultural differences in their clients.

"We’re doing peer support for breast feeding mothers and we have this group of women from different cultures and er one of the nurses, a white nurse who was co-facilitating with us at the work-shop, she would tell them all the time that ‘I’d be using very simple language so you can understand me’. I think it’s nice to say if you don’t understand me ask and I’ll repeat. Then you repeat it in simpler language, but she would say it all the time and one of the mothers said you know, you are really putting us off by reminding us that English is our second language that we may not understand what you are telling us so I leave it up to them to call her on that” (Diane, p.7).

Bo felt that nurses did not value the experiences of the clients, nor were they accepting of their cultural norms. For example, some cultures practice breast-feeding well past what was considered to be the normal, acceptable age in Canada. When this practice was frowned upon those parents felt that they were doing something wrong which made them uncomfortable in that environment. This led to poor attendance at the programs.

“For her there are a set of things that are acceptable and she expects all the parents to feed, educate and expect their children to develop in that certain way... Around breast-feeding, we have a few parents from other cultures, they breast-feed their children until they are three or four years old and it is pretty normal and natural for them - and she doesn’t say very nice thing to do she say you have an old enough child. You know their child is old enough to be eating er, a balanced diet from er, you know, a plate. So er sometimes its hard for the er clients to see this. They have done it for their whole lives and now it is not acceptable to do it here” (Bo, p.12).

According to this next community worker, there were many cultural practices that nurses did not understand. She suggested that nurses refrain from mentioning research in support of their teachings, because, first of all many of the clients did not understand what research meant and secondly, they did not understand the significance of research findings.

“They’re used to putting powder on the babies, you’re coming in with do not do that, well if you come in and say don’t do that and they’ve been doing it for years they’re still
going to do it. You, you, you’re coming in and giving them orders, I mean, that doesn’t work. Understand that they are coming from a cultural point, some don’t see it. Some, well, you know, I use this remedy for colds - honey and milk. Well research shows that has nothing to do with colds. You know, it’s always bringing it back to research when all along, for years and centuries they’ve been using these things. And it’s been working so don’t discredit what they’re saying. That’s some of the insensitive things that I have seen” (Eva, p.19).

**Lack of Respect for Cultural Norms**

The nurse in the following quote was described as insensitive and lacking in knowledge. It seemed that the expectations of the nurse were grounded in the world-view of the mainstream culture rather than in the world-view of the culture of her client. According to the community worker, the nurse expected the client to do as she was told without regard for the safety of the client. This unfortunate incident changed the nurse/client relationship in that group.

“She expected the women to make a decision when they disclosed that they were in an abusive relationship. Without any education or support she expect her to make a decision at that moment to leave that violent relationship and er, er start a new life again somewhere. we’ll be wasting our time if you stay in this abusive relationship, being here in this group is not helping you because you should be strong enough to stand up for yourself...She was sponsored by her husband, he would be holding her passport, and until she get her own accommodation and her landed immigrant she couldn’t, you know, she couldn’t just leave the relationship. She could, but she doesn’t have the information on how, it wasn’t given to her...And then after that no one want to share anything you know. What if you say something that is wrong and she expects you to change it right away” (Arika, p.12).

**Agendas**

It was accepted by community workers and clients that even though nurses had an agenda, they could still be considerate and respectful of the clients’ feelings.

“The nurse they visit once a month, know? I would like to have a nurse come more than once a month...the nurse she have no time, know? We try and talk about what the
clients want, know, but that no always work. The nurse, she talk about what she want, it’s easier for her, know?” (Erin, p.14).

Anita stated that some nurses were better than others, her comments, however, did not focus on the good nurses. She said that the nurses who were accepted are the ones who were accommodating to the needs of the client rather than to their own itinerary, all but one nurse met the standards of this community worker.

“There are some nurses who will just go, they come with their agenda and that’s it, they go. What’s nice is that some nurses have a sensitivity... that er some nurses are easier to work with than some. I know of some that are straight to the books. It’s like saying, no we don’t do it like that here” (Anita, p.5).

Some nurses were flexible and therefore effective in their role. Some nurses allowed the community to lead the discussion; other nurses followed their scheduled agendas.

“It’s a casual interaction format, we do it in a round circle, so the nurse is a facilitator and me a co-facilitator and we’re in-between so we are seeing everybody, so we’re seeing if one participant is not participating in the group and not talking... and I think it’s er, it’s a public health nurse thing, they just love agendas. They go by it, it has to be done, nooo it doesn’t. If you don’t finish this time well fine, we’ll finish next time” (Carol, p.7).

Here was a more subtle reference to agendas. This one was rather amusing in that the rule was that there were supposed be no strict rules in this particular mother/child group. The setting was a north American style of pre-school where (in an allotted period of time) the children were relatively free to wander around the class-room from one learning centre to another. The mothers, who were from cultures other than North America, were aghast; they wanted a more formal school setting.
"The nurse keeps telling them no no you are here now, those are the rules, we are more informal. But what’s missing is valuing their experiences and their expectations" (Diane, p.12).

Summary

The data has shown that the criteria for determining whether a nurse was culturally sensitive was based on whether or not the nurse displayed certain traits. These characteristics were also in line with the nurses perspective of the meaning of cultural sensitivity. The nurse was expected to show an appreciation for the historical background of clients, incorporate the clients’ practices, norms and customs in education sessions and treat clients with respect.

According to the community workers, nurses varied in the degree of cultural sensitivity they possessed or displayed and there were considerable gaps in their knowledge of various cultural groups. According to the community workers, nurses, for the most part, made an effort to convey a sensitivity to cultural variations. It was clear that some community workers perceived nurses to be the authority while others felt that nurses perceived themselves to be the authority. Community workers knew that nurses had an agenda which involved providing information and education on health. Implicit was the recognition that the agenda was the priority rather than the client.
CHAPTER 6
DISCUSSION

In this chapter I will shift away from specifics as identified and discussed in chapters 4 and 5 and instead offer a commentary on the broader contextual issues of this study in relation to the literature. Specifically, I will address social relationships and the construction of cultural sensitivity. The key themes that emerged in the analysis of data include the following: 

a) In relation to their professional work, it seems that nurses perceived themselves to be quite clearly an authority on health related issues.

b) It would appear that nurses interpreted cultural sensitivity to be a behaviour which was acceptable and in keeping with the norms and customs of the individual or group with whom they were interacting.

c) Cultural sensitivity did not include condoning norms, values and customs of others i.e. there was little evidence of internalization of ethno-cultural values other than nurses' own mainstream cultural values.

d) Demonstration of cultural sensitivity seemed to be a means to an end for nurses.

Key Themes

Nurse as Authority

Public health nurses are in positions of power and authority. This manifests itself in a number of ways. Nurses belong to the mainstream culture, that is, they possess mainstream cultural values by virtue of the fact that they hold post-secondary education, are professionals and are employed by a structure, which belongs to, and is supported by, main stream culture.
health departments have committed to imparting the norms, practices and habits of mainstream culture on the sub-cultures that exist within the mainstream culture. The nurses are given a mandate from the public health departments which implies that health information which belongs to the mainstream culture must be imparted to all other cultures in order for those cultures to be as knowledgeable and healthy as the mainstream culture. The dominant/mainstream culture utilizes science and evidence based practice as support in its stance for knowing the best or most appropriate methods for achieving health.

The nurses take their cues from the public health departments. Empowered by the public health departments, nurses venture out into the community to achieve a goal in which they believe, i.e., to give their clients the opportunity to have what nurses believe to be the right of all people: the right to health as defined in Canada. The fact that nurses expressed frustration with their challenging clients who did not readily accept information that was regarded by the nurse as “for their own good” may have had little to do with the altruism on the part of nurses and more with the questioning of their authority.

The concern with language interpretation caused a great deal of frustration to the nurses. It seemed that they were not in control of the situation, in the moment. The perceived loss of control of the situation seemed to leave the nurses feeling powerless in the process of interpretation. They had no idea what was being said and whether or not the information they gave was being conveyed to the client.
In one area in particular, the trust factor which, in discourse, is deemed to be very important did not seem to exist in practice. For example, when a male acted as translator to a female, nurses felt that their words were interpreted. The idea that the translator may modify the message in order to increase the understanding of his audience did not appear to have been acknowledged or even recognized by the nurses. In some cultures for example, topics such as sex or discussion regarding the female body is inappropriate between males and females, unless they are married to each other. A male translator, therefore, would need to choose his words carefully in order to maintain propriety. The fact that some males would change the words/views of the nurses because they don’t consider those views to be right may also have existed.

It seems reasonable to deduce that the challenge with regard to the issue of language was more than with the spoken word itself. It would appear that anxiety existed due to the fact that the nurses were no longer in control (the authority figure) during translation, their position was secondary to the one conveying unknown information. The fact that nurses experienced difficulty in extending trust to the community members implied that the notion of trust, which was deemed to be so important by nurses, seemed difficult for the nurses themselves to extend in the process of translation. Whether this meant that the nurses’ concern was due to the fact that the translators were perhaps not educated individuals and may therefore inadvertently convey misinformation and therefore harm to the client or that control of the situation was temporarily in the hands of the interpreter, is unclear.
With the nurses, there seemed to exist a negative bias to males of various ethno-cultural groups. Nurses acknowledged that their perception was that they were resented by the men simply because they are women. It may well be that it was more than simply being women, they are women with power. The male could also viewed nurses as a disruptive influence on marital harmony and for that reason may appear to be resentful. Nurses held strong views in their support for equality of genders and their opposition to the male dominance/female subservience model that they say exists in many ethno-cultural groups. In light of these views it seemed quite natural for the assumption to exist among nurses that the male is not to be trusted. There are numerous comments made by nurses regarding having to defer to the male on a regular basis. This was certainly not in keeping with the nurses’ perception of themselves as authority figures.

**Culture, Gender, Class**

It is important to keep in mind that those challenges which were identified by nurses as “culturally generated” may just as easily have an origin in class or gender differences. For example, nurses and community workers in this study belonged to different classes by virtue of their professional/occupational status, education and income. It seems that culture does not play a major part in creating “differences” between individuals when their social class is the same or similar. There is also data which suggests that gender bias may have played a part in the perspectives of the nurse participants in this study in terms of those issues they identified as “challenging”.

Public health nurses need to recognize that beyond the ethno-cultural backgrounds of their
clients other factors exist which may contribute to the challenges faced by nurses. For example, factors such as not belonging to a privileged class, of being an uneducated woman in a new country dependent on the male as bread winner, of being a female, sole support for her family, and so forth.

Acknowledged only briefly in one of the nurse interviews was the notion of male clients. This is a group that seems to be marginalized in public health for reasons which will be interesting to explore. Interaction with males in the ethno-cultural community occur mostly in relation to the nurses’ female clients. Nurse participants in this study stated that males rarely use the services of public health nurses. Is this cultural bias or is this gender bias on the part of the males? Certainly it is an interesting question for further study.

Cultural Sensitivity as a Demonstrated Behaviour

Both nurses and community workers agreed that the most important factor in providing and receiving health care was the need to establish trust. In order for trust to be established the nurse must: Have knowledge of the political and historical context of their clients; b) utilize and integrate various ethno-cultural practices into the teachings; and c) show respect for the cultural norms and traditions of various groups. Nurses perceived themselves honouring the norms and habits of the cultures they interact with, to the best of their abilities. Nurses articulated what cultural sensitivity meant to them and they demonstrated that they certainly walked their talk. The nurses’ descriptions of themselves and ways in which they claimed they demonstrated cultural sensitivity are commendable indeed. The nurses presented themselves
to me as exemplary role models of cultural sensitivity. While on the surface this seems to be
the reality, closer examination of the data suggests otherwise.

In keeping with Cooley’s (1902) concept of the “looking glass self”, nurses assessed whether
they were culturally sensitive based on the way they think they appear to their clients and the
way they think they are perceived by those clients (in Ritzer, 1988). An interesting observation
surfaced through the process of exploring how nurses came to believe they are being culturally
sensitive. Public health nurses expected to be seen as culturally sensitive by the community
because they (the nurses) behaved in a culturally acceptable manner and therefore could only
be seen as sensitive.

Internalization of Cultural Norms

To Berger and Luckman (1966), there exists a “we” and a “they” relationship. The “we” being
the personal and intimate and with the passing of time the “we” interactions become more
personal and intimate. The “they” interactions are out there and with time become more
impersonal and distant. The clients are often referred to as “they”, thereby maintaining
distance. “We” consists of professional colleagues and anyone of mainstream culture. If
“people are the products of the very society that they create” (Ritzer, 1983:346) then it is
reasonable to assume that since nurses inadvertently created a division between them and the
community they served simply by the reference of the community as “they”. This served to
reinforce distance to the community. In turn, the "we" reinforced the internalization of their
own mainstream cultural values.
Schutz pointed out that people “engage in the social construction of reality and that their constructions set the limits for their activity...the constructions, in turn, constrain further creative reality” (in Ritzer, 1983: 330). Again we see that the very act of defining one's social reality confines one to that reality. Implicit in the data is the suggestion that the thought processes of nurses emerge from the mainstream society to which they belong. By unconsciously creating their reality as apart/different from that of the culturally diverse community with which they work, public health nurses may be limiting themselves to a very narrow frame of reference.

Nurses expressed frustration in relation to the issues and events they cited as challenges. When nurses were asked about challenges it seemed that each one stated issues and events which challenged her way of thinking and/or being and which she felt threatened her sense of authority and perhaps also threatened her sense of professional identity. Most of what they declared to be challenging and in light of the fact that some nurses also seemed to lack appreciation for the norms and practices of the cultures with whom they interacted, may be possible indicators that these nurses could perhaps benefit from additional cultural education/knowledge.

**Means to an End**

Analysis of the data suggested that nurses did indeed try their best to show that they were culturally sensitive because, according to them, that was the way to capture the attention of the clients. There was some data that suggested that cultural sensitivity (articulated or demonstrated) may have been a means to an end. Although there was data that suggested that
cultural sensitivity may have been more than a means to an end. For the most part, public health nurses conveyed a willingness to learn about their clients' culture and to be sensitive to their norms and practices. By their own admission, when they demonstrated knowledge and sensitivity to the cultural norms of their clients their ability to be successful in accomplishing their agenda increased. Being culturally sensitive toward their clients, however, seemed to be secondary to success in fulfilling the purpose of their visits. This is supported by Lock (1995), who suggests that demonstrating cultural sensitivity may be one way to obtain compliance from clients or to coerce clients into doing what the health professional thinks is best for them.

The statement that caring becomes at best "an exercise in the imposition of an ethnocentric authoritative allocation of professional (i.e. middle class) values, where the client is defined as a passive recipient of what is professionally designated as appropriate efficacious treatment" (Morley, Toumishey and Pocius, 1982: 1 quoted in Masi, 1995: 117) also nicely captures the way nurses seem to interpret cultural sensitivity. This was evident in the nurses use of words such as "ensure compliance" and "teach them what's right"... Implicit in the data is that the driving force may well be the agenda of the nurses. This can easily be translated into the needs of the clients as priority of the nurses, because, there is plenty of data which suggests that nurses believed that their agenda was in response to the needs of the clients.

Supportive Audience

According to Goffman, individuals present a sense of self that is acceptable to others but in the act they are aware that there is a need to control the audience because that audience can be
disruptive to their presentation of self (in Ritzer, 1983: 306). Impression management is a technique used by actors to maintain certain impressions, problems they are likely to encounter, and methods they use to cope with problems (Ritzer, 1983: 307). In turn, the audience contributes to successful impression management by the actor (Ritzer, 1983: 310). The audience save the show by giving great interest and attention to it, avoiding emotional outbursts, not noticing slips and giving special consideration to neophyte performance (Ritzer, 1983: 310).

Some community members articulated that they recognize that nurses try their best to be sensitive so "we don't bother to correct them" or "we let them believe we follow what they say - because we don't want to upset them" and so forth. In the data, from interviews with community workers, there was information that could indicate that clients contributed to the nurses' impression that they were culturally sensitive and contributed to the nurses' construction of cultural sensitivity. In chap four we saw that nurses relied on feedback from clients i.e. if clients appear to willingly accept what nurses teach then nurses took that to mean they are being culturally sensitive, and so forth. This suggests that the nurses' source of information may not always be accurate and that they may need to develop other ways of determining whether or not they are being culturally sensitive.

The community workers expressed an awareness that nurses try to be culturally sensitive but the driving force behind that is the nurses' agenda. Some displayed anger at (what they believed to be) the nurse placing her agenda first (her needs before the needs of the community), some were tolerant, some even amused. For the most part, they seemed to be
accepting of the fact that in order to be heard it was necessary for nurses to adhere as much as possible to the value system of the cultural group with whom they were dealing. Overall, it seems that clients were very sensitive to nurses, which contributed to the nurses' beliefs that they were culturally sensitive.

Nurses believed that they were culturally sensitive and that their behaviour demonstrated that they were so indeed. Indeed, to say otherwise would be admitting incompetence. Contrary to the nurses’ beliefs, according to community workers, nurses did and said many things that are in opposition to the norms and practices of certain groups. It is well recognized by community workers that nurses try hard to be culturally sensitive but the driving force is in accomplishing that which they set out to do, and that is, to teach the community the correct ways of doing things. For example, according to a few community workers, nurses have an agenda of “proper” health teaching, which really means - teaching health from the North American perspective. This implies that health practice is only good when it matches the nurses’ view of health practice and poor when it does not.

Lack of Professional Development Opportunities

In order to provide client focused care, public health nurses ought to be cognizant of the cultural particularities which exist in their catchment areas (Meghani-Wise, 1996). The data suggests that nurses are familiar with the cultural variations and peculiarities in their catchment areas. My thesis found that nurses gained their knowledge and experience regarding cultural sensitivity on the job, and in particular, from their professional colleagues. These public health
nurses admitted to receiving some (very little) formal training/knowledge in the public health departments by way of inservices/professional development sessions. Other studies (Green, 1995; Kapel, 1994; Sharma, 1994; Frideres, 1988) which explored efficient methods for developing cultural sensitivity i.e. professional development training versus on the job training (experience) found no definitive solution to the best method for accomplishing this.

Despite the plethora of information and research which exists relating to the need for nurses to be more knowledgeable about their culturally diverse clients, it would appear that public health departments may not facilitate a process whereby their employees can gain knowledge on cultural diversity issues/topics. Although some of the nurses claimed that the lack of inservices and professional development in terms of cultural sensitivity is the responsibility of the public health departments, they demonstrate defensiveness on behalf of the department. Many nurses explained at length that the lack of education at the level of the department is not the fault of the department. The responsibility, they say, belongs at the level of the federal government.

Nurses were quick to point out that the lack of inservices in cultural diversity was due to lack of funding. According to the nurses, the department offered educational sessions a number of years ago, however, since the cutbacks there has been no money for inservices.

It may well be that the way health professionals are educated needs to be revised so that multicultural health issues are considered and integrated into the curriculae (Rosenbaum, 1995; Voelker, 1995). It is well to note that healthcare professionals acquire information regarding cultural issues from colleagues whose own knowledge may be limited and may also not be
accurate. The literature (Green, 1995; Sharma, 1994) is not conclusive as to the most appropriate method for accruing cultural education which suggests that perhaps a combination of academic and on the job learning may be the best. Rather than rely on the department to provide education the fact remains that nurses can also take courses and attend educational sessions on cultural diversity on their own time such as evenings and week-ends. This, however, encroaches on family time, the nurses own private recuperating time and rest and recovery from a stressful day.

According to the literature (Chalander, 1995; Kapel, 1994; Hoeman, 1989), it would seem that education on a well-planned cultural sensitivity training program may influence the attitudes of a person by changing his or her behavior due to increased knowledge of cultural awareness. While this may be so, it is important to consider that there are other factors which determine priorities in terms of agendas and cultural sensitivity. Nurses are socialized into their profession to believe in the normalcy of the status quo. Nurses are educated in institutions where white middle class North American values prevail. Any other value, while tolerated, remains a deviation from the norm. Public Health Departments are institutions which uphold the philosophy of the status quo. Interestingly, the public health departments (at the time when data was collected) did not have a policy on cultural diversity; however, they were in process of creating such a policy.

The data suggests that the priority of the nurse was in performing her role as a nurse to the best of her ability. That role includes being culturally sensitive or at the very least appearing to be
culturally sensitive. Whether she was indeed sensitive to other cultures, however, is unclear. From the data it seems that nurses want to appear to be sensitive for a number of reasons. a) They want to be cast in a positive light for professional and personal reasons i.e. they want to be liked or appear to be good nurses; b) they do not want to offend another and; c) they will be heard if they behave in keeping with the norms of the cultural group with whom they are interacting.

The way in which nurses see the world is based on a combination of factors which include but are not limited to a) Their socialization into the health/nursing profession; b) Their expert knowledge of health; c) Their required role as an employee of an institution devoted to public health; and d) the power and authority which comes with that role. It does not necessarily follow that the provision of more education on cultural groups would produce a more sensitive nurse. It may only mean that the nurse has knowledge of how she ought to be and may adopt behavior in keeping with the norms/customs of her clients thus appearing to be sensitive to cultural variations. I would suggest that a course, a workshop or program on self awareness/self reflection would be appropriate and of benefit in truly being culturally sensitive rather than in simply acquiring the tools to make one appear to be culturally sensitive.

Another point to consider is that the community workers who were interviewed may have moved beyond the perspective of client. On a few occasions community workers mentioned "the agenda" of the nurse. It is possible that they too had agendas. In at least one area, the data suggests that, for a few, participation in the interview process was a means to an end; it gave
community workers an audience and a chance to be heard. Some saw themselves as advocates for the community and as such participated in the interviews, bringing to light what they believe to be issues and concerns. For others the agenda was to sing the praises of the nurses. In the position of community worker there was power with little authority which may also have contributed to hidden agendas.

Contributions of the Study

a) This study adds to what seems to be little documentation on the experiences (in interaction with each other) of both health professionals and the multi-cultural community with whom they work. b) The study identifies the 'quality' of the relationships between health professionals/public health units and the community (i.e. where strengths and weaknesses lie), as perceived and described by selected members of each group.

c) Nurses service a wide variety of cultures. They believe that success in their work depends on their knowledge of the various cultures with whom they interact. It behoves the public health department to support the staff in whatever way necessary to allow for maximization in quality of service. I hope that results from this study will be useful (at both public health departments) for policy design and policy implementation in terms of:

1) Addressing strengths and weaknesses in their relationships with the community;

2) meeting professional development needs, which have been identified by both staff and community;

3) accessibility of professional development measures for all staff;

4) meeting educational needs (of health professionals) which have been identified by
the community.

d) This study may be useful to other health organizations, such as public health units and hospitals, and health professionals at those organizations for identifying their own strengths and weaknesses, and addressing those at the level of policy.

**Dissemination of Findings**

1) A summary of findings to be given to the two participating health departments (participants identities will be kept confidential).

2) A summary of a condensed report will be made available to all public health departments through the OPHA newsletter.

3) Request an invitation to present study to Public Health Departments.

4) Send abstracts to various health facilities/hospitals requesting invitation to present study findings.

5) Submit an abstract for publication.

**Implications for Practice and Research**

Despite the limitations previously mentioned, in closing, I would like to propose some practical applications for findings and suggestions for further research.

**Practice**

**Public Health Departments**

There seems to be a need for public health departments to provide opportunities for staff development in terms of ethno-cultural education. a) It may be appropriate to include “best
practice” education in relation to ethno-cultural communities; b) it may also be timely to invite community leaders to give workshops and presentations on topics pertaining to their cultures; c) education sessions are only useful if staff can attend, therefore, the public health departments need to explore ways of facilitating nurses’ attendance at staff development sessions.

Nurses
Nurses confessed to feeling a great deal of frustration regarding the lack of community resources for a culturally diverse community. a) Perhaps encouragement and facilitation of the process from the public health departments for nurses to be proactive in developing the resources which they believe are needed is not only timely, but overdue; b) another useful activity for nurses may be in taking initiative for personal and professional development, that is, recognize that self-reflection in terms of one’s own biases is essential. Workshops on self reflection and guidance on how to solicit feedback from peers would be an advantage to nurses; c) nurses need to be proactive in development of ethno-cultural community resources in collaboration with communities. Nurses may also wish to encourage clients to participate in decision making regarding their needs and programming.

Research
a) Development and evaluation of a cultural assessment tool may be an asset; b) studies, which evaluate nursing assessments and interventions that promote culturally sensitive health care are needed; c) further exploration into the implications of the language barrier that exists.
CHAPTER 7

CONCLUSION

The trend toward immigration is increasing. Due to the diverse nature of the immigrant population there is a need for research in ethno-cultural studies. In response to that need this research focused on exploring the experiences of public health nurses who work with a culturally diverse population. The objectives focused on the meaning of cultural sensitivity as defined by public health nurses and community workers. A secondary objective examined whether nurses believed themselves to be adequately prepared to work with an ethno-culturally diverse community.

Methodology

Due to the nature of the research question which was interested in the lived experiences of the participants qualitative methodology was employed. This methodology is in keeping with the interpretive worldview. Participants consisted of ten public health nurses and ten community workers who were recruited from two public health departments by non-probability convenience sampling. Data was collected by utilizing semi-structured interviews with guide questions. Data was transcribed by experienced transcribers and analyzed using a cut and paste method and my computer to code and categorize.

Findings

When asked how they acquired their expertise for working with a culturally diverse population the responses identified three ways: on the job experience, reading and to a lesser
degree inservices (educational sessions) which were offered by the public health departments. Nurses were aware that they were culturally sensitive in two ways: 1) when they demonstrated behavior which they knew to be acceptable to the particular culture of the individual with whom they were interacting and; 2) feedback from the community indicated that they were sensitive or not sensitive.

According to public health nurses, working with a culturally diverse population was a challenge in itself. Nurses stated that the most important variable in providing health care in a culturally diverse milieu was the need to establish trust between the provider and consumer. That meant nurses needed to: a) understand the political and historical context from which the clients' culture was derived; b) integrate the clients' ethno-cultural practices and beliefs into information which was given to them and; c) show respect for the clients by demonstrating behavior that was acceptable to the particular culture of the individuals with whom they were interacting.

Further analysis revealed that nurses: a) perceived themselves to be an authority on health related issues; b) interpreted cultural sensitivity to be a behavior which was acceptable with the norms and customs of the individual or group with whom they were interacting, it did not include condoning those norms and customs and; c) demonstration of cultural sensitivity seemed to be a means to an end for nurses. Nurses were required by their employer, the public health department, to impart health care and education to their clients. The agenda of the nurses was their priority and nurses believed that their agenda was in response to the needs of the clients.
Clients contributed to the nurses' notion that they were culturally sensitive by a) overlooking occasions when nurses made mistakes in terms of cultural practices; b) their reluctance to communicate with nurses the fact that they disagreed with the health practices of the nurses and; c) often falsely giving nurses the impression that they complied with instructions and education.

Next Steps

Practice

Implications for practice and research include public health departments providing opportunities for personal and professional development of staff. Nurses ought to be encouraged to take a proactive role in areas of professional concern and build partnerships with communities. For example, a team of nurses and community members may want to identify needs and gaps in resources then develop and implement plans to address those gaps.

Research

Studies, which evaluate nursing assessments and interventions that promote culturally sensitive health care are needed. Further exploration of the implications of the language barriers that exist is essential. Perhaps development and evaluation of a cultural assessment tool would be an asset.
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APPENDIX A

INFORMATION SHEET FOR NURSES

A STUDY ON CULTURAL DIVERSITY IN PUBLIC HEALTH: PERSPECTIVES OF HEALTH PROFESSIONALS AND COMMUNITY.

Canada is a rapidly growing country in terms of its ethno-cultural mix. In light of this, the Ontario Government set out guidelines to ensure that health services are distributed equitably to all groups. Incorporated within the guidelines is the suggestion to educate health professionals in cultural diversity. Public health departments, in turn, have responded to diversity by creating policies geared toward education of health professionals in ethno-cultural awareness.

This study will examine what policies are in place for the professional development of health professionals, and the way in which those policies are implemented. The purpose of this study seeks:

a) To understand how public health nurses experience working with individuals from a variety of cultures.
b) To understand the experiences of the community in dealing with public health nurses.

What is my role as participant in this study?
My role will help to identify the educational needs of the health professional re: cultural diversity, and ways in which those needs may be more fully addressed. I understand that there may be no direct benefits to me, however, findings from this study may benefit others in the future.

What do I have to do if I agree to participate in this study?
If I agree to participate in this study, the researcher will require approximately an hour to an hour and a half of my time. During this time we will have a discussion about issues such as my experiences in dealing with a diverse ethno-cultural community.

With my permission the interview will be tape-recorded. I will be able to review and make comments on the interview transcript if I wish.

My name and any information I give which can be traced directly to me will be kept confidential. My name will not be used in any discussion or in any publication of results. The final results of the research will be made available to me if I wish.

My participation in this study is entirely voluntary. If I choose not to participate in this study there will be no penalty. I HAVE THE RIGHT TO WITHDRAW FROM THIS STUDY AT ANY TIME. Any information given up to the time of my withdrawal will be kept confidential, if I wish.

I have read and understood the above information.
I consent to participate in this study.

DATE:

SIGNATURE OF PARTICIPANT

SIGNATURE OF WITNESS

If there are any questions or concerns regarding this study please feel free to contact:
Lydia S. Baksh - 905 820 8527 or Dr. Blake Poland (Research Supervisor) at the University of Toronto:
416 978 7542
APPENDIX A

INFORMATION SHEET FOR COMMUNITY MEMBERS

A STUDY ON CULTURAL DIVERSITY IN PUBLIC HEALTH: PERSPECTIVES OF HEALTH PROFESSIONALS AND COMMUNITY.

What is this study about?
Canada is rapidly becoming more culturally mixed. Public health departments therefore, have taken steps toward education of nurses in understanding people of various cultures.

The reasons for this study are:
a) To understand how public health nurses experience working with individuals from a variety of cultures.
b) To understand the experiences of the community in dealing with public health nurses.

What is my role as participant in this study?
My participation in this study will help the researcher to understand and explain the feelings of the community toward nurses and public health departments. The information I give may help build a better relationship between community and public health departments. I understand that there may be no direct benefits to me. However, findings from this study may benefit others in the future.

What do I have to do if I agree to participate in this study?
If I agree to participate in this study, the researcher will require approximately an hour to an hour and a half of my time. During this time we will have a discussion about issues such as my experiences in dealing with public health nurses. With my permission the interview will be tape-recorded. I will be able to review and make comments on the interview transcript if I wish.

My name and any information that can be traced directly back to me will be kept confidential. My name will not be used in any discussion or in any publication of results. The final results of the research will be made available to me if I wish.

My participation in this study is entirely voluntary. If I choose not to participate in this study there will be no penalty. I HAVE THE RIGHT TO WITHDRAW FROM THIS STUDY AT ANY TIME. Any information given up to the time of my withdrawal will be kept confidential, if I wish.

I have read and understood the above information.
I consent to participate in the study.

DATE: ____________________________

SIGNATURE OF PARTICIPANT

SIGNATURE OF WITNESS

Any questions or concerns regarding this study please feel free to contact:
Lydia S. Baksh – 905 820 8527 or Dr. Blake Poland (Research Supervisor) at the University of Toronto: 416 978 7542.
APPENDIX B

INTERVIEW GUIDE QUESTIONS FOR NURSES

1) Can you describe what a typical day is like for you (in terms of work routine)?
2) How do you see your role in relation to the ethno-cultural community?
3) Which ethno-cultural groups do you come in contact with during the course of your work?
4) Which ethno-cultural groups do you have the most contact with on a daily/weekly basis?
5) Tell me about your experience in general working with a culturally diverse community.
6) What are some of the challenges/issues that keep coming up in your dealings with a culturally diverse community?
7) Are there distinctive challenges with any group or groups in particular?
8) How do/did you deal with these? What do you do when an issue arises which is related to the ethno-cultural background of the client/s?
9) Tell me about a particular experience that went exceptionally well.
10) Tell me about a particular experience that did not go so well.
11) What (for you) are some of the benefits in working with a culturally diverse community?
12) What do the terms "culturally appropriate" and "culturally sensitive" mean to you?
13) How did you acquire your expertise working with a culturally diverse community?
14) The department offers in-services that are geared to the professional development of staff re: cultural awareness training. Are in-services mandatory or optional? Are these accessible to you? How do you organize your day to fit these professional development sessions into your schedule? Which disciplines are most represented at these sessions? Is it easier for some to attend than others? What are the reasons for this? And so forth.
15) If it were your job to structure education/professional development on cultural awareness what would you do?
16) What advice (in terms of professional development) would you give to a nurse who expresses a desire to work with an ethno-cultural community?
17) What do you think would make your job in dealing with a diverse ethno-cultural community easier?
18) Would you feel comfortable recommending community members for the 2nd part of this study? (The interviewing of community members who have worked closely with public health nurses).

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>Ethnic origin</th>
<th>Years in Canada</th>
<th>Education - high school and nursing</th>
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<tr>
<td>Years in nursing</td>
<td>Years in public health</td>
<td>Years in current public health department</td>
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<table>
<thead>
<tr>
<th>Marital status</th>
<th>Age - 20's 30's 40's 50's 60's</th>
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APPENDIX B

INTERVIEW GUIDE QUESTIONS FOR COMMUNITY MEMBERS

1) Can you tell me how many interactions you've had with public health nurses from the City of Toronto/City of North York? For example, how often have you had contact with public health nurses this month? How long did the visits last?

2) Can you give me an example of when you found the staff to be particularly knowledgeable and helpful in an area which involved being sensitive to your cultural background?

3) What are some of the challenges/issues that keep coming up in your dealings with public health nurses?

4) How do you deal with these? What do you do when a problem/issue arises which is related to the difference in ethno-cultural backgrounds between yourself and the nurse?

5) Tell me about a particular experience that went exceptionally well.

6) Tell me about a particular experience that did not go so well.

7) Do you find that nurses are generally aware and sensitive to your ethnic origin and health practices? Can you tell me more about that?

8) If the public health department asked your advice on ways to enhance the education of public health nurses on cultural awareness and cultural sensitivity, what suggestions would you offer to them?