



PCERII Funded Research

Progress Report

Minority Nurses for Minority Populations:
A Pilot Study in Public Health Nursing

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Problem

Alberta has become home to more than 157,232 immigrants since 1980. Over 65% of these newcomers are from countries significantly different both culturally and socially from Canada and more than 50% arrive with no knowledge of English. Age profiles reveal that more than 50% are between the ages of 20 and 39. Thus many immigrant women are in the childbearing years (Alberta Career Development and Employment, 1992). Over 40% of new immigrants to Alberta settle in Edmonton. As a result, Edmonton is currently the second most ethnically diverse city in Canada, with approximately 23% of its residents being foreign-born (Statistics Canada, 1993). There is, therefore, a growing need for culturally and linguistically appropriate strategies to ensure the health of immigrant families and communities.

In the areas of public health and community health, **Community Health Promotion and Preventive Services (CHPPS)** of the Capital Health Authority (formerly the Edmonton Board of Health) has striven for over 15 years to be responsive to the evolving health issues within the immigrant population. The full spectrum of responses include the establishment of the Newcomers' Clinic (1978-83), participation with other public institutions in the creation of a city-wide interpreter service (CIS) from 1989 to 1992, joint investigation with immigrant communities in determining priority health issues, training of cultural minority health educators/brokers, and implementation of culturally and linguistically appropriate health education programs (e.g. Chinese prenatal classes). The two initiatives that have brought about the most significant learning for CHPPS regarding culturally responsive health care were the incorporation of CIS interpreters into service delivery and the introduction of cultural minority health brokers (Multicultural Community Health Developers) into perinatal health development.

The original intent of employing trained interpreters was to ensure equitable access and high quality service delivery. Three years later, it was apparent that the use of interpreters was essentially a "springboard" from which efforts for addressing more fundamental issues of staffing, practice shifts, and community health development could be advanced. Some of the insights gained include the realization that, in the triadic relationship of health provider, client, and paid interpreter, care provision (while linguistically appropriate) tends to be provider-driven. The interpreter often functions as a "technical tool" to ensure understanding between the health provider (often a community health nurse) and the client, within the context of care provision/health education as determined by the provider. CHPPS also gained a stronger sense of the nature and extent of linguistic barriers to community health services as experienced by the different immigrant communities. For the three years ending in 1996, around 60% of the use of interpreters (up to \$60,000 of an annual budget of \$100,000) was for Cantonese-speaking and Vietnamese-speaking families in the area of perinatal health.

The multicultural community health developer initiative emerged from a desire to respond to immigrant women's concerns and experiences with pregnancy and childbirth. Since 1991, a number of efforts have been made by CHPPS and local hospitals to learn more about immigrant women's perinatal experiences. A study of Chinese-speaking women's circumstances during pregnancy and childbirth (Chiu, 1991) revealed that aside from encountering linguistic barriers to health education and services, immigrant women often experience anxiety and stress regarding conflicts that arise between traditional and biomedical practices. They often suffer from a lack of social/practical support and hence feel a great sense of isolation. They tend to have limited

knowledge about the health care system and enter into interactions with health professionals with expectations based on their exposure to the health care systems in their own countries. The training (1992-94) and utilization of cultural health brokers (The Multicultural Childbirth Education Steering Committee, 1995a) in the area of perinatal health was an attempt to address such issues in Chinese and other immigrant populations. While a wide variety of initiatives have been implemented and well received by client groups (Multicultural Childbirth Education Steering Committee, 1995b), integrating the multicultural community health developers into the health care system posed a significant challenge. "Doubts" and resistance were expressed by mainstream health providers.

On the basis of the learning gained from the interpreter and multicultural community health developer initiatives, CHPPS recognized the need to explore an alternative strategy that was timely and relevant to local health system restructuring. CIS data suggested that there were more Chinese and Vietnamese families in the northeast quadrant of Edmonton experiencing difficulty with access to perinatal services than in other sections of the city. In addition, three of the multicultural community health developers were nurses with experience providing perinatal health education and care. All of these women speak Cantonese. In addition, one nurse speaks Vietnamese and a second speaks Mandarin. None of them have baccalaureate degrees in nursing but all of them worked for more than three years as perinatal educators in their communities. Two of them are qualified lactation consultants and two are qualified as midwives. A pilot project for these three multicultural health developers to begin working out of the four health centres in the northeast quadrant of Edmonton was approved.

This action research project focused on the integration of these nurses into community health nursing positions in northeast Edmonton, including the relationships developed with other community health nurses and other health centre staff and the knowledge and insight gained in the process. These nurses were targeted to work with the Chinese and Vietnamese communities. What was anticipated was a research approach that allowed for innovation in developing the potential embedded in these positions while also providing the data required for evaluation of benefits, satisfaction, efficiency and effectiveness.

Purpose and Rationale

The purpose of this research was to explore the potential roles and responsibilities of these three nurses in enhancing community health services and community development possibilities in Vietnamese and Chinese populations in northeast Edmonton. In this process, the cultural awareness of health centre staff was increased and the community health knowledge of the nurses in these positions reinforced and expanded. Options of how these three nurses may best be integrated into the health care system were explored.

Research Questions

- In working in the maternal/infant health program with the Chinese and Vietnamese populations, what are the areas of expertise of all participants?
- Roles and responsibilities are the three nurses assuming 6 months into the project and 12 months into the project?

- How satisfied are these three nurses at 6 months and at 12 months?
- How satisfied are the other community health nurses at 6 months and at 12 months?
- How have respective roles and responsibilities been negotiated?
- Are the Cantonese and Vietnamese-speaking populations increasing their contact with community health services as the year progresses and the employment of the multicultural nurses becomes known?
- How satisfied are the clients with their interactions with these three nurses and what recommendations would they make?
- How satisfied are the clients with their interactions with the non-Cantonese and non-Vietnamese speaking community health nurses and what recommendations would they make?
- How has the expertise of participants changed after 12 months in the project?
- What recommendations would these three nurses make about their future roles and responsibilities?
- What recommendations would the other community health nurses make about the future roles and responsibilities of the Cantonese and Vietnamese-speaking nurses?
- Where is the meeting ground for joint recommendations and what recommendations would the research group make?
- What are the recommendations for programming changes emerging from the data and reflections on the findings?

Research Methodology

Action research "is an approach to research that blends scientific inquiry with education and political action" (Dickson, 1995, p. 640). It has developed partly as a response to traditional research which, when used to study vulnerable populations, often leads to subjects feeling anger at the lack of direct benefit to participants. As Elliott, an educational researcher states:

Action research might be defined as 'the study of a social situation with a view to improving the quality of action within it'. It aims to feed practical action in concrete situations, and the validity of the 'theories' or hypotheses it generates depends not so much on 'scientific' tests of truth, as on their usefulness in helping people to act more intelligently and skilfully. In action research, 'theories' are not validated independently and then applied to practice. They are validated through practice. (1991, p. 69)

Action research is inherently collaborative, with input and participation sought from all stakeholders. There are no set data collection methods other than what are required to address the

research questions but there is a tendency to emphasize qualitative forms of data (Altrichter, Posch & Somekh, 1993; Dickson, 1995; Elliott, 1991). Changing and reflecting on current practices are core principles of the action research approach.

A research team consisting of the three minority nurses, representatives of all four health centres (five community health nurses, three supervisory nurses, and a health educator), and a nursing professor from the University of Alberta was formed. A research assistant for the project, a graduate student in nursing, also became an integral person in the research team as taking minutes of all research team meetings became one of her responsibilities. Five other research assistants contributed to other aspects of the research process.

Interviews, focus groups, and research group discussions were principle sources of data. In addition, 12 healthy beginnings clients were interviewed and attempts were made to monitor activities and clients seen by the minority nurses. While the clinical project started in January of 1996, it was March of 1996 before research data collection was initiated. All data except research group meetings to discuss findings and analyse data were collected by January of 1997. The final research group meeting was in June of 1997. Almost a year into the initiative, the team of minority nurses became known as the Dragon Rise Health Team, the label now being used to describe the project in presentations and publications.

Research Group Discussions: The research team was modified from the original intent of four community health nurses and one supervisor based on the interest expressed by staff at the health centres. This change to increased participation by supervisory staff did affect group dynamics in that staff community health nurse participation was inhibited, particularly in early meetings. Increased participation by the managers, however, likely contributed to the success of the initiative. When changes were warranted, the decision-makers were present.

The research group met 12 times for three hour meetings during the course of the initiative. A sub-group of the minority nurses, a supervisor, the health educator and the nursing professor met once. Each of these meetings was audiotaped and transcribed verbatim. Minutes were kept of the complete meetings. Near the end of the research process, four analysis meetings comprised of research team subgroups were held without being audiotaped. The approach taken for analysis will be described later in the report.

Diaries: While journals kept by research team members to record their thoughts, feelings, ideas and concerns about the initiative were predicted to be major sources of data, this data collection method was soon discarded. Early in the process, one person submitted journal notations but others found the process too burdensome. While the literature strongly supports the value of journal-keeping in action research (Altrichter, Posch & Somekh, 1993), in practice other demands on one's time take priority.

Interviews with Staff: Interviews began as soon as ethical clearance was obtained as it was important to have an initial data base. Of particular importance was to interview all research team members and health centre supervisors as to their expectations of the outcomes of this joint initiative and what their hopes for future development were. Interviews were repeated six months

and 12 months into the initiative. The nursing professor did all interviews. In total, 36 interviews were conducted.

Focus Groups and Questionnaires: Focus groups, as described by Morgan (1988), were used in conjunction with open-ended questionnaires to solicit data from community health nurses and other professional and support staff working in the health centres affected by the project. Questionnaire data, submitted by community health nurses, were analyzed prior to focus group meetings and used to generate focus group discussion among interested staff. As with the interviews, there were three data collection points (initial, six months, and 12 months). All focus groups were audio-taped and transcribed verbatim. All focus groups were facilitated by the nursing professor.

Thirty-one community health nurses returned questionnaires, with 30 indicating experience working with Chinese or Vietnamese clients and 29 indicating experience working with interpreters. Responses indicated a high level of satisfaction working with interpreters on the part of most of the nurses, although they did differentiate between skill levels and suggest that the Central Interpreter Service had solved problems experienced in the past. It was suggested, however, that interpreters increase the time needed to provide service leading to less opportunity to deal with issues "below the surface". There was awareness that translation of words alone leads to loss of information and difficulty validating if information has been understood. Additional concerns raised in the questionnaire data included not being made aware when cultural differences arose, uncertainty regarding whether client's concerns were fully met, and issues related to potential inaccuracy in interpretation. When asked about advantages or possibilities perceived in employment of community health nurses with cultural and linguistic backgrounds matching those of their clients, many were identified. More concerns were raised, however, than benefits suggested. As these advantages and disadvantages of the initiative were explored more fully in the focus groups and interviews, these data are reported in the findings. From the questionnaire data, a guide for the first round of focus groups was formulated.

A total of 26 focus groups were held. Ten initial focus groups were held (four with community health nurses at each of the health centres, four with support staff at each of the health centres, one with dental and speech professionals from all health centres, one with community developers from two of the health centres). For the 6 month and 12 month focus groups, it was decided to have multidisciplinary groups at each health centre. Thus four focus groups were held during each of the second and third data collection points. Participation in focus groups ranged from 2 (the community developers) to 9 during the first round increasing to from 10 to 15 people during in the final round of focus groups.

It became obvious during the first round of focus groups that: i) there was a lack of understanding from staff regarding the minority nurse initiative; and, ii) there was substantial resistance to the initiative. Substantial focus group time was needed to explain what was happening to the health centre staff. Dialogue within the research group meetings led to a major change in the organization of the project based on this data.

The three minority nurses had each been placed at separate health centres. Plans were made to bring them to one central location. A community health nurse on the research team who worked

at the location to which all project nurses were to be moved was designated as their mentor, a move that was highly successful, and a decision was made to include the Dragon Rise Health Team nurses in the second round of focus groups. The rationale was to allow them the opportunity to describe their work, including how cultural knowledge was integrated into their practice. Thus one or more of the Dragon Rise Health Team nurses was involved at each of the focus groups during the second round of data collection. These became information sessions more than focus groups and, in some ways, the research added a dimension on how to implement change into its goals. At the end of each focus group, staff were asked what they would like to see happen in the final round of focus groups. From the questions generated from staff and questions generated in discussion with the research team, guidelines for the third and final round of focus groups were generated.

Statistical Data: While it was anticipated that the number of interactions health centre staff had with Vietnamese and Chinese clients (home visits, clinics, prenatal classes, immunizations, telephone contacts) would be kept to assess whether the availability of the Dragon Rise Health Team increased utilization by these clients, in reality the data are incomplete. The data collected at the health centres was not classified according to ethnicity and thus project data could not be separated from total data. Within the research group, it was recognized that the meaning of any such increases would also need to be assessed. It was also anticipated that any new programs or changes in programs as a consequence of the multicultural initiative would be tracked.

Client Interviews: Twelve client interviews were done (6 Vietnamese clients and 6 Chinese clients) who had healthy beginnings home visits after the birth of a healthy baby. One Vietnamese client was ethnic Chinese. Thus research assistants with the requisite language skills were hired with five interviews done in Vietnamese and seven done in Chinese. Six clients (three Vietnamese and three Chinese) had home visits from the nurses from their own culture while six clients had other community health nurses accompanied by interpreters for their healthy beginnings visits. Criteria for inclusion were developed by the research team during an early team meeting as were forms for demographic profiles and interview guides. Findings, including a description of the sample, are presented in the next chapter.

What needs to be discussed here, however, are the safeguards taken because of the language differentials among clients, interviewers and research team members. One research team member (the community developer) is fluent in Cantonese as are all of the Dragon Rise Health Team nurses. One Dragon Rise Health Team nurse is also fluent in Vietnamese. The minority nurses, however, gave services and, therefore, did not have access to the client research interview raw data. Consents were translated into Chinese and Vietnamese by the Dragon Rise Health Team nurses. Client interviews were conducted in the appropriate language and then translated and transcribed by the bilingual research assistants. Independent persons, fluent in the relevant languages, checked the English translations against the audio- tapes for two Vietnamese interviews and two Chinese interviews. As there was agreement regarding translation decisions, no further checks were made. More stringent arrangements would have been made if anything but simple content analysis had been planned for the client data. Analysis of client data consisted of comparing preferences for services from nurses from their own cultural background who have facility in the relevant language or services from other nurses with the assistance of interpreters.

Research Progress to Date

Data collection and preliminary analysis is complete. What needs to be stated, however, is that in this type of qualitative research, analysis continues as the final report is written. Substantial qualitative data were generated. As analysis of questionnaire, statistical, and client data has already been discussed, emphasis in this section will be on the interview, focus group and research team meeting data. These data were all audiotaped with verbatim transcriptions made. Minutes from research group meetings supplement these data. With a few exceptions, research group meetings were monthly over the course of 16 months (12 meetings). There were 36 interviews and 26 focus groups. To summarize, while content analysis to detect themes was planned on an ongoing basis concurrent with research group meetings so that data could be presented to research team members in a timely fashion, delays were encountered. Thus the data were often reflected back to the team by the nursing professor after interviews and focus groups but prior to transcripts being available. Thus it was important that detailed notes of such data collection activities be kept and examples rather than impressions be relayed. It helped that data tended to fit with what the Dragon Rise Health Team nurses were experiencing or other team members observing. Interviews were less of a problem than focus groups as the interviewees were usually present at the research team meetings. Much analysis, therefore, was actually recorded in the research group meetings as the research team discussed the meaning and implications of findings.

A research decision early in the research process also affected data analysis. It was decided by research team members to keep transcripts of individual interviews confidential with only the interviewee, nursing professor, and graduate student research assistants having access to raw data from interviews and focus groups. The challenge became how to involve the entire research team in analysis while respecting confidentiality. What we did will be discussed in detail.

The nurse researcher conducted all interviews and focus groups and read all transcripts, including transcripts of research team meetings. Each transcript underwent preliminary analysis by two additional persons. All research team members read transcripts of their personal interviews and were asked to make notes of all relevant ideas. Volunteers from the research group did the same for all research team meetings. Thus each research team meeting and research team interview had preliminary content analysis done by a research team member. A research assistant (graduate nursing student) independently pulled the ideas from each of these transcripts as well. Focus group transcripts and interview transcripts from persons not on the research team underwent the same type of analysis from two graduate students for each transcript. These ideas or general themes were then typed and distributed to all research team members with identification as to whether they were from the first, second or third data collection point (with research group meetings also divided into three groups according to the time periods involved). Thus three sets of documents (in point form and up to 25 single-spaced pages each) were generated during the preliminary analysis.

The research team was then divided into three groups ensuring that at least one Dragon Rise Health Team nurse, one community health nurse and one supervisor was in each group. The nursing professor facilitated and was involved in the entire analysis process. Each group was assigned to data from the preliminary analysis for a data collection point and three all day meetings were scheduled. The aim of each meeting was to take the ideas generated from the raw

data and develop themes and categories that seemed to be emerging. Thus data were reduced in a way such that development of a conceptual map became possible. There were striking differences in the issues emerging at each data collection point, indicating shifts in perceptions about the project over time. Attitudes seemed to change from resistance to acceptance and then to suggestions for expansion occurring during the first, second and third data collection points, respectively. The Dragon Rise Health Team nurse involved in the analysis of data from the first data collection point was visibly shaken by the content revealed. The nurses involved with data analysis from data collected at later points in time had different experiences.

From the work done by the three research team groups, the health educator, a research assistant and the nursing professor met to develop a conceptual map. This map was shared with all research team members for their comments, revisions or support. After adjustments, this map was used to return to all transcripts and code them for input into the NUDIST program for handling of qualitative data. Research team members with the time were encouraged to code data on transcripts to which they had access. The remaining transcripts were coded by research assistants with two research assistants involved in data entry into NUDIST. Three binders of analyzed data were generated. It is from this analysis and ongoing discussion with research team members that the findings for the final report will be written. The validity of the findings is grounded in the collaborative process of examining alternatives, suggesting meanings, and interpreting findings.

Preliminary Findings

What Happened: In my presentation of findings, I would like to report that everything went smoothly and that the initiative was embraced by health centre staff as important for the provision of culturally responsive care to Chinese and Vietnamese clients. This, however, would be wishful thinking. Interpretation of findings will be discussed as they relate to issues of organizational structure, practice norms, and cultural responsiveness. Included within the category of cultural responsiveness will be what the research team consider to be the benefits to clients.

Organizational Structure: Issues related to the organizational structure of community health services emerged early in the research process. During the first round of focus groups, staff nurses vented their frustration with how decisions were made and communicated. Many public health nurses saw no need for the immigrant nurses and perceived the project as a devaluation of their knowledge and skill. From this perspective, the use of interpreters had solved the problems once encountered in working with immigrants and refugees. The initiative was seen as another example of a top down decision made without consultation with front-line staff. Many health centre staff either were not aware of the initiative or not informed as to the rationale and scope of the project. Thus focus group time was needed to explain what was happening and respond to questions. There seemed to be inconsistency in how the project had been introduced to staff in the different health centres. The specifics of the introduction of the initiative to staff had not been planned.

Communication within the organization seemed to be a major issue. What I as a researcher who had not worked in the system did not know until the last round of focus groups was how unique this project was. It was the first time that a quadrant initiative had been undertaken. Most

projects in the past had been unique to one health centre or adopted by the entire organization. Cooperation rather than competition among health centre staff was a new experience. Issues related to whether each centre was receiving an equitable proportion of services according to their funding contribution were raised. There were perceptions among some staff that other clients were receiving fewer services to subsidize the project, even though health centre supervisors were convinced that this was not happening. There was resistance to providing "special services" for certain populations and not for all immigrants. That Canadian-born clients took such services for granted was not perceived as a valid argument by all health centre staff.

The question of support services arose. During the first round of focus groups, support staff expressed a need for cultural orientation. A workshop was arranged and all health centre support staff in the city, not just those at the participating health centres, were invited to attend. Of note is the feedback that I received from support staff. Several thanked me for including them as participants in the research. Several helpful suggestions were received from this group. At two health centres, immigrant support staff with the required language skills were hired to support the work of the Dragon-Rise Health Team.

Practice Norms: In discussion of potential roles and responsibilities of the Dragon-Rise Health Team other concerns were voiced. While the three immigrant nurses were employed initially to work in the area of perinatal health, the needs of the Vietnamese and Chinese populations were such that it seemed likely that the positions would expand to incorporate community development activities. Thus prenatal classes, baby talk groups, and some work with English as Second Language classes soon became incorporated. Other programs such as the car passenger restraint initiative, work with immigrant elders, facilitation of dental and speech programs, and school health activities could have been included as such needs were identified. It seemed as if the Dragon-Rise Team might be allowed to do the type of generalist public health nursing work which other nurses perceived they had been required to relinquish. Questions regarding fairness were raised. Were the Dragon-Rise team members, whose qualifications were perceived as inferior, going to have more flexibility in planning their work than other more experienced public health nurses? There is no doubt that the scope of practice of the three immigrant nurses was broad. Information hotlines in Vietnamese, Cantonese, and Mandarin, already available to the English-speaking population, could be added and some of their time was spent developing culturally and linguistically appropriate health education materials.

In addition, the immigrant nurses suggested that evening and weekend classes and clinics were more appropriate for their clientele and requested permission to schedule activities for such times. Working weekends on a regular basis would violate union rules in existence for other staff. Nurses raised questions regarding the fairness of providing services for Chinese and Vietnamese clients at times unavailable to other clients who may also prefer more options.

Questions were raised regarding the qualifications of the Dragon-Rise Team nurses. That they lacked degrees in nursing was of concern to many nurses as in Canada the community health component of the nursing curriculum is not a part of diploma programs. Strong ethnocentric statements, many of which seemed racist, were made, particularly during the first round of focus groups. There was a perception that maybe Vietnamese and Chinese clients would prefer "Canadian" nurses. Whether foreign qualifications were adequate to nurse in Canada was also

queried. An organizational concern was the quality assurance aspect of their work. How could nurses who worked predominately in languages other than English be evaluated?

Cultural Responsivity: Early in the data collection process, public health nurses voiced their satisfaction with what they were accomplishing in their work with the Chinese and Vietnamese populations. These immigrant groups had high immunization rates and appeared to have their needs met by the use of interpreters in collaboration with public health nurses. The addition of the Dragon-Rise Health Team was perceived as a loss by many of the nurses. Nurses also expressed concern that offering services so attuned to the cultural and linguistic origins of clients would foster dependency and limit opportunities for integration into Canadian society.

The Dragon-Rise Health Team nurses perceived their services as having the opposite effects. Clients sometimes asked them how they had learned to communicate in English so effectively. Their success in achieving professional status in Canada could be seen as a motivating force for others. To address the questions raised by the public health nurses during the first round of focus groups, the Dragon-Rise Health Team nurses participated in the second round. Using specific examples of how they used cultural knowledge to enhance their work, they articulated how they perceived the benefits to clients of receiving care from a team member. More recently, the benefits to clients have been articulated by one of the Dragon-Rise team members as:

- **Enhanced knowledge of the health implications of the use of traditional practices, including use of herbs and cultural beliefs guiding perinatal practices.** The Dragon Rise nurses use their cultural knowledge in exploring options for healthy choices with clients. Sharing such knowledge with public health nurses led to much greater awareness of the impact of culture on the health status of clients and definitely increased support for the Dragon Rise team.
- **Greater understanding of when and where to access health services.** The Dragon Rise nurses understand the health care systems in clients' countries of origin. They are in unique positions to communicate such differences to the families with whom they have contact. They have been able to share with other public health nurses why client expectations are often incompatible with services offered.
- **Greater control over their information and learning needs.** Translation takes time. In the interviews with clients, time and again we heard that clients tend to ask fewer questions or engage in real dialogue when an interpreter is present. Often questions of a sensitive nature remain unasked. Clients assume that mainstream nurses will not understand their cultural practices so do not reveal when advice will not be followed.
- **More informed decision-making around health choices.** Chinese and Vietnamese clients in northeast Edmonton can now access more up to date information on a regular basis than was generally available before. Clients from other sections of the city often access the Dragon Rise nurses at clinics and by telephone. A client who has moved out of province has recently contacted the Vietnamese nurse for child care advice.

The work of these nurses can best be described as cultural brokering allied with high quality professional service. They live between two worlds and by doing so enhance the knowledge and functioning of both clients and staff. That clients from health centres outside of the quadrant are accessing the services of the team by calling for information or booking appointments in clinics distant from their home is a good indicator of client preference for this linguistically and culturally responsive service. After one year as a pilot project, the positions were made permanent.

Why Did This Project Succeed? With regard to staff perceptions of this project we moved from resistance to acceptance to suggestions for expansion. In discussing this phenomenon, project team members raised six points.

- The idea was sound and met real needs.
- Nurses at all centres were committed to giving the best possible service to all clients.
- The Dragon Rise Health Team was successful in communicating how what they had to offer was superior to services given via an interpreter.
- The client data supported the Dragon Rise nurses' perceptions.
- There was strong administrative support.
- The action research component raised consciousness, gave voice to all stakeholders, provided support to the Dragon Rise Health Team nurses, and stimulated innovation.

From the research we learned much about initiation of change and many details regarding cultural practices related to maternal and child health in the Chinese and Vietnamese populations in Edmonton. What we learned at times contradicted what is commonly found in the nursing literature. The membership of the research team was a microcosm of the range of staff attitudes towards the initiative. Not everyone was in favour of the project at the onset. Thus reporting back on interview and focus group data led to lively debate. Three things that appear to be key to developing truly culturally responsive health services occurred over the 18 months of data collection:

- A staff nurse, in response to a focus group question regarding the influence of the project on her work with culturally diverse clients, stated: "I make fewer assumptions and ask more questions".
- The Dragon Rise Team members began, during the second year of data collection, to voice their concerns about the "Canadian" way of doing things. Differences among the three nurses were voiced and we as a research team were able to begin exploration of our multiple ethnocentrisms.
- The health educator in the research team, who has many years of experience trying to increase the sensitivity of health professionals working with culturally diverse

populations, has become a firm believer in the action research process. From her perspective, more was accomplished in a year than had happened in her years of struggle with other culturally focused initiatives.

Policy Implications

Findings relate to policy at three levels:

- **Targeting the determinants of health:** Findings relate directly to Health Canada's focus on population health in the areas of culture, social support, access to health care, early childhood development, personal health practices and coping skills, and education. These relationships will be elaborated more fully in the final report.
- **Encouraging diversity in the workplace:** As one support staff member stated in a focus group: "Health centres should reflect the diversity of the clients they serve". This was not happening at the time of data collection and was perceived by some participants as important to consider.
- **Facilitating integration of immigrants with professional qualifications:** It is known that immigrants with professional qualifications have difficulty integrating into positions in which their education and experience is recognized. Questions regarding qualifications and affirmative action were raised by participants in this research. There were concerns that using language capacity and ethnic origins as criteria for employment could adversely affect the ability of Canadian-born nurses to acquire positions as public health nurses. What was evident was the need for support for the three women employed in the Dragon Rise Health project as integration into the system was not easily achieved.

Staffing for the Conduct of the Research

Six research assistants, four masters' students in nursing, one PhD student in nursing, and a member of the Vietnamese community (for client interviews in Vietnamese) were employed for various aspects of this research. With the exception of one student supported by a Faculty of Nursing graduate assistantship, all were paid from research funds. Community Health Promotion and Preventive Services (CHPPS), a division of the Capital Health Authority, provided \$1500 to pay for a literature review and a research assistant for a transition period of three months when funding was inadequate to support the student employed in the most significant support position. In addition, there were 12 co-researchers as part of this research team. All were employees at health centres in the Capital Health Authority.

Dissemination Activities

Presentations

Ogilvie, L., McPherson, N., Ilesic, D. & Fung, M. (1997). Dragon Rise: Providing Prenatal and Postnatal Support to Chinese and Vietnamese Families. Investing in Health: The Shaping of Public Policy, Canadian Public Health Association 88th Annual Conference, Halifax, Canada.

Ogilvie, L., Wrightson, D. & Chiu, Y. (1997). Minority Nurses for Minority populations: A Pilot Study in Public Health Nursing. Making a Difference, 2nd International Conference on Community Health Nursing, Edinburgh, Scotland.

Ogilvie, L., McPherson, N., Ilesic, D. & Fung, M. (1997). The Dragon Rise Health Team: Providing Culturally Responsive Care to Chinese and Vietnamese Immigrant Families. Metropolis Year II Conference, Montreal, Canada.

Ogilvie, L., McPherson, N., Ilesic, D. & Fung, M. (1998). The Dragon Rise Health Team: Providing Culturally Responsive Care to Chinese and Vietnamese Immigrant Families. Prairie Centre of Excellence for Research on Immigration and Integration, Edmonton, Alberta, Canada (Brown Bag Lunch Presentation).

Ogilvie, L. (1998). Collaboration: Building the Research Team. Margaret Scott Wright Day, Faculty of Nursing, University of Alberta (part of symposium "Shifting the Focus of power: Reflections on Collaboration in Action Research" with J. Mill & H. Morris).

Ogilvie, L. (1998). Deriving Policy implications from Action Research: Lessons from the Dragon Rise Health Team Project. Regional Conference, Prairie Centre of Excellence for Research on Immigration and Integration (Metropolis Project), Regina, Canada.

Publications

Morris, H., Ogilvie, L., Fung, M., Lau, A., Ong, A. & Boyd, J. (In press). Cultural brokering in community health practice: Edmonton's Dragon Rise Health Team. Canadian Nurse.

Projected Date of Completion

Data collection and preliminary analysis are complete. The final report should be available by September of 1999.

Funding from Outside Sources

Research Funding

Alberta Association of Registered Nurses (\$5000)

Small Faculties Fund, University of Alberta (\$4,713)

CHPPS, Capital Health Authority (staff release time - \$6000; literature review and research assistance - \$1500, initial costs for tape recorder & external microphone - approx. \$200)

Funding for Conference Presentations

Small Faculties Fund, University of Alberta (\$1000)

Alberta Foundation for Medical Research (\$1500)

Other Support Received for PCERII Activities

PCERII - funded for two National Metropolis Conferences (Montreal in 1997 & Vancouver in 1999), one regional conference (Regina in 1998), and research meeting in Toronto (February, 1999)

Health Canada - funded for Metropolis Health Domain Seminar in Ottawa in 1996 & for Metropolis Health Research Working Group (as lead health researcher for PCERII) in Ottawa in 1998

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