

Immigrant & Refugee Women's Cultural Health Practices

A guide for health care professionals



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Personal Reflection

As a first generation Surinamese woman, I immigrated to Canada with my husband when I was eight weeks pregnant. Due to complications with my pregnancy, I became involved with the health care services in Calgary from the early pre-natal stage.

I consider myself reasonably well-educated, having a Masters degree in Social Work and I speak English fluently. However, I felt lost in most of my appointments due to the medical terminology used in the explanation of complicated procedures.

Because of my assertive nature, I would always ask questions or call my doctor again for more information and clarification. I was very lucky to have an obstetrician who understood me and was willing to spend twice as much time with me as he would with other patients who might have had the same difficulties but whose first language is English.

I have met many first generation immigrant women who were less fortunate and who felt frustrated in their pursuit of health and wellness.

It is not accidental that I became the Diversity Program Coordinator for Child and Women's Health.

This document is for all health care professionals who feel as lost as I did in the countless sessions that they have with first generation immigrant and refugee women so that they may provide quality health care to all.

Linda Kongnetiman, MSW, RSW

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Key Terms

It is highly recommended that readers familiarize themselves with the following terms for a general understanding of the context presented within this manual. The key terms and their definitions are as follows:

Immigrant – a person who has moved themselves (and often their families) to take up permanent residence and often citizenship in the new country. Immigrants are classified as skilled workers, provincial nominees or business immigrants, or may fall into the “Family Class” of immigrants.

Agger-Gupta

Refugee - a person who is forced to flee from persecution.
Canadian Council For Refugees

Convention Refugee - a person who meets the refugee definition in the 1951 Geneva Convention relating to the Status of Refugees. To meet the definition a person must be outside their country of origin and have a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.
Canadian Council For Refugees

Refugee claimant - a person who has made a claim for protection as a refugee. This term is more or less equivalent to asylum-seeker and is standard in Canada, while asylum-seeker is the term more often used internationally.
Canadian Council for Refugees

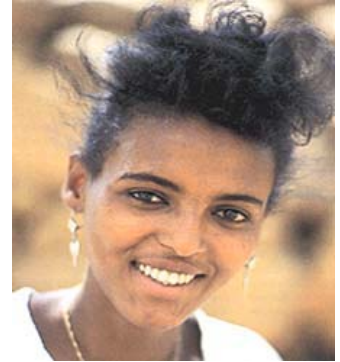
Resettled refugee - a refugee who has been offered a permanent home in a country while still outside that country. Refugees resettled to Canada are determined to be refugees by the Canadian government before they arrive in Canada (whereas refugee claimants receive a determination in Canada).

Canadian Council for Refugees

Permanent resident - a person who has been granted permanent resident status in Canada. The person may have come to Canada as an immigrant or as a refugee. Permanent residents who become Canadian citizens are no longer permanent residents.

Canadian Council for Refugees

Diversity - is simply all the ways we are unique and different from others. Dimensions of diversity include, but are not limited to, such aspects as race, religion, and spiritual beliefs, cultural orientation, color, physical appearance, gender, sexual orientation, physical and mental ability, education, age ancestry, place of origin, marital status, family status, socioeconomic situation, profession, language, health status, geographic location, group history, upbringing and life experiences.



Agger-Gupta

Culture - is a set of rules governing behaviour, creating shared traits and customs among people. It has the potential to impact every part of a person's life, from language to etiquette to belief systems and ideas. Yet different people adhere to different aspects of a culture and no individual exhibits all the traits of any given culture. Moreover, members of a cultural group will not all act the same way all the time. And, finally, cultures are not static entities; they are constantly being reshaped.

Madeleine Greey

Cultural Competence - is the process of being sensitive to issues related to culture, race, gender, sexual orientation, social class, and economic situation, among other factors. Cultural Competence requires gaining the necessary knowledge, attitudes, and skills in working with culturally diverse individuals.

Lipson, Dibble, & Minarik

Women's Health - generally refers to health issues and matters specific to the female anatomy. Such issues often relate to the female genitalia, breasts, and other physiological structures not found in the human male. It can also be relevant by conditions relating to hormones and other chemicals specific to, or notable in the female. The most common female health matters include menstruation, child birth, menopause, breast cancer, and so forth.

Wikipedia

Resource Manual Overview

The purpose of this manual is to provide health care professionals with information that will support them in their knowledge, and skill building in providing culturally competent services to first generation immigrant and refugee women. Cultural Competence refers to the ability of health professionals to deliver the “highest quality of care to every patient regardless of race, ethnicity, culture, or language proficiency” (*Betancourt et. al, 2005, 499*).

This manual will be divided into four sections:

1 **Section one** presents an introduction and literature review highlighting the values, beliefs, perceptions, and experiences of visible minority women in accessing health services. Special emphasis will be placed on research conducted among first generation immigrant/refugee women and some of the dilemmas faced by these women and health care professionals.

2 **Section two** is divided into two categories – the first category presents cultural summaries on five ethnic groups: Chinese, South Asian, Middle Eastern, Sudanese, and Ethiopian women. These five groups have been identified by staff within the Women’s Health Portfolio of the Calgary Health Region as the highest users of ac-

cess to health services. Furthermore, health care professionals experience more barriers in providing services to the women identified in these groups.

Each cultural summary describes the cultural values, beliefs, and perceptions held by the five ethnic groups on aspects of women’s health such as:

- ♦ Ante-partum with a focus on pregnancy
- ♦ Intra-partum with a focus on labour and delivery
- ♦ Post-partum with a focus on delivery and care
- ♦ Post-partum depression
- ♦ Gynecology with a focus on sexuality, breast health, menopause, papanicolaou (pap exams), and abortion.

The second category describes the influence of these cultural values, beliefs, and perceptions on the women’s *behaviours* in accessing health services; along with *strategies* to support health care professionals in providing culturally competent services.

3 **Section three** is a personal account of the experiences some of the women in the focus groups had in accessing health care services in Calgary.

Section four is a list of community resources that

4 provide services to immigrant and refugee women.

The information for this manual was collected using a variety of sources such as an extensive literature review; individual face-to-face and over the phone interviews using an interview guide; consultation groups with health care professionals and community organizations; and focus groups with first generation immigrant and refugee women from the five identified ethnic groups.

A Note on Stereotyping and Generalizations

This resource manual provides information on first generation immigrant and refugee women's health beliefs, values, perceptions, and behaviours specific to the five identified cultural groups. When considering cultural differences, there lies a danger in stereotyping groups of people based on a specific and indistinguishable set of assumptions.

The contents of this manual are to be used as a *guide* to educate health care professionals regarding some behaviours that first generation immigrant and refugee women may portray when accessing health care services. This manual is **NOT** designed to promote stereotyping of all women from these five identified ethnic backgrounds. *It is to be used as a tool to enhance cultural sensitivity, awareness, and practice*

within health care service delivery. The information *may* apply to *some* women from the identified groups but not necessary all. It is recommended that health care professionals negotiate health services with their patients by asking culturally relevant questions and use this manual as a baseline to engage first generation immigrant and refugee women in playing an active role in defining and determining their health.

***A tool to enhance
cultural sensitivity,
awareness, and practice
within health care***

Introduction

Like most urban cities, Calgary is growing quickly and is becoming increasingly diverse. In 2005, Calgary received approximately 65 newcomers per month. India, China, and the Philippines were identified as the top three countries of origin for immigrants to Calgary. This is a dramatic shift in immigration trends compared to twenty years ago when the majority of newcomers came from Europe and the United States (*Citizenship and Immigration, 2003*). Female immigrants made up over half of the total amount of immigrants in comparison to males; 51.5% versus 48.5 % (*City of Calgary, 2003*).

Upon arrival most of these women face many changes in adjusting to their new environment. These changes may include language and cultural barriers; assuming roles that differ from their traditional roles as primary care taker; and employment challenges. Additionally, individuals who are refugees may be faced with issues including: mental illness, limited education, underemployment, poor housing, and lack of extended health benefits.

Keeping in mind the difficulties that first generation immigrant/refugee women face in settling in Calgary, their health and well-being has been identified to be at greater risk as compared to Canadian born men and women, as well as immigrant/refugee men; despite the fact that immigrants to Canada generally

are in better health than Canadians upon arrival (*Oxman-Martinez, 2000*). The health and well-being of first generation immigrant/refugee women has become a growing area of concern among policy makers, researchers, and health care professionals. However the experiences of these women in accessing health services have been given limited attention (*Health Canada, 1999*). First generation immigrant/refugee women face additional risks to their health due to challenges associated with accessing our health care system. These challenges often include: cross cultural communication barriers; differing perceptions of diagnosis and recommendations between first generation immigrant women and health care professionals; lack of adequate time spent with health care professionals; and a general lack of cultural sensitivity by health care professionals in addressing the women's health concerns.

Our understandings and experiences are often governed and conditioned through the cultural context in which we live (*Kim-Godwin, Clarke, and Barton, 2002*). Culture is defined as a "set of rules governing behaviour, creating shared traits and customs among people" (*Greey, 1994, 2*). Culture affects immigrant/refugee women's ideas around health, and their expectations of effective strategies to maintain and promote health.

Researchers worldwide have conducted studies on

various cultural groups demonstrating the influence of culture on the experiences of immigrant/refugee women. In one study, Kim-Godwin, Clarke, and Barton (2002) studied the menopausal experiences of Korean women living in Canada. According to the study, Korean women's experience of menopause was influenced by their culture. Korean culture not only affected how the women perceived menopause; but also their perception of illness; informal or formal support; and other health seeking behaviours.

Nahas and Amasheh (1999) interviewed 22 Jordanian women, living in Australia, on their cultural meanings and experiences of post-partum depression. The researchers found that the symptoms of post-partum depression as identified by the women included severe loss of control over emotions, loneliness, hopelessness, and perceptions and feelings of being a bad mother. The symptoms were mostly attributed to fear of failure as a wife and mother, lack of family support, loneliness due to time spent away from husbands, and a lack of self care.

In a study of pregnancy and delivery practices of 19 Ethiopian women in Israel, Granot, et al (1996) found that culture played a large role in the pregnancy practices of Ethiopian women. The researchers found that the areas most affected by culture were religion, food, support, modesty and control during the birthing process. For example, the women in the study believed that birth and delivery outcomes were determined by God's power and further linked to the moral behaviour of a woman and her husband prior to pregnancy. Food on the other

hand, was another important contributor to pregnancy outcomes as it aided in overall health during pregnancy, facilitated labour, and strengthened women after delivery. Support was highly valued during the time of pregnancy, and was often provided by female family members, friends, and traditional birth attendants. Modesty was identified as one of the most important aspects of pregnancy for Ethiopian women. A woman's body is covered at all times including delivery, except under extreme circumstances. Finally, control during the birthing process was identified as being important by the women. During delivery most women chose a position that would provide them a great deal of comfort while giving birth.

A study conducted by Holroyd and Lai (1997) was similar to that of Granot et al. (1996); however; they focused on the post-partum practices of seven Chinese women. According to the researchers, 6 categorical themes emerged on the postpartum practices of the women in the study. These themes are as follows:

Good and bad food - food was described by the women as a type of remedy to restore the balance of the body. It was extremely important for women to adhere to the Yin and Yang (hot and cold) principal during the recovery stage of pregnancy.

Dirt and prohibitions - not bathing or washing their hair until one month after delivery was practiced to prevent the wind from entering their bodies through open pores.

Rest and appeasing the “Placenta God” - adequate rest was also cited as essential for women for at least one month after delivery. From the women’s perspective not following the cultural expectation around rest would result in upsetting the “Placenta God” causing harm to both mother and baby.

Housework - housework arose as another theme in the study; however, there seemed to be no cultural significance attributed to the role of house work by the researchers.

“Polluted” sex - women were expected to abstain from sexual intercourse for at least one month after delivery, as a means of not polluting a new mother.

Competing loyalties - women felt obliged to follow and maintain cultural practices during postpartum despite their personal beliefs. They often felt pressure from their husbands and older relatives to adhere to practices that were outdated.

In an exploratory, descriptive research study on the use of the Breast Self-Examination (BSE), Rashidi and Rajaram (2000) explored thirty-nine Middle Eastern, Asian-Islamic immigrant women between the ages of 20 to 40 years on their awareness, knowledge and frequency of breast self-examination. The results indicated that the majority of these women were not knowledgeable about the importance and practice of BSE as a means of early detection of breast cancer. This was related to a lack of awareness on breast cancer screening, and a lack of access to health care services. The study also showed that the women who had some knowledge of BSE ob-

tained their knowledge from sources other than medical professionals.

In a similar study, Underwood, Shaikha, & Bakr (1999), conducted a study with nine Muslim women on the role of religion and spirituality in breast cancer screening. The results from the study indicated that the religious beliefs of Muslim women greatly influenced their health behaviour, particularly around breast cancer screening. Many of the women in the study cited the Qur’an’s strict adherence to “modesty of dress, manner, and behaviour” (p.288) as a contributing factor to why breast cancer screening was not routinely used. According to the women they would seek BSE only under exceptional circumstances such as an imminent disease.

**the Calgary Health Region has
been a leader in advocating for
culturally competent health care**

The information presented within the literature review show a clear link between the influence of cultural values, beliefs and perceptions, and experiences on the behaviours of first generation immigrant and refugee women. This information somewhat corresponds with some of the data provided by the focus groups that were held as a part of this project. The women interviewed identified modesty, concepts of labour and delivery, nutrition before and after labour, and BSE as important issues in accessing health care services upon arrival in Calgary.

Health care professionals face a dilemma in providing care to newcomers who follow their cultural values, beliefs and perceptions especially if the behaviour portrayed does not conform to the norms of the health care system. In this situation they need to respond using a culturally sensitive approach by incorporating cultural competency into their practice. Cultural competent practice requires health care professionals to gain the knowledge on specific cultural beliefs and behaviours of various ethnic groups; become sensitive to the cultural needs presented when providing services to culturally diverse clients; and incorporate the necessary cultural skills to practice (*Kim-Godwin, Clarke, Barton, 2001*).

Cultural Competence in health care has gained increasing attention as health care professionals have strived to improve the quality of services for vulnerable populations by removing barriers along the lines of race, ethnicity, culture, and language (*Betancourt et. al, 2005*). As the city of Calgary becomes more diverse, health care professionals will be expected to provide culturally competent services to clients with different values, beliefs, and perceptions on health (*Papadopoulos & Lees, 2001*). Failure to provide culturally competent services predisposes their clients to negative health outcomes, poor quality of care and a general dissatisfaction with the health care system

The Child and Women's Health Diversity program within the Calgary Health Region has been a leader in advocating for cultural competent health care, and is striving to enhance cultural competent best practices. This resource manual represents one initiative within the Child and Women's Health Diversity Program.

The following pages (**Section two**) will provide some information on the values, beliefs and perceptions of immigrant/refugee women from Chinese, South Asian, Middle-Eastern, Sudanese and Ethiopian backgrounds. It is certainly not expected of health care professionals to know all these values, beliefs and perceptions surrounding women's health care but hopefully this will aid in the relationship between health care professionals and immigrant and refugee women.

Chinese Women

Women from the Peoples Republic of China, Taiwan, and Hong Kong



A three-day old newborn of Chinese descent was diagnosed with intestinal problems. To further treat this young child an intravenous (IV) was requested.

A nurse attended the bed side to in-

sert the IV and was not successful after five attempts. The mother of the child noticed at that time that the heart-rate of her child exceeded a rate of 200. This caused a great deal of stress for the mother, and prompted her to stop the nurse. She could not bear to see her baby suffer so much pain. As she shared her concern with another health care professional, the mother explained that in China, a baby is poked only twice by a nurse for an IV. If that nurse is unsuccessful in her attempt then another nurse is called in to try inserting the IV. The mother felt that in her case, it seemed as if the nurse who had poked her baby up to five times to insert an IV was inexperienced and was using her baby for practice.

Between 1884 and 1923, the Canadian government placed increasing restrictions on Chinese immigrants. However, the promise to build the railroad from West to East created the need for diligent workers and the Chinese were recruited as indentured labourers. They worked uncomplainingly and lived frugally, unlike their non-Chinese counterparts. This difference in work ethic did not bode well with the other workers and caused a great deal of hostility between them. After completion of the railway, the cheap labour provided by Chinese workers was no longer needed and to discourage Chinese immigration, the government placed a "head tax" of \$50 on all immigrants of Chinese descent. The tax was later raised to \$500. This economic barrier made it difficult for Chinese men to bring their female relatives and children to Canada. For some the only recourse was to return to China but for others, they continued sending money home to their families in China and took common-law wives in Canada. Some took Canadian wives and started another family. To add insult to injury, people of Chinese origin had their vote taken away from them in British Columbia and Saskatchewan; and



there were a number of anti-Asian riots in Vancouver, B.C. This open hostility further discouraged Chinese men from

bringing their families to Canada for fear of their safety. Between 1885 and 1902, less than 1% of Chinese immigrants were women. Between 1923 and 1947, The Chinese Immigration Act openly prohibited any individuals of Chinese origin from immigrating to Canada. The Immigration Act of 1919 was also amended to prohibit people of any Asian descent from immigrating. In 1946, persons of Asian origin who were denied the vote regained it. Immigration increased slightly after the Second World War when Canada allowed close relatives of Chinese residents to enter the country. Many Chinese men were eventually reunited with their wives and children. A new Immigration Act was passed in 1976 and by 1978, the point system was revised to emphasize occupational experience and demand. Chinese immigrants, especially those who could generate employment in Canada, were encouraged to settle as "economic" immigrants.

In Chinese society the family unit is the most important social unit. Important health related decisions are usually made in consultation with all members concerned in a given situation.

VALUES, BELIEFS AND PERCEPTIONS

ANTE-PARTUM

Pregnancy

Pregnancy is perceived as a vulnerable time for pregnant women. Consequently, women and their support networks are expected to take great care and caution in protecting the health of the expectant mother as well as the health of the unborn baby. Some women may hold the following beliefs during pregnancy:

- ♦ Not using sharp objects such as knives and scissors on their bed, for fear that this may result in having babies born with cleft lips;
- ♦ Avoidance of taping or posting anything on the wall of their bed, such as posters or pictures, to prevent unwanted birthmarks on the faces of their babies;
- ♦ Avoidance of working with glue or other adhesives and working with tools such as hammers to prevent birthing complications and deformity in the unborn baby;
- ♦ Not using foul language as this may cause the baby to be cursed; and
- ♦ Abstaining from sexual intercourse to avoid miscarriage.

Food/Liquids

During pregnancy, many Chinese women adhere to the Yin and Yang (hot and cold) principle associated with food. They usually avoid hot foods like lamb,

or cold foods such as watermelon and bananas. Other beliefs commonly held around food include:

- ♦ Not eating foods such as shellfish as it is believed to make a woman ill during pregnancy;
- ♦ Not eating crab for fear of producing a mischievous child;
- ♦ Not eating foods that are not properly cut or mashed for fear the child will have a careless disposition; and
- ♦ Avoiding dark coloured foods and sauces in order not to give birth to a dark-skinned baby.
- ♦ Drinking strong herbal soup to ease labour pains.

In China, many women attend ante-partum educational programs to prepare them for child birth.

Labouring

Women usually prefer to eat during delivery, to get the desired energy they feel they require before going into labour (Calgary Women's Association, 2005). They also prefer to drink hot or warm water as opposed to cold water for fear of upsetting their internal hot/cold balance, and increasing their risk of health related illnesses as they get older.

INTRA-PARTUM

Site of Delivery and Support

Women usually give birth in hospital settings and are assisted by a medical professional. Traditionally, men have never been involved during labour and

delivery; however, with the changing nature of Chinese society, men are becoming more involved in the birth process.

POST-PARTUM

Rituals

After giving birth, many women follow a ritualistic practice called "*zuo yuezi*" or "*Tso-Yueh-Tzu*", literally translated as "doing the month", in which a woman rests for a period of 30 days and follows a variety of traditional activities. These activities are considered both curative and preventative and are crucial to a woman's health. They include some or all of the following:

- ♦ Not washing her body or her hair to prevent open pores and wind from getting into the body, and harmful effects later in life;
- ♦ Not going outside for a month to prevent getting cold;
- ♦ Getting plenty of bed rest to straighten out the backbone and correct what is believed to be the swayback shape created by pregnancy;
- ♦ If a woman has had a C-section she is expected to stay in the hospital for 1 week and is encouraged to seek bed rest;
- ♦ Not eating raw or "cold" (yin) foods, eating chicken, herbal chicken soup or "hot" (yang) foods instead in order to restore the body's harmony;

- ♦ Drinking lots of black bean chicken soup to maintain overall health;
- ♦ Eating pickled pig's feet, and pig's stomach boiled with peppers to restore lost energy during pregnancy. This is not regular pickled pig's feet. The pig's feet are cooked in dark vinegar with eggs and ginger so that all the bones of the pig's feet and the shells of the eggs melt into the vinegar. Therefore when the women drink the vinegar, they also take in the calcium dissolved in the vinegar. The pig's feet and ginger will also be shared with relatives and close friends, serving the same function as sharing a birthday cake;
- ♦ Drinking warm water with brown sugar to help with blood flow;
- ♦ Avoiding the wind to prevent getting sick;
- ♦ Avoiding walking or moving a lot;
- ♦ Not visiting others;
- ♦ Not getting sick during the month;
- ♦ Not engaging in sexual intercourse for at least one month after childbirth, as it could endanger and bring bad luck upon a woman and her husband; and
- ♦ Not eating at the table with the rest of the family since a woman is perceived to be in a contaminated state.

Support

Women usually move in with their parents or in-

laws or have a relative staying with them after birth.

POST-PARTUM DEPRESSION

Symptoms

The direct translation for post-partum depression in Chinese is *emotionally imbalanced*. The symptoms of post-partum depression are similar to that found in Western cultures in which a woman experiences feelings of helplessness and hopelessness, loss of control, infanticide and self -destruction. Other feelings typical to Chinese women may include ambivalence and "*phantom crying*" (excessive crying). In Chinese culture, post-partum depression is usually something that is not talked about. Traditionally many in the Chinese community were not quite aware of the existence of post-partum depression. They often thought it was due to the "mental illness" of the mother or a dirty spirit. Nowadays, more and more people in the Chinese community are aware of this problem.

Support

It is believed that support from family and friends after childbirth protects a woman from post-partum depression.

Help Seeking Behaviours

Screening for post-partum depression is usually conducted by a health care professional using a bio-medical approach, however, only when a woman seeks help through clinics or hospitals. Some women are reluctant to seek help due to the lack of

knowledge with post-partum depression clinics, or a cultural stigma around mental disorders. If a woman seeks help for post-partum depression, the use of medication, to treat related symptoms is often discouraged by family members based on strong beliefs about associated side-effects.

GYNECOLOGY

Papanicolaou (Pap Smears)

Women only go for a pap smear examination when there is a problem. In contemporary China, only professionals (teachers, lawyers, etc.) go for regular check-ups as it is a requirement of their jobs. Also, most companies (in major cities only) offer benefits for their employees to go for such check-ups. However, for the general Chinese population; with the exception of those living in Taiwan, pap smear examinations are not free. When women go for a pap smear exam, they prefer to be seen by a female physician. For many not being able to find a female physician could be a key factor in not following through with an annual check-up.

Breast Health/Breast Cancer/treatment

Four traditional Chinese treatments are generally used to treat cancer of all sorts, they include:

Acupuncture: A method in which needles are used to restore the body's balance by either putting energy into the body or taking it out of the body.

Acupressure: A system of massage in which finger pressure on acupressure points is used.

Qi Gong: An energy medicine that is a non-strenuous form of physical exercise consisting of slow circular movements and centering or meditation. There are many different types of Qi Gong, most of them consisting of special breathing, concentration, and posture exercises specific to the type of cancer.

Herbal Medicine: Herbal medicines are the most popular form of traditional Chinese treatments, and are prescribed primarily to reduce symptoms affecting the major organs.

(Simpson, 2003)

Menopause

Many Chinese women do not experience common menopausal symptoms experienced by many Western women such as hot flashes, sweating, and vaginal dryness (Eumn-Ok & Chee, 2005). It is believed that Chinese women do not exhibit these symptoms because they employ cultural specific management strategies, such as *Dong quai* a Chinese herb usually prescribed as a tonic for women, or acupuncture. For women who may exhibit menopausal symptoms, they attribute this to a "lack of vital energy" and use exercise as a management strategy.

Abortion

There are no restrictions against abortions in China. Some families may request having the procedure done on the basis of adhering to China's one child policy (Wang, 2005).

Behaviours Displayed in Health Settings

Behaviours	Strategies for Health Professionals
<p>Nurses have observed the adherence, by Chinese women, to the Yin & Yang (Hot & Cold) principle. For example, many 1st generation Chinese women don't like anything cold during and after pregnancy such as cold water, or ice packs on their vagina.</p>	<p>Health care professionals should negotiate with Chinese women around what will work in terms of care. They could begin by asking the women their preferences for hot and cold drinks, and educating the women on the benefits of cold ice packs used after delivery in our health care system for speedy recovery after giving birth.</p>
<p>The experiences in women's health are that some Chinese women who are unfamiliar with our health care system are generally against the use of amniocentesis in discovering birth defects. They generally believe that if there have been no birth defects in their families historically then there is no use for the procedure. They believe its use could severely harm the unborn baby or lead to birth complications. On the other hand, women familiar with our health care system don't mind having amniocentesis performed, since they have been taught that the procedure is beneficial in detecting birth defects.</p>	<p>More outreach needed by Health care professionals to educate Chinese women on the benefits of prenatal screening and early birth detection.</p>
<p>Chinese women often display what has been described by nurses as the "No Milk Syndrome" in which they refuse to breast feed for the first couple of days after giving birth. Women who display the "No Milk Syndrome" believe they are not able to produce milk, or that what is produced is too dirty to give to their new born baby. They prefer to feed their babies formula for the first couple of days until they are able to produce milk. For some, they think that formula is better than breast milk. However, some become frustrated over the "No Milk syndrome, worrying one may not be able to feed her own baby and therefore, will feel very upset if nothing else is given to the baby. This could often be the key reason for emotional problems for many new mothers.</p>	<p>Listen to women's concerns on breast milk production and explore where these concerns come from. This would present an opportunity to teach women about colostrum based on the specific values, beliefs, and perceptions that are commonly held around this subject.</p> <p>If women hold on to their beliefs, encourage them to start breast feeding right after colostrum (dirty milk) stage. In some situations this may even mean after they have been released from the hospital.</p>

Behaviours Displayed in Health Settings

Behaviours	Strategies for Health Professionals
Nurses have found that because of the traditions around a woman restricting herself to bed rest after labour, they have found that when Chinese women have had a procedure such as a C- section, they rarely follow Western medical practices such as becoming more mobile and active to reduce pain.	Traditionally not many women receive a C- Section. Also, having a C-section is not preferred by the Chinese culture. Therefore, it is very important for health professionals or physicians to reconsider this aspect when recommending a C-section. Very often, Chinese women believe that surgery will create a long lasting negative impact on their health. Explore women's perceptions around practices after pregnancy in a respectful non-judgmental manner. If their cultural health practices have proven to be disadvantageous to their health, educate them on alternative health practices.
From the experiences of health care professionals, many Chinese women do not shower or bathe anywhere from 15-50 days after delivery. They restrict themselves to sponge baths where they use a wash cloth to wipe down their bodies.	Ask women what their preferences are on post-natal care and how they would like to be supported in the process, keeping in mind that if they decide to take a shower their mother or mother-in- law would be upset with them.
Health care professionals have experienced that some Chinese women don't take care of their babies after delivery, they usually call on nurses to change diapers, bathe, or place their baby in the nursery so they can rest.	Differentiate the roles of health care professionals from that of new born mothers. Clarify the specific duties that health care professionals carry out within the hospital setting, as well as explore if there is someone in the community that might assume this responsibility to support the family.
Health related decisions are usually shared between a husband and wife.	Invite opportunities for patients to engage in the process of directing their care.
Women generally don't eat food provided by the hospitals. They prefer their traditional foods to be brought in by family members due to the cultural differences in food and nutrition.	Make women aware that it is acceptable to bring their traditional foods during their stay in a hospital.

Behaviours Displayed in Health Settings

Behaviours	Strategies for Health Professionals
<p>According to health care professionals it is normal for husbands or extended family members to do everything for a woman during and after pregnancy. Although this is a great opportunity for women in this culture to rest, this practice might be more effective in the home than in a hospital setting. After the hospital visit the family leaves and the women is on her own. The nurses are then expected to take over the role of the family.</p>	<p>Encourage husbands to support women with self-care after pregnancy such as by taking walks with their wives, feeding the baby, and changing the baby together.</p>

South Asian Women

Women from Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka, and countries such as Fiji



A second generation South Asian woman had just given birth through a caesarean

section. As a part of follow up, the nurse who was providing care to the new mother, had recommended that she follow hospital protocols around caesarean sections in order to regain her strength. As the nurse had explained this to the new mother, the woman's mother-in-law interjected and explained that hospital protocols around caesarean sections went contrary to South Asian beliefs around delivery. Back in India when a woman had given birth she was expected to rest for 40 days and was not encouraged to engage in extraneous activities; especially activities that would weaken or harm her in any way. When the mother-in-law was out of sight, the new mother explained the role culture plays in the labour and delivery process in some South Asian communities and even though she does not fully agree with her mother-in-law, she is expected to follow her mother-in-law's advice. The woman expressed the nurse would be in her life for a short period of time whereas her mother-in-law would be in her life for a prolonged period of time.

From 1870 to 1939, thousands of South Asians, mostly Sikhs from rural India, immigrated to North America in search of work or political asylum. There was a second wave of Indian and South Asian immigrants in the mid-60s with preference being given to highly trained professionals. Urban, educated, and English-speaking, many of these immigrants were unable to find comparable employment as the most challenging barrier was their lack of Canadian training and experience. They had to accept whatever jobs they could find to make ends meet. This forced them to take employment that was different from their original occupation with lower pay and longer hours. Since the 1980s, immigration patterns have shifted to bring political refugees from Afghanistan and Bangladesh and from the Hindu-Sikh conflict in India. Many new immigrants face not only cultural but also severe communication and economic barriers. They face long hours at work and encounter discrimination in hiring and promotion. Traditional family roles have been affected by the need for both husband and wife to work outside the home and by the increased independence of children. Historically, women did not work outside the home and were therefore financially dependent on their husbands. Today, the majority of women work outside the home as unskilled farm workers, janitors, and factory workers, and in restaurant kitchens



and canneries. Within most South Asian societies, men and women have distinct domains.

Most of the women will manage the family, finances, and social gatherings while the men are typically the bread-winners and will take charge of any community interactions, for example, health care. Since the men are the initial contact for the family, it appears that they take a dominant and authoritative role and the women will seem to be more passive.

When South Asian couples decide to start a family, they may find pregnancy and childbirth a stressful and lonely time as often they miss the support of their extended family, in particular, the women who are knowledgeable about the nurturing rituals and foods of their native country. If language is a barrier, the women will seldom attend prenatal classes.

VALUES, BELIEFS AND PERCEPTIONS

ANTE-PARTUM

Pregnancy

Among South Asians, pregnancy is considered a normal occurrence, and as a result many women may not seek medical attention unless under severe circumstances. Women do not seek prenatal care for

the duration of their pregnancy unless it is absolutely necessary. For those women who live in rural areas, knowledge about pregnancy is usually sought from a woman's mother and mother-in-law or a traditional midwife. There are no restrictions on sexual intimacy between a husband and wife during pregnancy. Many South Asian women view pregnancy as a "hot state", or a time of increased body heat. Consequently, many women avoid putting themselves in a state of becoming overheated as it is believed this will lead to miscarriage, a difficult delivery and/or the production of an extremely large baby. Traditional symptoms related to pregnancy are attributed to hot and cold. For example morning sickness or minor swelling such as in the hands may be explained as the result of increased body heat.

Food/liquids

Because a woman is believed to be in a "hot state", pregnant women avoid hot foods such as meat, eggs, nuts, herbs and spices as these are believed to cause miscarriage or premature delivery. Women are encouraged to eat foods that are cool in nature such as milk products, fruits and vegetables. Women are restricted from drinking cold water, and are encouraged to drink warm liquids.

Role of Religion

It is believed that during pregnancy the unborn child is vulnerable to evil spirits, therefore, it is customary for groups such as the Hindus to perform rituals to protect the mother and unborn child. Some women, depending on the community, wear a special type of

amulet called a *valai* or *valayal*, meaning to surround, to create a protective barrier that keeps the mother and newborn safe from evil spirits. Some South Asian women, such as those who are baptized into the Sikh faith, follow practices which safe-guard their religious beliefs. For example, many Sikh women follow 5 pillars of faith that include:

- ♦ Not cutting hair
- ♦ Wearing a steel bangle
- ♦ Wearing long underwear
- ♦ Carrying a small comb at all times
- ♦ Wearing a sword or small dagger

INTRA-PARTUM

Labouring

During labour, a midwife encourages the woman to be active, to walk around, and may even give her herbal medicines to facilitate the birthing process. Labouring women usually assume a passive role and follow the instructions of a birthing attendant. Women may moan, grunt, or scream during labour.

Site of Delivery and Support

When a woman is about to deliver her child, she usually returns to her parents' home where an older female family member or traditional birth attendant assists the woman when she is ready to give birth.

There are no cultural practices preventing men from being present during delivery, however, men are usually not involved in the delivery process. When women are ready to deliver they usually prefer the squatting or sitting position. Medications used to relieve pain during the birthing process are usually avoided as they are believed to complicate delivery.

POST-PARTUM

Herbal medicine and religious healers and practices are usually used after childbirth.

Pregnancy Outcomes

In India after a woman delivers, the sex of the child is usually not told until after the placenta has been delivered. Because of the high preference for having boys, it is thought that the birth of a girl may cause the mother to become so emotionally upset that the uterine contractions may become inhibited and delay the delivery of the placenta. Because there is a belief among South Asians that a woman is susceptible to chills, backaches, among other ailments after giving birth, a woman is expected to rest anywhere between ten to forty days. During this time she is encouraged to stay at home, obtain adequate rest, and eat a special food to accompany her meals (see section on "food/liquids" for further information).

Support

A new mother is usually supported by female family members after pregnancy.

Food/liquids

A common traditional food usually given to women after giving birth is called *Katlu* or *Panjiri*. It is a special dish made out of whole wheat flour, butter, sugar, almonds, pistachios, and a powder made from a variety of herbs. During the post-partum period, women are permitted to eat hot foods as they are believed to restore the energy lost to a woman during pregnancy. Other foods consumed by women during the post-partum period include dried fish, brinjals, dhal, drumsticks, and greens; foods that are good for lactation. Cold foods on the other hand are not recommended as they are believed to cause diarrhea, indigestion and gas, and are highly avoided.

Physical Care

After giving birth a woman is required to adhere to a variety of activities in order to promote physical care. These include not having a bath more than once a week, and washing her perineal area with warm water every time she eliminates urine or feces. Because a woman is considered to be in a cold state after giving birth, she is encouraged to keep warm at all times.

Sexuality

There is a commonly held belief that women are unclean during the post-partum period; therefore they usually do not engage in sexual intercourse.

POST-PARTUM DEPRESSION

There is no commonly used word for post partum depression in many South Asian languages. Rather women describe the concept according to the symptoms.

GYNECOLOGY

Sexuality

Sexuality is a very sensitive and secretive subject in many South Asian communities. As a result women keep matters of sexuality to themselves, and avoid talking about the subject with family, friends, and strangers.

Breast Health

Women typically do not participate in breast health practices due to a variety of cultural beliefs and practices. The most commonly held beliefs that may prevent women from breast self-examination screening include beliefs on privacy, modesty, and general breast health. Some women are often concerned about family appearances and keep concerns about

their health private. They often resist partaking in screening activities for fear of finding out health related illnesses and receiving repercussions or being known by community members as a family with health problems. Modesty also plays a role in the rate of breast-self examination screening among South Asian women. Because women are taught from an early age not to talk about or expose their bodies to strangers, many refrain from breast self-examinations as such practices go against the values and beliefs they were taught around modesty. In terms of general breast health women believe that if they keep healthy by eating well, exercising and maintaining a balanced life there is no need for breast screening measures.

Papanicolaou (Pap Smears)

There is a low take up of Pap screening among South Asian women in their country of origin. The two most common reasons for this are a lack of self-perceived need for such screening among those who have been educated on the procedure; and, the lack of general knowledge on the nature of pap testing for those who are unfamiliar with the procedure.

Menopause

There is no name for menopause in many South Asian languages. Women refer to the event as 'period stop'.

Abortion

Because of the high value placed on male children among some South Asians, some women may have an abortion if they find out early in pregnancy their child is a female.

Female Genital Mutilation (FGM)

FGM is not known to be practiced among South Asians.

Behaviours Displayed in Health Settings

Behaviours	Strategies for Health Professionals
Health care professionals in women's health have observed that when some South Asian women deliver their babies, they usually follow traditional practices of rest for one month. Nurses have observed that when in care, South Asian women rely on nurses to do everything for them. This is quite consistent with the values and beliefs listed in the cultural profile section.	Clarify with patients the roles of health care professionals within our health care system. Awareness and sensitivity around this will lead to discussing labour and delivery practices with South Asian women.
Health care professionals have witnessed that extended female family members in the South Asian culture accompany the expectant mother during the birthing process .	Identify the role of family members in health related decisions.
It has been experienced by health care professionals that South Asian women prefer to see female physicians .	Incorporate patient preferences into health related decisions where appropriate. If this preference cannot be fulfilled, accommodate this aspect by possibly having a female nurse or female family members present during an examination such as for a pap smear, obstetric or delivery check-ups. Reality is that our healthcare setting does not have many female physicians therefore, it is crucial to recruit female physicians as well as have an open dialogue with female patients to identify what they perceive as more comfortable in this situation.
South Asian women prefer to bring in their cultural foods during their stay in the hospital.	Welcome the opportunity for women to bring in their traditional foods.

Middle Eastern Women

Women from Arab and non Arab countries; Arab countries include Lebanon, Syria, Jordan, Saudi Arabia, Egypt, Jordan, Iraq; non-Arab countries include Turkey, Iran, and Afghanistan



The first significant wave of immigration from the Middle East began around 1875. After

1940, the ongoing Arab-Israeli conflict and civil war saw an increase in immigration to Canada. This meant that people came from many more places. The second wave of immigration also involved many people who practiced Islam, a religion that was fairly unknown in Canada. Immigrants in this group tended to be more financially secure when they arrived than people who had come earlier for economic opportunity. Many people in the second wave were students. In the most recent years, civil unrest and political dictatorship have caused an exodus from countries such as Iraq and Afghanistan. Like many immigrants who came to Canada, Middle Easterners were seeking opportunity. Factors in the first wave of immigration were Japanese competition that hurt the Lebanese silk market and a disease that destroyed Lebanese vineyards. Most early immigrants were from Lebanon and Syria, and most were Christian.

Canadian Middle Eastern families are, on average, larger than non-Canadian Middle Eastern families

and smaller than families in Middle Eastern countries. Traditionally, more children meant more pride and economic contributors for the family. This is changing as the cost of having large families in Canada and adaptation to Canadian customs seem to encourage smaller families. As women pursue careers, they are not expected to marry so young. Middle Eastern women might also marry older men who can provide greater financial security. Some Middle Eastern women wear garments that cover their faces or heads as a religious practice, not a cultural practice. It is rooted in Islamic teachings about hijab, or modesty. While some say that veiling denigrates women, some women say that it liberates them. Covering is not universally observed by Muslim women and varies by region and class. Some Middle Eastern governments have, at times, banned or required veiling. In Canadian families, a mother or daughter may cover her head while the other does not. Ultimately the choice belongs to the individual woman. A woman might wear a particular garment to practice *hijab* because one interpretation is that everything should be covered except hands, face and feet. Long clothing and a scarf would accomplish this and the headscarf might be called a *hijab* or *chador*. The long, robe like garment is called an *abayah*, *jilbab*, or *chador*. In Iraq and Saudi Arabia especially, a woman may wear a cloak that covers her head. Beneath a robe, a woman may be wearing a

traditional dress, casual clothes or a business suit. The veil, in particular, has been made controversial by governments, gender politics and religious biases. Many Middle Eastern women wear black but this may not have any special significance other than that black is a popular colour. It may also be a sign of mourning. Black, when worn in mourning, may be worn for a few days to many years. The *hamsa* is a charm with an eye, or an eye on a hand, and is often worn as jewelry; it is a non-religious symbol for protection or good luck. The eye, usually blue when colored, wards off the 'evil eye' or evil spirits. For example, the charm may be put on a baby to protect the child from harm. Many people of different religions share this cultural tradition. There is a misconception that Canadian Middle Eastern women are subservient to men. However, no sweeping statement can reflect all the roles of Middle Eastern women. They range from leaders of matriarchal societies to independent businesswomen to women living under extreme oppression. In Canada, their roles are affected by their country of origin; whether they are from urban or rural areas; their religion; their degree of assimilation; and, of course; their own individual characteristics. The family unit is very important to the structure of Middle Eastern communities. This unit generally includes that of extended family members and close friends in the community.

VALUES, BELIEFS AND PERCEPTIONS

ANTE-PARTUM

Pregnancy

Pregnancy in Middle Eastern culture is generally considered a blessing and a positive life event. For women, pregnancy is a time in which their status remains uncertain until they are able to give birth to their first baby and prove that they are fertile. After giving birth to their first child, there is often pressure on women to have additional children, for fear that the first child may die and leave the parents childless. Because of the high value of boys in Middle Eastern culture, most women are expected to continue having more children until they bear a son. Two to six months prior to delivery, husbands and wives refrain from sexual intercourse and usually sleep in separate beds. During pregnancy a woman is not expected to perform strenuous work and is encouraged to rest. Health related decisions are always made in consultation with members of the extended family; usually a family head such as an older man in the nuclear or extended family. In emergency situations, major decisions involve a male family member. In general, pregnancy represents a time in which family support is much needed by a woman who is about to give birth. Many women do not seek prenatal care during pregnancy unless they have complications that warrant attention by medical providers. Advanced planning for pregnancy is believed to negatively affect the future

of both mother and unborn child. A Middle Eastern woman usually gains knowledge on pregnancy from female relatives such as a mother, or mother-in-law, or friends who have gone through pregnancy.

Food/liquids

During pregnancy it is important for a woman to pay special attention to her nutrition. She is expected to eat well and incorporate the five food groups into her diet. She is to avoid spicy goods and sour edibles or any type of food that may cause cramps or diarrhea, and general discomfort to herself and the baby in her womb. For those Middle Eastern women who follow Islam, diet is very important. For Muslims, pork or pork products are abstained from, along with alcoholic beverages or any food prepared with alcohol. Permissible meats must be slaughtered according to Islamic tradition, otherwise known as *Halal* or *Zabin*. Seafood is allowed as a part of diet; however, fish for example, must have scales removed before it is eaten.

Role of Religion

Muslim women who are pregnant during the holy month of Ramadan, are exempt from the daily rituals associated with the religious event if they choose to be.

INTRA-PARTUM

Labouring

Women tend to go to the hospital as soon as they experience their first contractions. They generally do not stay at home until contractions are stronger and more severe for fear of harming or jeopardizing the life of the baby. Middle Eastern women are generally very vocal and express their feelings during labour. It is not uncommon for labour and birth to be accompanied by loud moans, groans, and screams, rather than breathing and relaxation techniques found in Western cultures.

Pain relievers

Middle Eastern women may accept some pain relievers during labour and delivery such as an epidural, spinal, and combined epidural-spinal; however, some may refuse these pain medications based on the belief that they cause long-term risks to a woman's health.

Site of Delivery and Support

A woman who is about to give birth is usually surrounded by female relatives and friends. Men are not involved during the labouring process. Midwives are held in high esteem in Middle Eastern society and play a crucial role during the birthing process.

Modesty

Middle Eastern women are very modest and every

attempt is made to keep all parts of their body covered. A woman's modesty may be due to her religious faith or the belief that her nudity is meant to be observed only by her husband.

POST-PARTUM

There is usually an expectation that women observe the traditional practice of rest for 40 days after giving birth and by engaging in post-partum practices such as:

- ♦ Not leaving the house for up to 40 days;
- ♦ Not showering or washing hair after childbirth due to post pregnancy as being a 'cold-state';
- ♦ Washing private parts thoroughly with soap and water because they are considered to be in an unclean state;
- ♦ Abstaining from prayer since they are in a time of cleansing;
- ♦ Abstaining from sexual intercourse;
- ♦ Eating plenty of hot soup made from meat or chicken bones to aid in recovery after birth;
- ♦ Walking around the house as a form of exercise;
- ♦ Binding the abdomen to aid and hasten uterine involution and flatten the abdomen;
- ♦ Taking baths with salt sitz (salt crystals) so as to hasten the healing of episiotomy wound or perineal tear;
- ♦ Avoiding bad news so as not to affect the milk supply; and
- ♦ Avoiding foods such as cabbage, cauliflower, and spicy foods as they are believed to give "gas" to the baby.

POST-PARTUM DEPRESSION

Many Middle Eastern women have no concept of post-partum depression.

GYNECOLOGY

For pregnancy and gynecological concerns, women are reluctant to discuss these concerns with male physicians; they prefer to see female physicians.

Breast Health

Women typically do not practice breast self-examination screening in their home countries due to lack of awareness on the health practice.

Menstruation

For Middle Eastern women, a woman's first menstruation or *menarche*, is considered a happy event. It signifies a changing role for a young girl into

womanhood. Since she is now a woman she is expected to behave maturely. Menstruation is considered a woman's issue and is not to be discussed in the presence of men, such as a girl's father, or brother(s). Some women in Middle Eastern culture may follow all or some of the following practices during menstruation:

- ♦ Avoiding cold drinks and foods since they are believed to increase menstrual pain;
- ♦ Increasing their intake of boiled herbs such as mint, sage, thyme, and chamomile in order to reduce menstrual pain;
- ♦ Not showering until the end of period;
- ♦ Exempting themselves from certain religious duties such as prayer, fasting, pilgrimage, and touching of the Holy Qur'an;
- ♦ Not engaging in sexual intercourse;
- ♦ Showering after their menstrual period ceases in order to resume religious duties; and
- ♦ Sanitary napkins and pads are the most common methods of sanitation during menstruation for Middle Eastern women. Tampons and douches are not often used due to the value placed on a woman's virginity. Many perceive that such materials used during menstruation would break a woman's hymen and cause her to lose her virginity.

Contraceptive Use

The use of contraception is usually prohibited by many Middle Easterners. Some cite religious verses by the prophet Mohammed in the Qur'an as evidence against contraception use. They believe that it is God or Allah's will to multiply during marriage. Other beliefs revolve around the use of contraceptives such as the pill; which is believed to potentially cause adverse affects on the health of a woman such as morning sickness, weight gain, cancer, back pain, headaches, dizziness, hair loss, and thrombosis.

Abortion

Middle Easterners do not approve of abortions based on the religious belief of having multiple children. In the event that abortion is considered, it is only when a mother's life is in jeopardy.

Behaviours Displayed in Health Settings

Behaviours	Strategies for Health Professionals
<p>From the experiences of health care professionals in one hospital, Middle Eastern women of the Islamic faith prefer the bed farthest from the door, or a private hospital room. This is explained by Islamic beliefs on modesty; Middle Eastern Women take great precautions to protect themselves from being exposed to strangers which is what would happen if they are in the bed closest to the door.</p>	<p>Where possible, support Middle Eastern women who have a preference for a semi-private room .</p>
<p>Health care professionals have noticed that in Middle Eastern cultures, important health care decisions and information are always shared with a woman's husband. It is preferable for bad news to not be disclosed to a woman by health care professionals; such news must be shared with the husband who will in turn share such information with his wife.</p>	<p>Ask women and their husbands how to approach the communication structure. Also identify that the practice within our health care system is that we share the assessment with both the father and the mother. Provide an interpreter where needed.</p>
<p>It is not uncommon for husbands in Middle Eastern cultures to request that their wives be treated by female physicians.</p>	<p>Because Islamic and cultural teachings regulate relationships between men and women, it is important for health care professionals to be of the same sex as their patient.</p> <p>If possible support the cultural observances of individuals. If not, explain in a culturally sensitive manner why such support is not available.</p>
<p>Health care professionals have witnessed that during pregnancy, Middle Eastern women are usually accompanied by female relatives such as mothers, mother-in-laws and aunts.</p>	<p>Recognize and accommodate the role of supports with health related events such as labour and delivery. Possibly offer space for extended family members to sit and wait either in the birthing room or elsewhere.</p>

Behaviours Displayed in Health Settings

Behaviours	Strategies for Health Professionals
Health care professionals have noted that one common behaviour in Middle Eastern culture is that after a woman has delivered, the sex of her baby is not announced to the mother unless the father is present to announce it. There have been situations where nurses announced the sex of the baby and the mother pretended that she did not hear.	During the initial admission procedure elicit cultural health practices of patients in terms of how to proceed with service provision. This might be helpful if critical situations arise such as during the results of a pap smear; premature labour; or the death of a newborn.
For those who follow Islamic traditions, when babies pass away, families usually request for them to be buried before sun down.	Accommodate requests made around cultural health practices associated with death. Some families may not feel comfortable making such requests, so attempts should be made by health care professionals to elicit such information and process the documents for release of the baby as soon as possible.
Nurses have observed that many Middle Eastern women have no concept or knowledge of post-partum depression. In fact, it has been indicated by health care professionals that there is no word in many Middle Eastern languages for post-partum depression .	Explain the indicators/symptoms of post– partum depression. Possibly follow up with women who may show signs of depression. Identify on the discharge sheet for the Public Health nurses that Middle Eastern may need multiple visits. Make sure these women know that not all women experience post-partum depression.

Sudanese Women

Arabic women from the North and Dinka, Azande, Dalfur, Nuer, and Shilluk women from the South



A Sudanese woman gave birth to her fifth child and was being released from

the hospital. The discharge nurse felt that the woman had too many children and suggested to this mom to start using birth control. The Sudanese woman was offended by the nurse's suggestion to go on birth control, and felt that such a decision was up to her and her husband, and was not a decision for the nurse to impose.

For centuries Sudan has been faced with discord. Hundreds of years of insurgencies have created a segregation of North and South Sudan. The North is largely Arab and Muslim, while the South consists predominantly of black Nilotic peoples, some of whom are members of indigenous faiths and others who are Christians. The Republic of Sudan was formally established on January 1, 1956. Sudan became a member of the Arab League on January 19 and of the United Nations on November 12, 1956. The following forty years have witnessed political infighting by the southern rebels known as the Sudanese People's Liberation Army against the Muslim Arab

government. The most recent civil war resulted in an exodus of refugees mostly from South Sudan who fled the hardships of life in the refugee camps. They hoped for a better life and a country free of tyrannical leadership. The refugees resettling in Calgary were Government sponsored and faced the daunting task of integrating into western society. Family separation and family reunification challenges due to low-income have created ongoing emotional stress for individuals and extended families. Although the family is often male dominated, the home is managed by the women of the family. In southern Sudanese culture greater value is placed on women than on men. Gender role changes in Canada have profoundly, and sometimes adversely, affected Sudanese women, men and families. More women than men reported difficulties with getting around and communicating. Major health related decisions are made by a male family head such as a father brother, or husband.

Values, Beliefs and Perceptions

ANTE-PARTUM

Food/liquids

In general, there are no specific food restrictions during pregnancy; however, women are encouraged to eat a special kind of clay which is believed to increase the appetite and decrease nausea. There are restrictions on the kinds of drinks ingested during pregnancy. For example, women are to refrain from cold drinks as they clog the blood; cause an excess of blood to remain in the uterus after delivery; and delay delivery. Women on the other hand drink hot liquids with cloves to keep the blood flow running and aid in cleansing the uterus.

Modesty

It is important for Sudanese women to demonstrate their modesty when seeking health services.

Sexuality

Men and women refrain from sexual intercourse 3 months prior to delivery. During this time, a man is permitted to go elsewhere for sexual intimacy.

INTRA-PARTUM

It is important for women who have undergone Female Genital Mutilation (FGM) to be deinfibulated (cut open the sewn labia majora) in order to give birth.

Labouring

Women are encouraged to walk before delivery as it speeds up the delivery process.

Women are taught not to express pain while labouring and giving birth.



Site of Delivery and Support

Many Sudanese women deliver in their homes with the assistance of a midwife. The only time women deliver in hospitals is when severe birth complications arise. During birth, women are usually supported by female family members such as mothers, sister(s), and mother-in-laws. Men do not partake in the delivery process since such practice is not culturally appropriate.

Process of Delivery

Women prefer the squatting position when delivering their babies; however, because this position is known to cause birth problems women are encouraged to lie down while giving birth.

POST-PARTUM

Pregnancy Outcomes

For those populations who practice Female Genital

Mutilation, reinfubulation (closing off or obstructing the genitals, especially by sewing together the labia majora in females, so as to prevent sexual intercourse) is usually performed after a woman has given birth. The most common reason for this practice is the sexual satisfaction of the husband.

Food/liquids

Women are encouraged to eat a special porridge made of sorghum (porridge) and soup of boiled meat as it stimulates breast milk production. They are still restricted from drinking cold drinks, and are encouraged to drink lots of hot liquids. After a woman has given birth it is a common cultural practice for her to rest for a period of 40 days. During this time a woman receives help from family members with minimal assistance from her husband.

Sexuality

After delivery, women are to refrain from sexual intercourse; this varies depending on which region women are from. For women living in Northern Sudan sexual abstinence is observed for 40 days and in Southern Sudan it is observed for 2 years.

POST-PARTUM DEPRESSION

Many Sudanese women are not aware of post-partum depression. They believe that after delivery there is no need for a woman to get depressed based on the available amount of supports from female family members and friends. Besides, there is an expectation that women are to cope after birth.

GYNECOLOGY

Papanicolaou (Pap Smears)

Most Sudanese women rarely go for pap smear examinations due to a lack of awareness on the procedure.

Sexuality

Most Sudanese women are open around sexuality, especially when discussed amongst each other.

Abortion

Many Sudanese women are generally against abortions. The only situation in which women may consider having one done is if a pregnancy poses a risk to a woman's health. Abortions are not performed when congenital abnormalities are detected.

Female Genital Mutilation (FGM)

FGM is a common ritualized practice that is mostly practiced in the Northern part of Sudan. It is a practice in which the fleshy, inner layers of the labia minora or majora are scraped and sewn together leaving a tiny pinhole-size opening for urine and menstruation. Culturally, it is believed that the female clitoris and labia minora and majora are unclean; therefore, it is important for girls and young women to have them removed. If not removed, it is believed that they could potentially be a danger to the manhood of their future husbands. In general, the practice is intended to desensitize a female's sexual desire.

Behaviours Displayed in Health Settings

Behaviours	Strategies for Health Professionals
Nurses find that many Sudanese women do not use birth control due to a lack of knowledge and awareness on the use of contraceptives.	Connect with community members to educate them on the options in Calgary around birth control and other contraceptives, if the woman is willing and open to this information. Offer suggestions of resources in the community where women can go for information on birth control.
Elders play a crucial role in the health care decisions of individual community members. From the experiences of health care professionals, many Sudanese women rarely go for annual physical check-ups such as pap-smears, or breast examinations.	Educate men or key informants in the community around birth control, especially around annual check-ups, pap smears, and breast self examinations.
It has been noticed by health care professionals that when some Sudanese women are about to deliver, they may have their other children accompany them to the hospitals due to barriers associated with childcare. For example, some women may not be able to afford childcare; or may not have access to extended family supports to assist with such care. This was also expressed by participants in the focus group conducted with Sudanese women.	Accessing community services such as the Children's Cottage through hospital social workers may alleviate some of the barriers families face in finding childcare.
Nurses have observed that many Sudanese women have no concept or knowledge of post-partum depression.	Educate women on the indicators of post-partum depression within our health care system by asking specific questions around social support, settlement issues and family support. Suggest multiple visits for identified women through the Public Health Nurses. Possibly follow up with women who may show signs of depression.

Ethiopian Women

Ethiopia is a diverse country with over 80 cultural groups, with major ones being Afar, Amhara, Gurage, Sidama, Somali-Ethiopian, Tigre, Oromo, and Wolaita women



A woman from Ethiopian background had been

in labour for 10 hours when her physician noticed that there were complications with her unborn child. Vaginal birth became impossible and an emergency caesarean section was necessary. Upon requesting consent to perform this procedure, the physician along with other health care staff present during the woman's labour, had noted a great deal of resistance on the woman's part to the cesarean section. In fact, the woman had expressed that there was nothing that would make her have a caesarean section. As a result of the amount of resistance put up by this woman, the nursing staff present for her delivery, made a referral to a social worker to explain the importance of having the caesarean section performed and the consequences of not following through. The social worker tried to convince this woman to have a caesarean section, but failed. The woman was adamant about not having a caesarean section; therefore, the physician had no choice but to grant the woman's request. Fortunately, the woman ended up delivering a healthy baby and did not suffer any complications during labour. The social worker who was initially called to talk to

this woman during labour, met with the woman once again. In the meeting, the social worker explored why the woman had put up so much resistance to having a caesarean section during labour. According to the woman, she was required by her doctor during the delivery of her second child to have a caesarean section. The woman's experience with the procedure was so traumatic that she vowed never to have another one performed. From her first experience she found it difficult to care for her two children, and found that the procedure made it difficult to bond with her second child. She felt that with this pregnancy the outcome would be in God's hands.



Before 1974, migration of Ethiopians was rare. The deposition of Emperor Haile-Selassie and the adoption of communism started the exodus. Years of political turmoil, civil war in Eritrea, and border conflicts

with Somalia forced thousands of Ethiopians, many of who were well educated, to leave the country. After long periods spent in refugee camps or third country havens, Ethiopians who met the immigration criteria of sponsoring countries, such as Canada and the United States, received political asylum and resettled. According to data from Canadian Immigration and Citizen reports, 21,591 Ethiopian immigrants (excluding refugee claimants) arrived in Canada between 1974 and 1996. In the years following the Ethiopian Revolution in 1974, Ethiopian and Eritrean refugee women at the Sudan-Djibouti border had to submit to the sexual demands of border guards. Women were also subjected to harassment and rape at the hands of administrators and soldiers in refugee camps. Women continued to experience aggression, isolation and exploitation at the hands of government authorities and the police while in exile. In the cities and towns of Sudan, Ethiopian women were at the mercy of police who would demand to see their identity cards, and would assault them during the interrogation and arrest. Many lived in extreme poverty. When asked what sustained them, a number of Ethiopian women said that their faith in

God gave them the strength to endure these hardships.

It is well established that arrival and resettlement in a new country involves a period of significant readjustment and stress. It appears that re-establishment of family stability after migration is of prime importance to Ethiopian women, and compared with men, Ethiopian women may be more willing to accept a drop in professional or social status, set aside educational goals, and assume dual responsibilities at work and at home. On the other hand, men were less willing to accept changes in occupational roles and felt more threatened by changing gender roles. Consequently, Ethiopian men, compared with women, are more likely to be exposed to adverse mental health consequences of migration and settlement stresses.

Values, Beliefs and Perceptions

ANTE-PARTUM

Pregnancy

Pregnancy is generally considered a vulnerable time for both mother and child in Ethiopian culture. Within some cultural groups, precautions are taken to prevent the 'evil eye' (misfortunes), and sorcery since these are believed to cause miscarriage, premature delivery, and deformations in the baby. In order to prevent further problems during pregnancy, a

woman is expected to avoid the following:

- ♦ Carrying heavy loads;
- ♦ Climbing stairs; and
- ♦ Exposure to emotional situations such as funerals, bad fights, and bad news.

Women typically do not seek prenatal care until during the end stage of labour. For these women, pregnancy is viewed as a normal occurrence that does not require medical attention. An expectant mother is usually supported by her family and friends.

Food/liquids

Food is essential for pregnancy and delivery outcomes, as it maintains the overall health of women, facilitates labour, and restores women after delivery. Many foods contain therapeutic properties that aid in the pregnancy process. For example, milk and butter initiate labour if a baby is late; a drink called telva/telba made of flax seeds aids in a woman's full recovery after giving birth. It is believed that not giving a woman the food she craves during pregnancy might cause a deformity in the baby or lead to miscarriage. Women refrain from taking vitamins and other supplements during pregnancy; they believe that traditional Ethiopian foods provide the essential nutrients needed for pregnancy. Most women also believe that Western prescribed vitamins and supplements lead to birth defects.

Labouring

Women prefer the freedom of directing the labour process. For example, during labour, they prefer to have the freedom to walk around or use the wash-room right up until the moment they are ready to give birth. Women are generally expected to tolerate labour pains. A low level of moaning or groaning is acceptable; however, screaming is culturally unacceptable during labour.

INTRA-PARTUM

Food/liquids

One week prior to pregnancy a woman is encouraged to drink a hot mixture of ground toasted flax seed and water sweetened with honey or sugar for taste. This mixture is believed to ease pains associated with labour.

Site of Delivery and Support

The site of delivery mainly depends on whether women live in urban or rural dwellings. Women in rural Ethiopia usually deliver their babies at home, with assistance from traditional birth attendants, female family members and friends. Men are typically not involved during labour and delivery. Women in urban settings deliver their babies in hospitals with the assistance of medically trained professionals.

Modesty

Modesty is highly valued by Ethiopian women during pregnancy and delivery. A woman is expected to cover all parts of her body during the stages of pregnancy. Under special circumstances the midwife and Doctor (in a hospital setting) may see intimate parts of her body.

POST-PARTUM

Pregnancy Outcomes

Pregnancy and delivery outcomes are often attributed to good and evil spirits, food, and weather. For example, women enter pregnancy with the notion that both pregnancy and delivery outcomes will be determined by God's power. When pregnancy complications occur (i.e. delivery complications, deformed baby, or infant/death and/or maternal death), it is believed (in some cultural groups) that it is a punishment for disobeying God's order, or improper behaviour. After a woman has given birth, she and the baby are expected to stay at home and rest for 40 days based on the belief that post pregnancy is a very delicate time for both mother and child. Every effort is made during this time to protect the mother and newborn from disease and harm.

Food/liquids

After pregnancy a mother is fed a variety of special foods such as: porridge made from barley and other cereals, meat, and chicken stew. Foods and drinks must be warmed before given to the mother.

POST-PARTUM DEPRESSION

Many women in Ethiopian culture have no concept of post-partum depression.

GYNECOLOGY

Female Genital Mutilation or Female Circumcision is generally practiced throughout Ethiopia, however, the tradition, including the extent of the procedure may vary among cultural groups.

Behaviours Displayed in Health Settings

Behaviours	Strategies for Health Professionals
It has been observed that Ethiopian women rarely consent to having a C-section performed during labour. This behaviour is based on the amount of women who have died in their home country from the procedure.	Education by health care professionals becomes crucial for Ethiopian women who may require a C-section. It may be helpful to give a general overview and explore the advantages and disadvantages of the procedure, identifying the technologies as compared to some areas in Ethiopia.
Health care professionals have noted that Ethiopian women are very stoic during the labour and delivery process.	Respect cultural behaviours displayed by women during the birthing process, ask women what they feel like doing.
In some situations, delivering a baby too early can cause quite a bit of anxiety for Ethiopian women as they fear being labeled as bad mothers. This is based on some cultural beliefs that a woman who delivers a baby too early is being punished for something she did in her life that was wrong .	It is useful to acknowledge cultural beliefs held around complications with pregnancy and delivery, however, a cross-cultural analysis of how birth complications are handled in our health care system may alleviate the anxiety some Ethiopian women may feel for such complications during pregnancy.
Health care professionals have observed that many Ethiopian women have no concept or knowledge of post-partum depression. This is based on the fact that there is no literal translation for this illness in many Ethiopian languages. As well the mother is never isolated, receiving constant help from family and friends.	Educate women on the indicators of post-partum depression within our health care system. Possibly follow up with women who may show signs of depression. Link women up with ethno-specific supports on post-partum depression. Screening used should have specific questions focusing on immigrant and settlement issues such as social/family support, employment and financial issues.

Personal Experiences

Of Women Accessing Health Services Through the Calgary Health Region



A Chinese woman was discharged from the hospital after giving birth to her newborn. Unfamiliar with birth practices here in Calgary, the woman and her husband asked if a nurse would be coming home with them to care for the

woman and her baby while the woman observed the Chinese birth practice of rest for 40 days.

I remember staying a couple of days after giving birth in a hospital and being served Canadian food.

I wasn't familiar with the foods served here so I

hardly ate anything for many days. I also didn't know at that time that patients were allowed to bring their cultural foods into



the hospital. If I had known that, I would have arranged for a family member to bring in food during my hospital stay.

Going through the delivery was an extremely difficult one here in Canada. When I delivered my first child in Ethiopia I was able to control the pace of the delivery process. In Canada, I was expected to follow



the doctor's orders around delivery and deliver at the pace that was requested of me.

While recovering after giving birth, I was shocked when a nurse providing care had given me cold

water with ice, and a bowl of ice cream to eat. According to traditional Chinese beliefs around after pregnancy care, women are not allowed to eat or drink anything cold as it is believed to cause an imbalance in their bodies.

Physical exams such as breast exams are very different in Canada than they are in Pakistan. When doctors do breast exams in Pakistan, women leave their upper wear on, however, in Canada you are expected to take it off; I find this very uncomfortable.



Watching my daughter go through delivery in Canada was a negative experience for me. The doctors and nursing staff were so insensitive to the

needs of my daughter while giving birth. I would have expected that they would have been a lot more sensitive to someone who was going through the birthing experience in Canada for the first time.

While visiting a hospital in Canada I prefer to keep my traditional clothes on. I don't feel comfortable wearing the hospital gowns.

Back home in Sudan it is culturally inappropriate for men to take part in the birthing process. When I was giving birth to my first child in Canada, my husband was waiting outside the delivery room when a nurse had called him into the room to tell him I had delivered. Against our cultural beliefs and practices, my husband had walked in when I was completely exposed. My legs were propped in a birthing position, and my vagina was completely open. Both my husband and I were distraught by this experience.



CONCLUSION

Providing Culturally Competent Care is probably not an easy task but very rewarding for both health care professionals and new comers. Practice has shown that health care professionals are more than ever striving to provide quality services to all families. This project highlights specific values/beliefs and perceptions that some immigrant/refugee women might have when accessing health services. The focus group discussions and interviews show that these are reflected in the behaviors in accessing services.

Our intention is for health care professionals to explore these beliefs/values and perceptions with their individual clients. Although there is considerable research around cultural diversity and health we believe that the issues around specific immigrant/refugee women's health issues need to be investigated further. By always considering how culture, values, beliefs and perceptions might impact access to services; health care professionals will hopefully negotiate with and personalize care for immigrant/refugee women.

“Seeking diversity automatically leads us to excellence, just as focusing on excellence inevitably leads us to diversity”.

William C. Steele



IMMIGRANT SERVING AGENCIES

Calgary Immigrant Aid Society Settlement/Language Bank Centre (SLBC)

This program provides services to assist with the settlement needs of newcomers to Canada. Services are provided individually and in group settings in the newcomers' first language or in English. Services include:

- ♦ Information, orientation, and referrals to community services.
- ♦ Supportive counseling
- ♦ Seminars/workshops on various topics, such as: Employment, Immigration, Health, legal, and Citizenship.

Interpretation and Translation Services:

Provides interpretation to help newcomers access vital services. Translation on basic, personal documents, certified by a Commissioner for Oaths is also provided.

THE NEW FAMILY PLACE PROGRAMS

Parent Link Centre Outreach

Provides child care supports to parents.

Family Resource Centre

Delivers social and life skills programming for immigrant and refugees. These programs include a collective kitchen and toy lending library all geared

towards promoting social networking and attachment, and family relationship building.

New Canadian Children in Calgary

Offers settlement support to newly arrived families; assists parents and child care centres with subsidy applications and screenings, and supports Child & Family services in working with newcomer families.

Mosaic Centre (service of Calgary Immigrant Aid society)

Multicultural Family and Child Training Program

Is a crisis intervention program for high-risk immigrant/refugee families with young children, age birth to 6 years. Families in the Multicultural Family and Child Training Project are provided supportive counseling and referrals, positive parenting skills, information on Canadian culture and information on health care, nutrition, safety, fitness, education, and literacy. Clients are then referred to other group programs operating for clients experiencing challenges to integration.

Community Access Project

Works to improve the ability of immigrants/refugees (over 36 months in Canada) to participate in the new social context in the host society. Workshops on community services and resources, physical and mental health, nutrition, and safety are held regularly in the community. One-to-one supportive counseling in the community is also provided.

Immigrant Language and Vocational Assessment - Referral Centre

- ♦ Assessment of immigrants' English proficiency and/or first language literacy;
- ♦ LINC eligibility determination;

Information and referral to LINC/ESL classes; Counseling in first language or English for education, career planning, accreditation procedures and job search techniques.

Located at:

1200, 910-7th Avenue S.W.

Calgary, Alberta

T2P 3N8

Tel: (403) 265-1120 or (403) 268-6093 or (403) 262-2656

E-mail: info@calgaryimmigrantaid.ca or

mosaic@calgaryimmigrantaid.ca or

ilvarc@calgaryimmigrantaid.ca

Calgary Catholic Immigration Society

Services include business, employment and training; community education, settlement services; child and family services; in-home assessment; counseling support and referral; and licensed daycare.

Located at:

3rd Floor

120 - 17th Ave SW

Calgary, Alberta

T2S 2T2

Tel: (403) 262-2006

E-mail: contact@ccis-calgary.ab.ca

**Calgary Immigrant Women's Association
Settlement & Integration**

Ensures that new immigrant and refugee women successfully integrate into Canadian society. Services include needs assessment, information, referrals, and supportive counseling. Group orientations and workshops are also available.

New Friends and Neighborhood Groups

Provides weekly meetings for immigrant and refugee women. The group provides an opportunity for women to increase their level of self-sufficiency, confidence, and create a support network.

There are also opportunities for women to practice conventional English, make friends, and learn about available community resources.

Integration Program

Assists immigrant and refugee women who experience conflict or other barriers with basic necessities such as housing, social services, food, legal assistance, etc.

Language Instruction for Newcomers to Canada (LINC)

Offers a variety of part-time English classes (ESL) for immigrant women who have lived in Canada for less than three years.

Pebbles In The Sand

Provides literacy classes to women who face multiple barriers in accessing mainstream programs and services. This program is for women who have 0-6 years of education in their native country and are not already accessing ESL classes.

Individual Employment

Assists clients to identify, create and implement employment plans resulting in employment self-sufficiency or labour market integration.

Making Changes Partnership

A pre-employment, life-skills orientation program designed to assist immigrant women to become more knowledgeable about the current labour market and gain confidence in order to access employment opportunities.

Family Conflict Program

Provides services for immigrant families who are experiencing abuse and problems in their marital/family life. Free professional cross-cultural counseling is provided in the first languages of clients at CIWA and off-site locations.

Cross-Cultural Parenting Program

Educates immigrant parents regarding laws, institutions, and services that affect parenting in Canada.

The program strives to improve communication between families, increase confidence in parents; and teach new parenting skills.

Baby Club

Is a 10-week interactive program that teaches new mothers about child development from 0-12 month stages.

Volunteer Training

Designed to train women on the concept of volunteerism, to meet Canadian born and other immigrant women, and learn about the community at large.

Volunteer Cooperative

Are programs designed to increase small business opportunities for immigrant women and CIWA.

Small Business Development

Offers immigrant women a link to workshops and volunteer experiences in the community to learn, develop, and build small business skills.

Located at:

Suite 200, 138-4th Avenue SE
Calgary, Alberta
T2G 4Z6
Tel: (403) 263-4414
E-mail: general@ciwa-online.com

Calgary Mennonite Centre for New Comers Employment Resource Centre

Is focused on meeting the employment needs of individuals and refugees. Services are available in a variety of languages such as Arabic, Cantonese, Chu Chau, English, Hindi /Punjabi, Mandarin, Russian, Somalian, Spanish, Sudanese, Vietnamese, and former Yugoslavian languages.

Immigrant Support program

Provides peer group support for newcomers in meeting their needs. Newcomers receive support and assistance on child benefits, banking, the legal system, housing subsidy, and policy services among others.

Collective Kitchens Catering

A program providing an opportunity for immigrant women to learn about nutrition, food safety, food preparation, shopping, and budgeting in their first language peer groups. The program also provides employment opportunities for participants.

Multicultural Parenting Program

Are self-support parenting groups that are facilitated in the first language of participants. The program provides an opportunity for immigrant parents to get together and discuss issues affecting their children and families in Canada.

Volunteer Development

Provides volunteer skills for newcomers to enable them to integrate in to Canadian society by participating in their respective communities.

Located at:

125, 920-36 Street N.E.
Calgary, Alberta,
T2A 6L8
Tel: (403) 569-3326
E-mail: newcomer@cmcn.ab.ca

Young Women's Christian Association (YWCA)

Provides programs and services for women and their families providing them with the skills, abilities, and opportunities to contribute to and benefit from healthy communities. Additional services include:

Special Summer Program

Offered during July and August and provides an opportunity for participants to practice their English through cultural outings around Calgary.

English for New Canadians

Provides subsidized day and evening English classes for permanent residents and Canadian citizens.

Visitor's Program

Offers full time or half time day classes for newcomers to Canada. Participants are given the opportunity to study and practice practical English language skills.

Canadian Employment Skills Program

Provides programs for unemployed, recent immigrants to Canada. Participants are given the opportunity to improve their fluency and confidence in speaking English. There are also opportunities to learn about Canadian Workplace Culture, update computer skills, and gain valuable Canadian work experience. For further information contact (403) 294-7336.

Located at:

320 5th Avenue SE
Calgary, Alberta
T2G 0E5

Tel: (403)263-1550

E-mail: ywca@ywcaofcalgary.com

Sheriff King Home (part of YWCA)

Provides services for women who have witnessed or experienced violence in a relationship. Women who access shelter can stay for a period of 21 days. Services during stay include: shelter, food, individual counseling, child support, advocacy, and referrals at no cost. Walk in and short term counseling is also available. Victorian Order of Nurses provides a registered nurse to give clients information on health issues and address other medical concerns.

Located at:

N/A

Tel: (403) 266-4111 (General Information) (403) 266-0707 (24 hour crisis line)

E-mail: sheriffk@ywcaofcalgary.com

Mary Dover House (part of YWCA)

Provides emergency housing to single women and single mothers with children. The cost for housing is based on customer needs and room availability.

Located at:

YWCA at 320 5th Ave. S.E.
T2G 0E5

Tel: (403) 232-1599

E-mail: ywca@ywcaofcalgary.com

ETHNO-CULTURAL ORGANIZATIONS**African Community Association of Calgary**

Is an umbrella organization for African associations in Calgary. The community organization assists individuals and families with employment, education, and family issues. The organization also promotes African culture through performing arts, visual arts, literary art, education, recreation and youth groups.

Located at:

639 Maryvale Way NE
Calgary, Alberta
T2G 0Y1

Tel: (403) 292-6130

E-mail: N/A

Arab Canadian Association of Canada

Provide educational programs that promote greater understanding of Arab communities.

Located at:

Post Office Box 573
Station "M"
Calgary, Alberta
T2P 4Z1
Tel: (403) 265-0317
E-mail: N/A

Chinese Culture Centre Services

- ♦ A place for people of all backgrounds and heritages to enjoy and explore Chinese culture;
- ♦ Classrooms for Calgary Chinese Public School and special interest classes;
- ♦ Library (computer use available to members);
- ♦ Seniors lounge;
- ♦ Special interest language classes (Mandarin and Cantonese);
- ♦ Cooking classes; and
- ♦ Recreation.

Located at:

197 1 Street SW
Calgary, Alberta
T2P 4M4
Tel: 403-262-5071
E-mail: info@culturalcentre.ca

India Canada Association of Calgary

To promote and preserve the understanding of the history, culture and traditions of the Indian sub-continent among Canadians of Indian origin as well as other cultural and ethnic groups. As an umbrella organization of a dozen different societies, INCA strives to represent them to governments at various levels and to other ethnic councils. Additional ser-

vices include computer literacy classes, advice and counseling to any member but especially new immigrants, celebrations of various cultural traits of regions in India, awards night to honor individuals who have contributed outstanding service to the community, and social activities.

Located at:

826 Edmonton Trail NE
Calgary, Alberta
T2E 3J6
Tel: (403) 277-0206
E-mail: indiacanada@shaw.ca

Ethiopian Community Services and Programs

- ♦ Provides an opportunity to celebrate social and religious ceremonies;
- ♦ Provides a forum to discuss issues relevant to socio-economic advancements for the Ethiopian community;
- ♦ Addresses social issues of its constituents by partnering with other groups and social service providers;
- ♦ Assists with the integration of newcomers to Calgary communities;
- ♦ Assists with sponsorship

Located at:

Suite #207
223 12 Avenue SW
Calgary, Alberta
T2R 0G9
Tel: (403) 262-7260
E-mail: ceca@calcna.ab.ca

Calgary Chinese Elderly Citizens' Association

Information and supportive counseling;

- ♦ Filling of forms and application for social benefits;
- ♦ Commissioner of Oaths service;
- ♦ Translation and interpretation;
- ♦ Escort service and arrangement of transportation; and
- ♦ Telephone reassurance and referral service as well as home and hospital visitations.

Located at:

111 Riverfront Avenue SW
Calgary, Alberta
T2P 4Y8

Tel: (403) 269-6122

E-mail: cceca@telus.net

Agape Language Centre Society

Centre teaches English (ESL) and Canadian culture to new immigrants, refugees, visitors and international students, through high quality interactive classes, one on one conversation/tutoring sessions, field trips and workshops. Facilitation of integration of newcomers to Canadian society is also provided.

Located at:

16 Bermuda Drive NW
Calgary, Alberta
T3K 1H7

Tel: (403) 516-1846

E-mail: agapenw@telus.net

PLACES OF WORSHIP

For further information: <http://www.faithandmedia.org/>
or <http://www.calgaryinterfaith.ab.ca/faiths.html>

- Agger-Gupta, N. (1995). The Terminology of Diversity. Alberta Multiculturalism Commission citizenship & Women's Secretariat, Alberta Community Development.
- Betancourt, J.R., Green, A.R., Carillo, E., Park, E.R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs*, Vol. 24, No. 2, 449-505.
- Calgary Immigrant Women's Association. (2005).
- Canadian Council For Refugees. (2004).
- City of Calgary, Community Strategies, Policy and Planning Division. (2003). Facts About Calgary Immigrants.
- Citizenship and Immigration Canada. (2003).
- Elliot, J., Berman, H., Kim, S. (2002). A critical ethnography of Korean Canadian women's menopause experience. *Health Care Women International*, Vol. 23, 377-388.
- Eun-OK., Wonshik, C. (2005). A Descriptive Internet Survey on Menopausal Symptoms: Five Ethnic Groups of Asian American University Faculty and Staff. *Journal of Transcultural Nursing*, Vol. 16 No. 2, 126-135.
- Greey, M. (1994). Honouring Diversity: A Cross-Cultural Approach to Infant Development for Babies with Special Needs. Centennial Infant and Child Centre: Toronto.
- Granot, M., Spitzer, A., Aroian, A., Ravid, C., Tamir, C., Noam. (1996). Pregnancy and delivery practices and beliefs of Ethiopian immigrant women in Israel. *Western Journal of Nursing Research*, Vol. 18, No. 3, 299-313.
- Health Canada (1999). Canadian Research on Immigration and Health. Ottawa: Minister of Health.
- Holroyd, E., Lai, F.K. (1997). 'Doing the month': An exploration of postpartum practices in Chinese women. Retrieved on May 30, 2005 from <http://90-weblinks.2.epnet.com.ezproxy.lib.ucalgary.ca:2048/citation.asp?tb=bo+...>
- Hung, C., Chung, H. (2001). The effects of postpartum stress and social support on postpartum women's health status. *Journal of Advanced Nursing*, Vol. 36, No. 5, 676-684.
- Kim-Godwin, Y.S., Clarke, P.N., Barton, L. (2001). A model for the delivery of culturally competent community care. *Journal of Advanced Nursing*. Vol. 35, No. 6, 918-925.
- Lipson, J.G., Dibble, S. L., Minarik., P.A. (1996). Culture & Nursing Care: A Pocket Guide. UCSF Nursing Press: California.
- Nahas, V., Amasheh, N. (1999). Culture Care Meanings and Experiences of Postpartum Depression Among Jordanian Australian Women: A transcultural study. *Journal of Transcultural Nursing*, Vol. 10, No. 1, 37-45.
- Oxman-Martinez, J. (2000). Immigration, women and health in Canada. Retrieved May 17, 2005 from http://www.findarticles.com/p/articles/mi_qa3844/is200009/ain8917190/print
- Papadopoulos, I., Lees, S. (2001). Developing Culturally Competent Researchers. *Journal of Advanced Nursing*. Vol. 3, No. 3, 258-264.
- Rashidi, A., Rajaram, S.S. (2000). Middle Eastern Asian Islamic Women And Breast Self-Examination: Needs Assessment. *Cancer Nursing*, Vol.23, No. 1, 64-70.
- Simpson, P.B. (2003). Family Beliefs about Diet and Traditional Chinese Medicine for Hong Kong Women with Breast Cancer. *Oncology Nursing Forum*, Vol. 30, No. 5, 834-840.
- Underwood, S.M., Shaikha, L., Bakr, D. (1999). Veiled yet vulnerable: Breast cancer screening and the Muslim way of life. *American Cancer Society*. Vol. 7, No. 6, 285-290.
- Wikipedia (n.d.). Wikipedia: The Free Encyclopedia. Retrieved May 26, 2005 from http://en.wikipedia.org/wiki/Women%27s_health.

Suggested Reading

- Almroth-Berggeren, V., Almroth, L., Bergstrom, S. (2001). Reinfibulation among women in a rural area in central Sudan. *Health Care for Women International*, 22: 711-721.
- Al-Oballi Kridli, S. (2002). Health Beliefs and Practices among Arab Women. *MCN*, Vol. 27, No. 3, 178-182.
- Bener, A., Alwash, R., Miller, C.J., Denic, S., Dunn, E.V. (2001). Knowledge, Attitudes, and Practices Related to Breast Cancer Screening: A survey of Arabic women. *Journal of Cancer Education*, Vol. 16, No. 4, 215-220.
- Blacktown MRC (n.d). Fact Sheet: Sudanese women's experiences of child rearing in Western Sydney in comparison to their experiences in Sudan. Retrieved June 10, 2005 from www.africanuz.com/at-study/sudanchild.pdf.
- Bottoroff, J.L., Johnson, J.L., Bhagat, R., Grewal, S., Balneaves, L.G., Hilton, B.A. Clarke, H. (1999). Breast health practices and South Asian Women. *The Canadian Nurse*, 24-27.
- Bottoroff, J.L., Johnson, J.L., Bhagat, R., Grewal, S., Balneaves, L.G., Clarke, H., Hilton, B.A. (2004). Cultural competence in health care: Is it important for people with chronic conditions? *Centre on an Aging Society*. No. 5, 2-8.
- Bottoroff, J.L., Johnson, J.L., Bhagat, S., Grewal, S., Balneaves, L.G., Clarke, H., Hilton, B.A. (1998). Beliefs related to breast health practices: The perceptions of South Asian women living in Canada. *Soc. Sci. Med.* Vol. 47, No. 12, 2075-2085.
- Chan, S., Levy, V. (2004). Postnatal depression: a qualitative study of the experiences of a group of Hong Kong Chinese women. *Journal of Clinical Nursing*, 13, 120-123.
- Choudhry, U.K., Stivastava, R., Fitch, M.I. (1998). Breast Cancer Detection Practices of South Asian Women: Knowledge, Attitudes, and Beliefs. *Oncology Nursing Foundation*, Vol. 25, No. 10, 1693-1701.
- Ethnomed (n.d.) Tigrean Cultural Profile. Retrieved May 26, 2005 from http://ethnomed.org/ethnomed/cultures/tigrean/tig_cp.html
- Fisher, J.A., Bowman, M., Thomas, T. (2003). Issues for South Asian Indian Patients Surrounding Sexuality, Fertility, and Childbirth in the US Health Care System. *JABFP*, Vol. 16, No. 2, 151-155.
- Galanti, G. (2000). Iranian Births. *West J Med*, Vol. 173, 67-68.
- Gupta, A., Kumar, A., Stewart, D.E. (2000). Cervical Cancer Screening Among South Asian Women in Canada: The Role of Education and Acculturation. *Health Care for Women International*. Vol. 23, 123-134.
- Hilton, B.A., Grewal, S., Popatia, N., Bottorff, J.L., Johnson, J.L., Clarke, H., Venables, L.J., Bilkhu, S., Sumel, P. (2001). The Desi Ways: Traditional health practices of South Asian women in Canada. *Health Care for Women International*. Vol. 22, 553-567.
- Ho, I., Holroyd, E. (2002). Chinese women's perceptions of the effectiveness of antenatal education in the preparation for motherhood. *Journal of Advanced Nursing*, Vol. 38 No.1, 74-85.
- Hodes, R.M. (1997). Cross-cultural medicine and diverse health beliefs: Ethiopians Abroad. *Western Journal of Medicine*, Vol. 166, No. 1, 29-36.
- Hung, C., Chung, H. (2001). The effects of postpartum stress and social support on postpartum women's health status. *Journal of Advanced Nursing*, Vol. 36, No. 5, 676-684.
- Im, E., Chee, W. (2005). A descriptive internet survey on menopausal symptoms: Five ethnic groups of Asian American university faculty and staff. *Journal of Transcultural Nursing*. Vol. 16. No. 2, 126-135.
- Jezewski, M.A., & Sotnik, P. (2001). The rehabilitation service provider as culture broker: Providing culturally competent services to foreign born persons. Buffalo, NY: Center for International Rehabilitation Research Information and Exchange.
- Kemp, C. (n.d). Sudanese Culture Health Refugees Immigrants. Retrieved May 30, 2005 from http://www3.baylor.edu/Charles_Kem/chinese.htm

Kemp, C. (n.d). Chinese Culture Health Refugees Immigrants. Retrieved May 30, 2005 from http://www3.baylor.edu/Charles_Kem/sudanese_refugees.htm

Kemp, C. (n.d). Indian Culture Health Refugee Immigrants. Retrieved May 30, 2005 from http://www3.Baylor.edu/-Charles_Kemp/indianhealth.htm.

Lawrence, P., Rozmus, C. (2001). Culturally Sensitive Care of the Muslim Patient. *Journal of Transcultural Nursing*, Vol. 12, No. 3, 228-233.

Light-foot-Klein, H., Shaw, E. (1991). Special Needs of Ritually Circumcised Women Patients. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, Vol. 20, No. 2, 102-107.

Liu, H., Moore, J.F. (2000). Perinatal Care: Cultural and Technical Differences Between China and the United States. *Journal of Transcultural Nursing*, Vol. 11, No. 1.

Mackinnon, M., Howard, L.L. (2000). Affirming Immigrant Women's Health: Building Inclusive Health Policy Final Report. Prince Edward Island: Maritime Centre for Women's Excellence.

Matthey, S., Barnett, B. (2002). Adherence to cultural practices following childbirth in migrant Chinese women and relations to postpartum mood. *Home Care for Women Immigrant*, 23: 567-575.

Ott, B.B., Al-Khadhuri, J., Al-Junaibi. (2003). Preventing Ethical Dilemmas: *Understanding Islamic health care practices*. *Pediatrics Nursing*, Vol. 29, No. 3, 227-230.

Roberts, K. (2003). Providing Culturally Sensitive Care to the Childbearing Islamic Family: Part II. *Advances in Neonatal Care*, Vol. 3, No 5. 250-255.

Shah, A., Z. D. (2004). The Future of Healthcare in Canada: Diagnosing the needs of immigrants. *University of Toronto Medical Journal*. Vol. 82, No. 1, 21-23.

Sheikh, A., Gatrad, A. (2001). Muslim Birth Practices. *BMJ*, Vol. 4, No.4, 10-13.

Simpson, P. B. (2003). Family beliefs about diet and traditional Chinese medicine for Hong Kong women with breast cancer. *Oncology Nursing Form*, Vol. 30, No. 5, 834-840.

University of Virginia Health System (n.d.) Islamic Beliefs and Practices Affecting Health care. Retrieved on May 5, 2005 from http://www.healthsystem.virginia.edu/internet/chaplaincy/muslim.cfm?printfriendly=1_&

Waxler-Morrison, N., Anderson, J., Richardson, E. (1990). Cross-Cultural Caring For Health Professionals. UBC Press: Vancouver.

Wang, F. (2005) Can China Afford to Continue its One—Child Policy? East—West Centre, No. 77, 1-12.

