THE EXPERIENCE OF REFUGEE WOMEN IN A PERINATAL NUTRITION EDUCATION PROGRAM

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Authorization to Submit Dissertation

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Abstract

Since 2000, refugees have come to the United States from more than 60 countries across the world (HHS, 2012). Once refugees arrive in the United States, their adjustment is affected by cultural, socio-economic, and literacy barriers (Baird, 2012; Frye, 1991). These barriers also may hinder their ability to practice healthy behaviors or seek healthcare for themselves and their children (Edberg, Cleary, & Vyas, 2011). The complexity of the experience is often compounded for refugee women (Deacon & Sullivan, 2009). Understanding and addressing the history, cultural values, and challenges refugee women face are essential in dealing with their healthcare concerns (Leininger & McFarland, 2002). Many programs strive to address health concerns in a culturally competent manner, responding to the specific healthcare needs of refugee women. However, these programs may not always meet their objectives due to misunderstanding and unintentional ethnocentric methods (Peek et al., 2010).

This study explored the experience of refugee women who are participating in a perinatal nutrition program. A conceptual framework guided the study that included aspects of Culture Care Theory (Leininger and McFarland, 2002) and Health Belief Model (Pender et al., 2002). This was a qualitative study, based on the ethnonursing research design, utilizing focus group interviews with refugee women who participate in a perinatal health education program related to diet and nutrition. Eight women who were pregnant or recently delivered a baby and who had participated in a nutrition education program participated in the study as key informants. The women were from 21 to 37 years of age and had from one to five children. Their countries of origin were located in the Middle East, Asia and Africa. General informants included a refugee woman who was familiar with the refugee population but had not attended the nutrition classes and four healthcare professionals who worked

closely with refugee women. The four healthcare professionals included two registered nurses, a nurse practitioner and a social worker.

Two major theme clusters encompassed the participants' statements related to the women's experiences in the nutrition classes and their assimilation of the information learned at the classes. The first theme included culture care factors which affected their learning and diet choices. The factors addressed by the women were kinship and social factors, economic factors, education, religion, and factors related to environment or context. The second theme cluster focused on cues to action, perceived barriers, and perceived benefits to incorporating the recommended health behaviors. This cluster included what they viewed as relevant new information, the processes of the women utilized in learning new information and adapting their diets, their need to address their traditional choices and practices, and suggestions for improving the classes.

This study is significant in providing some insight into the experience of refugee women who attend perinatal education classes related to nutrition and diet and their beliefs and values, which influence diet choices. Implications related to this study included awareness of the factors affecting the women's learning about nutrition, their impact on the women's diet choices and healthy behaviors, and the role cultural proficiency can play in achieving better outcomes for this vulnerable population. Strategies for improvement of nutrition education among this population and increased advocacy were suggested. More research is needed to understanding the health needs of this group and the cultural factors impacting their health behaviors, as well as identifying teaching and learning strategies which are effective in addressing these topics.

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Dedication

This study is dedicated to the women in my life who continue to inspire me: my daughters, Lindsay and Marissa, granddaughters, Marley Jo and Elle, my friends and colleagues, and the refugee women who I met and admire for their resilience and dedication to making lives better for their children.

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Chapter One – Introduction

The United States has a history of accepting refugees from around the world. More than 3 million refugees have resettled in the United States since 1975, with more than 500,000 in the past decade alone (HHS, 2012). The United Nations High Commissioner for Refugees (UNHCR, 2012) defined refugees as individuals who were forcibly displaced outside their native countries because of persecution, or hardship, which includes war, famine, and violence due to political, religious and ethnic conflict. In addition, many refugees spend years in refugee camps, enduring limited access to food, water, sanitation and healthcare (Deacon & Sullivan, 2009). These experiences with physical and emotional trauma and forced relocation make their resettlement experience different and more complex than voluntary migrants (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Murray, Davidson, & Schweitzer, 2010). The complexity of the experience is often compounded for refugee women, due to gender inequities and greater vulnerability to sexual assault (Deacon & Sullivan, 2009).

Since 2000, refugees have come to the United States from more than 60 countries across the world (HHS, 2012). In 2011, refugees were resettled in 47 different states and the District of Columbia (HHS, 2012). Once the refugees have arrived in the United States, cultural, socio-economic, and literacy barriers affect their adjustment (Baird, 2012; Frye, 1991). These barriers also may affect practicing healthy behaviors or seeking healthcare for themselves and their children (Edberg, Cleary, & Vyas, 2011). In addition, the challenges of adapting to life in the U.S. can create much stress for refugees (Okigbo, Reierson, & Stowman, 2009). Understanding and addressing the history, cultural values, and challenges

refugees face are essential in dealing with their healthcare concerns (Edberg et al., 2011; Leininger & McFarland, 2002).

Programs to address health concerns in a culturally competent manner are needed to respond to the specific healthcare needs of refugees. One of these programs is the St. Francis RFC Clinic of a mid-size city in the northwestern United States.[1] The RFC Clinic has focused on providing healthcare for perinatal refugee women since its inception in 2009. Through this program, an effort to improve the health of perinatal refugee women and their babies has included medical care, educational programs, and social support (Reavy, Hobbs, Hereford, & Crosby, 2012). Targeted health conditions among this group include hypertension, diabetes, and iron deficiency (Gautam, Saha, Sekhn, & Saha, 2008; Khan et al., 2006). Iron deficiency, indicated through low hemoglobin levels, is the most common micronutrient deficiency in the world (Gautam et al., 2008) and an important concern for refugee women who attend the RFC Clinic.

Micronutrient deficiency among refugee populations reportedly affects their health in a variety of ways (CDC, 2004; Seal et al., 2005). Poor dietary practices, morbidity, and pregnancy complications are examples of the effects of micronutrient deficiency due to food insecurity, limitations in availability of nutritional and safe food or the ability to acquire such foods (Dharod, Croom, Sady, & Morrell, 2011; Laraia, Siega-Riz, & Gunderson, 2010). Maternal nutrition during pregnancy involves both the mother and the baby. Inadequate nutrition of the mother can result in preterm birth, gestational diabetes, and Cesarean birth as well as restricted fetal growth and low birth weight (Barger, 2010). Low birth weight is

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[1] Pseudonyms are being used for the regional medical center and clinic in order to protect the anonymity of the participants.

cause for concern as it is considered the most significant determinant of mortality for babies in the first year of life (Scanlon, Yip, Schieve, & Cogswell, 2000; Sekhavat, Davar, & Hosseinidezok, 2011).

Nutrition education is one intervention used to address diet and micronutrient deficiency among refugees and to increase health promoting behaviors. Studies indicate a link between health literacy, health education and health outcomes (HHS, 2000). However, there are various factors affecting the dietary habits of refugees and the impact of health education, such as access, literacy, cultural and religious practices, economics and language among others (Barnes, Harrison, & Heneghan, 2004; Carroll et al, 2007b; Dharod, Croom, & Sady, 2013; Garnweidner, Terragni, Pettersen, & Mosdel, 2012; Ikeda, Pham, Nguyen, & Mitchell, 2002). Practitioners who design and implement nutrition education among this group can improve outcomes by exploring and addressing these factors.

Background of the Problem

More than 90% of refugees experience trauma, such as harm to them or their family members (Kaplan, 2009; Robertson et al., 2006). These events often resulted in psychological trauma related distress, with prevalence of post trauma symptoms as high as 75% among refugee populations (Thulesisus & Hakansson, 1999). Refugee women reported an even greater number of traumatic experiences and more psycho-social problems than men (Halcon, Robertson, & Monsen, 2010). Many refugee women spend an extended amount of time in refugee camps or in dire situations before being resettled in the United States (Deacon & Sullivan, 2009). These circumstances often affect their diet and nutrition, which in turn influences a mother's health, pregnancy and fetal outcomes.

One of the most widespread nutritional issues throughout the world is iron deficiency. Iron deficiency in pregnant women is of particular concern due to the effect on both the mother and the baby. The iron requirement during pregnancy increases notably with a high percentage of women becoming anemic during pregnancy. Iron deficiency is recognized as the cause of anemia with diets containing insufficient iron or low iron bioavailability as a contributing factor (Berger, et al., 2005; CDC, 2004; CDC, 2008; Gautam et al., 2008; Sifakis & Pharmakides, 2000). Anemia can result in adverse pregnancy outcomes, threatening both the mother and baby, although research in this area was inconsistent in its findings (Scholl & Reilly, 2000). Gautam et al., (2008) reported anemia was the cause of more than 10% of maternal deaths related to childbirth in Asia. Risk of preterm birth was indicated among women with low hemoglobin levels in the first and second trimester of pregnancy (Guatam et al., 2008) . Anemia due to iron deficiency was associated with low birth weight and preterm delivery in some studies (Scanlon, Yip, Schieve, & Cogswell, 2000, Sekhavat et al., 2011). Deficiency of iron is common in long-term refugee populations, but wthe introduction of micronutrient fortified food resulted in significant improvement in tissue iron as well as iron in breast milk (Stuetz et al., 2012). Improving iron availability through good nutrition is a concern of the RFC Clinic and one of the objectives of nutrition education of the perinatal mothers they serve.

Addressing the health and nutritional needs of newly resettled refugee mothers is impacted by various factors. Access to services is needed, as well as effective interventions that include consideration of cultural, financial, language, educational and social concerns faced by refugee mothers (Dow, 2011; HHS, 2000). Addressing health literacy and affecting health practices and healthy eating among perinatal refugee women necessitates the use of a

variety of interventions, such as food-based approaches, micronutrient supplementation, food fortification, and nutrition education (Barger, 2010; Berger et al, 2005; Boccio & Iyengar, 2002; Peterman, Silka, Bermudez, Wilde, & Rogers, 2011). The most common approach to addressing iron deficiency has been iron supplementation, targeted particularly to pregnant women. Food-based approaches of increasing availability of micronutrient-rich foods and educating about nutrition to improve dietary habits can increase bioavailability of iron in the diet (Barger, 2010; Boccio & Iyengar, 2002). Regardless, strategies utilized by healthcare practitioners need ongoing assessment to determine effectiveness in improving health outcomes for both the mothers and their babies in particular settings (Morris et al., 2009; Rimer, Glanz, & Rasband, 2001).

Statement of the Problem

Much of healthcare focuses on addressing disease or the effects of poor health situations or practices (Rimer et al., 2001). Refugee mothers represent a population who are susceptible to poor health conditions due to limitations in access, environment, education, choices or stability (Peterman et al, 2011; Morris et al., 2009). By intervening with effective health promoting activities, including health education, the incidence of many disease conditions can be reduced (Barger, 2010; Boccio & Iyengar, 2003; Carroll et al., 2007b). However, interventions are often based on the experiences and cultural standards of healthcare providers or educators and may not be effective in meeting the needs of refugee women (Giger & Davidhizer, 2008; Leininger & McFarland, 2002; Morris et al., 2009). Instead, culturally competent care calls for utilizing the perspective of the patients for which care is being provided rather than relying solely on the outsider views of providers (Garnweidner et al., 2012; Giger & Davidhizer, 2008; Leininger & McFarland, 2002; Purnell

& Paulanka, 2003). Exploring the experience of refugee women participating in a perinatal nutrition education is important for understanding this vulnerable population engaged in the health promotion activity of nutrition education in order to increase the effectiveness of the intervention by responding to their cultural and experiential needs (Campinha-Bacote, 2002; Peterman et al., 2011; Leininger, 2002).

Purpose of the Study

The purpose of this research was to explore the experience of refugee women who are participating in a perinatal nutrition education program. Insight into their experience could lead to improvements in their learning and healthy behaviors. The domain of inquiry was the study of the cultural factors, reflected in the beliefs, values and attitudes of the refugee women who have completed the perinatal nutrition education classes and their attitudes about how the program affects the likelihood of adapting health behaviors. This was a qualitative ethnonursing study utilizing interviews with perinatal refugee women who were asked about their experience with attention to the cultural factors affecting their attitudes and behaviors and about integration of new information about nutrition. The research questions for this study were:

1. How does Leininger's (2002) Culture Care Theory, inform our understanding of refugee mothers' experiences in a perinatal nutrition education program?
2. In what ways might Pender's (2002) Health Belief Model help us understand refugee mothers' cues to action in a perinatal nutrition education program? What did they see as their benefits for participating? What were the individual and organizational barriers to participation?

3. How might St. Francis alter its perinatal nutrition education program to best meet these mothers' nutritional needs to better acculturate into Western culture?

Significance of the Study

Addressing health issues among perinatal refugee mothers is an area of concern for the health of both the mother and the baby. Finding relevant and effective ways to decrease threats to a healthy pregnancy is important in contributing to the health of refugee mothers. This study was significant in providing an understanding of the experience of refugee women who attend perinatal education classes related to nutrition and diet. The women's impressions of these classes were explored, along with cultural aspects of nutrition and diet and the health behaviors and barriers experienced in participation in health promotion education. This information is useful to provide a background for improved interventions and further research.

Research among this particular population is complex and requires consideration of multiple factors; including level of vulnerability, cultural, literacy, linguistic factors, access to the population, healthcare institution structures and requirements, and federal program structures (Carroll et al, 2007a; Leininger, 2002; Morris et al., 2007). Research methods were utilized that are adaptable, yet attentive to the needs of a variety of refugee women, particularly those of low literacy, limited English speakers, and who come from a background of trauma, abuse or exploitation.

The primary audience for this work is healthcare administrators, providers, policy-makers, and educators who deliver healthcare and health promotion programs. Healthcare administrators, providers and educators can use information from this study to create

appropriate health delivery systems and education programs for underserved populations or groups who are most at-risk for health issues. Policymakers in local and federal governments must consider how health promotion and health access policies will impact health outcomes, particularly for vulnerable populations.

Limitations

Data collected in this study reflect information obtained from key and general informants of the domain of inquiry. Data was obtained through the use of an interpreter when appropriate. The eight key informants available for this study were limited in number and were restricted to those women who have completed the RFC nutrition education program within the study period and agreed to be interviewed. General informants were limited to those persons who are familiar with the population of refugee mothers who are taking nutritional education classes at the RFC. This study was conducted in collaboration with the RFC Clinic with concern for the effectiveness of their nutrition education program. The involvement of the RFC Clinic and St. Francis Regional Medical Center may have influence over the study, due to factors such as access to participants and input of the staff.

Delimitations

For the purpose of this study, the population of interest was confined to refugee mothers. This study was delimited to data obtained from refugee women who participated in the RFC perinatal program to increase nutrition knowledge and general informants familiar with this population.

Definitions

- Culture –values, beliefs, norms, and lifeways of a particular group of people that guide thinking, decisions, and behaviors and can be viewed intergenerationally, over

time and in different geographic locations (Giger & Davidhizer, 2008; Leininger & McFarland, 2002).

- Cultural and social structure factors – "broad, comprehensive, and special factors including "philosophy of life, cultural beliefs and values" influencing care expression and meanings (Leininger & McFarland, 2006, p. 14)."
- Cultural competence –practice which strives to acknowledge the importance of culture, incorporates assessment of cultural differences and knowledge of diverse cultures, and adapts services to meet the unique cultural needs of individuals and groups from diverse cultural backgrounds (Betancourt, Green, Carrillo, & Park, 2005; Campinha- Bacote, 2002).
- Cultural proficiency – an approach to taking action to the issues that come to light in diverse environments that includes tools that enable individuals and organizations to develop cultural competence, respond in a supportive manner, and create positive change (Lindsey, Robins, & Terrell, 2003).
- Cultural safety – the characteristic of an infrastructure that addresses power differences in healthcare provider/patient interactions so that the patient is empowered as a participant and partner in the healthcare relationship (Polaschek, 1999).
- Ethnonursing – a research design that takes into account the cultural beliefs, values and practices of a specific population in the process of exploring a nursing care domain of inquiry (Leininger, 1991; Leininger & McFarland, 2006).

- General informant – a person who is not as knowledgeable about the domain of inquiry as a key informant, but who has general ideas and knowledge and able to provide reflective information (Leininger & McFarland, 2002)
- Hemoglobin level – Hemoglobin is a protein in red blood cells that carries oxygen. Hemoglobin levels are determined by a blood test which tells how much hemoglobin in found in one's blood (NIH, 2012).
- Key informant – a person who has been purposefully selected (in this case, by inclusion of a subculture) due to being most knowledgeable about the domain of inquiry (Leininger & McFarland, 2002).
- Peer health advisor - refugee women who go through training from RFC Clinic staff and who bring their lived experiences as refugees "to assist healthcare providers to deliver culturally appropriate care, responsive to refugee maternity and pediatric patients' unique needs (SARMC, 2010, pg. 2)."
- Refugee – A person "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country (UNHCR, 2012)."
- Trauma-informed care – care that acknowledges the impact of trauma on an individual and strives to reduce trauma symptoms and promote healthy behaviors. Principles of trauma-informed care include providing safety, promoting of healing relationships, and development of self-management and coping skills (Bath, 2008).

Organization of the Study

This study will be reported in five chapters. Chapter One provides the background to the problem, an introduction to and the significance of this topic. In addition, Chapter One states the research questions, delimitations and limitations, and provided the technical definitions. Chapter Two includes a literature review of previous research and theories related to refugee health, anemia in pregnant women and nutrition education in refugee women. Chapter Three describes the dataset, research design and procedures for analysis. Chapter Four includes the findings for the study and Chapter Five provides the conclusion for the study and includes implications for improving care of refugee women and recommended future research.

Chapter Two – Literature Review

This chapter begins with an overview of culture, cultural competence and cultural safety related to health education. This section then continues with discussion of various factors related to the health of refugees and in particular, refugee women. These factors include refugee health and healthcare, health and healthcare disparities, acculturation/assimilation, health decision-making, and health literacy. Next, it explores health conditions and, in particular, micronutrient deficiency in refugees and in women during the perinatal period. This is followed by a section describing theory which supports the conceptual framework for this study. Lastly, the literature is synthesized to explore how St. Francis RFC Clinic approaches their goal of improving healthy behaviors of refugee mothers.

Culture, Cultural Competence, Cultural Proficiency, and Cultural Safety

Behavior is not executed in a vacuum. While culture has been defined in a variety of ways, it often is related to the boundaries and guidelines for behavior (Giger & Davidhizer, 2008). Giger and Davidhizer (2008) described culture as “a patterned behavioral response that develops over time as a result of imprinting the mind through social and religious structures and intellectual and artistic manifestations” (pg. 2). Campinah-Bacote (2002) depicted culture as how one sees the world, accesses and utilizes information in decision-making, and contributes to value judgments and selections. For example, members of cultures that value collectivity may appraise their own self-efficacy on how they perform as a group member, producing behaviors which serve the group as a whole. Members of more individualistic cultures may be expected to be more competitive and focused on individual accomplishment in order to be valued (Oettingen 1995).

Leininger and McFarland (2002) described the cultural context as “the totality of shared meaning and life experience in particular social, cultural and physical environments that influence attitudes, thinking and patterns of living” (pg. 60). Spector (2013) expressed that “one’s personal cultural background, heritage and language have a considerable impact on both how patients access and respond to healthcare services and how the providers practice within the system” (pg. 5). In recognizing the diversity of cultures, delivery of care can be enhanced by attention to the unique total context of the individuals seeking care (Andrews & Boyle, 2003; Giger & Davidhizer, 2008; Garnweider et al., 2012; Purnell & Paulanka, 2003; Spector, 2013). This holistic view holds that each of the facets of the individual, as well as the healthcare delivery system, is linked in the process of the provision of care (Andrews & Boyle, 2003; Giger & Davidhizer, 2008; Purnell & Paulanka, 2003; Spector, 2013).

Cultural competence is a term that refers to the process of continuously striving to work with others with effective communication and collaboration based on understanding and appreciating cultural values, beliefs, and differences (Campinha-Bacote, 2003; Purnell & Paulanka, 2003; Spector, 2013). Campinha Bacote (2003) described the process as one of “becoming” rather than “being” and which involves “cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural desire” (p.3). Cultural competence is a dynamic process, with changes occurring within and across cultures at all times. It is a complex active attribute, utilized in varying degrees by healthcare providers and the patients being served. The provider who is able to balance and adapt to meet the needs of the individual patient within the healthcare delivery process can potentially enhance healthcare outcomes (Spector, 2013).

Cultural competence is an important factor in the process of transcultural care decisions and actions which are culturally congruent in the provision of care for health, well-being, or dying (Leininger and McFarland, 2002). Professions such as healthcare, social work and education utilize cultural competence (Betancourt et al., 2003). Distrust can be a factor when cultural views conflict in the healthcare setting (Andrews & Boyle, 2003; McKinney, 2007). Conflict can be due to unintentional ethnocentrism on the part of the professional or the patient or student (Spector, 2013). Key aspects of cultural competence implemented to lessen conflict in intercultural relationships are valuing diversity, being aware of the dynamics of differences, acquiring knowledge of relevant cultures, adapting to different cultures, and recognizing the cultural uniqueness of every individual (Betancourt et al., 2003, Giger & Davidhizer, 2008; Leininger & McFarland, 2002; Spector, 2013).

Another area of particular concern in the provision of culturally competent healthcare is communication (Andrews & Boyle, 2003; Giger & Davidhizer, 2008; Purnell & Paulanka, 2003; Spector, 2013). Health communication is defined as "the study and use of communication strategies to inform and influence individual and community decisions that enhance health" (CDC, 2012). In order to be effective, communication must respond to the language spoken, behaviors, needs, cultural beliefs, and literacy of the target audience (Carroll et al, 2007a; Kosoko-Lasaki, Cook, & O'Brien, 2009; Wittenberg-Lyles, Villagran, & Hajek, 2008).

Cultural proficiency is another concept used in education, as well as other settings, which goes beyond cultural competence in addressing equity issues and healthy and unhealthy practices which result from different worldviews (CampbellJones, CampbellJones, & Lindsey, 2010; Lindsey, Robins & Terrell, 2003). CampbellJones et al., (2010, pg. 19),

described how cultural proficiency is built on a moral framework which furthers the ideas of cultural competence and provides a continuum on which to assess organizational and individual behaviors. The core values of cultural proficiency describe the moral underpinnings for culturally competent decision-making and action. In addition, five essential elements of cultural competence indicate the criterion for personal, professional and organizational values, practices, and polices. CampbellJones et al., (2010) described the essential elements as "(a) assessing cultural knowledge, (b) valuing diversity, (c) managing the dynamics of difference, (d) adapting to diversity and (e) institutionalizing cultural knowledge" (p. 28).

However, barriers exist that obstruct the provision of just, effective, and healthy practices and policies for underserved populations. These barriers to cultural proficiency are manifested through "resistance to change, systems of oppression and a sense of privilege and entitlement" (CampbellJones et al., 2010, pg. 20). Unhealthy practices that result include cultural destructiveness, cultural incapacity and cultural blindness (CampbellJones et al., 2010). Through acknowledgement of the barriers and a shift in perspective that embraces the guiding principles of cultural proficiency, individuals and organizations can move away from unhealthy practices, adopting healthy practices and moving along the continuum towards cultural precompetence, cultural competence, and ultimately to cultural proficiency (CampbellJones et al., 2010: Lindsey et al., 2003). This shift in perspective can result in advocacy for change built on moral justice and resulting in empowerment of oppressed and vulnerable populations (Lindsey et al., 2003).

Literature has extensively considered other ethical complexities of caring for or conducting research with traumatized participants (Dow, 2011; De Haene, Grietens, &

Verschueren, 2010). One of the ethical issues is power differences in provider/patient interactions. Cultural safety is a term used in nursing that also goes beyond cultural competence by addressing these differences (Polascheck, 1999; Reavy eta l, 2012). Polaschek (1999) stated that cultural safety is “about setting up systems which enable the less powerful to genuinely monitor the attitudes and service of the powerful, to comment with safety and ultimately to create useful and positive change which can only be of benefit to nursing and to people we serve” (p. 453-4). It involves social change and implies organizational and structural facilities that meet the needs of vulnerable populations, while empowering them with voice, participation, and partnership (Polaschek, 1999; Reavy et al., 2012). The RFC Clinic strives to integrate cultural safety, utilizing interpreters and peer health advisors as two examples of contributions to a culturally safe infrastructure (Reavy, et al., 2012).

Cultural safety is also an issue related to research among vulnerable populations. Often members of vulnerable populations will be reluctant to participate in studies due to mistrust and fear of exploitation or negative consequences (Ruppenthal, Tuck, & Gagnon, 2005). They may not feel able to give negative feedback due to their own feelings of inadequacy or powerlessness (Ruppenthal, Tuck, & Gagnon, 2005). Utilizing cultural proficiency and providing cultural safety to the best of one’s ability is vital in creating a health care or research environment in which the members of a vulnerable population can participate in a safe and positive manner in order to improve the quality of health, health care, and research practices for these populations (Leininger, 2002; Polaschek, 1999; (Ruppenthal, Tuck, & Gagnon, 2005).

Providing culturally proficient and culturally safe care depends on awareness of the cultural factors impacting both the providers and the clients they serve. Examining the concepts related to the health and healthcare of refugees can provide insight into those factors.

Concepts Related to Refugee Health and Healthcare

Refugee health and healthcare are influenced by a variety of aspects of their culture and personal histories (Edberg et al., 2010; Dow, 2011). Because of their experiences, refugees are especially vulnerable to health concerns, and perinatal women from this population face many challenges having their health needs addressed (Deacon & Sullivan, 2009; Merry, Gagnon, Kalim, & Bouris, 2011). To better understand their perspectives, this section will review the literature related to some of these concepts, namely, migration factors, biospychosocial factors, health and healthcare disparities, acculturation, health decision-making, health literacy, health issues among refugees, micronutrient deficiency, and other factors related to the health of resettled refugee women.

Migration factors. The lived experience and cultural context of refugees necessitates consideration of a different type of healthcare practice in order to meet their healthcare concerns in an effective manner (Lacroix & Shabbah, 2011). The resettlement process affects and is influenced by the individuals themselves, as well as at the family and community level (Dow, 2011). Understanding the context and pertinent aspects of the refugee experience is vital in providing appropriate interventions to meet healthcare needs (Dow, 2011; Morris et al., 2009; Peterman et al., 2011; Silove, 2004) Many refugees spend a great number of years, perhaps much of their lives, in refugee camps (Deacon & Sullivan, 2009; Mirza, 2011). The living conditions and challenges of the refugee camps can result in

health issues, with little access to appropriate healthcare (Adams & Assefi, 2002; Cronin et al., 2008; Mirza, 2011). The resettlement experience also can present numerous challenges and stressors to the process of seeking healthcare and practicing healthy behaviors (Dow, 2011; Morris et al., 2009). Along with personal issues, language, culture and complex systems may create impenetrable barriers to accessing healthcare (Dow, 2011; Morris et al., 2009).

Pre-migration history includes reasons and events that lead the refugee to migrate, exposure to trauma, and, in some cases, life in a refugee camp (Dow, 2011). This historical context can give a background to the conditions and changes experienced by the refugee. Factors affecting this experience relate to whether or not the refugee's family remained intact, the degree of trauma, and length in the camp (Adams & Assefi, 2002; Begic, 2006; Silove, 2004). Post-migration stressors include losses associated with leaving their home, unemployment and discrimination in the host country, and lack of knowledge of the host language, culture and processes (Dow, 2011; Morris et al., 2009). Financial and status changes and role and family difficulties may cause additional stress (Kaplan, 2009). Any of these stressors can compound effects of exposure to trauma (Begic, 2006; Kaplan, 2009). Social support may be lacking and networks lost. The attitudes of the receiving communities can either be a source of stress or provide community support, related to such factors as resources, established ethnic communities, and levels of discrimination (Dow, 2011; Morris et al., 2009; Silove, 2004).

Biopsychosocial Factors. Not all refugees describe their experiences as being traumatic, though the vast majority experience trauma to some degree (Beiser, 2009; Kaplan, 2009; Robertson et al., 2006). Refugees who have endured trauma may be reluctant to seek

medical care, discuss the lived traumatic experiences, or describe physical or psychiatric symptoms that may be a result of the trauma (Blanch, 2008; Kaplan, 2009; Nicholl & Thompson, 2004). In addition, their experience of oppression may cause them to be reluctant to offer criticism or question the healthcare professional (Begic, 2006). Adair, Nwaneir, and Barnes (2011) found these factors affected how healthcare providers interpreted responses from refugees. Even providers who were familiar with the characteristics of particular refugee groups often were mistaken about how the refugees felt about their healthcare.

Refugee women, in particular, are vulnerable to mental and physical health problems due to such factors as past living conditions or experiences of violence (Begic & McDonald, 2006; Blanch, 2008; Deacon & Sullivan, 2009; Kennedy & Murphy-Lawless, 2003). Refugee women are more vulnerable to sexual assault and exploitation prior to resettlement (Beiser, 2009; Robertson et al., 2006). Performing household and gender-specific duties, such as agricultural labor or duties related to caring for others, also leave them open to attack (Robertson et al., 2006). Resources in refugee camps, such as food or healthcare, are often given to men and boys first, limiting the availability to women (Deacon & Sullivan, 2009).

Trauma symptoms that arise due to past violence and unsafe environments can create barriers to accessing health services and hamper health treatment and recovery (Blanch, 2008; Elliot, Bejalak, Fallott, Markoff, & Reed, 2005). The effect of trauma may result in mental and physical health problems, including depression, unresolved grief, post traumatic stress disorder, psychotic episodes, somatoform disorders, and health complaints (Blanch, 2008). Study results related to trauma in resettled refugees suggest the effect of pre-migration trauma and stressors are not continuous but traumatic memories are sometimes suppressed or concealed, and can be recovered at a later time (Beiser, 2009). Recovering

memories of trauma may relieve suffering from its effects, but can also cause retraumatization (Beiser, 2009). Many factors are to be considered in helping traumatized refugees, such as postmigration factors, timing, context, individual needs, and cultural identity (Beiser, 2009).

Care interventions that recognize the impact of violence and trauma on the lives of refugees implement principles of trauma-informed practice (Blanch, 2008; Elliot et al., 2005). Trauma-informed practice strives to reduce trauma symptoms and promote healthy behaviors in a culturally competent manner and through providing safety, promoting healing relationships and empowerment, and development of self-management and coping skills (Bath, 2008; Blanch, 2008; Elliot et al., 2005). There is little in the literature related to trauma recovery in refugees, particularly in post resettlement (Beiser, 2009; Blanch, 2008). However, past studies point to the need for trauma-informed practice among health care providers to promote vigilance in addressing the mental health needs of this vulnerable population (Beiser, 2009; Blanch 2008).

After resettlement, utilization of health promoting behaviors by refugee women continues to be influenced by many factors. The resettlement process can be especially stressful for women, who often have less education, language skill, work experience, and social support than their male counterparts (Deacon & Sullivan, 2009; Merry et al., 2011). Refugee women who are from male-dominant cultures may live with sexual inferiority, coercion or violence and with few rights, privileges, or choices even after resettling (Deacon & Sullivan, 2009; Robertson et al., 2006). Women who are sole providers may be susceptible to role overload (Hoga, Alcantara, & de Lima, 2001). Formal support from healthcare providers and community resources can facilitate help-seeking and health

promoting activities. However, barriers, such as language, access, fear and lack of awareness need addressed in a socially and culturally appropriate manner in order to increase effectiveness (O'Mahony, Donnelly, Bouchal, & Este, 2012).

Health and Healthcare Disparities. Health disparities are defined by the National Institute of Health as "differences in the prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups" (NIMHD, 2012). Racial/ethnic minorities report inferior healthcare incidence (Stone & Dula, 2009). Differences in health and healthcare access among different groups of people are not a new phenomenon, although the concept of health disparities related to justice and ethics is fairly recent (Kissell, 2005). Disparities can arise from a variety of reasons but are often associated with minority status, financial constraints, lack of education, differences in health knowledge and practice, migration and immigration experiences, mistrust and discrimination (Edberg et al., 2011; Sheikh-Mohammed, MacIntyre, Wood, Leask, & Isaacs, 2006).

Health disparities are defined as "population-specific differences in the presence of disease, health outcomes, or access to healthcare" (NIMHD, 2012). Similarly, healthcare disparities refer to the differences in healthcare services that different people receive (HHS, 2000). Various models describe the contributing factors to healthcare disparities. These models explore the role of health before care, access to care, healthcare delivery and patient input. An example is the trajectory model for understanding and assessing health disparities in immigrant/refugee communities, which strives to not only to assess healthcare disparities, but also to identify interventions and policies to address them (Edberg et al., 2011). System issues and provider-dependent factors can create significant barriers, lacking response to the needs and characteristics of the patients (Sheikh-Mohammed et al., 2006; Pavlish, Noor, &

Brandt, 2010; Silove, 2004). Patient factors related to healthcare disparities include such issues as language, literacy/education level, insurance and financial status, segregation, immigration/refugee status, lifestyle and health behavior (Kosoko-Lasaki et al., 2009; Pavlish et al., 2010). Significant factors of access to and quality of healthcare are health disparities due to communication barriers related language or culture (Morris et al., 2009; NIMHD, 2012; Pavlish et al., 2010).

Acculturation and Segmented Assimilation. Acculturation is defined as the process in which persons are changed as the result of coming into contact with culturally dissimilar people, groups, systems and social structures (Berry, 1980; Schwartz, Unger, Zamboanga, & Szapoznik, 2010). Authors describe acculturation in literature as a complex process in which various aspects of heritage, ethnicity, gender and cultural practices influence mental and physical health outcomes (Ellis et al., 2010; Piedra & Engstrom, 2009; Schwarz et al., 2010). Dimensions of acculturation can be defined as *assimilation*, in which the new culture is adopted and the heritage culture is discarded; *separation,* in which the new culture is rejected in favor of the heritage culture; *integration*, where both cultures are adopted to some extent; and *marginalization*, in which both the new and heritage culture are rejected (Berry, 1980; Piedra & Engstrom, 2009; Schwartz, Unger, Zamboanga, & Szapocnznik, 2010; Xie & Greenman, 2011). However, a clear differentiation does not exist between the different dimensions of acculturation, as most people draw on both heritage and receiving cultures to some degree. Integration, which is referred to by related terms such adaptation (Porter, 2007) and biculturalism (Berry, 1980; McBrien, 2005), relates to positive social outcomes (Schwartz et al., 2010). Biculturalism refers to identification with two different cultures, whereas the individual combines the two cultures to create their own

individual culture (Benet-Martinez et al., 2002; Berry, 1980). Understanding acculturation requires an insight into the interactional context in which the person exists, including understanding the characteristics of the migrants themselves as well as the cultural factors, systems, socioeconomic factors, resources, languages and social structures of both the heritage culture and receiving culture (Porter, 2007; Schwartz et al., 2010). This expanded view of acculturation raises both critical issues and challenges for influencing practical and policy action to impact health and psychosocial outcomes (Schwartz et al., 2010).

Changes in immigration and characteristics of new immigrants created a need to view acculturation in a different manner than traditional models. Segmented assimilation theory attempted to explain the diverse experiences of assimilation and identify factors which affect rates of acculturation and adaptation in our current society (Piedra & Engstrom, 2009; Portes & Zhou, 1993; Xie & Greenman, 2011). This new model takes into account the role of the social context in which the immigrants (refugees) are embedded, recognizing the diversity and segmentation of American society. Because of the differences in individuals and the social context in which they settle, new immigrants may take different paths. These paths may be the conventional upward (or "straight-line") assimilation, downward assimilation or "selective acculturation (Xie & Greenman, 2011)." Conventional upward assimilation is characterized as a process of adaption to the new culture by the first generation immigrants and their children resulting in upward mobility. Downward assimilation often results in an urban underclass (Xie & Greenman, 2011). Selective acculturation allows the preservation of the community's culture and values, accompanied by integration of economic and other practices (Xie & Greenman, 2011).

An important contribution arising from segmented assimilation theory is intergenerational acculturation, which focuses on the different rates of acculturation among of immigrants (refugees) and their children (Piedra & Engstrom, 2009). Parents who arrive in the United States with more human capital, which includes education, occupational skill, wealth, English language knowledge, and skill in navigating social systems, will acculturate more quickly, with less dissonance with their children (McBrien, 2005). Those parents most lacking in these assets are more likely to be socially isolated, with less success in traversing complex support systems such as healthcare. They will be most likely to require culturally competent agents to help them to understand and interact with the human service systems needed to improve their lives (Piedra & Engstrom, 2009).

Other studies have explored the connection between acculturation and health. Acculturation for some immigrant groups relates to poor health outcomes, including preterm birth, declining infant birth weight, gestational age at birth, neonatal mortality and pregnancy-related hypertension, with stress and barriers to healthy eating as possible factors (Ruiz, Stowe, Wommack, & Brown, 2012). Other personal factors and health conditions also are linked to positive or negative assimilation experiences among refugees during the resettlement process (Ellis et al., 2010, Schwarz et al., 2010). Single status during transition has been associated with more levels of distress. Length of time in the country of resettlement, being female and premigration trauma all are also highly correlated with depression and anxiety when adapting to a new culture (Baird, 2012; Ellis et al., 2010). Nursing interventions providing social and informational support for women contribute to positive assimilation and may affect health and well-being during cultural transitions (Baird, 2012; Leininger & McFarland, 2002).

Health Decision-making. Decision-making in the healthcare context is a complex process involving various contextual factors, selection options, results from the selections, and patients' thoughts and feelings related to any of these factors. Patients have a variety of cultural, experiential and educational backgrounds which may limit or bias their preferences for selections during the process and for outcomes (Galesic & Garcia-Retamaero, 2011; Loeffert et al., 2010; O'Connor et al., 2002; Pauker, 2010). In addition, healthcare providers can influence the decision-making process through their actions and responses to the patient (Entwistle, Watt, Gilhooly, Bugge, Haites, & Walker, 2003; O'Connor et al., 2002). Cultural norms of the U. S. healthcare system may be in conflict with some of these factors or perspectives (Peek, Odoms-Young, Quinn, Gorawara-Bhar, Wilson, & Chin, 2010; Say, Murtagh, & Thomson, 2006; Xu, Borders, & Arif, 2004). For example, the use of shared or negotiated decision-making does not always fit the U.S. medical system with its individualistic focus on patient autonomy. Studies have focused on a deeper understanding of how different cultural groups approach decision-making, in areas such as parents' perceptions (Liang & Oshansky, 2005; Xu et al., 2004), specific disease conditions (Ratanawongsa, Zikmund-Fisher, Couper, Van Hoewyk, & Powe, 2010; Peek et al., 2010) influences upon decision-making (McLaughlin & Braun, 1998), and advanced directives (Wittenberg-Lyles et al., 2008).

Health Literacy. Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Institute of Medicine, 2004). While an individual's reading skill is usually regarded as the basis for health literacy, the broader abilities of writing, listening, speaking, arithmetic, and conceptual knowledge needed to comprehend

and take action based on health-related materials are also factors. Several studies have found a link between low health literacy and poor health outcomes, including worse health, non-adherence to medical regimens, and increased mortality (Nokes et al, 2007; Osborn, Paasche-Orlow, Davis ,& Wolf, 2007; Wolf, Feinglass, Thompson, & Baker, 2010). Research also indicated that persons with inadequate health literacy utilize more healthcare services, use them more often, and use more expensive services such as emergency rooms (Mancuso, 2009). In addition, they will have fewer skills for navigating the healthcare system, more limitations for understanding their conditions and treatments, less success managing their diseases and higher risk for medication errors (Mancuso, 2009). Health literacy disparities also have been linked to racial and ethnic health disparities (IOM, 2004; Shaw, Huebner, Armin, Orzech, & Vivian, 2009). Research also indicated that factors affecting health literacy can be directly linked to characteristics found among refugee populations, indicating that assessing and promoting the health literacy of patients is vital for addressing their needs in an appropriate manner (McCray, 2005; Singleton & Krause, 2012).

The Institute of Medicine regards health literacy as an important concept within the context of culture and language (IOM, 2004). Culture influences lifestyle, diet, religion and emotional states. A review by Shaw et al. (2009) examined how cultural beliefs related to health and illness impact an individuals' ability to understand and make decisions related to instructions by a healthcare provider. Differences in cultural beliefs are often associated with disease etiology, treatments, health promotion, and doctor-patient relationships (Leininger and McFarland, 2002). Explanatory models used by a culture or society to describe illness may include specific signs, symptoms, and treatments; yet may lack any knowledge or understanding of the nature or meaning of chronic disease or treatment regimens. Shaw et al.

(2009) described how these explanatory models, along with other individual or cultural factors, can influence patients' health-seeking behaviors or compliance to recommended treatment regimens.

A lack of health literacy is associated with health disparities in several studies (Andrulis & Brach, 2007; De-Graft, Aikins, & Marks, 2007; Singleton & Krause, 2012; White, Chen, & Atchinson, 2008). In the United States, a variety of skills are needed and expected in order to be considered health literate. Familiarity with healthcare systems and cultural values and behaviors are expected in order to access services, along with a firm grasp of the English language, such as speaking, listening, reading and writing. Other necessary skills are computing basic math, critical thinking and problem solving. Factors affecting communication are also involved in accessing health information and health literacy. Effective doctor-patient communication has also been linked to the health literacy of patients (Carroll et al., 2007a). Language differences and socioeconomic status affect the ability of a patient to process information about health promotion or disease management (Morris et al., 2009). Access to health or disease prevention information and availability of culturally appropriate health education interventions can have a bearing on doctor-patient communication (Andrulis & Brach, 2007; Carroll et al., 2007a). One's culture and language provides the context for understanding and utilizing health information, so that a failure at any level to recognize the interrelationship of culture, literacy and language can result in interventions are unresponsive to the needs of a particular group or individual (Andrulis & Brach, 2007; Shaw et al, 2009; Singleton & Krause, 2012).

Health Issues among Refugees

Newly arrived refugees are screened for health issues as they arrive in the United States. The screenings include assessment of a variety of health conditions, including anemia, pancytopenia, neurological disorders, psychiatric disorders, cardiovascular conditions, hypertension, diabetes, fatigue and gastrointestinal disturbances (Benson, Maldari, & Turnbull, 2010; Morris et al., 2009). Previous research indicated that one half of newly arrived adult refugees have chronic health conditions (Yun et al., 2012). Many of these health conditions can be related to nutritional deficiencies (Gautam, 2008; Seal et al., 2005). Studies indicate that refugee populations lack many essential nutrients such as iron, vitamin A, vitamin B12, thiamine, niacin, iodine, and folic acid, particularly in women of reproductive age (Benson et al., 2010; Berger et al., 2005; Boccio & Iyengar, 2002; CDC, 2004; CDC, 2008; Mason et al., 2005; Preziosi et al., 1997; Seal et al., 2005; Sheikh et al., 2009; Stuetz et al., 2012).

Micronutrient Deficiency in Refugees. Many studies have focused on the effect of micronutrient deficiency among refugee populations and the significance on health and monetary costs (Gautam, 2008; Seal et al., 2005). Iron deficiency is the most common micronutrient deficiency in the world (Gautam, 2008). Insufficient iron intake, related to availability and consumption of iron in diet, can result in iron deficiency. Iron stores in the body are not replenished. Consumption of nutritional food is often related to access. Low dietary iron bioavailability is indicated in refugee populations who have limited access to food or consume mainly monotonous plant-based foods (Zimmerman & Hurrell, 2007). Food insecurity, reflecting limitations in availability of nutritional and safe food or the ability

to acquire such foods, can cause greater weight gain, poor dietary practices, morbidity and pregnancy complications (Laraia et al., 2010).

Iron deficiency in pregnant women is of particular concern to the CARE Clinic due to the effect on both the mother and the baby. Iron deficiency can result in anemia. Anemia is a condition in which the body does not have enough healthy red blood cells, characterized by a reduction in hemoglobin levels (Sifakis & Pharmakides, 2012). In pregnant women, anemia is recognized as a diagnosis when hemoglobin (Hb) falls below 11 g/dL (Stoltzfus & Dreyfuss, 2012). A high percentage of women become anemic during pregnancy, particularly those who are of low socioeconomic status (McKenna et al., 2003; Oumachigui, 2002). The World Health Organization has reported as many as 94% of women suffer from anemia in developing countries (Oumachigui, 2002).

Iron deficiency anemia has been found to be a consideration for adverse pregnancy outcomes, for both the mother and baby. Severe anemia reportedly caused 20% to 21% of maternal deaths related to childbirth (Berger et al., 2005; Oumachigui, 2002). Inadequate nutrition of the mother can result in restricted fetal growth, which leads to low birth weight. Low birth weight refers to infants who weigh less than 5.5 pounds at birth (Berger et al., 2005). Studies linked low hemoglobin levels due to iron deficiency in the first and second trimester of pregnancy with risk for preterm birth, gestational diabetes and Caesarean birth (Barger, 2010; Boccio & Iyengar, 2003; Scanlon et al., 2000; Sekhavat, et al., 2011). Severe maternal anemia has also been associated with spontaneous abortions (Sifakis & Pharmakides, 2000). Birth weight is considered the most significant determinant of mortality for babies in the first year of life (Sekhavat et al., 2011). In addition, low birth weight infants who are not able to store adequate iron during gestation have the risk of developing iron

deficiency while being breast fed (Zimmerman & Hurrell, 2007). Other studies indicated a link between the iron status of mothers and their children (Boccio & Iyengar, 2003; Preziosi et al., 1997). Iron deficiency has also been linked to complications during pregnancy such as urinary tract infections, pyelonephritis and preeclampsia (Oumachigui, 2002). Boccio & Iyengar (2003) found correlations between anemia and problems during labor including cardiac difficulties, intolerance to blood loss, decreased resistance to infections, and longer wound healing.

After resettlement, refugees generally are susceptible to factors which may contribute to micronutrient deficiency, particularly among women. These factors include low socioeconomic status and continuing to eat food that is familiar or convenient but may not be nutritionally appropriate. Unfamiliarity with a new food environment can also play a part in food insecurity among refugees (Benson et al., 2010, Rondinelli et al., 2011). In particular, refugee families with low incomes, and caregivers who are unemployed and less educated, are more vulnerable to food insecurity (Dharod et al., 2011; Laraia et al., 2010). Acculturation does not necessarily mean refugees access more nutritious diets after resettlement. Higher acculturation scores among immigrant and refugee groups have been linked to higher intake of sugar and processed and fast foods and lower intake of fruits and vegetables (Dharod et al., 2011). However, Peterman et al. (2011) found positive correlations between nutrition education and better nutrition decision-making among Cambodian refugee women.

Improving Refugee Women's Health

The diagram in Figure 1, adapted from Gagnon, Merry and Robinson (2002), illustrates how the various factors related to the health of resettling refugee women intersect.

Migration factors include the reasons, experiences, length of time in the migration process, and acculturation. Biopsychosocial factors include demographic characteristics as well as health conditions, nutrition, environmental, cultural, religious, and economic factors. Refugee health issues consist of health and healthcare disparities, health literacy, trauma, discrimination and systems issues. Women's health issues comprise such things as current, past and future pregnancy and childbirth, postpartum health, menopause, gender-based violence, and general healthcare needs and behaviors. Infant health includes birth weight, gestational age, infant mortality, growth and development, general infant health, mother's competence, and infant safety issues.

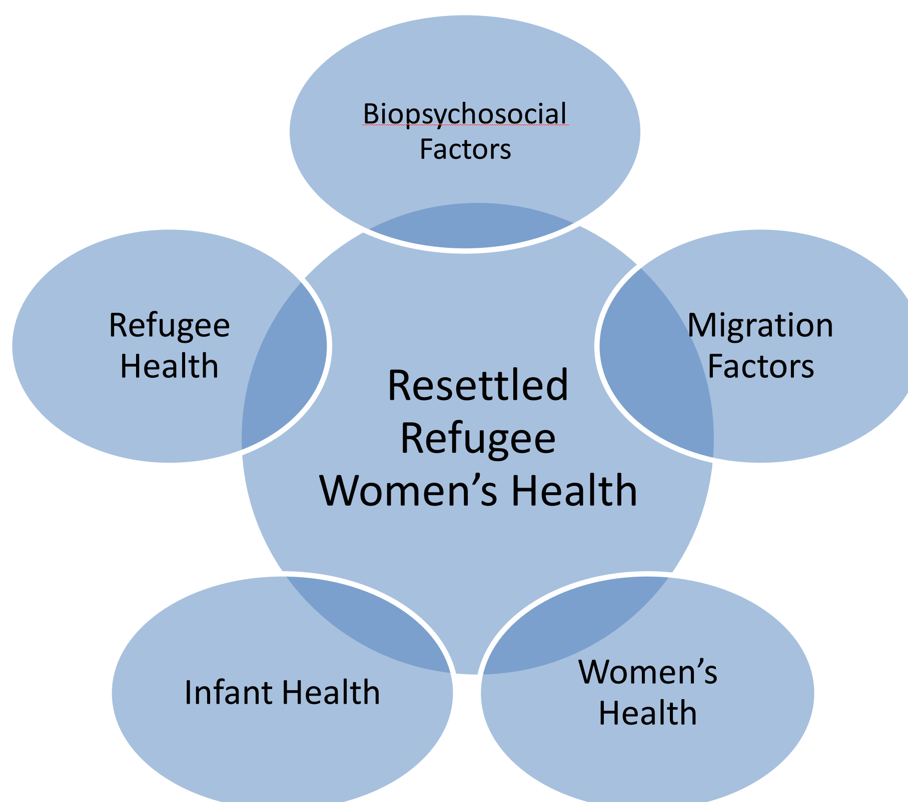


Figure 1. Factors related to the health of resettling perinatal refugee women (adapted from Gagnon, Merry, & Robinson, 2002).

Many interventions have focused on the health of resettled refugee women (Carroll et al., 2007; Dharod, Croom, & Sady, 2013; Garnweider et al., 2012; Guerin, Allotey, Elmi, & Baho, 2006; Halcon, Robertson, & Monsen, 2010). Selection of appropriate interventions depends on the prevalent needs of the population being served, the resources available, characteristics of the population and the involvement of the community (Adams & Assefi, 2002; McBrien, 2005; Nicholl & Thompson, 2004; Rimer et al., 2001). Cultural aspects together with low health literacy can result in a lack of patient adherence to medication and dietary regimens (Shaw et al., 2009). Researchers have focused on the aspects of treating vulnerable populations, including interventions that concentrate on particular conditions, as well as culturally relevant care (Ascoly, Halsema, & Keysers, 2001; Deacon & Sullivan, 2009; Kennedy & Murphy-Lawless, 2012; O'Mahoney et al., 2012; Stuetz et al, 2012). Programs addressing the needs and concerns of the population can result in significant improvement in health and healthy behaviors (Adams & Assefi, 2002; Carroll et al., 2007b).

Health education around diet nutrition has been described as appropriate for addressing culturally-influenced domains of behavior (Speirs, Messina, Munger, & Grutzmacher, 2012). Preventative approaches utilized by antenatal healthcare providers can be effective in controlling iron deficiency (Berger et al., 2005). A study by Charles, Campbell-Stennett, Yatich, and Jolly (2010) revealed associations between healthy body weight and antenatal medical care with lower incidence of anemia. Refugee women reported that many barriers affect their access to antenatal care after resettlement, including transportation, childcare, poor health, language, and no one to accompany them (Kennedy & Murphy-Lawless, 2003). Access to services is needed; but also consideration is required of the cultural, financial, language, education and social concerns faced by refugee mothers.

Addressing the health and nutritional needs of refugee mothers through education is impacted by many factors in the design and implementation of educational programs for refugee mothers. Culturally congruent delivery is needed to address barriers acknowledged by refugee groups (Leininger & McFarland, 2002; Naish, Brown, & Denton, 1994; Riggs et al., 2012). Additionally, attention to learning preferences and effective strategies utilized with refugee mothers are factors for consideration. Finn (2010) depicted an effective learner-centered approach which cultivated trust and included instruction that valued the needs and cultural identities of adult refugees. Vaynshtok (2002) found that one group of refugees preferred a traditional teaching role combined with experiential learning, including group discussions and hands-on learning opportunities. Riggs et al., (2012) described the success of flexible teaching models in language classes for refugee mothers, including using real-life situations such as cooking classes, children's playgroups, and bilingual story-time. By addressing health literacy, educational needs and preferences, and affecting health practices and nutrition among perinatal refugee women in culturally appropriate ways, the wellbeing of the mother and child could be improved.

St. Francis RFC Clinic. In response to the complex perinatal and pediatric needs of refugees resettling in a mid-sized city in the northwestern U.S., the RFC (Refugee Family Clinic) Clinic was opened in 2009 with funding provided by the St. Francis Health Systems. St. Francis Health Systems is a large faith-based Catholic organization with large hospital complexes in at least 4 cities and with a medical staff that numbers nearly 1000 (St. Alphonsus Health System, 2014). The RFC is a nurse-led clinical program which provides healthcare services and education in a group setting with emphasis on equitable care. The clinic serves perinatal and pediatric refugee patients, utilizing healthcare advisors who speak

the patient's preferred language and provide cultural insight. Patient group appointments are scheduled for both perinatal and pediatric well-baby care. Many different languages may be spoken at each of the clinics, reflecting the diversity of the refugee population accessing the clinic. The healthcare team includes six health advisors, a nurse-director, one or more certified nurse midwives, four family practice physicians, one pediatric nurse practitioner, three registered nurses, two licensed case social workers, a dietician, one or more medical assistants, several certified medical interpreters and two office staff.

The staff of the RFC Clinic specializes in a three pronged approach to care for refugee mothers. This includes intercultural understanding, provision of appropriate language services, and trauma informed care. Trauma informed care incorporates principles such as understanding trauma and its impact, practicing cultural competence, promoting safety, supporting patient autonomy, and protecting relationships (Blanch, 2008). Being identified as a "refugee" means the individual has been forced to leave their homeland, due to fear for their survival (UNHCR, 2012). This creates a vulnerability to stressors and trauma before, during, and after migration to a new country (Beiser, 2009). Recovering painful memories creates a risk for mental disorders, and clinical expertise is vital in helping refugees to remember and relate their traumatic experiences in a healing fashion, reducing the potential for retraumatization (Beiser, 2009; Blanch, 2008). The RFC Clinic provided training for its staff about trauma-informed practice, and had two social workers on staff specializing in trauma-informed care.

When refugees from diverse cultures access services within the healthcare system in the United States, the potential for a clash of worldviews is ever present (Morris et al., 2009). The staff of the RFC Clinic strives to provide cultural safety, which goes beyond cultural

competency, to address the barrier of institutional power for culturally diverse groups. The RFC clinic defines cultural safety as a context in which the recipient feels physically, mentally, and culturally safe but also empowered to actively engage in their own healthcare (Reavy et al., 2012). In keeping with the concept of cultural safety, the RFC Clinic utilizes peer health advisors to assist mothers in the visits with health providers and in the education classes. St. Francis defines a peer health advisor as follows:

> A person who contributes to the health status of refugee mothers, infants, and families through comprehensive case coordination and outreach to increase access to maternal/child health and family services, and to assist healthcare providers to deliver culturally appropriate care responsive to refugee maternity and pediatric patients' unique needs (SARMC, 2010, pg. 2).

The health advisors are refugee women who bring their lived experiences as refugees and who go through training from RFC Clinic staff. They become instrumental in providing a culturally safe milieu by bridging the cultures of the healthcare system and the refugees. The health advisors meet weekly for additional training, updates and discussion about the services and activities at the RFC Clinic for professional development activities (Reavy et al., 2012).

In a previous study, qualitative data related to effectiveness of the clinic indicated improved communication between the refugees and healthcare providers and improved capability of navigating the healthcare system and community (Reavy et al., 2012). Medical record reviews indicated a drop in missed clinical appointments among participants of the RFC Clinic program. Childhood immunizations have been sustained at a level of 100% for

the first year of life of babies born to mothers accessing the RFC Clinic services (Reavy et al., 2012).

The Nutrition Education Program. Refugee mothers utilizing the RFC Clinic receive a variety of services, including medical care and education. The RFC Clinic nutrition education program is a series of classes presented by an educator with experience in the health concerns of refugee women. The educator and curriculum are from the federally funded nutrition program for Women, Infants and Children (WIC) program and used in collaboration with RFC Clinic (Idaho Department of Health and Welfare, 2012).

WIC provides monies to states which provide supplemental foods, health and social services referrals, and nutrition education to mothers and children who are nutritionally at-risk and meet low income requirements (USDA, 2014). Over 9 million participants are served each month. Foods provided by WIC include infant cereal, iron-fortified adult cereal, vitamin C-rich fruit or vegetable juice, eggs, milk, cheese, peanut butter, dried and canned beans/peas, canned fish, soy-based beverages, tofu, fruits and vegetables, whole wheat bread and other whole-grain options, baby foods, and iron fortified baby formula (USDA, 2014). WIC participants receive checks, vouchers, or electronic benefit cards to purchase the foods, depending in which state they reside. Researchers have studied many aspects of the WIC program, such as the influence of WIC food packages on access to healthy foods (Andreyeva, Luedicke, Middleton, Long, & Schwartz, 2012), intake of fruits and vegetables among low-income women in a WIC program (Herman, Harrison, Afifi, & Jenks, 2008), and the effect of the WIC program on pregnancy outcomes (El-Bastawissi, Peters, Sasseen, Bell, & Manolopoulos, 2007).

The current nutrition education curriculum used by the WIC educator at the RFC Clinic includes the following topic areas:

1. **W**omen, **I**nfants and **C**hildren (WIC) program
    a. What happens at WIC appointments
    b. Review of food pyramid, food groups, and their importance
2. Weighing and buying WIC foods
    a. Pricing and weighing
    b. Using WIC vouchers
    c. Calculating costs
3. Cheese
    a. Why it is important (protein and calcium)
    b. Differences in cheese types
    c. Ways to utilize cheese in the diet
4. Whole grains and fiber
    a. Importance and distinguishing “whole grain”
    b. Types available through WIC
    c. Ways to prepare and eat cereals
5. Juice
    a. Benefits and appropriateness of juice
    b. How to utilize juice from WIC
    c. How to prepare juice from concentrate
6. Nutrition benefits of dairy
    a. Recommendations, types and serving sizes

7. Peanut butter
    a. Key nutrients, including protein and benefits of peanut butter as a protein source
    b. Importance of protein during pregnancy
    c. Ways to eat peanut butter
8. Tortillas
    a. Nutritional value
    b. Types and common uses of tortillas
    c. Preparing
9. Vegetables
    a. Nutritional value, varieties, colors, and recommended amounts
    b. Vegetables available
    c. Ways to prepare vegetables

The WIC curriculum was being used at the RFC Clinic because it was provided by the educator from WIC at no charge to the RFC Clinic. Because the RFC Clinic has limited resources available, the staff reported that they were favorable to utilizing the services provided by WIC. Participants of the RFC Clinic education program may or may not have attended other nutrition education classes offered at the WIC agency. Nutrition classes at the RFC Clinic were not attached to receiving WIC benefits.

Conceptual Framework

This study is complex in that it focuses on a vulnerable population with diverse cultural aspects, education, and personal experiences. In addition, the assimilation of health information is affected by myriad of perceptions and extrinsic factors and is not an all-or-

nothing process (Janz & Becker, 1984; Piedra & Engstrom, 1993). In order to address these multiple factors, aspects of two theories are being used. Culture Care Theory (CCT) (Leininger and McFarland, 2002) was used as a guide in discovering the cultural factors that pertain to the experience of this population. In addition, the transcultural care decisions and actions described in the CCT were used to explore current and potential teaching and learning strategies. Health Belief Model (HBM) (Janz & Becker, 1984; Pender et al., 2002) was used to explore factors affecting the likelihood of the participants taking action recommended by the nutrition education program, such as cues to action, perceived benefits and perceived barriers to taking action. I considered a conceptual framework based on a combination of these two theories the best way to capture the many different aspects of this study.

Leininger's Culture Care Theory

Decreasing health and healthcare disparities and improving health behaviors is challenging when working with vulnerable populations, such as perinatal refugee women. Culture Care Theory (CCT), guided this study in examining the diverse characteristics of the population and the various factors affecting health behavior change among them (Leininger and McFarland, 2002). CCT is a comprehensive theory utilized to discover, explain, and understand people of diverse cultures. CCT takes into account the multiple holistic factors of culture that influence human behavior (Leininger and McFarland, 2002; McFarland, Mixer, Webhe-Alamah, & Burk, 2012).

The emphasis of the RFC Clinic is within the scope of transcultural nursing and strives to have a culturally responsive focus by healthcare providers at the clinic, reflective of the mission of its parent company, St. Francis Regional Medical Center to "provide

compassionate care to vulnerable and underserved people" (Reavy et al., 2012, pg. 2). According to Leininger and McFarland (2002), transcultural nursing is defined as "a formal area of study and practice focused on comparative human-care (caring) differences and similarities of the beliefs, values, and patterned lifeways of cultures to provide culturally congruent, meaningful, and beneficial healthcare to people" (pg. 6).

The Sunrise Enabler of the Theory of Culture Care Diversity and Universality (Figure 2) is a conceptual holistic CCT research guide which depicts the multiple elements which may potentially influence the care, decision-making processes and health of people (Leininger, 2002). These elements, called cultural and social structure factors, are dimensions of culture care and include such influences as education, economics, and religion, among others (Leininger and McFarland, 2002). These factors can be examined for their influence on care expression, patterns and practices.

Through understanding of the influence of the cultural and social structure dimensions, transcultural care decisions and actions utilize one of three theoretical modalities in the provision of congruent care or educational practices:

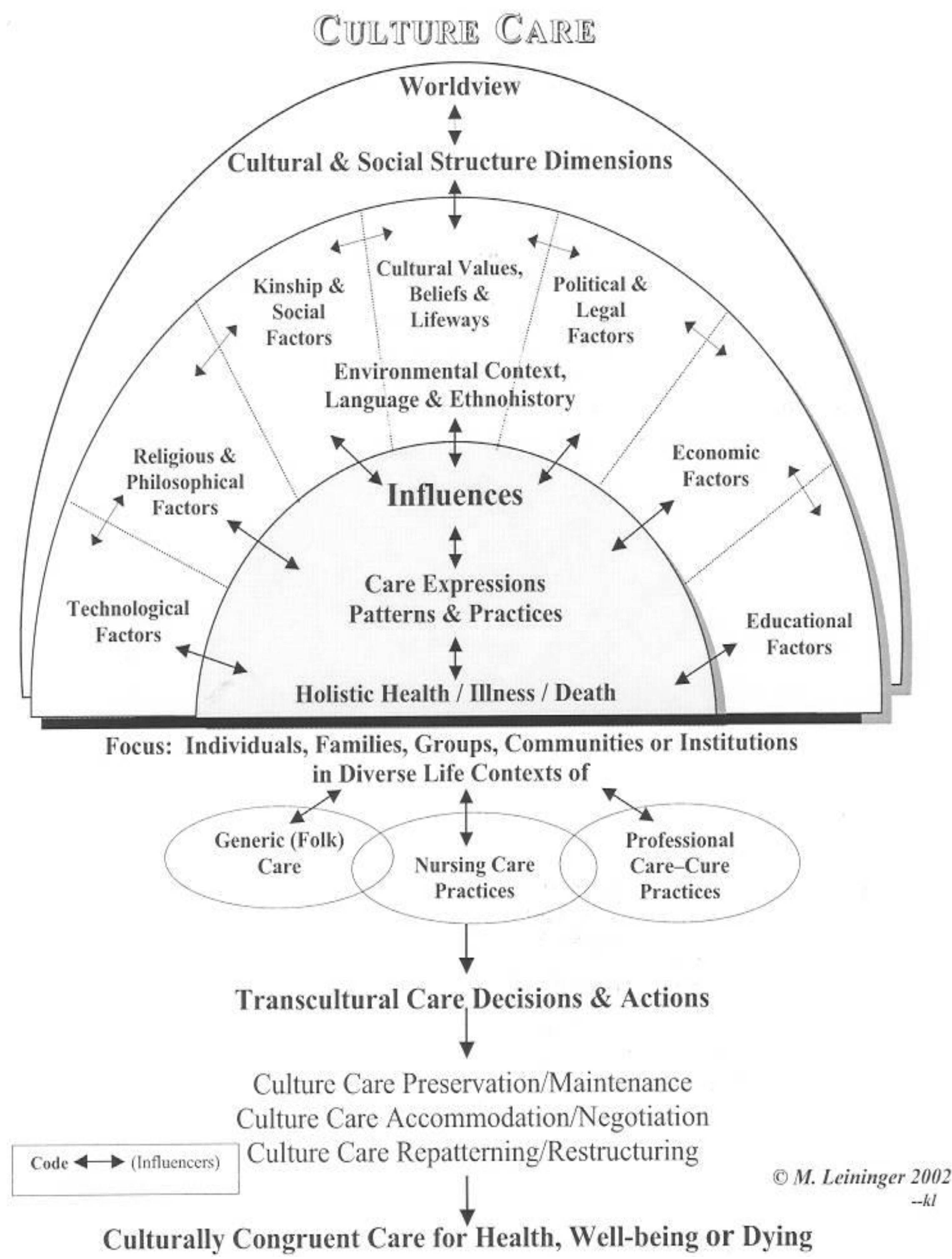
- culture care preservation/maintenance - refers to actions or decisions that help individuals or cultures to preserve, maintain or retain beneficial values and beliefs within their care.
- culture care accommodation/ negotiations - refers to actions or mutual decision-making that help individuals or cultures to adapt or negotiate with others for care which is culturally congruent, as well as effective.
- culture care repatterning/restructuring – refers to actions and mutual decision-making which facilitates change, modification, or reordering of lifeways and

> institutions of individuals or cultures for more beneficial practices and outcomes (Leininger and McFarland, 2002).

Through these three modalities, practitioners and administrators can purposefully make decisions and actions to retain, preserve, or maintain beneficial care beliefs and values, adapt to or negotiate with others, or help people to restructure their liveways for better healthcare patterns, practices or outcomes (Leininger & McFarland, 2002).

This transcultural nursing framework was useful in understanding social structures, cultural beliefs, language and environmental factors which influence the context of research (Leininger, 2002). CCT assists care providers and researchers to identify factors which impact healthcare delivery and can address health and healthcare disparities (Leininger & McFarland, 2002).

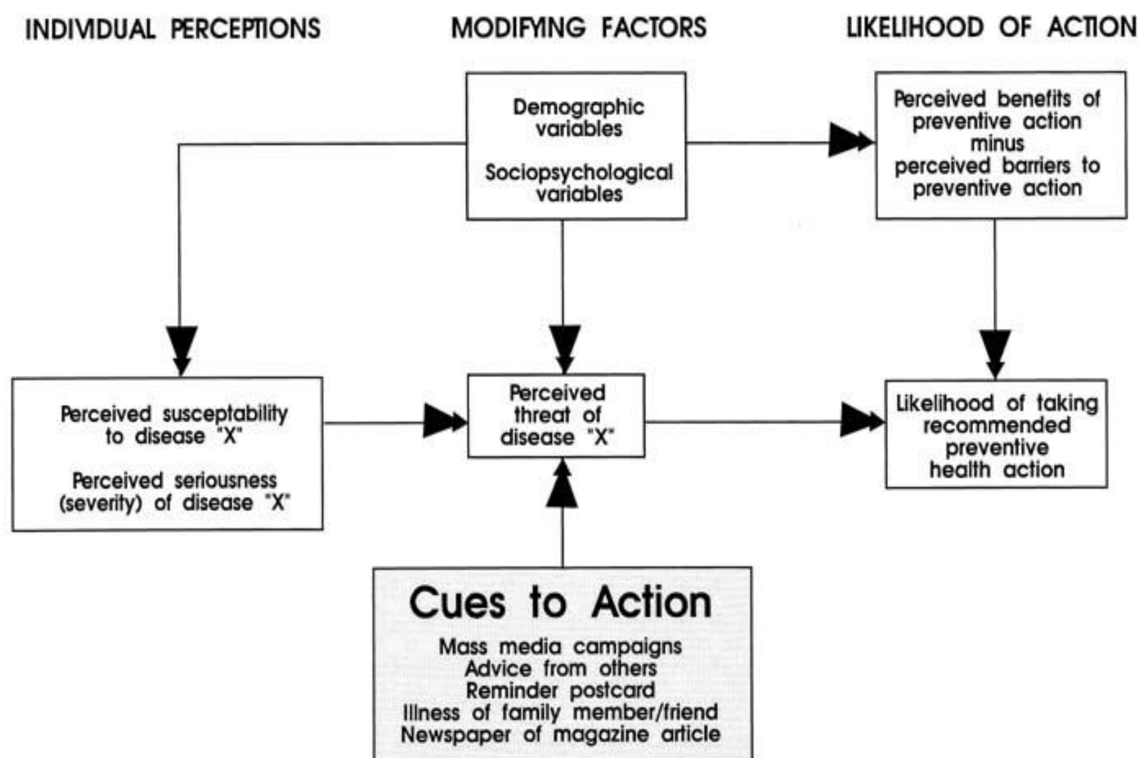
Figure 2.



Health Belief Model. The Health Belief Model (HBM) (Figure 4) was proposed as a model of human behavior developed to explain factors influencing health promoting activities (Pender, et al., 2002). This model explores differences between those who partake in activities which promote healthy lifestyles and those who do not. The model is based on Lewin's (1939) social psychological theory and built upon by Rosenstock (1974) and Becker (Janz & Becker, 1984; Pender et al., 2002). The HBM is utilized in this study to examine those variables which affect a predisposition to taking action which may not be explained by cultural factors. These variables include beliefs related to individual perceptions, such as perceived susceptibility to disease, perceived seriousness of disease.

Modifying factors, such cues to action and demographic variables, as well as perceived benefits of taking actions, and perceived barriers to taking action are associated with the likelihood of action (Pender et al., 2002). Cues to action include influences which motivate or drive an individual to taking a recommended preventive health action and can consist of such things as mass media campaigns, vicarious experience of a friend or relative or guidance from others, such as through an education program (Thalacker, 2011). Perceived benefits of taking action are beliefs about the effectiveness of a recommended action in promoting health or preventing health threats. The perception of benefit can be raised through actions such as conscious raising and positive reinforcement. Perceived barriers to taking action relate to concerns about the negative aspects of taking action, including such things as expense, inconvenience, and undue effort.

Figure 3. Health Belief Model (adapted by Ashford & Blinkhorn, 1999).



Rosenstock, Skecher, and Becker (1988) added self-efficacy as a construct to the HBM, suggesting individual's perceptions of self-efficacy influence health protecting behaviors over time. Self efficacy is described by Bandura, (1977) as a belief in one's own ability to make changes and accomplish goals. Self-efficacy can be measured in beliefs related to particular activities, tasks and situations. It is not, however, all-encompassing and transferable to other realms.

Numerous programs have focused on improving healthy behaviors, utilizing the application of self-efficacy. Maternal self-efficacy can decrease infant's fussing and crying (Bolten, Fink, & Stadler, 2012). In a study with first-time mothers, social support enhanced self-efficacy and reducing post-partum depression (Leahy-Warren, McCarthy, & Corcoran, 2011). Well baby clinic nurses revealed a reduction in secondary traumatization with improvement of self-efficacy (Berger & Gelkopf, 2010).

Healthcare professionals have applied the HBM in program planning and researchers utilized the theory to explain, predict, and influence health behaviors (Deshpande, Basil, & Basil, 2009; Kloeben & Batish, 1999; Neff & Crawford, 1998; Pender et al., 2002). However, applying the HBM with diverse cultures requires attention to factors such as gender roles, knowledge, attitudes, and self-efficacy (Franklyn & Sriram, 2008; Juniper, Omam, Hamm, & Kerby, 2004).

Summary

Chapter Two covers the topics related to health and healthcare for refugee women, micronutrient deficiency in refugees and perinatal women and the St. Francis RFC Clinic. This review of literature indicated a gap in the research about the numerous factors involved in perinatal nutrition education for refugee women. To address this gap, this study attempted to provide understanding about the multiple aspects of their learning processes and cultural influences. The chapter also describes the theories which provided a foundation for the study. Because of the complexity of the various factors of this study, a conceptual framework including aspects of two theories was used to inform the study. CCT provides a framework for exploring the cultural factors of this population in reference to the first research question. HBM delves into the individual aspects of integrating nutrition education in health promoting behaviors, which is the focus of the second research question. Chapter Three explains the research methodology used for instrument development, survey implementation and data analysis.

Chapter Three – Methodology

Research Objectives

The purpose of this research was to explore the experience of refugee women who are participating in a perinatal nutrition education program in order to gain insight into their experience which could lead to improvements in their learning and healthy behaviors. The domain of inquiry was the study of the cultural factors, reflected in the beliefs, values and attitudes of the refugee women who have completed the perinatal nutrition education classes, and their attitudes about how the program affects the likelihood of adapting behaviors. The research questions used to explore this domain of inquiry include:

1. How does Leininger's (2002) Culture Care Theory, inform our understanding of refugee mothers' experiences in a perinatal nutrition education program?
2. In what ways might Pender's (2002) Health Belief Model help us understand refugee mothers' cues to action in a perinatal nutrition education program? What did they see as their benefits for participating? What were the individual and organizational barriers to participation?
3. How might St. Francis alter its perinatal nutrition education program to best meet these mothers' nutritional needs to better acculturate into Western culture?

Description of Study

This was a qualitative ethnonursing study utilizing interviews with eight key informants who were refugee women and who had participated in perinatal nutrition education classes at the RFC Clinic and five general informants with knowledge of this population. They were asked about the experience of nutrition education classes with attention to the cultural factors affecting the attitudes and health behaviors of the women.

Research Design

Ethnonursing research method was used to explore the informant's knowledge and experience, within the context of cultural and social structures and life experiences. Leininger and McFarland (2002) define ethnonursing as a qualitative research method "focused on naturalistic, open discovery and largely inductive modes to document, describe, explain, and interpret informants' worldview, meaning, symbols, and life experiences as they bear on action or potential nursing care phenomena" (p.85). The framework facilitated my discovery about diverse cultures and effective culture care practices (Leininger and McFarland, 2002). The ethnonursing research method was designed to study transcultural human care phenomena of diverse people worldwide, shifting from the ethnocentric research views of Western standards and ways of life to include multicultural views (Leininger, 2002). A variety of studies involving diverse cultures and practices related to culture care have used the ethnonursing method (Hoga, Alcantara, & DeLima, 2001; McFarland et al., 2012; Wanchai, Armer, & Stewart, 2012).

Setting and Participants

The RFC Clinic. The RFC Clinic is a unique healthcare agency based on a new nurse-run clinic model that provides care to refugee mothers with attention to the specific needs of this vulnerable population (Reavy et al., 2010). The RFC Clinic has spent a number of years developing a healthcare program which strives to provide cultural safety and build trust among the refugee population. I do not work at the RFC Clinic but was familiar with the program and chose it because of its respected presence within the refugee community and the participation of refugee mothers in its services. The staff of the RFC Clinic is continually adapting the program to include culturally appropriate, effective interventions (Reavy et al.,

2012). Effective interactions with a vulnerable population such as perinatal refugee women require interpersonal relationship and cultural competency skills for me, as the researcher (DeChesnay, 1983). The potential vulnerability of this population required careful diligence to addressing ethical concerns related to refugee research (Ellis, Kia-Keating, Usuf, Lincoln, & Nur, 2007). The RFC Clinic staff and I collaborated with each other, other refugee service providers, refugee communities and the refugee mothers for this study in order to balance the need to engage in research that contributes to improving health and increasing knowledge, yet adheres to the ethical treatment of this vulnerable population.

Informants. Ethnonursing research utilizes two types of informants, key and general. Both types of informants were used in this study. Key informants are members of the population of interest and were studied in-depth (Leininger & McFarland, 2002). They included eight participants chosen from refugee mothers who are currently receiving services through the RFC Clinic at St. Francis Regional Medical Center in a mid-sized city in the northwestern U.S. and who have attended at least three nutrition classes.

General informants are members of the larger community who were asked for their reflection and perspective (Leininger & McFarland, 2002). The five general informants included members of the RFC Clinic staff and a member of the refugee community. RFC Clinic staff members included the director of the clinic, the nurse who sees the women at the clinic, the director of the health advisors, and a nurse practitioner who practices in the RFC Clinic well baby clinic. In addition, a refugee mother familiar with the RFC Clinic but has not attended nutrition classes there also provided input regarding the population and the context of the women coming as refugees to the U.S.

RFC Clinic staff were instrumental in giving a context to the participants, the Clinic services, nutrition classes, the health advisor program and issues related to access to the participants for this study. The RFC Clinic staff conveyed that the focus of the RFC Clinic is to provide equitable care, incorporating intercultural understanding, appropriate language support and trauma-informed care, with particular attention to cultural safety.

The general informants gave suggestions of how to best provide an environment which would encourage the key informants to participate. They also helped me meet with the participants and provide a sense of cultural safety throughout the study. They provided a place to interview the women and helped to coordinate health advisors to be present for linguistic and cultural interpretation, as well as cultural safety.

Health Advisors. In addition to general informants, the health advisors from the RFC Clinic also assisted in bridging the cultural and linguistic gaps between me and the key informants. The health advisors were an integral part of this research, as they provided insight into the cultural aspects of the study and served as interpreters and liaisons between me and the refugee mothers.

Together with the staff of the RFC Clinic, the health advisors gave suggestions for wording of questions and the consent to enhance understanding and respect. An example is avoiding the use of language that might imply that the participant was not able to understand the consent insinuating they lacked the capability. Also they advised not to ask about religious beliefs, educational background or financial issues directly. Rather these issues could be talked about only indirectly unless they brought up the subject themselves, as some cultures do not openly discuss these topics. The health advisors and staff suggested that questions that might highlight the women's status as a lower class or underprivileged were to

be avoided or asked in a manner that would not make them feel uncomfortable. For example, a question about their finances should not be asked because it may be regarded as disrespectful, cause the women to defend their lack of money or cause feelings of shame. The health advisors emphasized that this high-context manner of conversing is the cultural expectation in some cultures particularly among this population.

Use of Research Enablers

A research enabler is a guide used by the researcher to explore the various influences on the participant regarding their care and culture inquiry (Leininger & McFarland, 2002). In addition to the Sunrise enabler, two other ethnonursing enablers were utilized, the Stranger to Friend (SF) and the Observation-Participation-Reflection (OPR) enabler (Leininger & McFarland, 2002).

Leininger (in Leininger & McFarland, 2002) discouraged the term "researcher as instrument," but instead described the importance of the ethnoresearcher being a trusted friend. The Stranger to Friend (SF) enabler (Appendix A) guided me in evaluating that a trusting relationship was established in order to obtain accurate, meaningful data (Leininger & McFarland, 2002). Leininger (2002) encouraged researchers to become acquainted with the participants of an ethnonursing study so that they are trusted friends, therefore improving the quality of the data obtained. She promoted this view in contrast to the perspective that the researcher is an instrument collecting data. She argued that a lack of trust between researcher and participant could lend to lack of truthfulness in responses of a vulnerable population. With attention to protecting this vulnerable population, I utilized trusted members of the RFC Clinic staff and the health advisors to assist in providing information about the study and entry into the population. This included accessing the participants,

interpreting when needed, providing cultural insight, and gaining consent and collecting the data. Along with assistance from the RFC Clinic staff, I participated in the context of the RFC Clinic in order to interact with the informants and to gain familiarity with them and to build rapport and trust.

Even though I am familiar with the population of refugees, individual informants may have regarded me as a stranger. With this enabler, dynamic indicators, such as willingness to be open and less active to protect self (Leininger, 2002) were used to assess the relationship between me and participants in order to make decisions about appropriateness of gathering data through interviews. To reinforce this relationship, throughout the data collection process, I included other members of the RFC Clinic staff who were familiar to the participants and trusted by them. Including trusted members of the staff also served to help maintain the consistency of cultural safety that is foundational the RFC Clinic mission.

In addition, throughout this process, the Observation-Participation-Reflection (OPR) enabler was used to guide me to remain alert to CCT factors and to remain an active observer, listener, and reflector (Leininger and McFarland, 2002) (Figure 4). This enabler emphasized a gradual, natural entry, with as little emphasis on me as possible.
I moved between phases of the OPR, with the focus in the first phase primarily on observation and listening. This was done by spending time at the RFC Clinic, visiting the clinic, meeting the health advisors and sitting in on their meetings. Observation with limited participation in the second phase was done by being present at the RFC Clinic, interacting with the health advisors and patients and discussing topics pertinent to the research, health and healthcare, such as issues around interpretation. Primarily participation occurred in the

form of focus group interviews and with continued observations in the third phase. Finally reflection was incorporated as observations and participation unfolded (Leininger and McFarland, 2002).

Figure 4: OPR in Action (Adapted from Leininger & McFarland, 2002)

Phase	Observation	Participation	Reflection
Activities	Visiting the clinic, meeting the staff and health advisors, sitting in on their meetings,	Limited participation-being present at the RFC Clinic, interacting with the health advisors and patients and discussing topics pertinent to the research, health and healthcare, such as issues around interpretation. Primarily participation – conducting interviews and with continued discussion with the staff and health advisors	Use of diary to record reflections, discussions with staff about issues that arose, personal reactions, interactions with participants and staff, and reflective discussions with committee members. Time set aside for reflection weekly.
Time Spent	5 to 6 months	Approximately 8 months	Throughout (approximately 13 - 14 months)

Positionality

Even though Leininger (2002) preferred not to insert the researcher as instrument, but rather as friend, she still valued reflection by the researcher through the Observation-Participation-Reflection (O-P-R) enabler. This focus on the contextual aspects of the research and how the researcher engaged in the process is an important reflective activity. A qualitative research study will reflect the cultural and experiential background of the researcher throughout the project: from the topic they choose, to other aspects of the study such as who is interviewed, or how data is collected and is interpreted. The description of the researcher's personal culture and experiences and the resulting influence on the

qualitative inquiry process is known as positionality, (Sands, Bourjolly, & Roer-Strier, 2007). The positionality of the researcher will influence understanding of the context and participants of the study, particularly in cross cultural research (Sands et al., 2007). By reflecting upon their own background, researchers can increase their awareness of how their personal perspectives may have impacted the study.

Borrowed from phenomenological research, the process of bracketing is useful for the reflective pursuit (Wall, Glenn, Mitchinson, & Poole, 2008). Bracketing involves the process of highlighting the assumptions of a researcher in order to increase awareness of preconceptions while trying to make sense of the data. Wall et al. (2008) suggested the use of a reflective diary framework in the process of increasing self-awareness and finding meaning through bracketing. This framework includes pre-reflection, reflection, learning, and action from learning. I utilized a diary in this study to contemplate and reflect upon those beliefs and experiences which might influence the study. My reflection on the impact of my own cultural viewpoint and biases indicates my postionality and gives context to the study. I have organized my thoughts according to the bracketing model (Wall et al., 2004).

Pre-reflection. In this phase, I was encouraged to set aside time to reflect on those experiences and beliefs which might influence the study. My pre-reflection included self-reflection and a discussion with the director of the RFC Clinic. Our discussion included talking about our journey into work with diverse cultures, as well as the impact our journey has had on our nursing practice. The director had been a student of mine in one of the first classes on cultural competence I taught for practicing registered nurses. We have both come a long way in learning about and adapting to diversity yet our experience and increased knowledge seemed to have left us both with a feeling of knowing less. However, the belief

that we can still make a difference motivated me to conduct this research and for her to support the study and provide access to her staff and clients at the clinic. Analysis of my pre-reflection diary revealed I have a full range of emotions tied to improving health among the refugee population, including empathy, compassion, frustration, awe, and confusion. I was even embarrassed about how I had been unintentionally ethnocentric in the past, particularly since cultural competence has been a professional focus of mine over the past ten years. However, I was motivated by the potential to improve the health of mothers and babies through influencing health educators to provide more effective methods of teaching and learning.

Reflection. I have been interested in cultural diversity for decades, affected by experiences as student, educator, and businesswoman. Cultural awareness and responsiveness is expected to be a priority for effective care by professional nurses. My professional experiences have afforded me the opportunity to engage with a variety of different cultures and learn new perspectives.

I have a ten year history of working with refugees and refugee services that has provided me with knowledge and skills obtained from research related to the education and communication needs of refugees for the improvement of health outcomes. It has also provided an opportunity for me to become friends with several members of the refugee community. These relationships have been invaluable for collaborating in research and activities for improving healthy behaviors of refugees. I have conducted numerous studies with refugees, including community assessment of Somali Bantu refugees, the study of health conditions of African refugees, the treatment of non-emergency illness of Somali Bantu children by their refugee parents, research related to understanding and

communication with healthcare providers and refugees, and the use of interpreters in refugee research (Black, Springer, Lazare, & Martinez, in press; Soelberg, Temkin-Martinez, Black, & Springer, in press; Springer, Black, Martz, Deckys, & Soelberg, 2010). These studies have increased my insight into various groups of refugees, but more importantly, prolonged engagement with refugees has fueled my passion for improving the health of these amazingly resilient people, motivates me to continue to collaborate with them to improve their health, and inspires me in my personal life.

Past experience and expertise with diverse cultures and the use of interpreters was essential as the participants of this study came from many different countries and cultures and speak various languages and dialects. I came to this research study with a background in openness to cultural differences and knowledge of various communities. I hoped this would help me to understand my population of study in such a way to continue drawing out their views, values and experiences in order to further present their perspective to others. However, pitfalls are part of the process of becoming more culturally competent. My first position as an educator was on the Crow Indian reservation teaching literature to Native American high school students. I was in my early twenties at the time. I arrived at the school with little, if any, knowledge of the Native American culture, but armed with syllabi, schedules, and written assignments for my students. It didn't take me long to realize these people were a story-telling culture with a different view of time than I had coming from a university environment. Adapting teaching style and learning expectations is expected for all teachers, but the cultural implications in this setting meant adjustments were necessary in ways not addressed in my college's teaching curriculum. Being culturally competent can be about adapting whether you are teaching high school classes or providing healthcare.

Even though I have worked with diverse cultures for over 30 years, and with the refugee population for approximately 10 years, I still find ample situations in which I overestimate my ability to take others' points of view into consideration. Constant vigilance is needed to be mindful of my own cultural lens, as well as when others might have different values and perspectives.

A few years ago, I worked with refugee women both through volunteering at a free health clinic and also by working with them in English language classes. I had met with many of them at the clinic, in the classes, and in their homes. But a particular occurrence reminded me that while I may have a relationship with members of the community, my worldview is very different from theirs. When engaging with some of the refugee women while helping them to learn English, I was told by one of the men of a particular community that I still needed to go through the male leaders to gain access to the women. They wanted to know when and where I planned to meet with the women. The men were the protectors of the women and insisted on vetting their activities. This was after I had worked for several years with both the men and the women in this particular community. It struck me that it was not necessarily that I was not trusted, but that this was their culture, even though it might not fit my more feminist, individualistic personal value system. I had to adapt to continue working with the women but also in holding back my judgments or desire to change a cultural system that had been in place long before I arrived on the scene. I learned much from that encounter, mostly about having a constant vigilance about both my cultural beliefs and those with whom I am working and how those belief systems intersect.

Entry into this population was enhanced due to the long-term interactions with the refugee population, relationships with refugee organizations, refugee leaders, and the St.

Francis RFC Clinic staff, as well as a strong commitment to culturally congruent practices. Access to this community is limited so inclusion of these basic requirements for a study such as this is vital. However, incorporating cultural competence is a journey, not a destination (Campinha-Bacote, 2003). I learn continually from those around me, including refugees, of the diverse ways of seeing the world. The RFC Clinic staff members strive to provide a culturally safe environment, but the staff and I exchanged stories constantly of how we slipped back into our ethnocentric views. Trusting one another to give helpful suggestions about how we might say something differently or be more open to diverse points of view, as well as retaining a sense of humor about ourselves and the slips we inadvertently make are also vital. This cultural self-awareness and adaptation is necessary for maintaining cultural safety for the vulnerable population accessing the services of the RFC Clinic.

Much of what I learned through this study was not just about the domain of inquiry, but about research with extremely vulnerable populations, trauma informed care, and providing cultural safety. Using health advisors has been a vital step in implementing these principles, as they provide the link between healthcare providers and patients who come from cultures and backgrounds unfamiliar to those providers. The staff of the RFC Clinic has endeavored to provide culturally competent care, but the move to incorporate health advisors was a giant leap in providing a culturally safe environment for refugee women. In keeping with the principles of trauma-informed care, the most important assets to this study became the RFC Clinic staff and the health advisors.

At the beginning, I was asked by the RFC Clinic staff, “Do you want answers, or do you want the truth?” This became a driving factor for the study and is consistent with Leininger’s (2002) Stranger to Trusted Friend enabler. I felt there might be some value in

answers, so it was tempting to go the easier route. However, my concern and commitment to this population required that I seek the truth. The truth to me was sincere input from participants which hopefully will make a difference in how we seek to improve their health through nutrition education. The staff and I repeated that phrase "Truth or answers?" among ourselves several times throughout the study, holding to seeking the truth as best as we could. While really knowing whether one is getting the "truth" from the participants is not necessarily possible, one can include processes that encourage the truthfulness, such as building rapport and utilizing cultural competency. This seemed more likely if I followed the suggestions from the health advisors. The health advisors also wanted the truth to be told. Suggestions from them such as "Don't even ask if the interview can be recorded." reminded me of the vulnerability of this group and how past oppression created implications of danger and risk where I saw convenience or usual research protocols. Other suggestions came in the form of particular wording of questions, such as caution with the word "respect" as it means different things in different cultures, with different expectations of behaviors. Adapting the consenting and interviewing processes also required reflection and input about providing cultural safety for protecting this vulnerable population while not overwhelming them or causing them distress.

Concerns. When I went back over my pre-reflection and then reviewed my past experiences and feelings, and the situations and progression of the research process; I found my concerns were reflected in three areas. These areas included:

- my ability to build and sustain trust among this very vulnerable population,
- the cultural safety of the participants,
- the role of the RFC Clinic staff.

I had ties to the refugee community, but this study is with individuals who I may not have come in contact with in the past and with which I have very limited access. I knew I had to find a way to present the study in the least invasive manner possible, while still getting the truthful answers I sought. I needed to learn from my past mistakes and consider the input of the health advisors, my dissertation committee and others who could lead me to a well-designed study where I could also provide the cultural safety needed for a population who had been traumatized. As well, I needed to respect the work and skill of the RFC Clinic staff, knowing their continued success relies on the provision of cultural safety and responsiveness to the patients they serve while keeping in mind they had perspectives about this study that may be different than mine. I knew I needed to give up some control and work within established structures of the RFC Clinic while holding to established research standards, such as appropriate consenting procedures. I relied on the staff and the health advisors for recruitment and assistance in interviewing the women. This restricted my pool of participants; however, my conviction to find "truth, not just answers" as well as my ethical belief in providing cultural safety for the participants was of greater importance.

Learning. Learning was accomplished both through the experiences in the interview process and also in bracketing. Early in the study, I found I continued to make cultural faux pas, but I was learning to be humble. Reflecting through the journaling process was important in discovering how to improve my learning from my mistakes. Along with the reflective diary process, however, I found that continued conversations with my colleagues involved in diversity work helped to support my learning and morale. The RFC Clinic staff, in particular, understood the sensitivity of the situation, yet could provide the insight and support that motivated me to strive to increase my competence in working with this

population and complete the study. I continued to adhere to the belief that practicing with cultural competence is a journey not a destination and to embrace cultural learning as a continuous process. This included adding the practice of trauma informed care. Responding to cultural diversity in a competent manner is not limited to acknowledging different languages or ways of using time, but truly empathizing with the beliefs, experiences, and needs of those whom we serve.

A second area of learning was about the women themselves. The interviews were enlightening to me on many levels. But the most interesting to me was how resilient and inspiring these women are. While they have been faced with adversity throughout most of their lives, as a group, they are not just survivors, but mothers who are trying very hard to make the world a better place for themselves and their children.

Action from Learning. During this phase, I considered how to use what is learned in other situations, such as in following interviews. I utilized what was learned as the study progresses by taking action, such as adapting the methodology of the study. Keeping the reflective diary and discussing the process with the RFC Clinic staff was useful in bracketing and setting aside preconceptions, as well as seeing how changes could be made. An example was my reluctance to interview more than one participant at a time. As the study progressed, it was evident that trust and feelings of safety were more evident when two or more participants were interviewed together. The mothers indicated their preferred method of contributing to the interview, as well as learning, was in a group setting and so the interviews were held with two or three participants. As I learned more about how the mothers preferred to interact, it became important for me to respond to their input in the research process. Input from staff and health advisors aided in phrasing questions and statements in a manner that

implied respect rather than promoting any defensiveness. From this I also learned better ways of working with the women and asking questions. For example, rather than asking a participant if they understood, which might be construed as a lack of ability to understand, I learned to ask the participant if she had any questions.

It was important for me to enlist the help of my colleagues at the RFC Clinic in this study through frequent conversations with them, and to consider the input of the health advisors throughout the interview process. Consideration of the insider perspective of the health advisors and the participants contributes to more effective research as well as educational practices among diverse populations (Leininger, 2002). Recognizing my own beliefs and limitations in providing a culturally safe research methodology made the reflective process even more vital to find the truth I was seeking in this study.

Considerations of Cross Cultural Research. Conducting research with members of refugee populations requires particular attention to aspects of cultural competence and adherence to ethical principles regarding vulnerable populations. Cross-cultural research in healthcare provides an opportunity to improve outcomes of the populations of interest. It provides research findings built upon theoretical models and enhancing the provision of healthcare for clients of different cultures. However, researchers also must be cognizant of limitations and challenges of conducting cross-cultural research (Gagnon & Tuck, 2004; Smith, 2009; Temple, 2002). These include objectivity, access to sample, language, and methodological problems (deChesnay, 1983; Huer & Saenz, 2002). Maintaining objectivity can never be fully realized, but can be enhanced by reducing selective inattention, ethnocentrism, and prejudice as much as possible. Overcoming access obstacles can be achieved by using appropriate methods for gaining entry into the community, building

trusting relationships, and building strong partnerships (deChesnay, 1983;McFarland et al, 2012).

Maintaining good relationships with cultural informants and gatekeepers of the community is also crucial if language is an issue. When the investigator does not share the same language as the research participants, linguistic validation of interpretation of the instrument may be necessary, consensual validation must be ensured, and interpreters must be trained to promote valid, reliable data (deChesnay, 1983; Wallin & Ahlstrom, 2006). Instrument translation techniques utilized for this study included:

1) Bilingual techniques, where a committee of bilingual speakers evaluated how the original language versions could be interpreted,

2) Pretest, where a pilot study was carried out to evaluate how the participants may comprehend questions and procedures (Brislin, Lonner, & Thorndike, 1973; Maneeesriwongul & Dixon, 2004).

The peer health advisors were used in this process because of the unique qualifications they possessed. First, they were bilingual in the languages that were going to be used in the study. Also, they had cultural insight about the different groups from which the women had come. They were refugees themselves, and so had insight into the refugee experience, although it is unique to each individual. The health advisors also had training for interpreting, providing cultural information, and assisting the women in the healthcare setting. They met as a group twice a month and so were practiced in working together to assist in providing culturally appropriate and consistent processes for the women. They were chosen because of their good standing in their respective communities and maintained good relationships with both the RFC staff and the women who attend the clinic.

Instrumentation

An interview guide (Appendix B) was used in semi-structured interviews for the qualitative data collection based on the factors delineated in Sunrise Enabler and related to cues, perceived benefits, and barriers to action, as identified in the HBM (Janz & Becker, 1984; Pender et al., 2002). Open-ended questions focused on cultural factors were developed according to CCT (Leininger & McFarland, 2002). The *Resident Open Inquiry Guide* presented by McFarland et al (2012) provided a template for questions that were used for the interview guide for this study. In addition, questions were added to reflect perceived benefits to action, barriers to learning and adaptation, and effective cues that would affect the likelihood of taking recommended actions as guided by the HBM.

Using the interview guide (Appendix B), the focus group interviews were started with open-ended questions. Nearly all of the questions from the interview guide were addressed at some point, although we did not ask the questions related to religion and financial questions, as recommended by the peer health advisors, unless the topics were addressed by the participant without our directly asking. Once the topics of religion or finances were raised, however, the questions from the interview guide about these topics were used as probes. The questions were not necessarily asked in the order in which they are written on the interview guide. Probing questions were sometimes asked about topics from the interview guide already addressed by the participant in order to gain greater understanding.

Reliability and Validity

Instrument translation/interpretation. In order to enhance reliability, two methods of instrument translation/interpretation were used for this study: committee approach and pretest (Brislin et al., 1973; Maneeesriwongul & Dixon, 2004). Committee approach was

appropriate for this study as the informants may speak one of several languages or dialects; some of which may not have a written form and limited vocabulary. Committee approach allows the interpreters to come to consensus regarding wording so that the questions remain consistent (Soelberg, et al., in press). Health advisors and interpreters were given interview training and written instruction on how to conduct an interview, according to guidelines by Fowler (2009). Pretest was done through a pilot with 3 refugee women who have attended the RFC Clinic program or were health advisors.

Triangulation. Triangulation is defined by Morse and Field (1995) as "the use of two or more methods to simultaneously or sequentially examine the same phenomenon" (pg. 243). Triangulation was incorporated to seek confirmation of understanding of the data between two or more sources. Key informants were used as sources for data with general informants used to shed light on the context of the study and to corroborate understanding of the data. Data was triangulated through peer debriefing in collaboration with RFC Clinic staff and health advisors. Member checking was done by asking at least some of the key informants to confirm the accuracy of observations and interpretations. Auditing was incorporated through a paper trail of field notes, transcripts of interviews, journals, memos, and meeting notes documenting decisions and interpretations made throughout the research process.

Implementation

St. Francis Regional Medical Center and University of Idaho Institutional Review Boards were asked for approval to conduct the research. Identities of participants were masked. Each participant was given a number. The master list of the number and the respective respondent is confidential. Demographic information was described in general

terms so as not to give any indication of who the respondent may be. An example of this would be use of general identifiers, such as Asian, African or South American. This population has a history of trauma and abuse and the local population of refugees is small, so extra care was taken so no identifying information can be linked to respondents. This is consistent with the RFC Clinic priority of providing cultural safety.

This population represented diverse cultures, languages, and literacy rates. Input from the participants was utilized to adapt processes as the study progressed. Use of the OPR and ST enablers assisted in the process of recognizing when interviewing would be appropriate. For participants for whom language and/or culture was a concern, health advisors and interpreters familiar with the culture and competent in both English and the native language of the respective participants were utilized. RFC Clinic staff members and the health advisors were trained about consenting and data collection procedures that could uphold research standards while providing cultural safety for the participants. Informed consent was done orally with a standardized consent (Appendix C) being read to each of the participants by me, with the assistance of health advisors/interpreters as needed. The standardized consent was adapted to address the literacy levels of the sample.

Because of recommendations from the health advisors, interviews were not recorded. This is a vulnerable population who may not have felt comfortable with recording or may not answer truthfully if being recorded. Instead, data logging was done as directed by Lofland & Lofland (1995). This procedure includes fully attending, with focus on the informant, making mental notes, jotting notes inconspicuously, adding additional notes immediately following the interview, and by making full fieldnotes at the end of the day. The interviews were originally planned to be done with one participant at a time. However, by the request of

the participants, at least two participants were interviewed at once. This increased the comfort level of the participants and encouraged their participation. This was consistent in the literature related to resettled refugees which asserts that community support of persons with a similar background was found to be an important protective factor for their mental health, and something recently resettled refugees, in particular, actively sought (Beiser, 2009). Recognizing bonds of social support was associated with effective psychosocial programs designed for trauma healing among refugees (Blanch, 2008). In the literature, focus groups are recommended with this population, as they offer social support, meet the collective and oral tradition cultures of many of the participants, and allow community voice to emerge, revealing attitudes and behaviors that may not otherwise be heard (Ruppenthal, Tuck, & Gagnon, 2005). Because of the request of the women, the support for focus groups by the health advisors and staff of the RFC, and reinforcement of using focus groups for vulnerable populations in the literature, I used a total of three focus groups to interview the women.

Limitations to the Study

The participants of this study were limited to refugee women who have attended perinatal nutrition education classes at the RFC Clinic in a mid-sized city in the northwestern U.S. This is a narrowly defined group so the numbers of available participants were restricted. The sample size was small overall with five different ethnic groups included. Thus only one or two from a particular cultural/ethnic group participated. The sample size was necessarily sized because of the time available to conduct the study, gaining entry, and the myriad of issues related to trauma and oppression, such as getting the real perspective of the participants. Other barriers that became evident in accessing the participants included

providing appropriate interpretation services and transportation, and child care issues. These conditions also limited the participants to those women who felt confident enough to participate, spoke a language for which an interpreter was available, and could make the arrangements for transportation and childcare. Because of the limitations to gaining entry, even with my experience in the refugee community and standing with the staff of the RFC clinic, the three focus groups took months to schedule. However, because this population is difficult to access was not sufficient to deter my motivation to gain their input about their experiences in the nutrition education classes.

This study has been limited in the descriptions of the individual women who participated. Past traumatic situations of some of the women resulted in fear of disclosure if their identity was known, so great lengths have been taken to protect their anonymity. This was due to adherence to practices related to cultural safety utilized by the RFC Clinic, which I was bound to follow, as well as advice of the health advisors and requests from the women themselves. In order to participate, the women wanted assurances I would not use identifying information to describe them individually, only general information, and it would be presented in aggregate form. I feel ethically bound to respect their request since I have agreed to it, have included it in the Institutional Review Board processes, and consequently have adhered to it in this report. The number of women who attend the RFC is limited and so even small demographic details can indicate they were participants. There is much interest in this study by the RFC Clinic and the refugee community so the identities would be quite easy to ascertain. This indicates one of many examples of how identifiable information may be unintentionally recognized and recounted, and can affect rapport and collaboration. My

relationship with the refugee community in this area depends on maintaining a sense of trust between the refugees and me.

The interviews focused on topics reflected in the research questions. In keeping with principles of trauma-informed care and cultural safety implemented by the RFC Clinic, I did not ask about traumatic experiences the participants may have had because I wanted to avoid potential retraumatization (Blanch, 2008); I have very limited skills in trauma recovery; and uncovering traumatic experience was not within the role of this study.

This population was very difficult to access even though several of them indicated a desire to participate. Much consideration and effort was made by me and the RFC staff to develop relationships with the women and utilize principles of cultural competence, cross cultural research, and trauma informed care. However, logistical issues arose, such as finding a common time when the participants, support staff, health advisors, interpreters, and I could all meet. While I acknowledged the importance meeting in groups had for the women, the addition of more people created additional challenges in scheduling. Also, the women had problems with child care and transportation to come to the interviews. I waited for several weeks to schedule the first two focus groups and several months to schedule the third focus group. Having the women return for additional sessions was not seen as an option for them.

Data Analysis Design

Data preparation was adapted from the manual methods recommended by Leininger and McFarland (2006) and Morse and Field (1995). Interviews were logged in a notebook with a generous margin for researcher’s comments to be made during or directly after the interview for such things as changes in voice or tone, or non-verbal expression. Directly

after each interview, I added notes or clarifications to the interview log. This information was transcribed into an electronic version which were printed and backed up.

Data analysis was done according to the ethnonursing analysis process described by Leininger and McFarland (2006). This included the following four phases:

1. From the first day, data analysis began as I collected, described and documented raw data, including all data logged notes from interviews, field notes, observations, and continued until the end of the study.
2. In the second phase, data was prepared in a table and delineated as codes. The electronic version of the interpreted interview and my comments were coded according to relevant words or phrases. These were manually highlighted using color coding and then cut and pasted into categories. These codes were then categorized according to constructs of the CCT or specific to the study.
3. Content analysis was used, identifying the category labels according to the topic areas related to the conceptual framework as described by Morse & Field (1995). Data identified in categories were then analyzed for recurrent patterns, differences in meanings, and contextual significance of ideas. These patterns, meanings, and ideas were interpreted and synthesized into major themes. The major themes were then clustered into two groups.
4. Implications of the themes were used to make recommendations according to the three theoretical modalities of the CCT for the provision of congruent care or educational practices: culture care preservation/maintenance, culture care accommodation/negotiation, or culture care repatterning/restructuring.

Data analysis was done without the use of computer software specific to qualitative analysis. This was due to concerns the software might not adequately pick up the cultural nuances of the data. This is consistent with apprehension expressed in the literature of the rigidity of data analysis software when used in qualitative research with high cultural context such as this study (John & Johnson, 2000; Kyung, Mi, & Seung, 2009). Categories related to the factors delineated in the Sunrise Enabler (Leininger, 2002) included descriptors and indicators of thoughts, feelings and behaviors from the raw data. The HBM suggested categories related the different variables to taking action. Data may have been sorted into more than one category. Relationships between the categories were examined and described as topical areas. Recurrent patterns were then combined into themes based on interpretation of the meanings and ideas (see Figure 5). Thick descriptions were used to describe an in-depth view of the contexts, relationships, backgrounds, and affects of the informants in attempt to add to the interpretation of the feelings and meanings of the expressed views. Thick descriptions are rich, detailed and comprehensive depictions of the qualitative data (Polit & Beck, 2004).

Figure 5: Table of Categories, topical areas and themes

Categories	Topical Areas	Themes
Collective View	Using 3rd person, Describing themselves as a part of a group/family and role w/i the family	**Kinship and Social Factors**
Role of the woman w/I the household		
Impact of free samples	Limited access due to availability, finances, and utilizing benefits/free samples	**Economic Factors**
Limited access		
Utilizing WIC benefits		
Impact of religious beliefs on food choices	Impact of religious beliefs	**Religious Factors**
Don't know	How they learn, desire to learn, what was unknown to them,	**Education Factors**
Role of tradition		
Still Learning/asking		
Language	Contextual factors such as language issues, familiarity of foods/packaging, using context clues	**Environment/ Contextual Factors**
Familiarity		
Using other signs besides reading		
New information learned	What they've learned (content) preferred learning strategies (Demonstrations/tasting, group classes)	**Cues to Action**
Learning through demonstrations		
Group/Collaborative learning		
Problems transferring information	Transferring information learned to new situations, foods, Addressing traditional foods and practices, opportunities and effect, Issues related to integration of new information,	**Perceived Barriers**
Problems r/t taste/traditions		
Traditional foods not addressed		
Lack of sharing opportunities		
Improving health/healthy behaviors	How new information is integrated, and utilizing healthy behaviors	**Perceived Benefits**
Using new information		
Mixing the known with the unknown		
Addressing more foods	Recommendations for changing the nutrition education program	**Changes needed**
Allowing sharing opportunities and input from participants		

Summary

Chapter Three details the methodology of this study. The chapter began by explaining dataset that was used. It has outlined informant selection, interview procedures, enablers, and the structure and approach of the ethnonursing method used in this study. Finally chapter three describes how the ethnonursing data analysis guide was used in systematically analyzing the data. The data and findings of this study will be presented in Chapter Four.

Chapter 4

Findings

This research was conducted to explore the experience of refugee women who are participating in a perinatal nutrition program. The three research questions included:

1. How does Leininger's (2002) Culture Care Theory, inform our understanding of refugee mothers' experiences in a perinatal nutrition education program?
2. In what ways might Pender's (2002) Health Belief Model help us understand refugee mothers' cues to action in a perinatal nutrition education program? What did they see as their benefits for participating? What were the individual and organizational barriers to participation?
3. How might St. Francis alter its perinatal nutrition education program to best meet these mothers' nutritional needs to better acculturate into Western culture?

Ethnonursing (Leininger & McFarland, 2002) was used as the research methodology for this study. Findings from this study are described in detail in two major sections in this chapter.

Review of the Findings

The remainder of this chapter includes two sections. The first section is a collective description of the key informants and the RFC Clinic. Direct quotes have been used to describe important characteristics, such as religious beliefs. The second section summarizes the findings related to the research questions.

Description of Participants and the RFC Clinic

The St. Francis Health System consists of four large hospitals across the Northwest and has dozens of primary care and specialty care physicians throughout the region focused

on health care within the community setting. The St. Francis Health Plaza in this particular city offers multiple health services such as outpatient surgery, urgent care, lab and diagnostic services, rehabilitation services, primary and specialized physician care (St. Alphonsus Medical Center, 2014). The RFC Clinic offers specialized healthcare and outreach to perinatal refugee mothers and their families and is found on the bottom floor of one of the multilevel buildings on the St. Francis Health Plaza campus. Larger than most primary care clinic, the facility houses three exam rooms, three consult rooms, offices for the medical providers, nurses, and social workers, as well as a classroom, with a kitchen. The clinic offers medical appointments and classes for the mothers on Tuesdays and Wednesdays. On these two days the clinic is bustling with activity and when you step through the door of the clinic, it almost feels like you are in a different world; one of diverse cultures, children, and openness.

Wide automatic glass doors open as you step into the foyer of the building. The clinic is straight ahead with another glass door and side windows that let in the sunlight filtered through the foyer, giving the waiting room a well-lit, open feeling. The first thing you see when you come through the door is the display of children's play things that can be purchased. The bright colors immediately give a cheery feeling. The pleasant waiting room is carpeted with a dozen chairs, and on a typical day, a few will be filled with women who are pregnant or have a baby or small children, or sometimes a father who is accompanying his wife to her appointment. Some women will have another woman, perhaps a family member who has driven her to the appointment, or one of the health advisors sitting with them. The women are dressed according to their respective heritages: bright colors and large prints of the kanga worn by some of the women from Africa, subdued in black or brown

skirts or dresses from western Asia or the Middle East, or possibly a combination of mainstream American denim jeans with a scarf that covers the hair. The men wear dark colored pants and shoes, with a button down shirt. Whenever I entered and tried to greet whoever was in the waiting room, I never knew whether to expect shyness or a reciprocated smile. But the usual response is reserved, with a quick acknowledgement, followed by eyes lowering or returning to focus on a child, if present.

There is no counter in the clinic to give separation between the receptionist and anyone entering the waiting area. The receptionist sits at a u-shaped desk and responds cheerfully to whoever approaches. The hallway to the rest of the clinic is open, without a door. When women arrive to attend education classes or group meetings, they pass by the receptionist with a nod, directing themselves to the classroom down the hall. Those who are scheduled to see one of the caregivers sit in the waiting room until called back to one of the exam or consult rooms by the nurse or the social worker. The exam rooms, where the women will meet with the nurse and a medical provider, look typical of a medical clinic, with the exam table, a cupboard of supplies, and a sink. Consultation rooms, where the women will visit with the social worker or nurse, have a round table with two or three chairs and possibly, some literature or displays if space allows. The nurse and social worker are dressed in street clothes, usually a modest skirt or slacks, and no medical jacket. As either of them approaches the women, they offer a warm welcome, using a gentle voice and addressing them respectfully and with a sense of familiarity. Those who do not speak English well or are new to the clinic will be accompanied by one of the peer health advisors.

As I would often proceed down the hall towards the classroom, I might encounter a woman coming from one of the examination or consult rooms. Again, they would usually be

reserved, offering a nod or smile to acknowledge me, but not speak. If I stopped to address them or interact with one of their children, they would smile again and maybe offer a word or two in English, often with a strong accent. Once I am in the classroom, the atmosphere among the women is familiar and relaxed as they talk quietly among themselves, to me, or to one of the staff members. The classroom is set up with tables forming a large square with chairs around the outside so everyone is seated facing one another. A kitchen with a counter is in one end of the room. Those who bring new infants with them will have the baby strapped into a car seat. As they join the group, the baby will be unstrapped, cooed over by the group, and held by someone, often not the mother. If the baby appears to be hungry, the mother may breastfeed as the class progresses. Discussions are mostly focused on children or household concerns and are conducted in broken English, in their native languages if visiting with someone who shares it, or through interpretation by the peer health advisors. No one seems to mind the variety of languages or limited English being used as the conversations seem to flow casually, with explanations being given by health advisors or others in the group when language or context causes confusion. Peer health advisors who are attending will often be more talkative and interactive than the other women, leading the discussions or offering insight.

In the classroom, the women show a familiarity to the set-up, often getting up to get something they, or their child, might need, such as a snack or toy. They listen carefully to what is told to them by the teacher or staff members, with interpreters talking softly to those needing linguistic assistance. The pace of conversation or teaching is slow, due to the need for interpretation or extra time to process what is said in English, but this gentle tempo enhances the warmness of the setting. The women stay engaged, eagerly trying samples,

sharing among themselves with occasional comments or questions for the teacher. Interactions between them are casual and friendly. Occasionally, a woman will step out to visit with the health provider, nurse, or social worker and then will return to the group. The classes break up slowly, with the women visiting with the staff or one another as they leave or wait for transport back home by their husbands, other community members, or on occasion, a taxi.

The Care Clinic has worked hard to create a unique, welcoming environment for women with little to no familiarity with Western medicine. The participation of refugee women from a variety of cultures and the interactions between the women and the staff and one another serve as evidence that the women are comfortable there.

Key Informants. The key informants for this study included eight refugee mothers who are receiving perinatal care at the RFC Clinic. The participants belong to a particularly vulnerable population who have been oppressed and persecuted in their country of origin. Trauma and persecution experienced by these women can produce feelings of fear of speaking out individually about any organization or system, including healthcare. The health advisors were adamant that in order to get truthful answers, the participants needed to know their answers would not be used against them. One of them stated:

> Many of these women are trauma/torture survivors, so recording any of the conversations would be extremely troubling. Only pen and paper should be used to record as even typing the conversations on the computer while they are talking would be distracting and troubling.

In order to provide a feeling of safety while talking about their participation in a nutrition education program, they were assured the personal information about the participants would be aggregated, in order to reduce any chance of identification of the individuals.

The participants who are the key informants for this study included women from the various parts of the world. Three of the participants were from North or Central Africa, two from the Middle East, one from South East Asia, and two from Central Asia. Their ages ranged from 21 to 37. They were all expecting or have just delivered a baby. Four of them also had other children, with one participant having five children. Some of the mothers' other children were also born in the U.S., while others were born in the mother's home country, or in the refugee camp in which the mother lived prior to coming to the U.S. All of the women are currently married.

The participants described their religious affiliations as Muslim, Hindu, and Christian. They expressed diverse feelings about their adherence to their respective religions. One participant who described herself as a conservative Muslim stated,

> We have strong beliefs about many things which affect our daily lives. Not only does it involve food, but such things as when we change our baby's diapers. If the baby is a girl and has a messy diaper, we must wait until we are in our own home before we can change it. We do not change a baby girl's diaper in a public place. Even in our own home, we cannot change her diaper in front of her brothers. And we do not use the wipes even if babies poop. We don't take the wipes from here because we don't use them. We don't want to wash the baby somewhere else (besides home). When at the doctor, we cannot take off her diaper to have her weighed, so we decline to have her weighed.

Another participant described herself more liberally. In fact, she could be considered nonconforming, or at least not typical of the group of women I interviewed who are for the most part from collective cultures where challenging the established norms is prohibited. When talking about food behaviors, she stated:

> We had been told for generations to not eat milk with eggs. We were told it was poisonous. However, before I taught my children this, I decided to try it for myself. And when I ate them together, nothing happened. So I have not passed this on to my own children.

Most of the women have learned at least some English, while two of them preferred to conduct the interview with an interpreter. At least five of the participants could express themselves well in English. Three of the women were dressed as mainstream Americans, while the four others were dressed in clothing more reflective of their native culture, including long skirts and/or scarves or headdresses. Regardless of their choice of dress, they were clean and well groomed.

Overall, the key informants were very motivated to learn and the nutrition classes were an opportunity that they engaged for this purpose. This statement by one of the key informants reflected the feelings of some of others:

> Because they (the instructors) tell me what's important, I will try. They (the women) are changing how they eat. You can hear it at the store. In the class, we don't just hear what is good food, but also what isn't good. We can choose to know and then if we know what is good for us or not, they we can choose what to eat.

They described the desire to help make the classes better for other refugee women, but also discussed the impact the classes made on their own lives. They were enthusiastic in

participating in the discussions, seemed open to questions and ready to share, and were respectful to one another, the staff, and me.

Theme Clusters that Emerged Related to the Research Questions

The themes listed in Figure 5 that emerged from the data analysis related to the research questions. The first theme cluster is tied to the first research question and includes beliefs and values the participants related as significant to their nutrition education experience. These beliefs and values are cultural and social structure factors which are identified as dimensions of the Sunrise Enabler (Leininger, 2002). The second theme cluster is focused on the second research question and includes aspects of how the nutrition education program is presented and how the women learn and utilize new information, described by HBM as cues to action, perceived benefits, and perceived barriers (Janz & Becker, 1984). This theme cluster includes the process of the women learning new information and adapting their diets, how they wanted to address their traditional choices and practices, specific content utilized by the women, personal learning styles and preferences, and suggestions for improving the classes.

Research question one theme cluster: Cultural and social structure factors impacting the nutrition education experience. The women identified aspects of their own cultures that had an effect on their learning and behaviors. These cultural and social structure factors related to the dimensions of the Culture Care Theory (Leininger, 2002). Those factors addressed by the women included:

- Kinship and social factors
- Economic factors
- Religion

- Education
- Environment/Context: Language, Ethnohistory (trauma)

Kinship and social factors. The dimension of kinship and social factors includes how the participants see themselves within their social context. The category of expression of the collective viewpoint was included in this theme. Many of the participants come from collective cultures and consequently downplay their own individual perspectives. This was indicated in their use of the second or third person within their responses. They would say "people" or "women" rather than referring to themselves. They related their impression of what is happening among the women of their community when reflecting upon their own experience. They often relied on the health advisors to be a representative of their respective cultural groups to speak for them and their community. This was reflected in the comment, "The health advisors can tell you what the foods the people eat." The quotations used in describing the themes will often demonstrate this collective perspective.

This collective view is consistent with my experience with certain refugee communities with which I have worked in the past. By speaking in second or third person, the participants also many protect themselves from individual scrutiny, offsetting their own opinions by talking about the views of the community or "the women". Identifying with the group seemed to help reinforce social supports and give them confidence. In the past, I have had to learn to not expect individual opinions from refugee group members, but to have patience and wait for group responses when a quick individual opinion was what I was asking for. Reluctance to speak for oneself is a collective cultural quality that is not common in the individualistic world where I spend most of my time, but seems to contribute to the

resiliency of this population. Hearing the women speak in references to the groups in which they belonged was expected.

The influence of social support and identifying themselves as members of their communities also was evident in the category of how the women felt about group learning in the nutrition education program. One of them stated "I like to learn in a group. Often, I cannot think of a question, but someone will ask about something I want to know. And that might help me to think of something else to ask." Others echoed the value of the group classes for their families and communities, "Some do not go to WIC or to the classes here and so do not get the information, but those that do, go home and explain it to their family." The prevalent feeling of safety in a group was what convinced me to do focus groups as well. The feeling of support the women expressed to being interviewed in groups could be translated to learning in groups as well.

Kinship factors also included the category related to the role of the woman within the household, including her decision-making ability and influence upon her own eating habits, and that of her husband and other children if applicable. Each woman regarded herself as responsible for her own and her children's diets. They reported that most of their children willingly ate foods new to them if the mother provided them. One participant related, "When I prepare something, they want to try it. I don't force them. It smells good. Like hot cereal." They indicated that their role included getting their families to try healthy foods in comments such as, "You tell them 'It is mine, but try it.' Then they do it and like it. Let them taste new things and they will like it." Another said, "…those that do (get information) go home and explain it to their family."

Their role as being responsible for their children's healthy diets was evident in the comment, "(I) would like to know how to feed them (my children) here." and "Our kids will eat like we do…" This responsibility was particularly evident in pregnancy or while breast feeding. The concern for nutrition during these times was expressed by one woman who said, "I have not heard women, even me say, how can I take care of myself, but rather how can I produce more milk." Another said that "We learn about how the age of the child affects things, how to eat different thing for a child vs. when you are pregnant."

These women were centered on their children and some of them brought small children to the focus groups with them. The mothers who brought children were attentive to them, but the other mothers were also helpful and caring of one another's children. Again, the collective mindset prevailed in that tending one another's children is to be not just acceptable, but also expected. The interaction between the children and the mothers was loving and quite touching to observe.

The influence over their husband's diets was more indirect. This was reflected in comments such as the following: "My husband laughed at me but when he tried what I was eating, he thought it was good." "I tell my kids I am going to buy it and they will try it, but my husband, he is too busy so just needs something to fill his stomach!" "Some families say 'Why buy this (whole wheat) bread?' You tell them, 'It is mine but try it.' Then they do and like it. Let them taste new things and they will like it." The women did not talk poorly of their husbands nor complain about them, and did not dwell on trying to control their diets, but only to influence them by how the women themselves ate. This was not surprising to me as many of them come from male dominated cultures. Their attitudes about their distinct roles seemed to be realistic and workable for them. One of the husbands brought his wife,

along with two small children, to the focus group. He waited out in the hall while she participated. She also watched over the children that they had brought with them. It reinforced that it was her responsibility, not his, to care for the children and they maintained those roles.

Economic factors. Economic factors played an important part in food decisions, and their learning. This theme included categories related the women's limited access to food due to finances or availability, the impact of free samples, and how they utilized benefits, such as WIC. While I was asked by the health advisors not to ask about the women' finances or incomes directly, the topics of the cost of food, limitations of access because of cost, and the importance of WIC benefits and free samples all were topics that the women discussed.

Comments by the women reflected that their household incomes were quite low. I know that most refugees struggle with finances so it was no surprise to me the importance of getting free samples of food was reiterated. One woman said, "Here it is free to try. This gives us a chance to try but we can throw it out if we don't like it, where we wouldn't want to do that on our own." Another echoed her sentiments, "I like it here at the classes because you can test new foods for free."

Living with limited resources for food was not new to these women. The women lived with little access to nutritious foods in their home countries and the refugee camps due to the limited foods available and restricted ability to pay. One participant acknowledged:

> The food here was very confusing when I first came to the U.S. because it was the first time we had seen some of the food. It was not available in (my home country) and was much different than the food we were used to. The food was different and

> we could not get foods that were healthy for you. They cost too much. We were too poor to get healthy foods but mostly just got food from the camps.

Another declared the following:

> Many of the refugee women have never tasted milk. It is different in (my home country) and hard to get. People could not afford it and so are not used to it. At the nutrition classes and WIC, they give us samples and so some of the women now like it.

Regardless of what they learned at the nutrition classes, personal finances impacted the women's decisions about food here in the United States. One woman stated, "Not a lot of people (refugees), especially new arrivals, can afford organic food. Even so, we wonder about organic vs. non-organic foods and about reading labels, especially sugars." I was surprised to hear the wish to learn about organic foods, but then I remembered that many refugees work in community gardens and organic is a selling point for their products so the concepts of organic and non-organic could be quite meaningful to them. Another women seemed to be more direct about the costs of incorporating nutrition into her diet when she said, "In life, it is hard to be focused on nutrition; it depends on whatever I can afford to buy. If I can afford it, I can eat more vegetables and salad."

Foods which could be provided through WIC or food stamps influenced choices, although there were problems of understanding the process of using the benefits or for paying for these foods. "When cashing our check for vegetables, if we were getting more than the check would cover, we didn't know we could get more and pay for it." Another participant discussed how she was not sure how to use her benefits correctly, "We thought if you bought something wrong and didn't want it (after getting to the checkout), I would have to pay for it,

but (the teacher) told us we didn't have to take it." They needed to use their benefits but they indicated a fear in using them wrong and what it would cost them. It was another reminder to me of the fear and apprehension these women faced doing everyday tasks in a new country.

Frustration and lack of understanding about the use of the benefits were evident in comments such as, "Also about cereal, why do they limit the brands for WIC?" and "…I don't know why they don't allow us to buy the other beans (that we like) with our benefits." This was one of the areas in which I felt empathetic frustration. The women were limited in their own resources, but when benefits were given to help them, the restrictions and complexity of the benefits seemed to offset some of the advantages for them. Even though the RFC Clinic classes was not tied to WIC benefits, at least the women still were able to ask questions and get information about how to use them to get healthy foods.

Religion. I anticipated that religion would be important to at least some of the women related to food and food restrictions, due to the fact that they were dressed in conservative clothing associated with certain religions. At least three of the women wore headscarves, possibly signifying adherence to conservative religious directives of Islam. Religion's impact on food choices was also reinforced by the women. However, I was struck by the variance in how the women felt about or discussed their religious beliefs about diet. The woman who had stated that she personally challenged her religious belief about combining foods before she taught it to her children was an anomaly in my experience with refugees. But the other women did not question nor judge her actions within the focus groups. In the same way, the women did not seem to judge or respond to the woman who was very conservative, not even using wipes to change her babies' diapers. The prevailing

attitude seemed to me to be that they each had their own beliefs and other than describing them if they felt it was appropriate and they felt comfortable doing so, there was no need to comment.

Direct questions about religion were discouraged by the health advisors, as certain religions put limits on the women about discussing their beliefs and their impact with others outside their religion and I tried to respect those limitations. However, the women themselves brought up a few examples of how their religious beliefs affected their food choices. Once the topic was brought up, I would ask for clarification if needed. The reference most often brought up was about avoiding some meats, especially pork, but other references were made, such as eating dairy products in combination with other foods. "For Muslim women, there is conflict in the religion book. If eating fish, no drinking milk or yogurt but on WIC, they are both together." Another reiterated, "In Arab countries, no milk with fish." The non-conforming woman stated, "We've been taught that for a long time that you couldn't mix these foods. It has to be several hours between or it can be poisonous." Another stated that "Many of our people eat nuts but not meat," while another added "And also beans." One woman said that "She (the teacher) should explain about tuna; it is on the list for breast feeding mom and they can eat it (because of religious rules)." For most of these women, adhering to their religious food requirements was important.

Education. The theme of education included the categories of what the women stated they did not know, their desire to learn, and how they had learned in the past, prior to the nutrition education program. The women had various literacy levels, with many of them having limited formal schooling or learning opportunities and none of them had completed high school. This impacted their exposure to learning about nutrition. They reiterated over

and over that “Many of us…don’t know about nutrition” and “We don’t know what is good and what is not.” They did not mention the amount or lack of schooling they had. This reflects what the health advisors stated was a touchy area as it often made the women feel inferior, and also reflects the embarrassment I have observed with refugee women related to their lack of schooling. However, these women were not reluctant to state that they didn’t know about particular foods or healthy behaviors.

Their lack of knowledge didn’t impede their desire to know and use the information, as this woman indicated, “The new people don’t know but learn and understand.” In fact, it motivated them to gather new information. The women reiterated the importance of learning with these comments: “The nutrition classes give us new information. For some who are having their first child and are new here, they have no information. With the second child, they are now using the information.” and “When I was pregnant the first time, I was shy and couldn’t ask. But now I have the opportunity to ask. When I was shy I was left alone.” Another said, “Even those who have been here for five years are still learning what to buy and what they can buy. (The teacher) explains and people keep asking more, for example whole fruits vs. cut-up fruit.” The women related their appreciation of being able to learn about nutrition, attending the classes with the incentive to gain more knowledge. They reported with relish what new foods they were learning and liked. Their enthusiasm for discovery of new foods and new ways to prepare them was delightful.

Environment and contextual factors. The categories of this theme included contextual issues of language, familiarity of foods and packaging, and contextual clues they utilized. All of the participants were limited English speakers, so language was an issue for

many of the women, even those who have a fairly good command of English. Also, English words differ across different settings. One woman related:

> I was looking for semolina but could not find it here. Even though cream of wheat is here, it is in boxes and I didn't look for it in a box. When I was sick and in the hospital here, I wanted some, but I used the wrong name. In other English, they call it porridge, but not here.

Understanding the names of foods in English presented other challenges as well. One woman stated, "The teacher needs to explain the difference between Chicken of the Sea tuna and chicken. Some will not buy it because they think it is chicken." Examples such as this are not instances that would be obvious to me, or were not necessarily addressed in nutrition class unless someone pointed out the linguistic confusion.

Trying to explain the foods to family or community members in their native languages could also be difficult as another woman pointed out, "There is no word for cheese where I come from. Cheese is good. But there is no word to translate cheese in my language so I can't explain it." I have seen the lack of linguistic equivalents in health care frequently, but was not aware of this problem in food choices as well.

However, the women were resourceful. Because several of the women could not read English, they related how they determine what foods to buy based on other signs. One participant described how they learn to distinguish the various types of milk by the color of the lids:

> They give samples of the red top, blue top, and so on. The women learn that children need the red top for brain development especially in the first 2 years, but the women

should not drink so much fat. So even when they are pregnant, they should drink the blue top.

Different types of milk related to fat content was identified by color of the lid by several of the women in the focus groups. This could be cause for concern as there are inconsistencies in packaging, including the lid colors for milk, although this was not mentioned by the mothers. I wondered later if they used other signs, such as 2% in the label, or the consistency of the milk to verify the type of milk they thought they were buying.

Language was a concern for these women in accessing information and in buying foods. However, they were inventive in incorporating new words, such as cheese, and knowledge related to what they were learning in the classes and sharing it with their families. They did not indicate that they were sharing these linguistic challenges with the teacher or that they were asked about words that gave them problems.

In this theme cluster, the data included information shared by the participants regarding aspects of their respective cultures. In particular, they expressed the cultural beliefs and behaviors that influenced their diet and perspective about the nutrition education classes. The next theme cluster will take into account their input related to learning about diet and nutrition and integrating the information into their health practices.

Research question two theme cluster: Cues to action, perceived benefits and perceived barriers to taking recommended action. This theme cluster included categories about what the women are learning from the nutrition classes, the process in which they learn the new information; integration of new knowledge in their dietary choices, and the issues they encountered in seeing their own cultural practices addressed. This information was organized in following themes described in the HBM (Pender et al., 2002):

- Cues to action: new information learned and preferred strategies for learning
- Perceived benefits to integrating new knowledge
- Perceived barriers to integrating new knowledge

Cues to action: new information learned and preferred strategies for learning.

New content learned. One category included in this theme was content the women had newly learned. The participants of this study described the content of the nutrition education program that was relevant to them and how they have acquired the new information about food since participating in nutrition classes. Information that was highlighted by the women included learning about foods new to them, particularly milk, peanut butter, oatmeal, tortillas, bread, brown rice, and fresh fruits and vegetables. Also, they learned what foods are more nutritious. As one woman put it, "I have learned how to prepare new foods, such as peanut butter. It is good to know what ingredients are good for you." It encouraged the women to ask about other foods, "Many of us like corn flour. I don't know if it is nutritious. Also, kasaba flour. I just eat it." They learned to mix foods in ways that they had never done before as this woman expressed, "We are not used to mixing foods: tortilla with meat and other foods, peanut butter and bread. All of the things like cream of wheat and oatmeal. They can mix with milk and add sugar." Another said, "I used to eat bread with a kind of creamy peanut butter but didn't know to use banana or jelly with it." They were learning about combining foods and new tastes. It seemed that they had not had the choices of foods before, so mixing them was not possible and therefore in this new environment, they did not consider it until it was brought to their attention.

In addition, the participants discussed other aspects of foods that they learned were important, "I learned about expiration dates. In (my home country), we had no expiration

dates, but here they tell you when it is expired." They recalled many things that they had been taught at the nutrition classes and if and how they were utilizing the information. They also recounted how these new practices differed than how they had eaten before.

The category related to learning preferences was also included in this theme.

Experiential learning. I was aware that language, education, and literacy could be an issue for these women due to past experiences with refugees and the input of the RFC staff and the health advisors. So I was not surprised about the importance of experiential activities that was voiced by many of the participants. While one of the participants reported that, "Some of the women just don't like to try," most affirmed that trying or sampling was the way that they learned. One woman described in the following:

> When we first came here, volunteers took us to Winco and showed us the foods. That helped because we didn't know what they were. And then they cooked some so that we could test it. We didn't know if we could eat it or if we would like it because we had never tried it before. So when we tried it, we liked it.

These hands-on activities help the mothers to try new things at home, as this mother related, "When we try here, then we also try the foods at home. Sometimes it doesn't turn out as well at home, but my husband and kids think it okay, but I know it's not the same (laughing)." One woman said that another thing that would be helpful would be "if you can have more different foods for information and for trying. We often doubt how it will taste. Teach us how to prepare…here at the nutrition classes, we can ask." They reiterated how much they like to practice at the nutrition class and how important that sampling was in this learning.

Collaborative learning. As discussed in the first theme cluster, collaborative learning was important to the women for social interaction, as well as learning and integrating the

information into behaviors. They asserted that they learned through sharing with comments like: “They (some of the women) may not try in their own home or even in the class. But they will eat it in their friends’ home and like it and so will keep eating it.” Another said, “Some of the ladies don’t say anything here but back home they will tell one another whether they think it is good or not.” And another declared, “Yes we share among our friends. We show each other what we tried and then we would learn about it from one another.” Food sharing can be regarded as a way of establishing relationships and showing trust. Their collaborative manner of learning about food and sharing it among themselves seemed to me to indicate that it was a part of establishing and maintaining community among them.

Besides contributing to feelings of community, the advantages of learning in a group were reflected in comments such as this participant’s, “I like to be in the class, because sometimes others will ask a question that I didn’t think of or didn’t want to ask.” While most of them were highly motivated to learn more about nutrition and appreciated the group setting, others expressed reluctance to ask questions or were embarrassed about their lack of knowledge. As one participant put it, “Some people feel ashamed to respond or ask questions in the classes, especially if they don’t know about a food.” Oppression and lack of previous educational opportunities left them with shame. But the community could sustain them and promote their learning regardless if they felt they could speak up or not.

Perceived benefits to integrating new knowledge in dietary choices. The categories in this theme were related to how new information that the women learned was integrated into their behaviors, including purchasing, preparing and eating foods, what healthy behaviors they engaged in. One participant stated:

> Many of us just eat and don't know about nutrition. We eat what our parents ate. Here, teaching (learning) groups of nutritious foods encourage our people to know more because I learn what's important and then I try to eat that.

Making healthy decisions. The women emphasized their desire to learn about diverse foods available to them in this country and how to make healthy decisions about food. This was evident from one woman's statement: "In the class it is important not only to learn about good food, but also what isn't good or not. We can choose to know and make good decisions." They not only stated that they wanted to learn, but made a great deal of effort to attend the classes which were free to them, not required in any way and offered only one or two times a month.

Since many of the women had not attended school, learning tools and many teaching strategies were not familiar to them. Using food groups as a learning tool to think about diet was a new concept to many of them. The women expressed this in comments such as, "Learning about food groups are helpful." One woman explained that concept was difficult to them but they were learning how to use it with this comment:

> In our country we don't have the nutrition plate with the food groups. Learning how to divide the plate and limit what I eat has helped. They taught me to eat vegetables, fruits, bread, meat and I choose which ones. I can add more salads to feel full.

Some of the women tied their learning to other healthcare concerns. In particular, attention to portion size, related to calorie consumption or diabetes was often regarded as a new concept. "We didn't measure in (my home country), but here everything is weighed and measured so we know how much is in a portion." Another woman stated:

> We don't have peanut butter where I come from. We didn't buy it because we didn't know. We only have nuts. And the amounts…before I took whatever I wanted, maybe ten spoons of it or maybe only one for the whole day. I didn't know how much to eat.

Another echoed these sentiments, saying, "Everyone (in my community) thinks juice is good for you. But I've learned it's not good for you with no limit." The women as a whole did not appear to be greatly overweight, and in fact, one of them was quite small, so weight or appearance did not seem to be the primary reason to limit how much they ate. The main reason they talked about changing their views about portion size was related to diabetes.

Addressing health conditions and concerns. Diabetes is a concern for many of these women and learning new healthy behaviors to address this condition was motivating for them. One participant related, "(The classes) affect sugar intake and how to estimate the amount in various foods and how to read labels. For example, yogurt was making people diabetic because they were eating lots of it and they thought it was good for them." Another told her story about managing her diabetes through her diet:

> I have gestational diabetes so I have to be careful with orange juice. The dietician told me I have to take pills but I thought 'why do I have to?' I tried to control through what I ate. If I took the pills I thought I could eat whatever I wanted. It wasn't good. So I tried to control by eating different. The doctor told me to stop taking the pill, now that my BG (blood glucose) is good. I can't take the pills or my BG is too low. Maybe my body would have gotten used to the medicine.

I wasn't sure that the women had received her diet information for diabetes at the RFC nutrition classes, but she seemed to imply that information related to controlling her diabetes through diet was at least reinforced at the classes.

Another mother described how fear of diabetes and other health conditions affected her kids' diet, "Also, sugar is not good for kids. It is bad for their teeth; also it can cause diabetes." They adapted their own diets and that of their families because of the new information they were learning and the motivation of good health. This was a benefit that they saw to adjusting what and how much they ate.

Useful knowledge for buying and preparing food. Not only were the women learning about nutritious foods but also how to purchase and serve them. "The women are changing how they buy food. You can hear them at the store. Serving sizes is also a concept new to many of them that they are adapting." Another described how she had changed her shopping habits:

> I used to buy just apples with my check. Now I get other vegetables like salad. I never knew about salad. Now I can get it and other foods. It is a help for us and for the other women.

Buying foods, such as fruits and vegetables, which are sold by weight, was challenging for many of the women. "I had problems getting vegetables. The teacher explained how we can get them. Once we got them, we can now get them again." Another woman reiterated that "I heard how to do it (estimate cost of vegetables by weight) but was not sure. It has been very helpful to hear and learn how to do it here." Learning how to buy healthy foods was essential in accessing them.

Other information that they emphasized as useful included what foods are important during pregnancy and breast feeding. It was impressive to me how seriously they took their diet when pregnant. One participant asserted:

> I thought that blue milk tasted like water. I was used to eating fresh from the cow. I thought the blue milk was no good. Then when I was 7 months pregnant, I tried and now it's the milk I buy.

Improving the health of their children. Learning about nutrition for the sake of their children was reiterated among the mothers. "They are telling their children not to take so much, especially yogurt and ice cream." Another mother related that, "Many women don't want to try for themselves, but they find out here for their children." For these mothers, caring for their children motivated them to learn.

I was surprised how many of foods that were familiar to me were new to them. The women had examples of using information that they learned in the classes, particularly related to milk and peanut butter. They indicated this through statements such as, "I like peanut butter sandwiches. We had no idea about them in our country." Another related, "I have learned to prepare new foods, such as cereal and peanut butter." Another woman said, "We used to think that non-fat milk had no nutrition left in it. Now we know when to use it."

Perceived barriers to integrating new knowledge. This theme described problems they had related to assimilating the new information into their dietary choices and included issues around transferring new information learned to other situations. The women talked about issues related to literacy and their limitations in the ability to transfer information, as well as differences in taste and traditions and a lack of opportunities to share their own input or gain insight about their traditional foods and the nutritional value of them.

Transferring information. The women indicated that it was difficult outside the classroom to learn how to prepare foods with which they were not familiar. For example, cooking American foods is difficult for some as this woman described, “Sometimes I eat American food but I don’t know how to prepare it. Here we can ask. I would like them to teach us how to prepare more American foods.” Transferring the knowledge about one particular food to another was challenging for some of them. As one participant said, “The food groups can be confusing because we don’t know where a food fits.” The food groups helped most of them to understand how to utilize appropriate portions, but only some of them understood that the examples could be used to understand concepts that could be transferred to other situations and food choices.

Differences in tastes and traditions. The story of the beans and how they wanted to use the beans they were used to was evidence of how tastes and traditional practices can affect their food choices. They expressed a lack of understanding why WIC limited the choices, often including foods they did not like, such as tuna, as this woman described, “Many women don’t like it (tuna) so they trash it.” They also were frustrated that the benefits did not include foods they wanted, such as a particular cheese, as one mother declared, “We like the cheese we used to get; it was sticky, finger cheese. But the benefits don’t allow for it anymore.” Their individual and traditional tastes still impacted what they wanted as well as the use of some foods they received from their benefits, regardless of what they were learning. They were very vocal in describing how frustrating it was to not be able to use foods that they thought were nutritious and tasty, but didn’t fit WIC’s lists.

In this theme cluster, comments by the women indicated those cues to action which promoted changes in nutrition health behaviors, including new information learned and

experiential and collaborative learning. They described benefits to implementing the recommended health behaviors to be in the areas of being able to make healthy decisions, addressing health conditions and concerns, and gaining useful information regarding buying and serving healthy foods. Barriers in their learning process included challenges they encountered in transferring information, dealing with differences in tastes and traditions, and not being given an opportunity to share or ask about their own foods.

Research question three theme cluster: Changes needed to the nutrition education program. The women had suggestion about how they would like to see the nutrition program adapted**.** These included addressing more foods in the program and including more opportunities for the women to share about their own foods and provide input.

Addressing more foods. The women talked about how applying the information to foods beyond those provided by WIC was important to them, but the topic was not being addressed sufficiently well. I was surprised at the dissatisfaction of the limitations to what they were learning. The women reflected on the difficulty of understanding the various different foods available and how to use them but they also wanted more, "Teach us about others foods, not just the food available from WIC." This comment came up often in the groups, especially when it restricted them to use foods they were not familiar with or liked. One group of participants described this in length in the context of beans:

> There are different kinds of beans that we use; some for children and others for adults. We like the orange beans that turn yellow when you cook them, but WIC doesn't allow us to get those types of beans with our check. And we don't know how to cook the other kind.

Another woman was adamant: “We can’t buy the beans that we are used to eating with our WIC check. The cashier won’t let us. But if we buy the other kind, we don’t know what to do with them so we trash them.” “Trashing” seemed to be an act of disgruntlement and revolt against what they felt they were forced to buy. The women from one group emphasized that rather than this being an individual taste issue, it was a common feeling among the refugees, “If you would go to other groups, they will have the same ideas about beans. You may not want to hear it, but we all feel the same.” Comments such as these indicated a frustration with the limitations of the WIC benefits, but also with their lack of understanding of how to use the foods. There were problems related to integrating some of the information and foods given through their benefits.

Allow sharing opportunities and input from the participants. This theme also included categories related to how traditional foods and practices were not addressed in the nutrition education program, the lack of sharing opportunities for the women, and the effect this had on their feelings. This theme seemed to me to include some of the most fervently felt opinions of the women.

Regarding traditional cultural beliefs and practices, many of the women felt as this woman who stated:

> I think it is good information in the classes and most of us use the information, trying new foods and liking them. But what about other food, they never talk about. They need to ask what we eat. Teach what is okay and nutritious from *our* foods.

When the RFC staff and I heard this comment, we all looked at one another with astonishment. We were surprised to hear that they were not asked about their own foods and the classes did not help them to understand nutrition within the foods they normally eat.

Another woman described making her own yogurt which had lower sugar content than commercially available yogurt. Others wanted her to demonstrate how she made it, but there were no opportunities to share such information. Sharing by the participants also seemed to be an important omission from the classes.

These omissions suggested that the classes were not addressing the nutritional aspects of their own foods nor allowing for sharing and input from the women. These exclusions were also implying more than that. The women felt that addressing their foods and practices was not just about nutrition or food preferences. As one woman put it, "If you would talk about my food, you wouldn't be ignoring our foods; it would make us feel good. Also it would be good because then we would know how nutritious our food is." Another declared that, "Even if you ignore the information (about what foods they eat) at first, you might use it later." Their expressions seemed to me to indicate that they felt hurt and devalued by being left out of the conversation. They wanted the teacher to listen to their tastes and practices, and value their input and traditions.

Summary of findings

The themes described in this chapter represent the participants' perceptions of their experiences in a nutrition education program. The participants in this study discussed the cultural factors influencing on their dietary choices, and aspects of assimilating new information from their nutrition classes into their dietary decision-making. The entire group of participants regarded the classes as a welcome opportunity to learn about nutrition, even if some were reluctant to try new foods. Not only did they discuss what they were learning, but affirmed that they were using the new knowledge in many ways. As one woman put it, "Now I think about the nutrition in many foods." However, the women also had insight into

the challenges they were facing in the process of learning and implementing nutritional practices, including suggestions in making the classes more relevant to their personal lives by addressing foods from their respective cultures and attention to cultural factors such as religion and economics.

Chapter 5

Discussion

This chapter will discuss the findings of the research, the connection of the conceptual framework, limitations of the study, implications, conclusions, and recommendations for practice and research. The purpose of this study was to examine the experiences of refugee women in a perinatal nutrition education program. Previous research on refugee women had not focused on their participation in nutrition education classes or understanding their learning experience from the women's perspective. This research focused on the cultural factors affecting the women's learning experience, assimilation of information, and changes in health behaviors. The study was conducted by interviewing both key and general informants. Key informants included women who had participated in the nutrition education program through the RFC Clinic. General informants included persons who were not among the population of interest but who had significant knowledge and experience of working with them.

Summary of Conceptual Framework

A conceptual framework including aspects of Culture Care Theory and the Health Belief Model was used to guide this study. Culture Care Theory (CCT) (Leininger, 2002) was utilized to discover, explain, and understand people of diverse cultures. CCT takes into account the multiple holistic factors of culture that influence human behavior. The Health Belief Model (HBM) (Pender et al., 2002) suggested categories of variables which affect the implementation of the content of the nutrition classes and incorporation of healthy behaviors. Including cues to action, perceived benefits, and perceived barriers to taking action.

Discussion of the Research Questions

The results derived from the research questions are discussed in this section. These research questions include:

1. How does Leininger's (2002) Culture Care Theory, inform our understanding of refugee mothers' experiences in a perinatal nutrition education program?
2. In what ways might Pender's (2002) Health Belief Model help us understand refugee mothers' cues to action in a perinatal nutrition education program? What did they see as their benefits for participating? What were the individual and organizational barriers to participation?
3. How might St. Francis alter its perinatal nutrition education program to best meet these mothers' nutritional needs to better acculturate into Western culture?

Research Question One. The participants described different factors, which affected their response to the nutrition education program. These are described in the subsets of the factors delineated from the CCT, namely, kinship and social factors, economics, religion, education, and environmental and contextual factors. These factors include cultural dimensions, as well as those aspects of the population which result from environmental and contextual factors, such as language, exposure to trauma, or educational opportunities.

Kinship and social factors. The participants described how they visited about nutrition and food among one another and supported experimentation and learning with their friends and community members. Earlier learning about food and nutrition came from their communities for the most part, with limited formal opportunities for nutrition education prior to coming to the RFC Clinic.

The collective nature of most of the women's communities contributed to their following the traditions of their communities when it came to food as well as how they learn. This collective cultural perspective enhances the need of kinship and observance of social norms and was evident in discussions related to other cultural factors, such as religion (McLaughlin & Braun, 1998). Adherence to strict social rules and dependence on their respective communities was common among this group. Recognition of the influence of the community and the need to adhere to customs and traditions was reiterated as an important factor in their health behaviors, regardless of what they learned in the classes. The CCT transcultural care action of culture care preservation/maintenance can address the need to acknowledge and utilize the kinship and social factors of this vulnerable population (Leininger, 2002).

While these women came from different parts of the world, and had vastly different experiences, as a whole they were unwavering in their position as the person responsible for nutrition and diet decision-making for themselves and their children. Recognizing their ability to act through this role but within a collective community is an important factor of kinship and social factors (Leininger, 2002). While their influence over their husbands' diet was less direct, the women took their role of providing the best food choices for their children very seriously. Their children's health was a priority for them. This provided them with a great deal of motivation to participate in the nutrition education classes and incorporate healthy behaviors. Action responses to enhance the health of their children and their communities despite oppression and challenging circumstances have been described in literature as a common impetus to change among refugee mothers (Pavlish, 2005). The participants reflected this in their stories and descriptions of changes in health behaviors.

Besides their role within the family, the women also referred to their part within their respective communities and within the community of refugee women participating in the classes. These comments reflected the importance of supporting each other in the learning process as well as in their day to day activities. The nutrition education program can use this factor to enhance the learning for the women. Preserving and maintaining the strong community support factor is consistent with one of the CCT culture care actions (Leininger, 2002).

Economics. Economics is included in the CCT (Leininger, 2002) as a cultural factor and this is reiterated in the literature that refugee women, in particular, are likely to be of low economic status (Beiser, 2009; Spitzer, 2004). All of the key informants of this study received WIC benefits and were on very limited incomes. This had a significant impact on what foods they chose to eat and to learn how to prepare. Input from the RFC Clinic staff reinforced that this group had very little income, so buying expensive foods or experimenting was not described as an option for these women. The culture care action of accommodating was utilized in appreciation of these circumstances. Free samples were important for providing opportunities to try foods that they may not be able to try otherwise. If a particular food was provided to them, they were much more likely to want to learn how to prepare it and use it, but this only would go so far. Those who were given beans with which they were not familiar chose not to eat them, but rather threw or gave them away.

The cultural factor of economics described in CCT encompasses consequences of limited income of both the participants and the agencies (Leininger & McFarland, 2002). Limited income can be considered a barrier to incorporating healthy behaviors (Barnes et al., 2004). Economic issues were addressed by the participants in this study. Although the

women did not talk specifically about their personal finances, each of the participants reiterated the importance that cost made on their choices of the foods they choose and their ability to try foods and also how the agency policies affected them. They stated that cost or use of benefits often determined what they bought. They questioned the economic sense of providing information about only new foods, which meant they needed to buy food which was not familiar to their families and they may not eat. Additionally, they questioned why WIC benefits needed to be used on specific beans, ones they did not want, while not providing for the beans that they preferred.

Economics also affected what the agencies of the RFC Clinic and WIC could provide. This included the availability of nutrition classes. The women who attend the RFC Clinic have many needs and the resources that the clinic has are limited in meeting these needs. The RFC Clinic used the WIC curriculum and educator because it was a resource offered at no cost to them. Input from the women could help to make the most of the benefits both from their perspective and for the agency supplying those benefits.

Religion. In this study, I was advised that discussing religious beliefs was not acceptable among the religions of some of the women. This can lead to ignoring this important cultural factor, which can result in unintentional bias or racism (Spitzer, 2004). However, the women expressed their desire to know more about which foods were healthy choices, but wanted to make sure that their religious beliefs were included in the conversation so that accommodations could be made. Because of this, the transcultural action from the CCT that could be most appropriate is culture care accommodation (Leininger, 2002). This action allows for including the traditional beliefs of the participant while adapting their health behaviors and reflects the principles of segmented assimilation

(Piedra & Engstrom, 2009; Portes & Zhou, 1993). For at least three of the women, religious constraints were a major consideration of their food choices. They openly discussed those restrictions, and also the desire to learn how to address nutrition within their religious requirements. They were eager to try foods that were nutritious and fit within the limits of their religion, even if they were new foods to them. Increased awareness by the nutrition program educator about specific religious requirements of the participants could enhance their learning.

Education. Education was a factor for these women for various reasons. Most of them had little if any formal education. They were limited in their ability to read and write in their native language. As a group, their command of speaking English was limited, with only a couple of them who were able to read or write in English. This affects a variety of factors in the classroom, such as language learning, meaning making, power relations, and identity formation (Warriner, 2007). Limited English proficiency also affects how much information can be learned outside the classroom without interpreters. For example, reading the nutrition panel on foods or expiration dates while shopping or at home was challenging for these women. These linguistic and reading challenges need taken into account when establishing teaching and learning strategies.

The goals of the participants to learn about nutrition and to adopt new health behaviors relates to the CCT transcultural action of Culture Care Repatterning/Restructuring (Leininger, 2002). The participants were motivated to change food choices, such as limiting portion sizes and sugar within their diets, in order to provide a healthier diet for themselves and their families. Through learning about foods and nutrition, these behaviors were repatterned to include healthy behaviors.

Environmental and contextual factors. The women voiced various environmental and contextual factors regarding their learning about nutrition. They valued the opportunities available to them because of living in the U.S. and having access to the RFC Clinic. Yet, other factors affected their ability to take advantage of the nutrition classes. In addition to the cultural factors already discussed, the women dealt with logistical issues related to child care and transportation and language. Lack of understanding of government programs created frustration.

One of the most significant aspects of the environmental and contextual topics was not directly discussed by the women, but rather by the health advisors. That was the impact of trauma. The health advisors asserted that trauma, oppression, and persecution produced reluctance for these women to speak to any who they felt was an authority, for fear of repercussions (Blanch, 2008). Also, avoidance and denial are common coping strategies for refugees in the literature, whether discussing past experiences, defending cultural norms, or challenging new ideas or information (Ting, 2010). The question, "Do you want answers or the truth?" posed early in the study to us by the health advisors emphasized how protective this population is of any opinions they may have. In order to overcome the psychological threat that speaking out may represent to this population, great care must be taken in providing a sense of safety.

Leininger and McFarland (2006) acknowledged that building relationships and trust is important, including the Stranger to Friend (SF) enabler to assist the researcher in determining that rapport and trust are established to meet the needs of the researcher and the participants. This was done in this study by using a setting and familiar care providers with whom they had already built trust, by obtaining input from the cultural advisors for the

implementation of the study, maintaining culturally responsive processes, such as adapting the interview guide and consent, allowing the women to meet in groups of two or three, and providing health advisors for cultural and language interpretation. Research has elaborated about the ethical complexities of caring for or conducting research with traumatized participants (Dow, 2011; De Haene et al., 2010). Utilizing the principles of trauma-informed care is appropriate for any educational or healthcare setting for populations exposed to trauma, such as refugee women (Elliot et al., 2005).

Implications of Research Question One Theme Cluster. CCT (Leininger, 2002) emphasizes the effect of cultural factors on health behaviors. The responses of the women reiterated that their respective cultures had a considerable effect on food choices. The data included input from the women on the most significant cultural factors influencing their assimilation of the nutrition information and healthy behaviors. Important factors included the collective perspective of the women, financial and religious constraints, language and literacy limitations, and the need for trauma-informed care. These factors are considered by CCT as influential in healthcare expression, patterns and practices (Leininger, 2002). In order to enhance their healthy dietary practices, these factors need to be acknowledged and addressed. This may take time and effort, but failure to attend to the unique perspectives of different cultures can lead to misunderstanding and can create barriers to effective interventions (Leininger, 2002; Spitzer, 2004). Input from the women is essential in understanding what cultural values, beliefs and practices are important to them in making food choices and how to include these factors in an effective educational program. This understanding can impact care practices, such as the nutrition education program, in actions that utilize an approach of preservation/maintenance of culture, accommodation/negotiation

of cultural beliefs and practices, or repatterning/restructuring (Leininger, 2002). By gaining the input of the women, administrators of the nutrition education program can take into account those aspects of culture and tradition that are important to the women and which are to be considered best preserved or maintained. The examples of religious restrictions or preferences related to beans illustrate those practices which will be sustained by the women. Accommodation or negotiation could be appropriate for helping the women utilize foods they are already using in the healthiest manner possible. Examples were helping them to understand which milk is best in each stage of life and how to continue to eat foods they like, but to limit portions appropriately. Repatterning or restructuring can continue to be done by introducing new foods and new methods of preparation, while evaluating to see if new healthy behaviors are being implemented.

Research Question Two. The second research question was addressed in the theme cluster which related to applying principles of HBM by looking at modifying factors of implementing healthy behaviors, including cues to action, perceived benefits, and perceived barriers to learning (Pender et al., 2002). This theme cluster encompassed participants' attitudes about the educational process, including what new information the women had learned, how they described learning, how they integrated the new knowledge into their dietary choices, and how they felt about incorporating the information into their choices and practices. This information can be utilized by healthcare professional in nutrition education program planning in order to utilize those strategies that are most effective in promoting healthy behaviors.

Cues to action: new information learned and preferred strategies for learning. The women freely shared the new information learned which they believed was worthwhile.

Nearly all of them told of learning about new foods, including cheese, milk, peanut butter, cooked cereal, and whole wheat bread. They embraced these foods and added them to the foods they regularly fed to their families. They also discussed how they were not aware of portion size, expiration dates, different types of milk, or the effect of too much sugar. The phrase they used again and again was "We didn't know about this food before." Through CCT culture care restructuring/repatterning strategies, the nutrition classes helped the participants to incorporate healthier behaviors related to the new information they were learning (Leininger, 2002). Providing the new information to the women was effective in some cases as a cue to action, as referred to in HBM (Janz & Becker, 1984), increasing perceived benefits of utilizing healthy foods and practices, and resulting in a new healthy behavior, such as limiting portion size.

The group setting with demonstrations and free samples was of great help as a cue to action in overcoming some of the barriers to learning that these women had. The participants could describe the importance of particular foods during pregnancy which enhanced the health of their babies and how they adapted their diets once they were breast feeding. Often this was related to what was available to them through WIC during different perinatal phases. While they learned what foods were important in the class during these different phases, availability of the foods due to the WIC benefit reinforced the knowledge and practices. The ability to go back to their communities and discuss what they learned also helped those who did not necessarily want to try something the first time to have the chance to learn in their own comfort zones. Support among the women and their communities reinforced learning related to nutrition.

The participants described demonstrations and group classes as effective teaching strategies used by the nutrition education program. Most of the women related that learning in a group was helpful for them. A more learner centered approach might help the women to have input into how strategies could be used most effectively considering these perspectives. Addressing learning preferences can be an important aspect of a cue to action, particularly when the modifying factors of demographic and sociopsychological variables are taken into account (Pender et al., 2002). This reinforces the importance of making sure that the group learning strategy was being utilized effectively so that those who were comfortable asking questions, as well as those who were not comfortable with this, could learn successfully.

Perceived benefits to integrating new knowledge in dietary choices. The women expressed adaptations that they had made due to learning about nutrition in the classes. They had changed their views about how much to eat of a particular food, being aware of appropriate portion sizes. Different options for eating vegetables, such as salad, were being incorporated. Foods that were now known to them as having high sugar content, such as soda or yogurt, were seen as potentially a cause of diabetes and were now eaten with discretion. The woman's story about how she learned to change her diet so that she was able to change her medications for diabetes showed how they were integrating the information effectively.

The woman also considered the impact of food choices on their children. The effect of soda on their children's health and teeth helped them to consider other choices for them. They expressed concern for eating well during pregnancy, as well as during breastfeeding in order to provide more milk for their babies. New foods were utilized and some foods that

they had eaten in the past were now eaten in different ways and in different portions. The benefits to the health of their children and for themselves were highly motivating to them.

Perceived barriers to integrating new knowledge. The women expressed many perceived barriers to assimilating what they were learning in the nutrition classes. For the most part, the women embraced what they learned. However, transferring the knowledge about one food to other similar foods was difficult for some of them, so that information about one food didn't necessarily connect to other healthy food choices. The women were usually open to the benefits of the new healthy behaviors they were learning. However, HBM reiterates that addressing the barriers to taking the recommended action must be addressed in the case that they would outweigh the acknowledged benefits (Janz & Becker, 1984). The lack of ability to transfer the knowledge was rooted in a variety of factors and should be explored in order to make sure they were addressed if possible.

The story of the beans and how they did not fit their taste or traditional practices emphasizes how good intentions of an agency may not be helpful. The fact that the WIC benefits could only be used for the beans that the women did not like or want indicates a lack of awareness or responsiveness. The result is beans that are being thrown away, regardless of their nutritional value.

Implications of Research Question Two Theme Cluster. The RFC Clinic nutrition classes are directed by a nurse from WIC who is from the mainstream Western culture of the U.S., utilizing foods which are commonly found in grocery stores across the country. Information is given that reflects WIC's nutritional policies. However, the participants in the program are from foreign cultures, often with a lack of familiarity of foods or food preparation practices common to the U.S., and with limited resources due to language,

literacy, and poverty. HBM describes these as modifying factors which impact the likelihood that they will take the recommended actions (Pender et al., 2002). These women are utilizing the information from the nutrition education classes in a variety of ways that reflect their individual perspectives and through segmented assimilation (Piedra & Engstrom, 2009; Portes & Zhou, 1993; Xie & Greenman, 2011). The new information taught to the women was able to be assimilated if they could understand it, but also if it fit into their individual circumstances, such as economic situation or religious beliefs.

The literature revealed that a history of oppression, language and educational levels created barriers to learning (Adams, & Assefi, 2002; Andrulis, & Brach, 2007; Deacon & Sullivan, 2008; Pender et al., 2002). These dynamics point to the need for teaching strategies that acknowledge the cultural factors or barriers to learning among this vulnerable population. According to HBM, examining the cues to action, as well as the perceived benefits and barriers to integrating recommended healthy behaviors, can assist program developers to incorporate the most successful strategies (Deshpande et al., 2009; Kloeben & Batish, 1999; Neff & Crawford, 1998).

Research Question Three. The third research question focused on how the nutrition education program could be altered to best meet these mothers' nutritional needs to better acculturate into Western culture. The women spoke about two areas which they felt needed addressed. The wanted more foods, other than just WIC foods, addressed in the classes. In addition they spoke of how they would like to know about the nutritional value of their own foods and wanted more opportunities to share their own foods and provide input.

Implications of Research Question Three Theme Cluster. For most of the women, incorporating their traditional choices and practices was the important missing piece to the

nutrition classes for the participants. While they were eager to learn about new foods, they wanted to know how to utilize their traditional foods in a healthy manner. CCT emphasizes the need to understand their traditions and to integrate them through the appropriate level in the culture care actions (Leininger, 2002). True to the principles of Segmented Assimilation Theory (Piedra & Engstrom, 2009; Portes & Zhou, 1993; Xie & Greenman, 2011), the women adapted those behaviors that helped them, but held on to other traditional choices and practices which they felt served them well. For example, they still ate their traditional breads, but now limited their portion sizes. By not addressing the foods that the women traditionally eat, the classes did not address a major portion of the women's diet. While concessions were made around some religious restrictions in the nutrition classes, such as the use of pork, most food choices and traditions of the participants were not known and so consequently, went unaddressed. This lack of addressing traditional foods and practices, the absence of opportunities to share their own ideas, and the effect it had on their feelings of worth and inclusion seemed to be a significant barrier for full engagement in the class and could affect the likelihood of the women to take the recommended actions, as described in the HBM (Pender et al., 2002).

Importantly, consideration of the perspectives which are prevalent among the participants can enhance the effectiveness of the classes (Adams, & Assefi, 2002; Andrulis, & Brach, 2007; Baird, 2012; Deacon & Sullivan; 2008; Garnweidner e al., 2012). Gaining the input of the women is a vital step in this process. These perspectives, which were disclosed in this study, revealed the need of an educational program to utilize cultural proficiency in addressing the needs, diverse cultural factors, and preferences of the participants (Lindsay et al., 2003).

Conclusions

The theoretical underpinnings of this study examined how behaviors are related to beliefs. CCT (Leininger and McFarland, 2002) focuses on cultural factors, which are also considered in research question one and the theme cluster reflecting the participants' values and beliefs of their respective cultures. Additionally, CCT provides three levels of transcultural care decisions and actions that can be incorporated in order to most effectively provide culturally congruent care practices (Leininger, 2002). The HBM (Pender et al., 2002) explores the impact of the nutrition education program from the perspective of the participants. In addition to cultural factors, described as demographic and psychosociological variables in the HBM, cues to action, perceived benefits and perceived barriers were scrutinized in explaining the likelihood of the participant to engage in recommended healthy behaviors. These factors were examined through research question two and the second theme cluster that looked into what and how the participants were learning. Both of these aspects of the nutrition education program were important in discovering why and how information is assimilated into healthy behaviors and the reason that other information is not (Leininger, 1991; Pender et al., 2002; Piedra & Engstrom, 2009).

A conceptual framework utilizing aspects of two different theories was used for this study, reflecting the need for a theoretical approach that can take into account the various factors addressed in this study. No one theoretical framework was found that adequately described the cultural factors impacting the participants, the cues to action that were

important in the learning process, the perceived benefits to taking recommended actions, or the perceived barriers to taking those actions.

This study sought to give the insight about what is effective in the classes and what needs improvement. The participants of this study described in their own words what was important to them in making food choices and striving for healthy behaviors. Education programs are developed and taught with a set of assumptions. These assumptions often reflect the values and belief systems of the instructors and programs which offer the classes. Many of these assumptions have merit. The women acknowledged that much about the nutrition education program was useful to them. However, in order to overcome unintentional biases and to provide the most efficient and effective nutrition education programs, the perspectives of the women about what is not working should be taken into account. Data from this study indicated that many of their perspectives were not being sought nor being addressed in the nutrition education program.

Program planning by the administrators of the nutrition education program can utilize the input of the women to identify which modifying factors are important to address, which cues to action are most effective in helping the women to implement healthy behaviors, which barriers are impeding healthy actions, and ways the nutrition program can be most influential in promoting the health of the population.

Emergent themes of areas for improvement included the need for moving the RFC to a model of cultural proficiency and for changes in the design and implementation of the nutrition education curriculum. Cultural proficiency conveys how meeting the needs of oppressed populations involves more than gaining awareness about them and providing care that is congruent with those beliefs, values and traditions of their cultures. It builds on the

moral imperative that educators and healthcare providers should also advocate for those who are vulnerable to oppression (Lindsay et al., 2003). Advocacy among this population of perinatal refugee women includes helping them to increase feelings of self-efficacy which allows them to have confidence in their decision-making, as well as the ability to speak up for themselves with confidence in order to have their needs met more effectively. Bandura, (1977) described self-efficacy as the belief in one's own ability to make changes and accomplish goals. The participants in this study spoke of their desire to meet the goal of implementing recommended healthy behaviors, however, changes need to be made in order for them to overcome the barriers they felt were evident in the current education program. By incorporating cultural proficiency, the RFC Clinic can not only help the women to incorporate nutritionally healthy decisions, but also help to assist the women to speak up when their needs are not being met.

Recommendations for Practice

This study gave insight about which strategies of the nutrition program which were particularly effective and what could be improved. The CCT was utilized to examine the cultural factors of the participants that influenced their experience in the program. The CCT also provided descriptions of different levels of transcultural care practices that can respond to the cultural aspects of the population (Leininger, 2002). The HBM provided factors that relate to the women's likelihood of taking recommended health actions. In particular, this study looked at the cues to action that were being utilized by the program, and the perceived benefits and perceived barriers that were influencing the women's health behaviors in response to the nutrition education program (Pender et al., 2002).

The RFC Clinic has a history of striving to provide culturally conscious care, and adapting to the needs and views of refugee mothers as much as the staff is able (Reavy et al., 2012). Interventions with vulnerable populations that consider how to provide equitable care, intercultural understanding, awareness of the impact of trauma, and supportive cultural and language services increase the probability of effectiveness (Spitzer, 2004). That the nutrition program was provided within the context of the RFC Clinic helped to impart cultural safety essential for interactions with this population. The nutrition education program used interactive teaching strategies such as demonstrations and free samples to eat. The group setting helped participants learn from one another. The curriculum took into account some food restrictions of particular religions. However, even in the setting of the RFC Clinic, unintentional ethnocentrism can exist and requires mindfulness and input from the perspective of the participants to overcome it. As discussed in my reflection about the conversation with Judy Hobbs, the director of the RFC Clinic, overcoming biases in order to provide culturally competent care or to do cross cultural research is a continual process. Ongoing efforts to gain the input of participants will continue to expand the understanding of the women accessing the nutrition program by the RFC Clinic. A move within the RFC Clinic from cultural competence to cultural proficiency could assist the women to be more empowered in their health decision-making through further advocacy for the women with the WIC educator and policy makers, but also in helping the women to find their own voice for bringing out changes in the program.

The women's responses indicated that the nutrition education program that they attended was successful in helping them to learn some basic nutrition principles and experience new foods. However, their lack of experience in formal education, limited

contact with certain foods, inadequate finances, religious preferences, and long-standing food practices sometimes had an impact on their learning, and could be considered barriers according to the HBM (Pender et al., 2002). The nutrition classes provided information about food choices that are supported by WIC. This creates the potential scenario of telling them what they should be eating, rather than adapting the information to foods they are already eating, even if it is done with good intentions and with teaching strategies that tie the foods to nutrition information and practice in preparation. Segmented assimilation explains that the process of acculturation and assimilating new behaviors does not happen in an all or nothing manner (Portes & Zhou, 1993). Expecting the women to assimilate the new foods without recognizing the importance of their own does not take this into account. Allowing the women to share their traditional foods and food preferences could help in acknowledging their views as valuable, as well as provide another format for discussing the nutritional value of a variety of foods. Input could be given to WIC about which foods are not being received by the population and recommendations for substitute foods.

The women reported that WIC classes do not fully address how they can adapt the information to their traditional foods. The women desired to provide input about what they are eating so the teacher could address how it can be utilized in a healthy manner. Utilizing the traditional foods of the participants in the nutrition classes could have made the learning more relevant, the information more transferable, and at the same time, communicated interest in and respect of the traditions and practices of the participants. The women wanted to not only discuss the nutritional value of their own traditional foods, but also expressed a desire to share some of their foods and recipes in the classes. An example is the woman who wanted to show how she made yogurt with reduced sugar. The current nutrition education

program used by the RFC Clinic does not allow for this type of sharing. Research supports the fact that nutrition education is more effective when food cultures of the participants are included (Garnweider et al., 2012). Incorporating cultural proficiency would provide the framework for the RFC Clinic to help the women become empowered to share their opinions and traditions.

While the WIC curriculum is the basis of the nutrition education classes for the RFC Clinic, limiting the content to this curriculum based on WIC policies reduces the opportunity to include more inclusive teaching strategies and diverse foods from other cultures and traditions that may be more appropriate for this population. Expansion of the curriculum, including input from the participants, and utilizing strategies that are more responsive to the needs of the refugee population could enhance learning for this vulnerable population. Changing the WIC curriculum or teaching methods may take policy change. Utilizing cultural proficiency, the RFC Clinic could advocate for changes, not only in their own education program, but for changes in WIC and other agencies who serve this vulnerable population whose voice is often not heard. Including the women in the process of designing a curriculum, as well as asking for their contributions to the classes and giving them opportunities to voice opinions and information about their lives and cultures can boost their self-confidence and feelings of self-competence in the education program setting (Abusabha & Achterberg, 1997; Bandura, 1997). Bandura (1997) described self-competence as a precursor to performance success, which strengthens self-efficacy. Empowering the women through increasing self-efficacy, providing increased knowledge to other agencies, and addressing the perceived barriers to learning and implementing healthy behaviors could greatly enhance the effectiveness of the nutrition education program and WIC in helping to

promote healthy behaviors among this population (Bandura, 1977; Lindsey, Robins & Terrell, 2003; Pender et al., 2002).

Recommendations for Further Research

The ethnonursing research method (Leininger, 1991; Leininger, 2002; McFarland et al., 2012) has been used for decades to explore the factors which affect health behaviors of diverse cultures. This study adds to that body of knowledge. However, this study was limited in scope and depth regarding the perinatal nutrition education with refugee women. While this study explored the women's experiences in a nutrition education program, other aspects of nutrition education or the impact that it has on refugee women and their children could be explored.

Further research with this program. The goal of the nutrition education classes is to improve healthy diet choices among the participants. Ongoing studies could be done by the RFC Clinic through interviews or focus groups to gain the input of the participants about the factors affecting their nutrition choices and the effectiveness of the program in improving their healthy behaviors and nutrition knowledge. As cultural proficiency is implemented in the clinic, changes in teaching/learning strategies could be evaluated for effectiveness and satisfaction. Additional studies could focus on distinct populations, particularly those who are being served by the RFC Clinic at a particular time.

With a move to cultural proficiency, studies within this program could examine changes in self-efficacy among the participants and the effect changes in self-efficacy have on implementation of healthy nutrition behaviors. Studies could also look at how staff perspectives change as the principles of cultural proficiency are implemented.

The impact of improved bioavailability of micronutrients takes time. However, for the RFC Clinic program, longitudinal studies could help to examine whether or not health indicators improve in the women who have participated in nutrition classes over time. Scientific measures such as hemoglobin levels, birth weights of newborns, or instances of hemorrhage during childbirth could be examined. Additionally, health indicators of their children, as well as knowledge of nutrition and healthy diet choices, could be explored as possible second generation outcomes that have been influenced by their mothers.

Further research with this population. For other educational programs involving vulnerable populations, cultural factors, as well as environmental and contextual factors, can affect the learning needs and preferences of a group (Leininger, 2002). Characteristics such as literacy, language, familiarity with the educational setting, exposure to food choices in the past, or access to tools needed for food preparation, just to name a few, may impact how nutrition program participants are able to learn or apply new knowledge. This study included an overall picture of a diverse group of participants and characteristics which affect their application of new knowledge. Additional research could explore differences between various groups of refugees who attend nutrition education classes and resulting outcomes. Nutrition education programs which utilize different teaching strategies or curricula than the RFC Clinic program could be explored for effectiveness in improving the healthy decisions made by participants.

Another area for research could relate to how cultural proficiency is enhanced in education programs with refugee women. Cultural competence among healthcare providers has had a positive impact on the outcomes of their patients from diverse cultures (Giger & Davidhizer, 2008; Leininger & McFarland, 2006; MeFarland et al., 2012). The relationship

of cultural proficiency of educators and the outcomes of nutrition classes are also areas in which research might help to increase effectiveness of the learning and healthy outcomes.

Another recommendation for research of nutritional education for vulnerable populations could include effective methods of participant involvement in the planning process in a culturally safe and proficient manner. One of the topics revealed through the interviews in this study was that the women wanted more input into the classes, particularly about which foods are discussed. Research, which explores self-efficacy and feelings of empowerment in relationship to levels of satisfaction and integration of recommended healthy behavior among participants who provide input for programmatic planning, would be most helpful for this field. Levels of cultural proficiency within agencies offering the nutrition education programs could also be studied in relation to health behavior change or participant satisfaction.

Research has demonstrated effective strategies in nutrition education among various vulnerable populations, such as a learner-centered approach for low income women (Cena et al., 2008), and use of pictures with low income African American women (Houts, Shankar, Klassen, & Robinson, 2006). However, more research is needed to address the complex needs of perinatal refugee women and learning. Finding appropriate educational strategies which address trauma-informed practice principles, learner-centered education, cultural proficiency, and linguistic support is challenging. Yet establishing the value and impact of more effective interventions through research could enhance the health of this population.

Among this population, more research could be done to develop appropriate theoretical frameworks which explore the multiple facets of the learning process and acquisition of health promoting behaviors in multicultural groups who relocate to a new

country, such as refugees. This study incorporated two theories to include the many aspects of learning about nutrition and incorporating healthy dietary behaviors in perinatal refugee women. Further research is needed to develop theory which encompasses these multiple aspects, as well as exploring how they apply to various refugee groups.

A Last Word

The intercultural understanding of the healthcare providers from RFC Clinic and I grew throughout this study. Incorporating the input of the community supports that diverse perspectives need taken into account in order to make the intervention as effective as possible. CCT emphasizes that sometimes groups repattern behaviors, which is not the only answer or the best answer. The intervention which practitioners and teachers may find most helpful may be to maintain cultural behaviors or assist the client to accommodate them within their traditional value and belief system. However, leaving the refugee women out of the planning and implementation processes of the nutrition education program allows for unintentional ethnocentrism and omits vital input into creating relevant, effective interventions. By utilizing cultural proficiency in seeking cultural awareness and knowledge, incorporating cultural competency practices, advocating for this vulnerable population, and increasing their feelings of self-efficacy and empowerment; the resulting interventions can be more responsive and effective in achieving the goals for learning and health of this vulnerable population.

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Appendix A

Stranger to Friend Enabler

Stranger to Friend Enabler Guide (Leininger and McFarland, 2006, p. 51)

The purpose of this enabler is to facilitate the researcher (or it can be used by a clinician) to move from mainly a distrusted stranger to a trusted friend in order to obtain authentic, credible, and dependable data (or establish favorable relationships as a clinician); the user assess him or herself by reflecting on the indicators as he/she moves from stranger to friend.	
Indicators of Stranger Informant(s) or people are:	Indicators as a Trusted Friend Informant(s) or people are:
1. Active to protect self and others. They are "gate keepers" and guard against outside intrusions. Suspicious and questioning.	1. Less active to protect self. More trusting of researchers (their 'gate keeping is down or less'). Less suspicious and less questioning of researcher.
2. Actively watch and are attentive to what researcher does and says. Limited signs of trusting the researcher or stranger.	2. Less watching the researcher's words and actions. More signs of trusting and accepting a new friend.
3. Skeptical about the researcher's motives and work. May question how findings will be used by the researcher or stranger.	3. Less questioning of the researcher's motives, work, and behavior. Signs of working with and helping the researcher as a friend.
4. Reluctant to share cultural secrets and views as private knowledge. Protective of local lifeways, values and beliefs. Dislikes probing by the researcher or stranger.	4. Willing to share cultural secrets and private world information and experiences. Offers most local views, values, and interpretations spontaneously or without probes.
5. Uncomfortable to become a friend or to confide in stranger. May come late, be absent, and withdraw at times from researcher.	5. Signs of being comfortable and enjoying friends and a sharing relationship. Gives presence, on time, and gives evidence of being a 'genuine friend.'
6. Tends to offer inaccurate data. Modifies 'truths' to protect self, family, community, and cultural lifeways. Emic values, beliefs, and practices are not shared spontaneously.	6. Wants research 'truths' to be accurate regarding beliefs, people, values, and lifeways. Explains and interprets emic ideas so researcher has accurate data.

Appendix B

Interview Guide

Interview Guide

Health/Nutrition

1. Tell me about how you have chosen foods to eat in the past.
2. How is choosing food different here in the U.S. than from where you were before?
3. How do you think what you eat affects your health?
    a. Tell me what you think about iron in your diet.

Education

1. Who or what helped you learn about what to eat before you came to the U.S.?
2. I am interested in learning from you about the education classes here from your own experiences at this place. Tell me about what you learn here.
3. In your experience tell me some stories about what has helped you to learn.
4. Tell me about the things that make learning difficult.
5. How has what you learned affected what you eat?
    a. Have you changed any of the foods you eat in order to get more iron?
6. How has what you learned affected your health?

Economic Factors

1. Would you say having money is important here in relationship to healthy eating?
2. Do you ever worry about running out of money to pay for food?

Kinship Factors

1. How does what your family or friends eat influence what you eat?
2. Does your role in your family affect what you eat?

Religious Factors

1. How does your religion affect what you eat?
    a. Do you have specials diets or time of fasting?

Cultural Factors

1. The idea of culture refers to the customs or lifeways of people. Tell me about your customs about food.
2. What traditional foods in your family were important as health or good lifeways?
3. How have your traditions around food changed since you have come to the U.S.?
4. How have your traditions around food changed since you have taken the nutrition classes?

Summary

1. Is there anything else you want to tell me about the nutrition classes
    or what new things you have learned or do because of them.

Appendix B

Consent to be a Research Participant for RFC Clinic Participants

CONSENT TO BE A RESEARCH PARTICIPANT
for RFC Clinic Participants

This consent script will be used as a guide for the health advisors to gain oral consent of the participants.

Mikal Black, together with the CARE Clinic, is doing a project to explore your experiences about food and taking nutrition classes.

The reason for this project is to look at how well the CARE Clinic and the nutrition classes help you.

You are being asked to join this study because you are a refugee mother who is pregnant or just had a baby, and attends the CARE Clinic. You are **not** required to join this study, it is voluntary (you can say no)

If you agree to be in this study (say Yes), these will occur:

1. You will be asked your opinions about food and nutrition and about the nutrition classes you have attended.
2. The interview and questions should take about 30 minutes each time.
3. Some of the things you say may be shown in papers and presentations. No one will know who said the words (because your information will be given a number not your name)
4. Your answers with your name attached will not be shared with anyone by the researchers.

There may be some risks to being in this study, but we think they are very small.
- Some of the questions may make you feel bad (sad, angry or cry)
- We try to maintain confidentiality (your trust) of your data, but it is possible someone may hear what you tell the researchers

If a question makes you feel bad, sad, tearful or angry
- You do not have to answer a question if you do not want to.
- We will skip any questions you want to skip. Not answering the question is ok.
- You may stop at any time.

There will be no direct gain to you. But by taking part in this project, you will help us better provide health services to refugee women.

There are no costs to you for to take part in this study other than your time. It is free.

You will not be paid to take part in this study. Joining the study is voluntary. No money is paid for the study to you or your family.

If you have any questions or concerns about this study, please call, Mikal Black, at (208) 436-4143 or ask the nurse at the CARE Clinic. If you do not wish to do this, you may contact the Institutional Review Board, which is concerned with the protection of volunteers

in research projects. The address of the Institutional Review Board is **Institutional Review Board, University of Idaho, POB 443010, Moscow, Idaho 83844-3010**

TAKING PART IN RESEARCH IS NEVER FORCED. You are free to not take part in this study or to stop at any point. Your choice to take part in this study or not will have no sway on your present or future status with the CARE Clinic or University of Idaho.

*** If you give* ***your consent*** *to take part in this study please say yes. If you do not wish to take part in the study please say no.*

Participant answered yes no

You have said you would like to take part in the study.

Signature of person obtaining consent Date

If approved, the following will be added:
THE UNIVERSITY of IDAHO INSTITUTIONAL REVIEW BOARD HAS REVIEWED THIS PROJECT FOR THE PROTECTION OF HUMAN PARTICIPANTS IN RESEARCH.