2019 Online KT Conference: Innovative KT Strategies That Work

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Transmedia Knowledge for Innovating Knowledge Translation

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Transmedia Knowledge for Innovating Knowledge Translation

2019 Online Knowledge Translation Conference
November 1, 2019

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Cornell entomologist Michael Hoffman speaking at the March for Science rally at Ithaca Commons, April 22, 2017.
Transmedia knowledge is knowledge that moves across media—papers, podcasts, comics—to engage multiple stakeholders: researchers, community members, policymakers, young people, and the general public.
transmedia knowledge
Why transmediate your research?

- **New audiences**: community members, nonspecialist peers, funders, alumni, general public

- **New ways of making arguments**: inductive, deductive, abductive, conductive (associative)

- **New evidence tracks**: beyond textual: dynamic data, visual, aural, interactive, immersive

- **Co-creation of knowledge**: communities, patients, research collaborators

- **Produce impact**: communicate discoveries, change perceptions, inform policies, heighten funding, enhance treatment, improve and save lives
YOUR KT PROJECT
transmedia knowledge
Culturally Competent Care for Aboriginal Women: A Case for Culturally Competent Care for Aboriginal Women Giving Birth in Hospital Settings

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Lia Ruttan, Ph.D., Research Associate, Misericordia Child Health Clinic, Misericordia Community Hospital, Edmonton, Alberta
Tracy Muth, M.Ed., Department of Educational Psychology; University of Alberta, Edmonton, Alberta
Lola Baydala, M.D., M.Sc., F.A.A.P., F.R.C.P., Associate Professor, Department of Pediatrics, University of Alberta, Edmonton, Alberta

ABSTRACT
Increasing numbers of Aboriginal women are using urban hospital settings to give birth. Culturally competent care, including an understanding of cultural, emotional, historical, and spiritual aspects of Aboriginal Peoples’ experience and beliefs about health and healthcare, is important to the provision of quality care. While there is a body of literature on culturally competent care, there are no models specific to Aboriginal women giving birth in hospital settings. This article explores Aboriginal peoples’ historical experience with western health care systems, worldviews and perspectives on health and healing, and beliefs regarding childbirth. Some of the existing models of culturally competent care that emphasize provision of care in a manner that shows awareness of both patients’ cultural backgrounds as well as health care providers’ personal and professional culture are summarized. Recommendations for the development of cultural competency are presented.

Acquisition of knowledge, self-awareness and development of skills are all necessary to ensure quality care. It is essential that - at both systemic and individual levels - processes are in place to promote culturally competent care. Recommendations include: partnering with Aboriginal physicians, nurses, midwives and their representative organizations; conducting community-based research to determine labour and delivery needs; identifying and describing Aboriginal values and beliefs related to childbirth and its place in the family and community; and following Aboriginal women’s birth experiences in hospital settings with the overarching goal of informing institutional practices.

KEYWORDS
Aboriginal women, culturally competent care, hospital birth, obstetrics

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iving birth is a major life event for Aboriginal women and their families. The experience can be positively or negatively affected by the care received, (Callister, 2004; Callister, Callister & Stoneman, 2005; Matthews & Callister, 2004; Ottani, 2002), which can affect subsequent interactions with health care providers (Callister et al., 2005). Culturally competent care, pruritarily, during the birthing experience, and post-natally, is critical to the provision of quality care (Callister, 2001; Edgemon, 1996; Foster, 2006; Martin: Witcomer & Black, 1996; Matthews & Callister, 2004; Ottani, 2002; Smith, Varco & Edwards, 2005). Social, political and cultural changes that challenge Aboriginal women in Canada have faced have negatively affected their education and cultural identity and traditional values, as well as their health (Adelson, 2005; Carroll & Benoit, 2001; Dion Stout, Kipling & Stout, 2001). Culturally competent care is more likely to be successful than culturally-blind care in addressing population health disparities including gestational diabetes, high birth weights and higher post-natal death, including Sudden Infant Death Syndrome (SIDS) (Adelson, 2005; Smylie, 2001b). Given the history of negative experiences with mainstream health care institutions and the impact those factors have had on health outcomes of Aboriginal women, providing culturally competent care is particularly important for Aboriginal women who are giving birth in Canadian hospitals.

Aboriginal includes First Nations, Inuit, and Métis Peoples of Canada.

Over the past 30 to 40 years, increasing numbers of Aboriginal women have given birth in large urban hospital settings. For many communities, this change began in the 1970s when the Canadian government established an evacuation policy for women living in remote northern communities (Hiebert, 2001; Inuit Tapiriit Kanatami, 2004; Kautfer, Koolage, Kautfer & O’Neil, 1984; Smith, 2003; Smith et al., 2005). To give birth in urban facilities, women are often required to leave their families and communities, usually for several weeks at a time (Conchon & Sanderson, 2007). With the closing of many small, rural hospitals, women from reserve communities also give birth in large urban hospitals. In addition, half of all Aboriginal people in Canada now live in urban centres, adding another dimension to the picture of Aboriginal birthing. A needs assessment conducted by the National Aboriginal Health Organization (NAHO) (2006) found that 93 per cent (27 of 29) of the First Nations and Inuit women who completed the assessment questionnaire gave birth in a hospital setting. Efforts are being made to renew Aboriginal midwifery and birthing in homes or community-based facilities. In the meantime, the majority of Aboriginal women currently give birth in hospital settings (NAHO, 2006). While there is a rich body of literature on the general topic of cultural competence, little has been written about applying this concept to healthcare professionals working with Aboriginal women giving birth in Canadian hospital settings. The purpose of this article is to summarize the issues involved and to illustrate the need for increasing culturally competent care with Aboriginal women giving birth in hospital settings.

Models of culturally competent care
The concept of culturally competent care dates back to the mid-nineteenth century and was used by increasing numbers of nurses and other health professionals throughout the 1980s (Leininger, 1988). Several nursing scholars have formulated models and frameworks of culturally competent care to guide practice and research (e.g., Campinha-Bacote, 2002; Davidson & Giger, 2001; Leininger, 1988; Purcell, 2002; Schum, Doorenbal, Beekers, & Miller, 2007; Specter, 2002; Stah, 2004). The development of these models was influenced not only by the needs of historically marginalized communities but by the increasing variety of immigrant ethnic communities in health service populations in Western countries. In Canada, an increasingly vocal indigenous critique of health care practices and the colonial practices endemic in western-based health systems contributed to the development of culturally competent care practices (Dion Stout et al., 2001). The literature on models of culturally competent care is extensive and ongoing (Shen, 2004). Leininger’s (1988, 2002) culture care model, an early approach to culturally competent care, is also known as the “surprise model.” With the aim of facilitating enabling or maintaining well-being through transcultural care decisions and actions, it promotes nursing care that matches the worldview and experience of the patient through a process of cultural assessment (Shen, 2004). In another model, Specter (2002) integrates concern for what she refers to as heritage consistency (the degree to which people’s lifestyles reflect their traditional cultures), HEALTH traditions (the balance of all facets of a person’s physical, mental and spiritual, within a context that includes a person’s family, culture, work, community, history, and environment), and a range of cultural phenomena. Specter draws on Davidson and Giger’s (2001) six cultural phenomena that vary among cultural groups and affect health care environmental control, biologic variations, social organization, communication, space and time orientation. In another model, Campinha-

Chart based on Olson and Sollaci & Pereira.
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Acquisition of knowledge, self-awareness, and development of skills are all necessary to ensure quality care. It is essential that at both systemic and individual levels, processes are in place to promote culturally competent healthcare practices. Recommendations include: partnering with Aboriginal physicians, nurses, midwives, and their representative organizations; conducting community-based research to determine labour and delivery needs; identifying and describing Aboriginal values and beliefs related to childbirth and its place in the family and community; and following Aboriginal women’s birth experiences in hospital settings with the overarching goal of informing institutional practices.

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https://www.youtube.com/watch?v=Mj2WWtIlGaU
Video starts at 4:33; ends at 6:25.
<table>
<thead>
<tr>
<th>expert knowledge</th>
<th>common knowledge</th>
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<tr>
<td><em>episteme</em></td>
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<td><em>eidos</em> (ideas)</td>
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<td><em>logos</em> (logic)</td>
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<td>dialectics (method)</td>
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<td><strong>scholar</strong></td>
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Science Rap Academy

https://www.youtube.com/watch?v=VrTGclugG0k&t=16s
PechaKucha: 20 slides, 20 secs each
https://www.youtube.com/watch?v=cveD01nwgSc
Video starts at 0:08; ends at 2:16.
YOUR KT PROJECT
Transmedia Knowledge

- **Why** transmediate knowledge across forms?
- **What** are different transmedia forms?
- **How** to start transmediating your research?
<table>
<thead>
<tr>
<th>Article</th>
<th>Presentation</th>
<th>Story</th>
</tr>
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<tbody>
<tr>
<td>Written explanation</td>
<td>Oral delivery</td>
<td>Artistic presentation of</td>
</tr>
<tr>
<td>of ideas and evidence</td>
<td>to explain and persuade</td>
<td>emotion and experience</td>
</tr>
<tr>
<td>Logical, argumentative</td>
<td>Facts and storytelling</td>
<td>Dramatic/narrative plot</td>
</tr>
<tr>
<td>Interpret, analyze, evaluate</td>
<td>Illuminate, interpret</td>
<td>Experience, express, sense</td>
</tr>
<tr>
<td>Findings, evidence</td>
<td>Motivation, engagement</td>
<td>Memories, associations</td>
</tr>
<tr>
<td>Clear, simple style</td>
<td>Believable, engaging</td>
<td>Expressive, theatrical</td>
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</tbody>
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Table based on Duarte, *Resonate*
A narrative “sparkline” by Nancy Duarte

Diagram based on Duarte, *Resonate*
Duarte sparkline based on Tufte’s data sparkline.
Diagram based on LeFever, *The Art of Explanation*
Why
What
How

Sparkline by McKenzie

beginning
middle
end

Why
What
How

what is?
what could be?

less understanding
more understanding

the call to adventure
the call to action

context
story
connections
descriptions

the call
to action

24
Core Why-What-How Questions

**Why** is your research important?

**What** is the core question or potential solution?

**How** can other stakeholders get involved?
Scientific Poster

Why?

What?

How?
Transmedia Knowledge Workshop

*Translate your project idea into transmedia knowledge*. TED talks, PowerPoints presentations, and other visual storytelling forms draw on formal affinities between argumentation and narrative. Reports and research papers often have three-part structures of introduction/argument/conclusion, which is similar yet different from the classic three-act narrative structure found in myths, novels, and comics: set up/confrontation/resolution.

Narratives involve characters, plot, and setting, while arguments entail evidence, logic, and context. Project histories, case studies, even process description all rely on narrative. One way in is simply contextualizing the topic for a wider audience. Or as Lee LeFever suggests: contextualizing it, telling a well-crafted story, and connecting narrative elements to detailed descriptions of the issue. Nancy Duarte draws on narrative theory to design organizational presentations, which she says should mix story and argument to transport audiences from "what is," through a series of contrasts with "what could be," to produce a "state of bliss." The difference between "what is" and "what could be" measure the stakes, the why, of the project. Superimposing LeFever and Duarte's start with context (WHY), tell a story as call to adventure, contrast IS/COULD be, and end describing the project with a call to action (HOW).

**Use the presentation to gather and present arguments, stories, and images that create resonances between your project idea and your target audience or stakeholder: try to transport them from what is to what could be.**

<table>
<thead>
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<tbody>
<tr>
<td>Who are your stakeholders?</td>
<td>What makes the project distinctive?</td>
<td>How can project best succeed?</td>
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<tr>
<td>Why is your topic important to each stakeholder?</td>
<td>What are the core issues and potential solutions?</td>
<td>How does your project engage each stakeholder?</td>
</tr>
<tr>
<td>What is the adventure, what's at stake for each stakeholder?</td>
<td>What are the key perspectives and challenges?</td>
<td>What action can your stakeholders take?</td>
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Presentations and workshops

• Transmedia knowledge
• KT innovation
• Broader impacts
• Science communication
• Stakeholder engagement
• Design thinking problem-solving
• Strategic storytelling
• Professional development
References


Olson, R. (2015). *Houston, we have a narrative: Why science needs story*. Chicago, IL: University of Chicago Press.

Disclaimer

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Don’t forget to fill out the evaluation form!