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EDITORIAL

The Journey to Publication and Support for the Peer-Review Process

I have had the opportunity to serve as *CJNR* Assistant Editor for the last 18 months. During this time I have learned a great deal about the process through which nursing science comes to be published in our journal. I would like to share some of what I have learned with you and then hone in on the essence of a peer-reviewed journal — the peer-review process itself.

Each member of the team that transforms a manuscript into a published article has a specific role. The members of the Editorial Board — the Editor, Assistant Editor, and Managing Editor — determine the future of the Journal, revise policy, and put systems in place to improve quality and efficiency. The Managing Editor reviews each manuscript briefly upon receipt to ensure that the author has followed the general guidelines for *CJNR* submissions (see Information for Authors). The Editor and Assistant Editor, in conjunction with the Guest Editor in the case of submissions for focus issues, evaluate the content of the manuscript, determine whether it should be sent out for review, select appropriate reviewers, and finally accept or reject it. The Editorial Board bases its final decision on the comments of the reviewers, its own assessment of the manuscript, and practical issues such as the number of manuscripts awaiting publication at that particular time. The Editorial Board sends the reviewers' comments to the author with recommendations. The reviewers are selected to appraise a specific manuscript based on their area of expertise as well as their availability. The role of reviewer is key in maintaining the Journal's standards of scholarship. This will be discussed in greater detail below.

The Copy Editor is responsible for editing the manuscript once it has been accepted for publication. The Copy Editor makes whatever changes are necessary to ensure clarity and sharpness of the work, corrects syntactical and grammatical errors, and ensures that all citations are presented in full in the reference section as specified in the *Publication Manual of the American Psychological Association, 4th Edition*, and that only works cited appear in the reference section. The Copy

Editor makes recommendations to the author concerning the elimination of ambiguities, correction of misleading or inaccurate information, removal or addition of citations, and filling out of incomplete references. The copy-edited manuscript is returned to the author for review and, if necessary, final adjustment. Finally, the translator translates the titles and abstracts into French.

As you can see, the publication of nursing science requires several steps and the involvement of several individuals. To ensure maximal efficiency at every stage, the Editorial Board has recently put in place a system for evaluating its own performance. This includes a close examination of data permitting comparisons across time and against self-defined standards on: number of manuscripts received; number of days from receipt to final disposition of each manuscript, and number of days at each step; and quality of reviews. Based on our most recent evaluation, we have set benchmarks for each of these indicators for the coming year.

I am keenly interested in the review process and have wondered what role the Journal could play in maximizing the benefits of the process for our authors, reviewers, editors, and, most importantly, you, our readers. The goals of peer review are several: (1) to help authors maintain credibility by identifying errors they might have overlooked, (2) to protect readers from inaccurate or irrelevant information, (3) to protect clients from practice that is based on unclear or incorrectly presented research results, and (4) to help editors determine which submissions merit publication (Goldbeck-Wood, 1998). A well-executed review process will have beneficial outcomes even when a manuscript is not ultimately published: for the author, an improved manuscript and greater clarity of thought on the topic being addressed; for the reviewer, a firsthand look at the latest research and an opportunity to participate in the research community by helping to improve the work of colleagues. However, the literature on the topic of peer review suggests that the process also presents difficulties (King, McGuire, Longman, & Carroll-Johnson, 1997). It is slow, time-consuming, and subjective; and it can stifle innovation, harbour conflict of interest, be hurtful to the author if not conducted respectfully, fail to detect errors, and fail to respect confidentiality.

The *CJNR* Editorial Board currently has a pool of approximately 330 reviewers from which to draw. Most are researchers while some are clinical, non-research, experts. The selection criteria for reviewers are expertise in the subject or in the methodology used and a history of

having been published. The process is currently set up to be “double blind”: the authors are not told the identity of the reviewers and the reviewers are not told the identity of the authors.

In order to maximize the benefits of the review process, the Editorial Board has begun to offer greater support for reviewers. A new orientation packet comprises an information sheet clearly outlining the obligations of reviewers, a reading list, and sample reviews. An excellent reviewer is one with high standards, knowledge of the subject matter — including an ability to cite references that the author may have missed — and an ability to identify key issues and defend his or her comments. An excellent reviewer can see how a manuscript might add to the body of knowledge in the field and communicates suggestions to the author clearly, making specific recommendations on content, organization, and style in a constructive and courteous manner. An excellent reviewer is able to go beyond an emotional reaction to the topic or the results, shows a willingness to learn from the author, and identifies any conflict of interest to the editors.

The second form of support for *CJNR* reviewers is provision of the comments of the other reviewers and the letter to the author (blinded) indicating the final outcome of the submission. Thus reviewers are able to compare points they have raised against those raised by the other reviewers. This can be helpful in identifying errors in the manuscript that may have been missed by one or another of the reviewers, in gaining a deeper understanding of the manuscript under review, and in confirming remarks made to the author.

The third form of support for reviewers is an annual performance evaluation. This is currently being initiated. Reviewers are being given feedback on their review with regard to: (a) comprehensiveness; (b) specificity (clearly stating suggestions on content, organization, style, references); (c) constructive, courteous, mentoring tone; (d) validity; and (e) timeliness of response. Reviewers are being provided with group averages on each of these items to permit them to benchmark themselves.

I hope you have now learned something of the internal workings of the *CJNR* and will see that the initiatives being taken by the Editorial Board to promote efficiency are a logical step in our quest for excellence. We look forward to receiving your feedback on this process, and we encourage any interested potential reviewers (and, of course, authors) to contact us. If done well, reviewing and publishing nursing science can be a rewarding experience for everyone.

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Anita J. Gagnon
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GUEST EDITORIAL

Special Issue on Primary Health Care

Karen I. Chalmers

In 1978, at the 1st International Conference on Primary Health Care, held in Alma-Ata in the former Soviet Union, the World Health Organization declared primary health care (PHC) as the means of achieving "health for all" of the world's people by the year 2000. PHC is considered to be essential health care that is based on practical, scientifically sound, socially acceptable methods and technologies that are universally accessible to people in their local communities (World Health Organization, 1978). Professional nursing associations quickly embraced these principles and advocated for reform of the health-care system with PHC as the guiding framework. Nursing also called for more research on PHC, to explore and evaluate effective ways of working with individuals, families, groups, and communities to improve health.

In the papers, short reports, and book reviews that follow, we celebrate the successes achieved to date in the implementation of PHC and reflect on the challenges ahead. The three major papers in this special issue of the Journal illustrate different developments in PHC. Munro and colleagues discuss the Prince Edward Island Conceptual Model for Nursing, which they developed based on PHC principles. This model challenges nurses to work with clients, building on individual strengths within the broader framework of the collective influences of the determinants of health. Hilton and colleagues report on the impact of the AIDS Prevention Street Nurse Program, a program of collaborative work with clients and other personnel based on the PHC model. Whyte and Stone provide a retrospective analysis of the work of one provincial association, the Registered Nurses Association of British Columbia, to promote PHC as the foundation of the health-care system. Glass, in the *Discourse*, provides a comprehensive overview of the origins of PHC and the progress made to date. Edwards, in the *Happenings* section, highlights many exemplars of PHC projects and current and future opportunities for nursing research in this area. Finally, three books are

reviewed. Clarke, Gallagher, and Leipert each provide the reader with a critical examination of current resources available for educators, students, practitioners, and policy-makers.

These papers and reviews highlight the importance of development and action in many sectors if the goals of PHC are to be achieved — theoretical development of PHC, sustained and systematic efforts to influence policy, knowledge development, and program evaluation. I hope that this issue of the Journal will inform, challenge, and contribute to the further development of PHC.

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Discourse

Primary Health Care: Then and Now

Helen Glass

The term *primary health care* is now entrenched in our minds and our actions. A *health for all by the year 2000* strategy is being examined to determine what has been achieved and what has not. All countries and most professions, including nursing, are scrutinizing the progress they have made towards achieving PHC. It is my intention, in this discourse, to move from an historical view to present-day concerns as they relate to the achievement of PHC. It will be impossible to do more than mention many of the latter, but I hope to set the stage for the articles that follow in this issue of the Journal.

Historical Perspective

Nursing has been involved in the development of PHC from the beginning. Concerns about the state of basic health care surfaced in 1973 (World Health Organization [WHO], 1973), when alarming states of health and vast gaps in health services for populations in developing countries were identified. An Expert Committee on Community Health Nursing was convened to recommend ways in which nursing might make a real impact on urgent problems throughout the world (WHO, 1974). The Committee made recommendations on: (1) the development of community health nursing services responsive to community needs in order to ensure PHC coverage for all, (2) the reformulation of basic and post-basic nursing education to prepare nurses for community health nursing, and (3) the inclusion of nursing in rational distribution and appropriate utilization in support of nursing personnel.

Helen Glass, OC, BSc(N), MA(N), MEd(N), EdD(N), LLD(Hon.), DSc(Hon.), is Professor Emerita, Faculty of Nursing, University of Manitoba. She is the former Director of the (then) School of Nursing, University of Manitoba, Winnipeg.

Since 1974, there have been a series of closely related events aimed at reducing the pressing needs of society and improving community health as rapidly as possible. The Thirtieth World Health Assembly recognized the important role of nursing and midwifery in PHC by adopting *Resolution 30:48* (WHO, 1977), which asked World Health Organization (WHO) member states to: (1) study the roles and functions of nursing and midwifery personnel in providing PHC, (2) plan for a rational increase in the supply of these personnel in providing PHC, and (3) involve nursing and midwifery personnel in the planning and management of PHC.

In 1978 the adoption of *Resolution 36:11* (WHO, 1978b) confirmed support for these resolutions. There were many other WHO resolutions urging member states to support nursing in this endeavour. The International Council of Nurses (ICN) actively urged nurses to become involved. The ICN prepared and distributed much information to help its members understand the PHC concept, and it encouraged nursing organizations to assume a leadership role. The ICN and the WHO held a conference on leadership in Tokyo (WHO, 1986), which enabled many nurses to not only prepare themselves for leadership, but assist nurses in other countries to do the same. Further, the ICN was instrumental in helping nursing organizations participate in the PHC movement. Canada was particularly involved, assisting several countries that wished to train their nurses in PHC.

The federal health minister's 1974 report (Lalonde, 1974) declared health promotion, prevention, biology, and environment the cornerstones for health in Canada. The report would influence the next round of developments in PHC. The *Alma-Ata Declaration* (WHO, 1978a) marked a dramatic point in programming for community health nationally and internationally. The international conference on PHC that produced the Declaration also produced a universally applicable definition of PHC, described concepts and principles for the development of PHC, and recommended strategies for achieving universal health care — of which PHC was seen as key.

In *Community Nursing: Promoting Canadians' Health*, Rodger and Gallagher (2000) describe the move towards PHC in Canada, indicating the involvement of the Canadian Nurses Association and nurses generally (pp. 40–42). It is a litany of achievements and shows the deep commitment and involvement of nurses in the PHC approach. Yet much remains to be done.

The WHO's activities internationally stimulated the political move to implement PHC in Canada. The release of health minister Jake Epp's

Achieving Health for All (Epp, 1986) moved Canada a step forward in the overall strategy. All provinces responded, and all engaged in developing their own action plan for implementing PHC. For the most part they initiated health-care reform reflecting PHC principles. However, there are many different approaches to health-care reform, some of which have defied the *Canada Health Act* (1985) and in some instances may have strayed from the basic principles of PHC.

The *Ottawa Charter for Health Promotion* (WHO, Health and Welfare Canada, & Canadian Public Health Association, 1986), the WHO's first attempt to expand upon health-promotion principles, was developed in Canada by representatives of 32 countries. Co-sponsored by the WHO, Health and Welfare Canada, and the Canadian Public Health Association, it was the result of a WHO debate on intersectoral action for health, one of the major principles of PHC. Issues addressed were: health promotion, its prerequisites and resources; the advocacy required for people to achieve their full health potential; and mediation between different interests in society for the pursuit for health. The emphasis was on creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. There is much more to be achieved with regard to these important elements, but the *Ottawa Charter* was an impressive beginning.

Evaluation of Progress

The WHO examines its progress every year, and in the process hears from each country as to its success in implementing PHC. The book *Achieving Health for All by the Year 2000: Midway Reports of Country Experiences* (WHO, 1990), and Tarimo and Webster's (1997) report of advances in PHC, determined that the major challenge lay in implementation of the concept. The WHO reported on how each individual country had adapted the PHC approach to its own evolving circumstances. The Canadian study, conducted by Spasoff and Hancock (1990), covered one province only, though it included references to other provinces. Since that time there has been an increased awareness of advances made by other provinces, such as regionalization and various models of PHC. All provinces have established structures to embrace the concept. Refinement of the concept has been evident in the direction taken to implement population health and health determinants. Less headway has been made in community development, environmental protection, or clarity of the roles and functions of various health professions, or, indeed, in enabling communities to grasp the nuances in PHC and all of its interacting elements.

A great number of technical and annual reports offer valuable information on the advancement of PHC and the achievement of health for all. The World Health Report for 1998 (WHO, 1998) and its three predecessors draw a comprehensive map of the issues that dominated world health in the second half of the 20th century. *World Health Report: Bridging the Gap* (WHO, 1995) identifies poverty as a major stumbling block to achieving health for all. *World Health Report: Fighting Disease, Fostering Development* (WHO, 1996) identifies three priorities: fighting diseases, both old and new; addressing antimicrobial resistance; and combating newly emerged diseases. *World Health Report: Conquering Suffering, Enriching Humanity* (WHO, 1997) focuses on the causes of suffering, especially poverty, poor housing, and disabilities, and points out that increased longevity without quality of life is an empty prize. While this report reveals some decrease in disabilities, it notes the persistence of chronic, long-term disabilities, resulting in much suffering, and the need for preventive measures in cancer and in pulmonary, musculoskeletal, and visual disorders. A number of WHO technical reports also address these concerns. In addition, the 1997 report urges improvements in the education of health professionals and university involvement in PHC, especially with regard to evolving perceptions of PHC as countries seek to change their approach and institute PHC community interventions.

On the unfinished agenda, poverty remains the main item. Other important topics are safeguarding health gains already achieved and sharing medical knowledge, expertise, and experience on a global scale. The reports suggest that industrialized countries can play a vital role in helping to resolve global health problems. A third directional move suggested in the reports is enhancing health potential by reducing premature mortality, morbidity, and disabilities at all age levels. Finally, it is pointed out that increased longevity and quality of life, reduced disability, and increased community involvement will require much more research. Further, with regard to achieving health for all by the year 2000, research indicates that although substantial progress has been made worldwide in decreasing disparities between and within countries, the disparities have nonetheless persisted and in many cases increased.

Many differences have been observed in the interpretation of PHC as a concept. Not all countries have grasped the notion that PHC is an approach to health development and that it embodies specific principles and values: universality, accessibility, and coverage according to need; community and individual involvement and self-reliance; and

intersectoral action for health, appropriate technology, and cost effectiveness. While these principles are often cited by those working in PHC, little progress has been made in upholding them. Universality and accessibility truly represent a population health approach that should lead to health development. However, there is still confusion over *how* population health should be approached. There is a need to address the health status of the population in each community as health development occurs, either individually or as a collective. Further, without economic equity there can be little hope of narrowing the gap between the haves and the have nots. This was recently pointed out at the Canadian Conference on Shared Responsibility and Health Impact Assessment: Advancing the Population Health Agenda: "The population health approach has the potential to encompass much of humanity's accumulated knowledge, from biological insights to the lived experience of everyday life, to interplay among political, economic and social forces and their impact on health, well being and quality of life" (Frankish, Veenstra, & Gray, 1999, p. 6). The importance of policy-making, by health professionals and members of the community as well as by governments, was recommended as a means of furthering population health development (Frankish, Vreestra, & Moulton, 1999; Glass & Hicks, 2000).

The second principle, community and individual involvement and self-reliance, requires that a community play an active part in the process of improving its health status. This principle has two aspects: political and social. The political aspect relates to decentralization and an increase in community decision-making power. Governments are involved, but health professionals have the greatest opportunity to assist people in taking responsibility for their health.

The third principle, intersectoral action, deals with determinants of health, some of which relate to social economics, some to environmental forces. There is much to learn about ways of interacting with other sectors of society. Cost effectiveness includes strategies for yielding the greatest benefits for all people. The focus on strengthening preventive services and health promotion derives from this principle. It also requires a shift away from hospitals to community health centres or other models of care, a shift that is taking place in many countries. A good many of the solutions will be linked to the other concerns — that is, much more headway will be achieved once the public accepts the fact that it can largely direct its own health care and then assumes responsibility for doing so.

The 21st Century: Making a Difference

At the outset of this paper I indicated the early involvement of nursing in PHC. There is no doubt that nursing has done its part. It has also been heavily involved in research in many areas of PHC. The nature of nursing research is suited to the study of PHC, with its emphasis on both qualitative and quantitative methods. It serves to identify many elements, especially in qualitative research, that will be helpful in the study of phenomena that arise from this method.

Dr. Gro Harlem Brundtland, the current Director of the WHO, states in the World Health Report for 1999: "The world enters the twenty-first century with hope, but also with uncertainty. Remarkable gains in health, rapid economic growth and unprecedented scientific advances — all legacies of the twentieth century — could lead us to a new era of human progress. But darker legacies bring uncertainty to this vision and demand redoubled commitments" (WHO, 1999, p. vii). Tremendous insights can be gained from perusing the research that WHO has conducted over the years, in every aspect of PHC development. The 1999 World Health Report offers some direction as to what will make a difference. Dr. Brundtland suggests areas that would seem to lend themselves to study: poverty; the rising toll of non-communicable diseases; the quest for a tobacco-free world; the delivery of quality care to children, adolescents, and women; reproductive health. Nurses have been active in some of these areas; other areas, such as community development and intersectoral action, can be expected to engage nurses.

As we enter the increasingly complex world of cyberspace, we can expect to see a greater distribution of research results through the media, schools, interactive video, networking, and various technologies. This will serve to bring much-needed information to the community, thus stimulating residents to seek ways of improving their health. The four Community Nurse Resource Centres established in Manitoba have witnessed many instances of communities taking responsibility for projects they see as needed: establishing the projects; doing research with health professionals to obtain useful data; working intersectorally; and influencing policy development as a result of the findings. I am convinced that great strides will be made by nurses as they explore the intricacies of PHC.

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Evaluation of the AIDS Prevention Street Nurse Program: One Step at a Time

**B. Ann Hilton, Ray Thompson,
and Laura Moore-Dempsey**

Le programme de prévention du SIDA mené par les infirmières de rue utilise des infirmières spécialisées en santé communautaire dotées d'une formation spéciale dans le but de promouvoir la prévention du HIV et des MTS auprès d'une clientèle marginale, difficilement atteignable et à risque élevé. Cette démarche s'inscrit dans un effort pour diminuer les problèmes et promouvoir la santé. Des infirmières de rue ($n = 17$), des pourvoyeurs de soins ($n = 30$), des représentants d'autres programmes HIV/MTS dans la province canadienne de la Colombie-Britannique ($n = 5$) et des clients ($n = 32$) ont été interviewés au cours d'une évaluation dans le but de décrire le travail qu'effectuent les infirmières, les défis qu'elles doivent relever, l'harmonisation de ce programme avec les autres services et l'impact du travail des infirmières. Cet article décrit les effets du travail des infirmières auprès des clients. Les changements sur le plan de l'impact/des résultats indiquaient une progression en matière de niveaux de connaissances et de comportements, et des indicateurs majeurs de santé/maladie. Les effets exercés sur la clientèle incluaient : une meilleure connaissance du HIV/SIDA, de leur propre situation et des options; l'utilisation de fournitures essentielles destinées à réduire les problèmes et à promouvoir la santé; un changement de comportements visant à réduire la transmission de maladies, améliorer la résistance et promouvoir la santé; l'utilisation de ressources d'aide; un sentiment de mieux-être avec eux-mêmes et leur entourage; un sentiment d'être soutenu et d'exercer une influence sur les autres; le sentiment de recevoir plus rapidement de l'attention, face à des problèmes; un meilleur état de santé avec ou sans HIV; l'intégration de changements majeurs en ce qui a trait à l'usage de drogues; et une baisse probable de morbidité et de mortalité. Le programme s'est révélé nettement efficace et ses effets sur la clientèle se sont avérés positifs.

The AIDS Prevention Street Nurse Program uses specially prepared community health nurses to focus on HIV and STD prevention with marginalized, hard-to-reach and high-risk clients within a broader context of harm reduction and health promotion. Street nurses ($n = 17$), service providers ($n = 30$), representatives of other HIV/STD programs in the province of British Columbia, Canada ($N = 5$), and clients ($n = 32$) were interviewed during an evaluation for the purpose of describing the nurses' work, the challenges the

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nurses' face, the fit of the program with other services, and the impact of the nurses' work. This article describes the impact of the nurses' work on clients. Impact/outcome changes reflected a progression from knowledge to behavioural levels and to major indicators of health/illness. Impact on clients included: knowing more about HIV/AIDS, their own situation, and options; receiving essential supplies to reduce harm and promote health; changing behaviour to reduce disease transmission, improve resistance, and promote health; connecting with help; feeling better about themselves and others; feeling supported; influencing others; receiving earlier attention for problems; being healthier with or without HIV; making major changes in drug use; and likely decreasing morbidity and mortality. The Program was found to be clearly effective in making a positive impact on clients.

The AIDS Prevention Street Nurse Program (the Program), an innovation that uses specially prepared community health nurses to work "on the street," was initiated as a pilot project in Vancouver, British Columbia, Canada, in January 1988. Prior to 1988 a smaller, outreach sexually transmitted disease (STD) program was specifically targeted to persons in jail. This was redirected in response to the HIV/AIDS epidemic. In the Program, the nurses work with challenging clients and complex situations in an expanded nursing practice role that includes several delegated medical functions.

Two previous evaluations of the Program (Chan, 1990; Wachtel, 1992) did not, according to the nurses, address areas helpful in informing and influencing their practice. Also, several changes were made to the Program since these were conducted. Both studies used mainly quantitative methods. Chan administered a structured questionnaire to 86 street people and Wachtel primarily analyzed client contact records. The nurses wanted to have the nature of their work and its challenges described so that it was visible, and they wanted to have the impact on clients described. As Cohen and Kibel (1993, cited in Julian, Jones, & Deyo, 1995) suggest, in complex, natural environments, traditional evaluation questions related to cause and effect are less important than questions related to impact. Cohen and Kibel define key evaluation questions in terms of understanding the environment in which programs are implemented and tracking progress towards the achievement of specific outcomes.

The goal of the present evaluation was to describe the work of the street nurses and the challenges posed by that work from the perspective of the nurses and others (including clients), and to identify changes resulting from the nurses' work. It was believed that such an analysis would help the street nurses articulate their role and their contributions and identify ways in which the Program might be made more effective. The description of the nurses' work might assist others wishing to offer

community outreach services and might help identify gaps in service. This article describes the impact of the nurses' work on clients.

The Program

The primary mandate of the Program is prevention of HIV and STD within a broader context of harm reduction and health promotion, with a focus on the South and Eastside areas of downtown Vancouver. The target populations are marginalized, hard-to-reach, and high-risk street-involved adults and youth; non-street-involved gay, lesbian, bisexual, and transgendered populations; and refugees and immigrants at risk for HIV and STD who may or may not be street-involved. The target population is not homogeneous. The Program also serves as the provincial training site for STD/AIDS outreach programs.

The Program increased from 7.5 street nurses (Full Time Equivalent — FTE), one administrator, and one clerk in 1994; to 8.5 street nurses and two health-care workers in 1995; to 11 street nurses (FTE), two administrators (FTE), two health-care workers (FTE), and two clerks (FTE) in 1998/99.

The nurses and health-care workers go where the clients are, in addition to having established sites of contact such as jails, detoxification centres, clinics, and drop-in centres. Nurses also go door-to-door in single-room occupancy (SRO) hotels and make on-the-street contacts both on foot and via mobile van. The Program is operated by the STD/AIDS Control Division of the British Columbia Centre for Disease Control (BCCDC). Formerly a division of the Ministry of Health, the BCCDC is now part of the Greater Vancouver/Richmond Health Board.

Harm Reduction

The concept of harm reduction embodies beliefs and values that provide direction for social policy, programs, and interventions related to the unintended effects of the use of psychoactive substances (Drucker, 1995; Riley, 1993). Harm reduction has been most often associated with efforts to control the spread of HIV infection among injection drug users (IDUs) and more recently in slowing the rates of hepatitis C infection in the same population (Drucker).

Beliefs and values surrounding the use of non-medical drugs range from a prohibitionist/abstinence perspective to a legalization/decriminalization-of-drugs perspective (DuPont & Voth, 1995). While most of the recent discourse has focused on the use of illicit drugs, the notion of

harm reduction is also applicable to tobacco and alcohol use — for example, driving-under-the-influence laws (Griffin, 1997). Prohibition was the predominant model in the last century until the 1960s when the world saw a proliferation in the availability and use of illicit drugs (DuPont & Voth). The appearance of the AIDS epidemic among the IDU population in the 1980s raised serious questions about the effectiveness of existing drug policies (Drucker, 1995).

Harm reduction encompasses a range of strategies such as addiction treatment (including methadone maintenance), needle-exchange programs, education in safer drug use and safer sexual practices, and reformation of public policy and drug laws (Drucker, 1995). Nurses in the Program are directly involved in needle exchange and in educational measures directed towards safer drug use and safer sexual behaviour. They are indirectly involved in the referral of clients to addiction treatment programs and in the support of clients in those programs.

Methods

An Evaluation Advisory Committee (EAC) was established comprising representatives of the street nurses, the project coordinator hired for the evaluation, and the evaluators. Both qualitative and quantitative methods were used in this participatory evaluation. Participatory research was deemed appropriate because of its emphasis on collaboration (Erlandson, Harris, Skipper, & Allen, 1993). Qualitative methods are particularly appropriate in responsive evaluation because of their openness and sensitivity to the diverse perspectives of various stakeholders (Patton, 1987). The qualitative methods used in this evaluation included semi-structured interviews and focus groups as well as content analysis of relevant Program documents, such as BCCDC annual reports, for additional information.

A series of nominal group-process sessions conducted by the EAC identified key client groups and service providers to be interviewed. Interviews and focus groups were held with four main groups involved with the Program: clients ($n = 32$), street nurses ($n = 17$), other service providers ($n = 30$), and representatives of other HIV/STD programs in the province of British Columbia ($n = 5$) (Table 1). A total of 63 interviews were conducted with 84 individuals; these included 50 individual interviews, four client focus groups, four street nurse focus groups, and five service provider focus groups. Several of the client interviews were conducted in languages other than English.

Table 1 Client Groups Interviewed	
Client Group	Number
Female IDUs and sex trade workers	3
Male IDUs	7
Male/transgendered sex trade workers	6
Mobile outreach home-visit client	1
Street youth	6
Bute Street clients	2
Jail	2
Detox client	1
Latino outreach client	1
Francophone client	1
Southeast Asian client	1
Ex-clients	1
Total	32

Clients interviewed were representative of the various target groups of the Program. They were recruited through contacts with the street nurses or approached individually. Clients received a small remuneration for their participation in the study. Interview locations ranged from SROs in the Downtown Eastside to the British Columbia Correctional Centre for Women. In addition, individual interviews were conducted with six street nurses to provide further clarification in several areas. The interviews, which ranged from 30 minutes to two hours in length, were taped and transcribed and, if appropriate, translated. All participants were fully informed and gave their written consent. Procedures were approved by the University of British Columbia Ethics Committee.

Interview questions were developed in consultation with the EAC. Client questions that focused on impact included: (1) As a result of your work with the nurses, has anything changed for you? (2) What kinds of things have you learned from the nurses, and what have you done with that information? (3) Has your work with the street nurses changed how or which services, including health-care services, you use? If so, describe the changes.

Interview questions for the street nurses and other providers focused on client changes they believed to be a result of the Program. They were asked for case examples to help describe those changes, in order to obtain both general perspectives and perspectives related to

changes in particular clients. The client situations described by the nurses and other providers did not necessarily refer to the same clients who were interviewed.

The transcriptions were read carefully. Although the data were generally segmented by responses to interview questions, any comments in the interviews relating to changes that might have resulted from the nurses' work were included in the analysis of impact. Open coding was used to identify ideas, and further analysis reflected higher order themes. Constant comparative analysis was used to help clarify and refine (Strauss & Corbin, 1990). The team met to discuss the categories and to further refine and define them, as well as to increase the specificity of the codes and to develop higher order themes. Trustworthiness and rigour were supported by clarifying the decision trail (auditability), staying close to the informant's words, using quotations in presenting the results (credibility), discussing themes as they were identified, and supporting evidence with the team and others (fittingness) (Denzin & Lincoln, 1994; Lincoln & Guba, 1985). This process facilitated identification of properties and dimensions and verification of fit.

Findings

To help put the findings on the impact of the nurses' work into context, the themes that emerged on the nature of their work will be identified and briefly described. Further description of the nature of the nurses' work can be found in Hilton, Thompson, and Moore-Dempsey (1999, 2000). All participants contributed to an understanding of the nature of the nurses' work. Reaching marginalized populations at high risk for HIV/STDs focused on the nurses' accessibility, consistency, and flexibility in going where the clients were and establishing contact. Building and maintaining trust, respect, and acceptance focused on the nurses' provision of care in a user-friendly, non-threatening, non-judgemental way. Working towards HIV/AIDS/STD prevention, early detection, treatment, and referral focused on promoting harm reduction within a holistic framework — working with the client's agenda first; educating for harm reduction; testing, monitoring, and contact tracing for HIV/STD, tuberculosis, and pregnancy; providing resources such as needle exchange and condom distribution; and dealing with other care issues such as vein maintenance, wound care, and first aid. Connecting clients with and helping them negotiate the health-care system focused on the nurses' role in providing instrumental and emotional support. The nurses' work also reflected their role in influencing the system and other people to be responsive to the needs of the target population.

Changes Due to the Nurses' Work

Many Program-related changes were identified, but nurses commented on the difficulty of evaluating the impact of their work because of clients being influenced by many powerful factors. To make a significant impact, the Program would have to address core issues such as addictions, poverty, housing, and employment — issues that it could not effectively address in the short term. The nurses also found it difficult to evaluate change because it was impossible for them to know what happened to clients in the long term. As one nurse said, "Did they move out? Did they die? Did they clean up their act? We never know, but it's changing all the time." Nurses also explained that their expectations became more realistic after they had worked in the Program for a while:

I'm going to hand out a whole bunch of condoms — that's going to solve the problem? I mean, that's called a finger in a very large dike. There's no way that can happen, because you have to go for a core behaviour change before you're going to get anywhere, and you're not going to get core behaviour change in a short or long period of time... Survival is the biggest thing down there, so AIDS has never taken a big front seat, so in order to be able to offer services, you're going to have to deal with what's going on and then get to what it is you need to get to, and that happens over and over and over again with every interaction.

In spite of these challenges, results of the nurses' work were identified by clients, other service providers, and the nurses themselves. Their work also affected other services and programs. Its impact on clients reflected the theme *taking one step at a time*. Changes occurred both directly and indirectly. Clients were quite clear on how the street nurses' work impacted on them, reflecting a progression from knowledge changes through to behaviour changes related to primary and secondary prevention through to health promotion (Figure 1).

Major areas of nurses' impact on clients were reflected in the following themes: knowing more about HIV/AIDS/STDs, their own situation, and their options; receiving essential supplies to reduce harm and promote health; changing behaviour to reduce disease transmission, improve resistance, and promote health and well-being; connecting with help or care; changing feelings about themselves and others; feeling supported; influencing others; receiving earlier attention, thereby reducing the severity of problems; being healthier with or without HIV; making major changes in drug use; and changing indicators likely reflective of decreased morbidity and mortality. Each of these themes will be described using supporting quotes and information.

Knowing more about HIV/AIDS/STDs, their own situation, and their options. As a result of the Program, clients were more aware of and more knowledgeable about HIV/AIDS/STDs, risk behaviours, transmission, prevention, and harm reduction; other health problems and concerns; the availability of resources/services in general and those specific to the individual client; their own health state/situation; and how to care for themselves and make better health-care choices. Because efforts were made to provide services in languages other than English, these changes were noted in clients from diverse cultures. Their new awareness and knowledge helped clients to clarify misconceptions, but they did not necessarily apply all their newly acquired information. Making behavioural or attitudinal changes reflected higher levels of Program impact. Comments from clients included the following:

I know my health status: before, I didn't. When I was hustling. Before I got involved with them [street nurses] and got any tests done I had no clue whether I was positive or negative for any disease and now at least I know, and that's definitely a direct result of them.

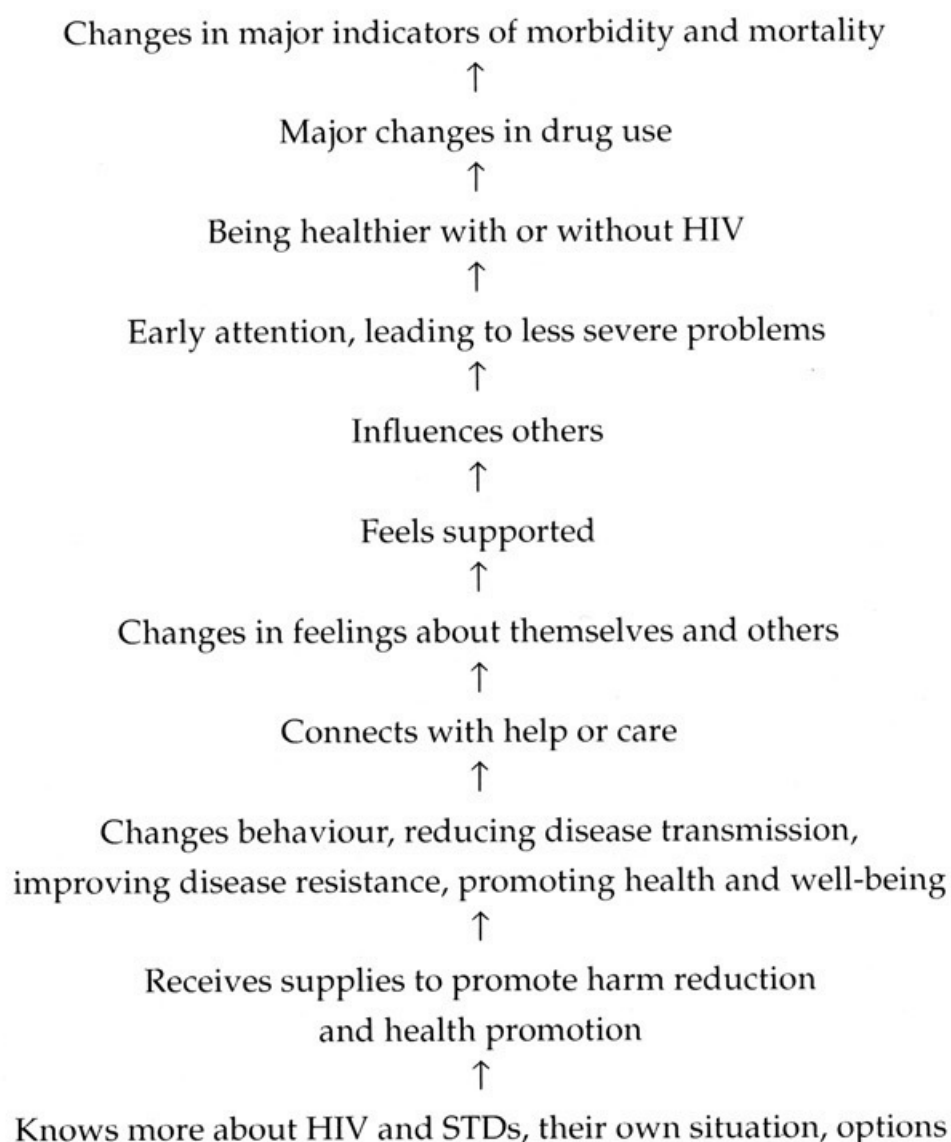
You shouldn't share your water without bleach...they give you a little paper with all this stuff on it and they sit down and talk about it and tell you what not to use...you should always clean before you inject.

Receiving supplies to reduce harm and promote health. Clients received supplies, such as condoms, bleach, and clean needles, for the prevention and transmission of disease. They also received medicines for the alleviation of discomfort and the promotion of health. These helped promote behavioural change; without them, change was not likely to occur.

In 1997/98 the Program distributed 386,067 needles; in 1999/2000 a projected 407,664 will be distributed (British Columbia Centre for Disease Control [BCCDC], 1998/99). In 1997/98 the return rate of needles exchanged was high, 391,910 — more than were distributed. The street nurses also instituted a bulk needle exchange to better meet the needs of IDUs who require a larger number of needles, partly because these clients were less likely to access exchange locations consistently.

Bulk needle exchanges also make secondary needle exchange possible. Secondary needle exchange occurs when nurses exchange needles for IDU peers unwilling or unable to access the services of street nurses. Other providers saw bulk exchange as a counter-productive strategy, whereas the nurses saw it as an appropriate strategy for increasing the likelihood of IDUs using clean needles each time they injected.

Figure 1 *Client Changes Reflecting a Process of Enablement*



Changing behaviour to reduce disease transmission, improve resistance, and promote health and well-being. Influencing behavioural changes in the marginalized, hard-to-reach population is an important step in preventing and reducing disease transmission and improving health. It is not easy to initiate behavioural changes in this population, yet clients said they did things differently because of the nurses. These behavioural changes were key to reducing disease transmission, increasing resistance, and promoting improvements in health and well-being. Clients changed their habits related to needles, drugs, and

condoms. They described themselves as using safer injection techniques more often, using condoms more often, managing wounds more effectively, and using drugs in a less dangerous manner. Clients said they now used new needles "every time," were more careful about sharing needles, and used condoms more consistently. One client said he would "never again" share needles. Another said he had been using condoms incorrectly until seeing the nurse demonstrate proper use. Another stated, "I would never do it without a condom," while another spoke about changing his injection methods. A street youth said, "I cleaned up my act when I learned my HIV status" from the nurse. Although it is not possible to know the number and consistency of these behavioural changes, it was evident that positive changes had come about as a result of the nurses' work and that these changes would lead to a decrease in disease transmission. The street nurses and other service providers corroborated each other's testimony on changes in risk behaviours.

Clients also said they looked after themselves more, had improved diets, and were taking better care of their bodies. They requested information on how to care for themselves. The nurses indicated that clients were making healthier choices, staying on their medications, and following routines. One of the nurses said, "I've seen clients go from living on the streets to being able to find, if not necessarily the best housing, at least some form of housing...and being able to find other options in terms of nutrition and how to feed themselves more adequately."

Connecting with help or care. The nurses also connected clients with resources. Clients had better access to care, increased STD and HIV testing, earlier diagnosis, and access to mainstream services. Reports indicated that street nurse encounters numbered approximately 45,000 annually, of which 8,500 related to clients with STD or HIV (BCCDC, 1999). The Program accounted for 11% of all STD visits in the province (BCCDC, 1997, 1998/99).

Because of the Program, many clients were tested and subsequently treated for HIV and STDs. Of all positive HIV tests in British Columbia (3,101, out of 140,278), the street nurses identified 10% — a clear indication of an effective program facilitating early treatment (BCCDC, 1997, 1998/99). In addition, the Program served to identify other STDs, many of which would have gone undetected for long periods, often leading to further complications. In 1997, 2,040 STD clients were seen in the Program (1,260 males, 767 females, and 13 transgendered persons). Of the 2,010 people screened for STDs, 776 were diagnosed with a variety

of STDs, some particularly serious — and the sooner treatment is begun the better, not only for the affected clients but also for those to whom they might transmit. The return-visit rate of clients after testing was excellent, ranging from 76% to 87% at various clinic locations.

The nurses were also effective in helping providers, such as Tuberculosis Control, to locate clients and contacts requiring follow-up. Service providers were very clear about the important role of the nurses in connecting and following up with clients who were hard to locate, those “no one else could find.” One of the nurses spoke about a client who had returned, after several years, to be treated for HIV:

You are trying to fit them in [to services] so that it would be helpful for them, but they make that decision. They're the ones that initiate that, but they know that you're there for them. It doesn't matter how many times they screw up or whatever happens to them, they can come in and sit down and talk to you and say, "Look, this is what is happening and I'm ready. I think I'm ready to change," and it happens. It's amazing how that happens sometimes. You haven't seen someone for years. Someone I hadn't seen for eight years who was HIV positive — she was just a young girl, 15, [and she] showed up at the clinic one day and said she remembered me and "I'm ready to do something about being HIV positive, now, what shall I do?" So we must make an impact somewhere for someone to do that and for her to know that she feels really comfortable doing that — no judgements.

The nurses provided clients with many services besides STD and HIV testing. They effectively addressed counselling and follow-up care, wound and abscess care, and crises such as thoughts of suicide. Clients became connected with mainstream services when they needed them and with health and social service providers that were acceptable to them. Because the nurses helped them negotiate the health-care system, the clients were more likely to receive the care they required. High-priority clients — for example, those with bleeding wounds or showing indicators of endocarditis — received more immediate attention.

Several case studies revealed the nurses' part in making those connections. Many clients would not have accessed care otherwise, or would have taken longer to access care, or would have only reluctantly gone to a clinic or sought out a service. Clients were asked what they would have done had the street nurses not been there. Several indicated that they would not have gone elsewhere: “If I can't see a nurse, well, too bad. I'll take care of it myself.” “I'd have nowhere else to turn to get anonymous testing.” Others said they would have taken longer to access care, waiting until the situation worsened: “I know I couldn't go to my regular doctor and talk to him or to any of the nurses [in other

programs] because they just, like I said, they just look at me as sort of, 'oh, you're an ex-junkie,' you know." "I probably wouldn't go for a pap smear until something felt weird." Others indicated that they would have used other resources, though in some cases only reluctantly: "I can open up with the nurses, but I cannot fully open up with the doctor, the doctor is not the same."

Changing feelings about themselves and others. Clients spoke about how their work with the nurses made them feel better about themselves and others. Gaining trust in marginalized populations is a challenge that must not be underestimated. Once the nurses had gained their trust, clients were more likely to be open to having their health issues, including HIV and STD, identified and dealt with, and more likely to accept and complete recommended treatment. Once trust was established, clients were also more likely to incorporate suggested harm-reduction strategies into their lifestyle.

After working with the street nurses, clients felt more positive about themselves, more trusting of other people, and more valued. They had a greater sense of self-respect and dignity, hope, and belief in themselves. One client said that the nurses "make me feel safe and I trust them... Somebody accepts me for who I am and even though some of my choices and those decisions aren't right, it's still OK." A woman in a correctional facility stated:

I'm OK even having HIV. They've given me that strength to believe that I can still be all of who I am with HIV...from nutrition to, like, all the things that go along with HIV and guiding me throughout like that time and you still come back and even so sometimes I wouldn't go there myself. Like, they've come out on the street looking for me. They work to bring me to the doctor. There was times that I had no hope left and stuff like that and they always been there to build me back up to say that things are going to be OK. Like, they do get better from here and at times when I know I need it because sometimes I don't have any hope and I just want to say forget it and I'd rather just be dead and I'd rather just OD and just being there sometimes, yeah, just opens up like more light like a whole new world kind of thing because you can just start again right from where you are and just look at what was going and keep on going.

In addition to the street nurse, some clients gained trust in others whom they would not have trusted previously. Gaining trust with one street nurse was important, but being able to extend that to other street nurses and other service providers was a significant shift.

I didn't trust anybody enough to let them into my life like that. I didn't. I guess because of fear and because I just didn't want them to know too much about me, and then slowly [because the same street nurse was not

in the clinic all the time] for [names another street nurse] to look at and take care of me and assist.

Feeling supported. Because clients felt accepted and supported, they were able to follow through with plans such as entering alcohol or drug detoxification centres, staying off drugs, commencing methadone maintenance, or going to the hospital for tests. Clients knew the nurses were there if needed. Clients felt accepted, whether or not they were successful in their attempts to change their behaviour. This acceptance influenced their participation in their own health care. A service provider said that when one woman who had been in and out of recovery houses ended up on the street again, the woman felt that the street nurses, unlike others, had not judged her for it. The nurses' unique attitude made her want to go back to them for support and medical care. In several other situations as well, clients said they felt it was acceptable to return to the nurses, but not to others, if the clients had — in their own eyes — failed in some way.

Influencing others. Several clients spoke about influencing others to go for HIV/STD testing and to seek assistance with their health-care needs. They did so through encouragement and support, through volunteering, and through teaching. A Spanish-speaking client said: "I could also accompany them [Spanish-speaking persons]. If one of the nurses could not speak Spanish, I could help translate. I want to help other people to know about the services that the nurses give."

Clients influenced others through one-on-one contact and were clearly proactive in making major system changes. One client was influential in having the street nurses first go to the women's correctional facility. Another client developed an excellent instruction packet for new staff about cocaine: how to prepare it for smoking and how to make a pipe.

Receiving earlier attention, thereby reducing the severity of problems. Early attention to health-care concerns can avert more severe problems. Because of the nurses, infections and abscesses were identified and treated early on. In some cases, endocarditis likely was prevented because of timely intervention. Although some conditions required emergency treatment and hospitalization, others were managed outside of hospital by the nurses, in some cases avoiding more serious problems that would have required hospitalization. Clients said they prevented or minimized problems by "fixing properly," "not tying too tight," and "doing proper vein maintenance." A service provider said:

The nurses have circumvented what could have been catastrophes. You see things that if a nurse hadn't gotten on to right away, it could have been a serious problem, and the nurses are more than just nurses. They're part counsellors... [A client] had slashes going up her arms...and you could see these marks going up...this kid was not aware. She thought it was a bruise. She wasn't really concerned with it at all, and this was a Thursday night...What would have happened if she had not seen a nurse? She could have died. It just could have become that much more serious... I had this kid that had a really bad abscess on the top of her hand and she was on the way to blood poisoning. It took a nurse to say, look, this is bad and you have to come with me.

Being healthier with or without HIV. Clients, nurses, and other service providers spoke about clients being healthier because of the Program; they were looking after themselves. Service providers commented that they "often see people start to improve health-wise just because they got that contact [with the street nurses] and they've got someone they can ask questions of and someone who can guide them." Even when clients were using drugs, they indicated that they felt healthier. As one nurse said, "One thing that we might have made a difference in is keeping them healthier during the time that they were using, or maybe helped them prevent catching HIV while they were using." Nurses also noted that they were seeing fewer wounds, likely because clients were using better injection methods. One client stated, "I was losing weight because of the dope I did and now I've been clean for a while and I'm gaining my weight back. I'm now riding a bike. I'm healthy."

Making major changes in drug use. Some clients, nurses, and providers linked the Program to major changes in drug-use behaviour. These changes would likely have been greater had sufficient detoxification beds or other addiction services been available, although nurses were working with some clients in home detox. A service provider said:

I'd love to say that the outcome of the street nurse program is that people get off the street and move to suburbia...that does happen and we know that, but because most of us work in that area we don't necessarily see those people...a lot of success stories get lost because of where we're situated...people don't necessarily want to come back downtown and say...I'm doing great... Those people might not be in contact with us any more.

Although this result was not universal, several clients spoke of major changes in their drug use. Some had been clean for a period of time — for example, 3 months off dope; some said the street nurses were instrumental in getting them off drugs. A service provider also made the connection: "One thing we've certainly seen in any number of the patients is perhaps a reduction in drug use, using drugs in a manner that's less

dangerous, in a safer manner." The nurses also recounted stories of successful entries to detox and of people who had "gone straight."

Changing indicators likely reflective of decreased morbidity and mortality. From the perspectives of clients, nurses, and service providers, changes in morbidity and mortality were likely, although it is difficult to quantify those outcomes. Clients said they felt better and had less pain and discomfort because of medications they had received through the Program. They also said the Program was responsible for their not getting AIDS. "If it wasn't for this place, I would have AIDS." Nurses likely played a part in reducing the magnitude of the HIV epidemic because of their effectiveness in tracking and testing clients. There were fewer conversions to HIV positive (seroconversion) because clients used condoms and practised safer sex. One service provider was very clear on the incidence of HIV and the positive impact of the Program.

What we've seen is a slow decline in [HIV] incidence among men who have sex with men, one of the target populations. We're still seeing new rates of seroconversion, but every year since the program began we've seen a drop in their rates...but we're not down to an elimination of transmission... What we've seen in the street kids is a decline or a levelling in the heterosexually transmitted HIV. I'd say there's been a pretty good impact there... I think the nurses are responsible for reducing one of the major co-factors for transmission, genital ulcer disease...genital ulcer disease is responsible for increasing the transmission of HIV heterosexually sixfold...[the nurses] are bringing a lot of reality testing for people in terms of making...HIV testing much more available... There's a low level of sexually transmitted disease compared to a few years ago.

Some clients believed they were alive because of the nurses: "If it wasn't for the street nurses, I would probably be dead. I really believe that." "If it wasn't for Street Youth Services and the street nurse I probably would have ended up killing myself that night." Prevention of HIV through harm-reduction strategies results in fewer AIDS cases, and early diagnosis/treatment of HIV considerably extends the period between then and the development of AIDS. Assisting and encouraging clients to take better care of themselves promotes health and prevents disease. Although it is not possible to tease out the influence of the Program from other services and the use of triple-drug therapy, the AIDS mortality rate has decreased considerably since 1992: from 241 in 1992 to 11 in 1997; in addition, reported AIDS cases decreased from 296 in 1993 to 101 in 1998 (BCCDC, 1999), and the HIV-positive rate per 100,000 population decreased from 30.46 in 1987 to 12.09 in 1998.

The Program has also influenced other people, services, and programs. For example, the nurses' observations were important in identifying new outbreaks and epidemics, such as levels of syphilis and hepatitis C, and in influencing studies and program changes at the STD Control Division and the BCCDC. Program workers persuaded others, including key members of the drug-trafficking world, to make changes, changes that could have a direct and positive impact. For example, drug dealers agreed to stop selling drugs to youth in the area, although it is not known whether the agreement was honoured, or for how long.

Discussion

The impact of the Program's street nurses can best be understood in the context of health promotion and the concepts of empowerment and enablement. The *Alma-Ata Declaration* states that health promotion is the process of enabling people to increase their control over and improve their health (World Health Organization, 1978). The *Ottawa Charter for Health Promotion* states that "health promotion is the process of enabling people to increase control over, and to improve, their health...an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment" (World Health Organization, Health and Welfare Canada, & Canadian Public Health Association, 1986).

However, as McKnight (1985) states, it is impossible to produce health among the powerless. It is possible only to foster health by transferring tools, authority, budgets, and income to the powerless. Thus the Program had to empower the clients.

The term *empowerment* has been used widely. Though its definition varies, a core set of values and meanings has certainly been agreed upon. To empower is to give official or legal power or authority, to endow with ability, to enable. To enable means to authorize, to empower, or to make possible or effective (Rodwell, 1996). Both words connote the transfer of authority, knowledge, skills, resources, opportunities, and anything else necessary in granting someone the ability to do something they were previously unable to do.

In the context of health promotion, empowerment is a helping process that respects and values individuals and is intended to develop belief in oneself and one's future. At its core, enablement alters the distribution of power, but it also recognizes that power over one's health and well-being originates in self-esteem. Individuals make choices and

must accept responsibility for their actions. Thus health-care professionals cannot empower people; people have to empower themselves; what health-care workers *can* do is provide the resources, skills, and opportunities necessary to develop the client's sense of control.

If this transfer of resources, skills, and opportunities is to be fruitful, it must take place in an atmosphere of mutual trust and respect, education and support, participation and commitment (Rodwell, 1996), and power-sharing (Gibson, 1991).

This trust and respect must flow both ways; the power in the caregiver-client relationship must be shared. Health-care professionals need to surrender control or risk fostering dependence. They need to accept the fact that clients will sometimes make decisions counter to what the health-care professional wants for them. In fact, clients may reject their help altogether, and it is their right, as free cognizant human beings, to do so. In such a process, outcomes depend on individual differences; specifically, they depend on the client's growing self-awareness (Labonte, 1989) rather than on the services provided. In other words, the success of the step-by-step process of empowerment (with occasional backsliding) cannot be defined in any single way; it needs to be defined by the people concerned (Rappaport, Swift, & Hess, 1984).

The literature consistently identifies the following concatenation of benefits as outcomes, impact, or products of empowerment: positive self-esteem or self-concept, the ability to set and reach goals, a sense of control over life and change processes, a sense of hope for the future (Rodwell, 1996; Zimmerman & Warschausky, 1998), a sense of connectedness, self-development, social justice (in that people's choices have been respected), and an overall improved quality of life (Gibson, 1991). Gibson also indicates that an empowerment approach minimizes the client's sense of indebtedness.

These instilled or enabled personal attributes engender self-determined, independent health-promoting behaviours (Ellis-Stoll & Popkess-Vawter, 1998; Zimmerman & Warschausky, 1998). They enable individuals to become well and whole, to develop potential, to develop quality of life, or, if necessary, to let go of life (Jones & Meleis, 1993).

Needless to say, groups with the least power tend to be the ones most difficult to empower (Jenkins, 1991). This poses a challenge because it is precisely the most powerless groups, such as the chronically poor and the homeless, who experience the worst health (Rissel, 1994; Winkle & Ward-Chene, 1992).

In the AIDS Prevention Street Nurse Program, the nurses work with a complex and marginalized population, clearly a challenge in enabling positive health changes. However, the results of the evaluation show that the Program has enabled clients to make changes towards preventing HIV/AIDS and STDs, reducing harm, and promoting well-being. The changes reflected increasing levels of application and complexity, from promoting awareness, knowledge, and greater understanding to facilitating behavioural and attitudinal changes, which in turn promoted changes in health, illness, and disease transmission and resistance (see Figure 1).

Within a framework of non-judgemental care, trust, and respect, the nurses assisted and enabled clients to take one step at a time in becoming more aware of their health, factors influencing their health, and how to more effectively look after their health. Clients became connected to appropriate services and health-care providers and dealt with health situations at an earlier, less serious stage. The nurses helped prevent the transmission of HIV/AIDS and STD, and they assisted HIV-positive clients in increasing their longevity. Positive changes in clients' emotional and psychological well-being were also quite evident and reported by clients to be a result of the nurses' work.

At various points in the study, both the nurses and the clients stressed that the Program's benefits progressed through a series of stages, stages that are consistent with the "hierarchy of changes" described by Cohen and Kibel (1993) and consistent with the process of empowerment.

The nurses had to first generate interest and prove "effects"; then consolidate those effects into "gains" — sustained changes in knowledge, skill, attitudes, or behaviours; then get the clients to "buy in" — that is, to commit to implementing a problem-solving approach to their health. The third level in the process is "capacity enhancements" — actual changes in individual or organizational practices that prevent the onset of or reduce the severity of problems. The fourth level is "outcomes," or observable changes in the behaviour of target populations. The fifth and final level is "impacts" — the changes in social indicators reflecting reductions in problems. All of these levels of results were noted in the AIDS Prevention Street Nurse Program.

Though many of the clients seen by the street nurses remained in poor health, they demonstrated a "health within illness" perspective that emphasizes non-physical dimensions of well-being (psychosocial, social, and spiritual) that may increase or strengthen during the experi-

ence of an illness or transition (Moch, 1989). These clients grew in self-esteem, in their sense of control and understanding of their illnesses, and in their acceptance of their condition. Clients reported that these perceptions improved their quality of life.

When nursing interventions empower individuals or groups to develop their health potential, the nursing profession contributes significantly to achieving health for all.

However, the findings of this report must be interpreted in the light of limitations evident in the study, primarily due to the pragmatics of conducting such an evaluation. The limitations pertain more to the client group than to the nurses or other providers. Only those clients who consented to participate in the study were heard from directly, through their own input. Because the clients were from a marginalized and difficult-to-reach population, they presented more challenges than usual in having their voices heard. It may be that those who had negative experiences in working with the nurses were not heard from adequately; however, every effort was made to register the variation in voices. Although several efforts were made to include ex-clients, this was not feasible because there was no way of contacting them. In addition, even though the investigators made the best use of the resources that were available, the evaluation had only limited funding. In spite of these limitations, we believe the sample is reasonably representative of the thoughts and concerns of nurses, other providers, and clients.

In conclusion, the results of this evaluation reflect the effectiveness of the AIDS Prevention Street Nurse Program in encouraging clients to take one step at a time towards preventing HIV/AIDS and STDs, reducing harm, and promoting well-being. A single program is not likely to result in significant change at the community level, and should be viewed in terms of its contribution to the achievement of broader community outcomes (Cohen & Kibel, 1993). Many core issues cannot be addressed by programs such as the AIDS Prevention Street Nurse Program. It is just one of many that work with this particular client population. For maximal effectiveness, all parties concerned should take advantage of every opportunity for partnering, coordinating, and collaborating on current and future health-care delivery. The AIDS Prevention Street Nurse Program is identified by the Vancouver/Richmond Health Board and other user agencies as a good example of partnering and collaborating with clients and with other programs in the downtown areas of Vancouver. It is often cited as an example of successful community collaborating and partnering.

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The Prince Edward Island Conceptual Model for Nursing: A Nursing Perspective of Primary Health Care

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L'approche sur laquelle reposent les soins de santé primaires tient compte du fait que la santé est le produit d'un ensemble de facteurs d'ordre individuel, social, économique et politique et que les personnes ont le droit et le devoir, tant sur le plan individuel que collectif, de participer à la préservation de leur état de santé. La majorité des modèles de soins infirmiers cantonnent le client dans un rôle dépendant, sans chercher à envisager la santé selon le contexte social, économique et politique. Le modèle conceptuel des soins infirmiers de l'Île-du-Prince-Édouard s'inscrit dans le courant mondial actuel vers les soins de santé primaires. Il permet de guider l'infirmière dans sa pratique, laquelle est indissociable de l'environnement social et politique. Ce modèle propose un partenariat entre l'infirmière et le client, l'objectif étant d'encourager celui-ci à se prendre en main et à agir. Cette manière d'envisager l'environnement en tant qu'incidence de nature collective sur les déterminants de la santé place l'infirmière et le client au premier plan de l'arène socio-politique sur les questions de santé et de soins.

The philosophy of primary health care (PHC) recognizes that health is a product of individual, social, economic, and political factors and that people have a right and a duty, individually and collectively, to participate in the course of their own health. The majority of nursing models cast the client in a dependent role and do not conceptualize health in a social, economic, and political context. The Prince Edward Island Conceptual Model for Nursing is congruent with the international move towards PHC. It guides the nurse in practising in the social and political environment in which nursing and health care take place. This model features a nurse/client partnership, the goal being to encourage clients to act on their own behalf. The conceptualization of the environment as the collective influence of the determinants of health gives both nurse and client a prominent position in the sociopolitical arena of health and health care.

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Primary health care (PHC) continues to be proposed as the cornerstone of health-care systems as we enter the 21st century (World Health Organization [WHO], 1998). In 1977, World Health Organization (WHO) member states declared that economic and social factors had to be addressed in the interests of global health. PHC was proposed as a strategy for the achievement of health for all (WHO, 1978). Landmark documents such as the *Ottawa Charter* (1986) and *Achieving Health for All* (1986) support PHC principles and philosophy. The decision to adopt PHC implies a need for a new approach to health care, one based on broad definitions of health and focused on the idea of partnerships among clients, health-care providers, and communities. PHC is defined as:

...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford...at every stage of their development in the spirit of self-reliance and self-determination... It is the first level of contact of individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (WHO, 1978, pp. 3-4)

PHC is both a philosophy and a delivery method of care. As a philosophy, it acknowledges that health is a product of individual, social, economic, and political factors. A system founded on this philosophy supports a social framework built around the ability of individuals, families, groups, and communities to control their own health. As a delivery method, PHC implies a commitment to essential health care (preventive, promotive, curative, rehabilitative, supportive) and equitable distribution of care to all populations, with optimal individual and community involvement (Kekki, 1990; WHO, 1978, 1998).

Nurse theorists have alluded to the importance of PHC but have so far failed to conceptualize a nursing model based on it (Meleis, 1990). The majority of nursing models focus on care of the ill client, with the client cast in a dependent role (Hughes, 2000). Furthermore, most nursing theories do not conceptualize health in a social, economic, and political context.

All nurse theorists address person, health, environment, and nursing, the four metaparadigm concepts of nursing, in ways that reveal the beliefs underlying their specific theory. The Prince Edward Island Conceptual Model for Nursing redefines these four concepts from a PHC perspective. The PEI model evolved from a need to provide

students with guidelines for nursing practice based on PHC. It was a response to new conceptualizations of health, changes in health-care delivery, and demands by consumers for a voice in their own health care.

We will describe the four metaparadigm concepts from the perspective of the PEI model. We will include a discussion of PHC principles and the implications of this approach for nursing practice, research, and education. The 16 assumptions underlying the PEI model represent our value statements about person, health, environment, and nursing and the relevance of PHC principles (Table 1). The assumptions are basic truths, accepted at face value and providing the basis for theoretical reasoning.

Person

In the PEI model the concept of *person* can mean individual, family, group, or community.

Individual

Person as individual is a unique human being who has both shared and unique characteristics but who ultimately has unique needs. Person as individual is a complex, holistic being, a biological, psychological, sociological, cultural, spiritual, and developmental composite. Person as individual functions within a system of beliefs and values and consequently ascribes unique meanings to life experiences.

Family

Person as family is two or more individuals bound together over time through mutual consent and/or birth, adoption, or placement. The family's structural, developmental, and functional dimensions (Wright & Leahey, 1994) describe the composition, developmental stage, internal and external relationships, and activities of family members.

Group

Person as group is a collection of two or more interacting individuals with a common purpose and a common goal.

Community

Person as community is all individuals who reside in a particular geopolitical entity (city or town) or who share some characteristic (e.g.,

religion, age, culture, occupation). The essence of any community is its people. The dimensions of a community include: communications, economics, recreation, education, safety, transportation, politics, and health and social services (Anderson & McFarlane, 1996). A community may be as simple as a few families living in close proximity or as complex as the world community with its highly organized institutions.

Table 1 *Assumptions of the Prince Edward Island Conceptual Model of Nursing*

1. Clients have the potential to become active participants in problem-solving on behalf of themselves or others.
2. Clients have the right to be informed, to essential health care, to independent choice, to participate actively in decision-making and problem-solving, to privacy, and to make choices concerning the use of appropriate technology.
3. Clients are partners in their own health care.
4. Health incorporates both wellness and illness.
5. Wellness promotion and illness prevention are the essence of nursing practice.
6. Wellness promotion is relevant regardless of the current state of health.
7. Health is a political process.
8. Environment is a source of support as well as stress.
9. Environment may positively or negatively affect health.
10. A supportive environment promotes wellness and prevents illness.
11. Nursing can be practised according to the principles of PHC in any setting.
12. The principles of PHC guide the nursing process and the roles undertaken by the nurse.
13. Wellness is promoted through a collaborative process and/or a partnership between nurses and others.
14. Nursing practice is based on a caring philosophy.
15. The five principles of PHC are applicable in any given health situation, but all may not receive the same emphasis.
16. PHC is the most effective means of achieving wellness for all persons.

Health

Health is conceptualized as a dynamic process incorporating both wellness and illness and influenced by political, economic, social, and biological factors. In the PEI model these factors are the determinants of health. The extent to which they exist in a client's life determines his/her level of health. Wellness and illness are understood to be unique, sometimes co-existing, facets of health. The overlap between the two represents the conceptual view that illness may exist in wellness, and vice versa. Wellness and illness are subjective concepts, influenced by: perceptions of health; health beliefs; the value placed on health; health practices; and the social, economic, and political context of health.

Wellness

Wellness is defined as a resource for everyday life, not just the object of living. It is the extent to which one is able to realize aspirations, satisfy needs, and change or adapt to one's environment (WHO, Health and Welfare Canada, & Canadian Public Health Association, 1986). It has biopsychological, political, economic, and social components.

Illness

Illness is defined as one's response to disease, loss, or dysfunction or to one's political, economic, and social circumstances. Like wellness, it has biopsychological, political, economic, and social components.

The extent to which the determinants of health are or are not in place will significantly influence the level of health or illness of the individual, family, group, or community. For example, an individual with a social support system, a job, and an education will experience more wellness — have a greater ability to realize aspirations, satisfy needs, and change or adapt to the environment — than a person without a social network, employment, or education.

Environment

Environment is defined as the context, both internal and external, in which one lives, works, plays, and learns (Gottlieb & Rowat, 1987; Haglund, 1997). The PEI model focuses on the sociopolitical factors that affect the health of individuals, families, groups, or communities. This perspective has led to a conceptualization of the environment as the collective influence of the determinants of health. In the PEI model these

determinants are: income, social status, education, social support networks, employment and working conditions, physical environment, biopsychological endowment and genetics, personal health practices and coping, early childhood development, and health services (Advisory Committee on Population Health [ACPH], 1994).

Income, social status, and education have been classified as the socioeconomic determinants of health (Reutter, 2000). Longitudinal population studies have found clear indications of increased mortality and morbidity (chronic illness, low birth weight, higher crime rates, higher rates of smoking, lower rates of exercise, increased prevalence of dental caries) among people in lower socioeconomic classes (Warren, 1994; Wilkinson, 1996). Lack of access to a fair share of a country's resources is a major cause of illness and mortality (Wilkinson). A socially just society seeks to reduce class inequities and thereby improve population health.

Income affects one's ability to eat nutritiously, dress warmly, and secure adequate shelter. It indirectly influences health in terms of stress, self-esteem, and life choices (Reutter, 2000). Education provides the knowledge required to make positive choices and thus maintain or restore wellness. It enhances one's ability to resolve problems and mobilize resources (Warren, 1994). Educated consumers are better able to protect their own health, help others, create healthful environments, advocate for healthful living and working conditions, and secure employment.

Research indicates that social support influences health by cushioning the impact of stressors. Social support networks provide a sense of predictability, stability, and acceptance (Stewart, 2000). Mutual aid and support, a central theme in health-promotion philosophy, is manifest in the self-help group (Stewart).

Employment is an important determinant of health. Mortality rates have been found to be 40 to 50% higher among the jobless (Wescott, Svensson, & Zollner, 1985). Unemployment, or the threat thereof, can result in physiological and psychological distress. Poor working conditions, such as exposure to toxins, extremely physically demanding labour, lack of control in the workplace, and poor working relationships can also contribute to diminished health.

The physical environment includes one's immediate and extended environment — home, school, workplace, community, stratosphere.

Elements of the physical environment affect the health and development of individuals, families, and communities. In Poland, for example, improved population health as a result of economic growth was followed by a decline as industrial development brought air, water, and soil pollution (Hertzman, Frank, & Evans, 1990). WHO (1998) reports that pollution leads to 3 million premature deaths each year.

Biopsychological endowment and genetics are determinants of health. Mutations in the genetic code of cells increase the potential for inherited disease such as cancer and heart disease. The exact expression of the inherited disease is determined by social and environmental factors (Mustard & Frank, 1991). The science of psychoneuroimmunology attempts to explain the biological, psychological, social, and environmental interrelationships that affect health, human behaviour, and physical development.

Empirical research and anecdotal reports show a relationship between personal health practices and health outcomes. Personal health measures such as exercise, proper nutrition, positive relationships, and stress management contribute to a sense of energy, vitality, and fulfilment (Pender, 1996). Coping is the process of regulating emotions and behaviours and managing one's environment (Pender). It can be used to adapt to or change one's environment in order to achieve a state of wellness. Negative methods of coping, such as substance abuse or other high-risk habits, increase the risk for injury and illness (Lazarus & Folkman, 1984).

Early childhood experiences can have a permanent effect on physical, emotional, and social health. At birth, the parts of the brain that control emotional and social behaviour, as well as thinking and remembering, are significantly underdeveloped. The neurons and the connections between them develop through warm and supportive relationships, particularly those with parents (McCain & Mustard, 1999). Such relationships also contribute to the development of trust, self-expression, self-esteem, and empathy (Premier's Council on Health Strategy, 1991).

The final determinant of health is essential health services. Currently, health services are focused on curing disease and providing medical care. While medical interventions can clearly benefit individual clients, evidence suggests that they do not result in a corresponding improvement in population health (Mustard & Frank, 1991). Thus resources should be allocated to those promotive and preventive services that address social and environmental health.

Nursing

In the PEI model the goal of nursing is to promote wellness and prevent illness. Nursing practice is influenced by the five principles of PHC: accessibility, public participation, appropriate technology, wellness promotion and illness prevention, and intersectoral collaboration.

Accessibility

Accessibility is the geographic, cultural, financial, and functional availability of essential health services to people where they live, work, and play. Geographic accessibility means that general services are available locally or through mobile clinics and that specialized services are available at larger health-care centres. Cultural accessibility means that services are sensitive to cultural beliefs and practices as well as to alternative approaches to health care. Financial accessibility means that cost is not a barrier to receiving essential health care. Functional accessibility means that physical or cognitive ability, literacy level, or language are not barriers to receiving care. Accessibility also implies access to the determinants of health (ACPH, 1994).

In the PEI model, the nurse is concerned with accessibility, especially regarding vulnerable groups such as the poor, the homeless, and the disenfranchised.

Public Participation

Public participation refers to the right of individuals, families, communities, and nations to self-determination and self-reliance in health matters (WHO, 1998). This principle originates in the concept that people have the right and the duty, individually and collectively, to participate in their own health. Governments and health-care providers have a coincident duty to provide information and the social framework for individuals, families, groups, and communities to be active partners in identifying their health concerns and in planning, implementing, and evaluating their own care (Epp, 1986).

The client works in partnership with health-care professionals, government and non-government organizations, lay helpers, and other sectors of society to promote individual and collective wellness. In PHC, "participation is encouraged out of recognition that [persons] bring their own perspective and their own expertise to issues, and these may contribute a great deal more to the quality of decisions than if the decisions are made by health workers alone" (Wass, 2000, p. 63). Access

to information concerning health and wellness is an essential element of public participation. This principle inspired the idea of partnership as the foundation of the nurse-client relationship in the PEI model. Partnership is defined as the:

...negotiated sharing of power between health professionals and individual, family, [group], and/or community partners. These partners agree to be involved as active participants in the process of mutually determining goals and actions that promote [wellness]. The ultimate goal of the partnership process is to enhance the capacity of individual, family, [group], and community partners to act more effectively on their own behalf. (Courtney, Ballard, Fauver, Gariota, & Holland, 1996, p. 180)

The nurse encourages the client to take an active role in determining his/her needs and planning appropriate interventions. The client retains the option to remain passive. However, if s/he accepts the partnership model, the nurse and client jointly establish the goals. Both partners' roles and responsibilities are continually negotiated and their contributions valued.

Appropriate Technology

Appropriate technology is the use of affordable, ethical, legal, relevant interventions, techniques, and resources to assist individuals, families, groups, and communities in achieving and maintaining health. The appropriateness of a technology is determined on the basis of its relevance to those who use it and/or on a scientific basis. It may be any combination of human resources, financial resources, information and its transmission methods, techniques, and equipment (WHO, 1978).

Appropriate technology supports the principle of staying healthy longer rather than extending unhealthy life. It includes preventive measures such as immunization, social frameworks to reduce poverty, availability of essential drugs, and universal environmental protection laws (WHO, 1998). The goal is to reduce premature mortality, morbidity, and disability by enabling people of all ages to achieve their intellectual and physical potential and improve their quality of life (WHO, 1998).

The PEI model incorporates technological innovations into the plan of care, to facilitate access to services and to help clients achieve self-reliance and self-determination. Simple, low-cost interventions that require little or no training are often most effective for the majority of clients (Stewart, 2000).

Wellness Promotion and Illness Prevention

Wellness promotion — creating environments in which people can care for themselves (Canadian Nurses Association, 1992; Epp, 1986) — is a process of enabling persons, whether ill or well, to have more control over their health and thus reach their full potential. Empowerment is the process of fostering “more equitable...relationships...in which there is greater equality in resources, status and authority” and greater personal strength, effectiveness, and power (Registered Nurses Association of British Columbia [RNABC], 1992, p. 9).

The nurse’s role in wellness promotion is to focus on enhancing the client’s knowledge, skills, and ability to act and to offer support in resolving and managing collective health problems (Courtney et al., 1996). In partnership with the client, the nurse identifies and builds upon existing strengths. Given the right environment, the strengths will come to the fore and wellness will emerge (Raeburn & Rootman, 1998).

In the PEI model, illness prevention includes helping people to cope with their circumstances, such as identifying factors that cause injury or illness and intervening to reduce or eliminate them (Epp, 1986).

In illness prevention, nurse and client work together to change or eradicate environmental barriers to one’s ability to realize aspirations, satisfy needs, or adapt. Nursing interventions encompass three levels of prevention: primary, secondary, and tertiary. Primary prevention refers to measures taken before a problem occurs (Leavell & Clark, 1965), such as encouraging the use of a bicycle helmet to prevent head injury. Secondary prevention involves screening of at-risk populations and intervening to reduce the risks (Leavell & Clark). Tertiary prevention involves minimizing the effects of illness and disability once a disease/injury has occurred and preventing complications or premature deterioration (Smith, 1995). In illness prevention, the nurse focuses on the client’s response to a situation and on helping clients to address their concerns. Nurse and client work together to achieve the client-identified potential (Hughes, 2000).

Intersectoral Collaboration

In intersectoral collaboration, individuals and groups work together across societal sectors to create conditions that support and promote wellness (RNABC, 1990; WHO, 1997). The societal sectors include not just those whose mandate is health, but also institutions and aggregates

such as government bodies, education, agriculture, transportation, environmental services, business, and health-care consumers (WHO, 1997). The interdisciplinary health team is integral to intersectoral collaboration.

The increasing interconnectedness of issues — the blurring of geopolitical, disciplinary, organizational, and functional boundaries — calls for a strengthening of intersectoral collaboration (WHO, 1997). Intersectoral collaboration is central to the idea that population health affects economic growth. Once recognized, this idea could result in health care's gaining equal status with economic and social security, thus strengthening world resolve to eliminate poverty and health inequities (WHO, 1997).

In the PEI model, the nurse is challenged to think "upstream" about the social, political, and economic factors that contribute to a health concern. The nurse identifies potential wellness collaborators both within and outside the health sector. Each member of the team is an equal contributor, with his/her expertise being valued and respected.

The Nursing Process

In relation to the nursing process, a conceptual model provides guidelines for observing and then interpreting the observations. It gives rationale for interventions and direction for evaluating the outcomes (Fawcett, 1995). In the PEI model, all steps in the nursing process — assessing, identifying the health concern, planning, implementing, and evaluating care — are carried out in partnership with the client. The second step, identifying the health concern, was renamed to fit the conceptual definitions of this model. The health concern can be either a strength or a problem.

While the PEI model assumes that all PHC principles are applicable in a given health situation, they will not all necessarily receive the same emphasis or be equally relevant to each situation. Public participation is a guiding principle at every step in the nursing process. Accessibility is also relevant for every step but is of most concern during planning, to ensure that the plan is truly accessible for the client. Appropriate technology is especially important during assessment, implementation, and evaluation. Intersectoral collaboration is integral to planning and implementation and is relevant to assessment in particular client situations. The overall emphasis of implementation, for all

individual, family, group, and community situations, is wellness promotion. Following are some brief examples of the nursing process in the PEI model.

Assessment. Conceptual definitions in the PEI model provide clues about what to assess. For example, a comprehensive assessment would include data on all of the dimensions and characteristics of *person* and the environment. The findings are confirmed with the client. During this phase, the principle of appropriate technology is demonstrated when the nurse uses her/his five senses and/or knowledge and assessment skills to draw a comprehensive picture of the client.

Identifying the health concern. Working in partnership, the nurse and client identify and assess the immediate health concern. The nurse shares his/her observations and findings, seeks the client's perspective, and works with the client to identify the area(s) of most concern. Once the client's immediate concern has been addressed, a more detailed assessment is conducted and the nurse and client redefine the concern. If they cannot agree on the identification and priority of health concerns, the client's decision takes precedence.

Planning. The plan must be accessible to the client geographically, culturally, financially, and functionally, and the appropriate resources for the particular situation must be considered. The client's situation may call for both intersectoral and interdisciplinary collaboration. The collaborators could include a nurse and a pharmacist (health sector), a teacher (education sector), and a policy planner (government sector). The client plays a key role in decision-making, including setting priorities and determining his/her ability to implement the changes.

Implementation. The goal of implementation is the achievement of wellness and the prevention of illness. For example, a community that is concerned about increasing numbers of adolescent smokers would identify the appropriate resources and sectors to address this concern. The nurse facilitates collaboration between the various sectors in drawing up a comprehensive non-smoking plan.

Evaluation. Nurse and client evaluate the process and outcome of the plan on the basis of PHC principles. In evaluating accessibility, for example, they could ask the following questions: Was there a convenient place for the client to take his/her health concerns (geographic accessibility)? Did the client have enough money to get to the clinic or to purchase the required resources (financial accessibility)? Was the educational material presented at a level the client could understand

(functional accessibility), and was it culturally appropriate for the client (cultural accessibility)?

Relationship Statements

The relationship statements concern the unique aspects of the PEI model, as follows: (a) clients influence and are influenced by their interaction with the environment; (b) environment is the context in which health-related activities take place; (c) health is influenced by the sociopolitical environment and the determinants of health; (d) clients function in partnership with nurses and other sectors; (e) clients achieve wellness through a process of collaborating with nursing and other disciplines and sectors; (f) the sociopolitical environment influences the interaction of clients with the determinants of health (within the context of their environment); and (g) nursing, functioning through a PHC filter, works in partnership with clients to achieve wellness and/or prevent illness. A schema of the person/environment/nursing relationship is presented in Figure 1.

Implications for Nursing Practice, Research, and Education

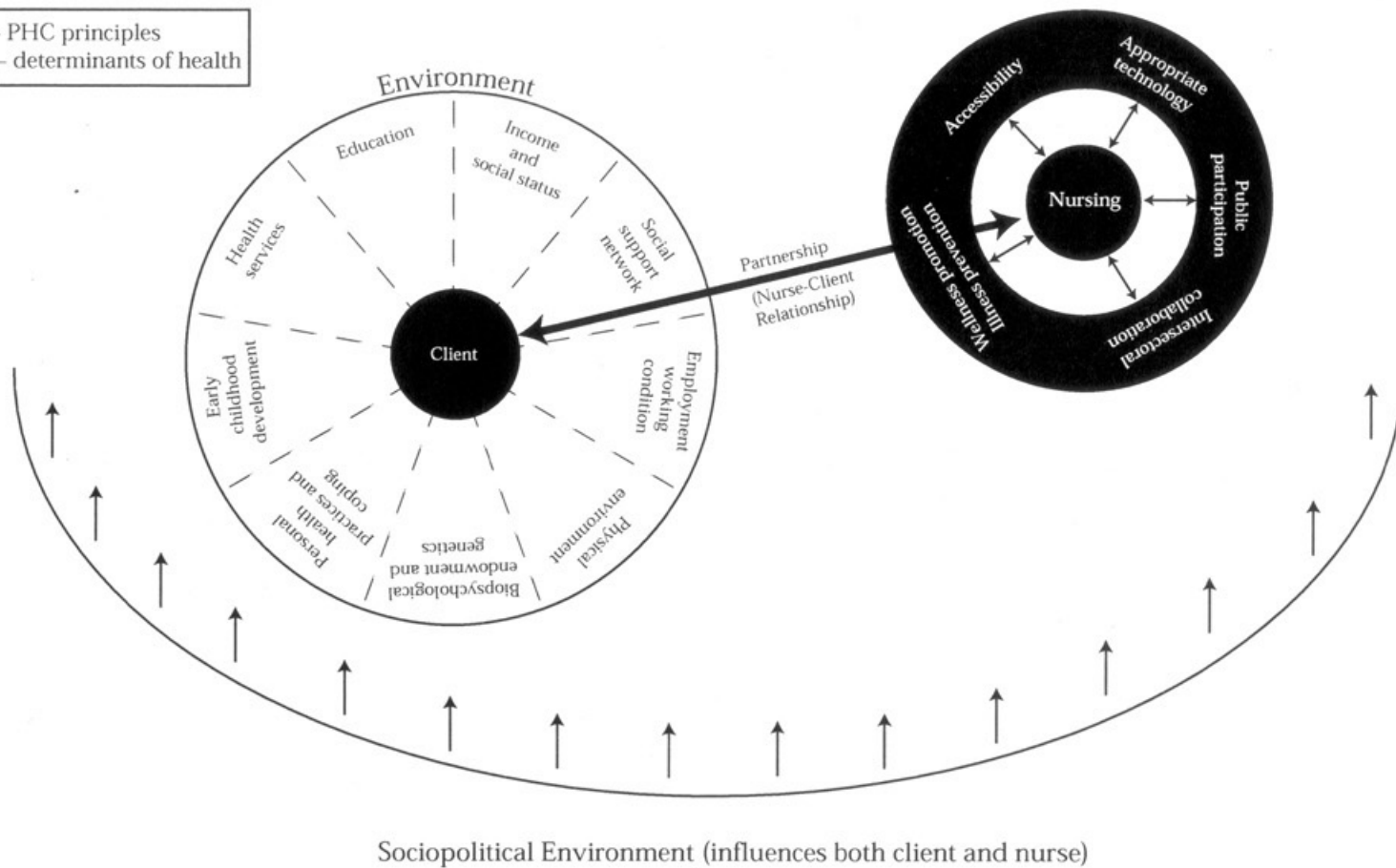
The PEI model provides rich opportunities for practice, research, and education. It guides nursing through identification of the dimensions of client and environment, description of the components of health, and articulation of the profession from a PHC perspective.

Research may include theoretical and practical testing of new concepts of the model as they emerge, testing of relationship statements linking the metaparadigm concepts, and testing of a newly derived set of propositions to validate the model. A demonstration project could be launched to determine how the five PHC principles interact with and influence implementation of the nursing process, and research could be conducted to determine what communications skills are required by practitioners in a partnership-based nursing framework. Central to any research in a PHC model is inclusion of the client partner in the process and products of research.

The PEI model can be used as a guide for curriculum design and implementation. The student-teacher relationship is one of partnership, teaching strategies favour student participation, and the content focuses on PHC philosophy and principles as applied to nursing. The political role of the nurse is stressed, with students learning to intervene at the sociopolitical level.

Figure 1 *Person/Environment/Nursing Relationship: A Primary Health Care Approach*

Black — PHC principles
White — determinants of health



Summary

Traditionally, nursing models have focused on the nurse-client relationship rather than on the social, economic, and political context of health, health care, and nursing (White, 1995). PHC clearly identifies health and health care as political, necessitating a model to guide health-care delivery and nursing practice in an emerging sociopolitical environment.

The PEI Conceptual Model of Nursing based on PHC is a response to the new conceptualizations of health and to changes in the health-care system. Consistent with the international movement for PHC, it challenges nurses to work with clients in new ways. A distinctive feature of the PEI model is that clients are urged to assume responsibility for decision-making in relation to their health care. The nurse-client partners identify and build on existing strengths in order to promote health. Conceptualization of environment as the collective influence of the determinants of health places nurse and client prominently in the sociopolitical arena of health and health care.

The challenge now is to invite dialogue, critique, and testing from a wider circle of colleagues in order to promote the model and, more importantly, further refine it. This is only a beginning.

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A Nursing Association's Leadership in Primary Health Care: Policy, Projects, and Partnerships in the 1990s

Nora Whyte and Sharon Stone

Cet article fait état de l'œuvre d'une association provinciale d'infirmières, la *Registered Nurses Association of British Columbia (RNABC)*, qui promeut les soins primaires (PHC) en tant que fondation du système de santé. En 1990, la RNABC a lancé un programme général de politiques dans le but d'influer sur les changements selon la perspective des infirmières. Un large éventail de stratégies a été mis en pratique au cours d'une période de 10 ans, afin d'introduire les soins primaires au sein du système de santé de la Colombie-Britannique. Les stratégies qui ont porté fruit comprennent, entre autres : la rédaction et la diffusion de documents de politiques, la mise en application et l'évaluation de projets pilotes, et la création de partenariats avec d'autres groupes. Certains des projets et les résultats obtenus sont mis en lumière et une réflexion critique est faite concernant les apprentissages issus des différentes initiatives. Bien que le travail de la RNABC dans les années 90 en matière de politiques ait donné lieu à des réalisations remarquables, l'intégration des soins primaires nécessite de plus amples efforts concertés s'appuyant sur des stratégies multiples.

This paper documents the work of one provincial nursing association, the Registered Nurses Association of British Columbia (RNABC), to promote primary health care (PHC) as the foundation of the health-care system. In 1990 the RNABC embarked on a comprehensive policy program to influence change from a nursing perspective. A wide array of strategies was used over a 10-year period to help make PHC a reality in British Columbia's health-care system. Successful strategies used during this period included: writing and distributing policy papers, conducting and evaluating demonstration projects, and developing partnerships with other groups. Some of the projects and their outcomes are highlighted, followed by a critical reflection on lessons learned through the various initiatives. Although remarkable achievements were made from the RNABC's policy work during the 1990s, the advancement of PHC requires further collaborative efforts using multiple strategies.

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In the years following the *Alma-Ata Declaration* (World Health Organization [WHO], 1978), nursing associations around the world endorsed primary health care (PHC) as a philosophy and approach to health care. The International Council of Nurses and its members, including the Canadian Nurses Association (CNA), articulated a role for nurses in PHC and emphasized that PHC should become a foundation of our health-care system (Canadian Nurses Association, 1988, 1995; International Council of Nurses, 1988). Likewise, provincial and territorial associations published position statements and undertook activities to promote PHC in their jurisdictions throughout Canada (Rodger & Gallagher, 1995).

This paper offers a description of activities undertaken by the Registered Nurses Association of British Columbia to institute PHC in nursing practice and influence provincial and local health policy. Specific projects and strategies will be used as examples of developments that took place in one province during the 1990s. Although individual projects have been reported upon, it is rare to find a reflective review of a series of activities to achieve major policy change. We begin with a brief description of British Columbia's health policy environment in the past decade and the groundwork done by the nursing association to influence the process of health-care reform. The latter part of the paper highlights activities carried out in partnership with other organizations to achieve desired changes in PHC. We conclude with a reflection on the lessons learned during the past decade and some recommendations for future policy initiatives.

The Context

The early 1990s provided a welcome opportunity to consider changes in the delivery of health services. Most jurisdictions in Canada embarked on major reviews of their health-care systems beginning in the late 1980s or early 1990s. The findings and recommendations of these royal commissions and other inquiries were similar across the country; most focused on the themes of cost containment, greater flexibility, integration of services, community-based care, and increased public involvement in decision-making (Lomas, 1993; Rachlis & Kushner, 1994). British Columbia opted for a decentralized model of governance with the eventual creation of 52 health authorities. Much of the health reform effort during this period was devoted to "regionalization," which focused on setting up and embarking upon local governance of the health-care system.

The Groundwork: New Directions for Health Care

The Registered Nurses Association of British Columbia is the professional regulatory body for the province's 35,275 registered nurses. Since the 1980s, the RNABC has advocated for a health-care system based on the well-known principles of PHC: public participation, accessibility, intersectoral cooperation, appropriate technology, and health promotion (WHO, 1978).

In 1990 the RNABC launched a policy program, *New Directions for Health Care*, to influence provincial health policy from a nursing perspective. The RNABC defined this unique nursing perspective as an outlook inherent to the profession of nursing. Consequently, the Association set out to influence health policy by drawing upon the profession's knowledge of the health-care system and existing health issues in the province combined with nursing's analysis of the need for health-care reform. PHC was the foundational concept on which the policy program was based because of the congruence with nursing's values and the RNABC's vision for the future of health care. Early work involved the publication of a position statement and a series of discussion papers on topics such as nursing roles, PHC, and health goals (Registered Nurses Association of British Columbia [RNABC], 1990a, 1990b, 1990c, 1991). These papers formed the basis of the Association's submission to the British Columbia Royal Commission on Health Care and Costs (RNABC, 1990d).

In carrying out its *New Directions* program over a 5-year span, the RNABC used multiple strategies involving its Board of Directors, its members, its staff, and other organizations. The Board made it a high priority and allocated resources to the program; for instance, the executive committee of the Board acted in a strong advisory capacity by setting targets and reviewing progress on a regular basis. The Board also provided an annual budget for a full-time coordinator and for program activities. A policy planning framework guided the program through four phases: position development, communication, facilitation of change, and evaluation.

Position development was the focus of the first year as issues were identified and clarified through discussion papers and strategic planning sessions with key constituents. Some of the long-term objectives of the program were: to incorporate PHC content in all nursing education programs; to promote a shift in health-care resources from acute care to prevention and health promotion; to promote the establishment of

provincial health goals; to increase the use of registered nurses as point-of entry to the health-care system; and to increase the number of community health centres.

Communication activities were extensive, targeted initially to RNABC members, then broadening to the public. As the program gained momentum, a speakers bureau was developed to communicate these messages to various audiences (service clubs, health-care providers, nursing schools) throughout the province. A documentary video series was produced and shown on community television throughout British Columbia. RNABC representatives gave presentations at national and international conferences, wrote journal articles, and disseminated materials widely.

A significant part of the program focused on projects as a method for clarifying and demonstrating PHC principles in practice. These projects examined changing roles of nurses in specific practice settings and recommended ways to ensure that nursing practice was consistent with PHC. One such project, carried out in collaboration with an urban public health department, examined the role of nurses in community development. Lessons learned from that 2-year project informed a later demonstration project (RNABC, 1996).

Another project, a study of the role of hospital nurses in health promotion, showed that nurses in acute care valued their health promotion role and sought to increase their competence in this area (Berland, Whyte, & Maxwell, 1995). In conjunction with a group of occupational health nurses, the RNABC also conducted an assessment of needs for nursing services and health promotion in small industry. These findings were used to communicate with decision-makers on the subject of nursing's contribution to workplace health. Experience gained from conceptualizing and implementing these small projects set the stage for the flagship Nursing Centre demonstration project, developed in 1994.

The projects served as concrete examples of the kinds of changes needed and stimulated members' interest in the program. A second method of facilitating change involved education of members through consultation in their agencies and workshops designed to help nurses apply PHC in their practice and in mounting community projects. Considerable work was done to influence change in nursing education through a curriculum study of PHC in British Columbia nursing schools (RNABC, 1994a) and meetings with nurse educators.

A formal evaluation of the overall program was carried out at its conclusion (RNABC, 1995). In reflecting on what had been accom-

plished, the RNABC concluded that the most significant outcome was the influence exerted on provincial health policy: government officials and other organizations had deemed the Association's submission to the Royal Commission as having an impact on the health reform process. Many of the RNABC's recommendations were incorporated into the government's framework for reform. With respect to influencing nursing education, 90% of the province's schools of nursing were, by 1994, using the New Directions discussion papers to educate students in PHC. Recognition by nurses in other jurisdictions also attested to the impact of the RNABC's work.

Comox Valley Nursing Centre

Building on the New Directions program, the RNABC embarked on a major collaboration with the Ministry of Health through the office of the Provincial Nurse Advisor. The purpose of the Nursing Centre demonstration project was to establish and evaluate a nursing service based on the principles of PHC. The 2-year demonstration period (1994–95) was funded by the British Columbia Ministry of Health; the external evaluation component was funded through two research grants awarded to a team of investigators (RNABC, 1996). A provincial advisory committee included representation from government, the nurses union, universities, and the medical profession. Comox Valley, on Vancouver Island, was chosen as the demonstration site following an extensive province-wide selection process. Once the project was underway, a team of registered nurses provided a wide range of services and programs in response to community needs. The practice included health assessment, counselling and health-care interventions, referral, and follow-up. The Nursing Centre became a responsive health resource centre, where clients could drop in and have easy access to a nurse and a wide array of health information. Over time, numerous support groups were formed and staff became involved in partnerships for public health promotion and advocacy.

Though not without its challenges — documented with considerable candour by the external evaluation team (Attridge et al., 1996) — the project was deemed a success. The evaluators and the RNABC issued comprehensive reports with recommendations for future action (Attridge et al.; RNABC, 1996). A strong recommendation to the Ministry of Health was that health-promoting nursing practice — as demonstrated in the project — be recognized as an essential component of future interdisciplinary health centres. A notable outcome is that the Comox Valley Nursing Centre continued beyond the demonstration

period because community members lobbied to keep it as part of the area's health services. Today it is fully funded by the Comox Valley Community Health Council (the local health authority), with which it shares a convenient storefront location in downtown Courtenay. Its programs have evolved in response to changing health needs and issues, as highlighted in a recent report:

Over the past five years we have been successful in identifying significant gaps in health service delivery and collaborating with a variety of other community agencies. Our biggest challenge now is to go beyond the "Nursing Centre" concept and create an enhanced multi-disciplinary practice. Integration with other agencies would be a long term goal. (Health Centre Working Group, 1999a, p. 13)

New Strategies for Influencing Health Policy

Following the success of its New Directions program and the Nursing Centre project, the RNABC continued to work with its members to support local initiatives in health reform. Some of the more recent activities and strategies are outlined below. It is also worth pointing out that by the mid-1990s the RNABC had adopted a regulatory framework for promoting good practice, preventing poor practice, and, when necessary, intervening with unacceptable practice. Policy initiatives aimed at the provincial health system, such as advocating for improved access to community-based health services, are one way of "promoting good practice." In recent years the RNABC has assisted its members in providing a nursing perspective on policy approaches to foster improvements in their health-care agencies and communities.

In 1998/99 the RNABC developed a five-module workshop, *Influencing Health Policy*, to help its members work effectively in groups, acquire the competency to identify and take action (at a policy level) on local health issues, and form partnerships in community action. The conceptual framework for the workshop was Labonte's (1994) empowering strategies model based on health promotion practice. The development of the workshop was a response to an educational need that emerged through member input from program evaluation, teleconferences, and other discussions. One of the workshop modules was designed as a result of lessons learned from the National Think Tank on Primary Health Care and Nursing (RNABC, 1998a).

In 1998 the RNABC published *The New Health Care: A Nursing Perspective*, a 70-page document that looks at PHC and health-care reform from a nursing viewpoint (RNABC, 1998b). It is an update of a shorter document produced in 1994. The 1998 document is currently

used by nursing educators and their students in most British Columbia nursing schools. In addition, the Association formulated a policy position on the subject, which was revised in 1999. Support for PHC as the foundation of the health-care system is apparent in the RNABC's current vision and statement of guiding principles.

That same year the RNABC held a number of teleconferences on community development and local capacity-building initiatives facilitated by nurses in British Columbia, as well as a provincial teleconference on PHC. Articles on nurses' roles in PHC continue to be published in *Nursing BC* (e.g., Griffiths, 1999; Stone, 1999). The RNABC has also participated on the steering and evaluation committees of Partnerships for Better Health, a 2-year self-care pilot project co-sponsored by the Ministry of Health and a local health authority (Capital Health Region). The project was designed to explore the potential of an information-based intervention to enhance the self-care skills of individuals in managing their own common health problems and participating in informed decision-making with their health-care provider.

In October 1998 a National Think Tank on Primary Health Care and Nursing (RNABC, 1998a) was held in Victoria. The think tank originated as part of a program objective of the RNABC and was a collaborative effort with CNA. Its objectives were to provide an opportunity for Canadian registered nurses, expert in PHC, to consider and prioritize issues in PHC they should be addressing, and to develop strategies to address one major PHC issue. An informal national survey carried out before the think tank identified four key issues for nursing and PHC: the need to clarify the role of nurses in PHC and to identify the voice and contribution of nursing; the need to partner with other sectors and the community; the need for funding; and the need for appropriate PHC educational preparation and competency maintenance for nurses.

Based on a set of criteria agreed to by the participants, the group chose to spend the day working on the following two issues: the need to partner among ourselves, with other sectors, and with the community; and the need to develop consensus in the profession regarding PHC nursing. After formulating a vision of what might be achieved if action were taken on these issues, participants identified strategies necessary to realize the vision. Themes of education; communication; partnership-building; research and evaluation; and the development of models, definitions, and frameworks emerged from the discussion. It was felt that nurses, other disciplines/sectors, and the public required educating in PHC and partnerships. The group recommended the

development of modules that could be either incorporated into any curriculum, including continuing education, or offered as a stand-alone program. It was suggested that distance-learning formats and existing community resources be used to provide nurses and others with appropriate PHC education. The group recommended that partnerships be the theme for Nursing Week in 1999 or 2000.

Participants agreed on the necessity of communication concerning successful partnerships and implementation of PHC. They suggested that a Web site be developed, consideration be given to establishing a journal dedicated to the theory and practice of PHC, and plain language be used in communicating with the public. They also recommended the development of interdisciplinary and intersectoral teams focused on specific populations and the encouragement of active consumer representation on boards and committees. It was suggested that partnerships be formed with local groups, such as women's institutes and seniors' coalitions, to develop joint strategies. The group recommended that studies be carried out in each province/territory to assess the baseline status of nurses' knowledge about PHC and partnerships. It recommended that the CNA be asked to lobby for funds to support this type of research. Existing successful PHC and partnership models need to be identified, it was believed, and information regarding them disseminated. The group recommended that a national stakeholders' forum be held to develop and clarify definitions of primary care and PHC.

Many individuals agreed to commit to specific actions in their own jurisdictions and spheres of influence. Participants emphasized the importance of continuing the process initiated at the think tank and developing an action plan to move the PHC agenda forward. In a true sense of partnership, they agreed that others, especially the public, should be involved in future discussions and forums. Almost all participants expressed a willingness to continue the process. However, development of a concrete action plan to implement these strategies has not been achieved to date. Action of this magnitude requires a unified effort of many partners in order to succeed.

Health Centre Working Group

As noted above, the RNABC had a longstanding interest in promoting community health centres as a vehicle for PHC. The Nursing Centre demonstration project contributed valuable insights into community dynamics and the challenges involved in establishing effective interdisciplinary partnerships. In reflecting upon the lessons learned and con-

sidering possible follow-up strategies, the RNABC and the British Columbia Nurses Union (BCNU) decided to mount an educational campaign to inform health authorities about the community health centre approach. BCNU produced a video (which was widely distributed) and published articles on community health centres. In 1997 the nursing organizations approached other groups and eventually formed the Health Centre Working Group, a coalition of 10 partners, including the Aboriginal Health Association of British Columbia, several health authorities, the Health Association of British Columbia, and the Ministry of Health. The coalition's purpose is to facilitate the establishment of new health centres — based on PHC principles — throughout the province. Its past work was funded by the Ministry of Health and supported by the in-kind contributions of partner organizations. From 1997 to 1999 the Health Centre Working Group provided education, resource materials, and planning assistance to local health authorities interested in re-orienting their community-based programs. Consultants worked with interested communities to develop health centres characterized by interdisciplinary team practice, broadly based community involvement, and an emphasis on prevention and health promotion.

The Health Centre Working Group's accomplishments during its first 2 years were: establishing a focal point for health centre information; providing education and practical assistance to 24 communities; creating the first directory of British Columbia community health centres; and contributing to government policy development in PHC (Health Centre Working Group, 1999b).

Reflections on Lessons Learned

Looking back on the decade, it becomes apparent that the RNABC's efforts to promote PHC had an impact at several levels. Members looked to their Association for leadership in a period of health reform and found guidance for changing their practice environments and contributing to local reform initiatives. Nursing education embraced the changes being promoted during the 1990s and readily incorporated PHC content. Some of the policy directions promoted by the RNABC in the early 1990s were realized by the end of the decade; for instance, a set of provincial health goals was approved by Cabinet in 1997 (British Columbia Ministry of Health, 1997). A renewed interest in community health centres and PHC was evident in Ministry of Health support for the provincial Health Centre Working Group. Today, the RNABC continues to assist nurses in influencing health policy so that they may promote and foster the growth of PHC as well as address other issues.

As documented in this paper and in evaluation reports over the past decade, there is no doubt that the RNABC's policy and partnership strategies have yielded results. Along the way, however, there have been numerous challenges to these achievements and many issues remain unresolved. We will conclude with some thoughts on strategies for making PHC a reality in Canada, based on the RNABC's experience. We recognize that each province and territory faces its own unique circumstances and challenges in moving the PHC agenda forward.

Demonstration Projects

Demonstration projects in aspects of PHC serve a useful purpose and should continue. Governments, local and regional health authorities, the professions, and the public need to see practical ways of re-orienting health care. Demonstration projects offer a visible means of applying new ideas in communities and a mechanism for public involvement. It is important that such projects be representative of diverse communities and that they not be carried out in isolation. In the urgency to meet grant competition deadlines or externally imposed criteria, these projects often suffer from lack of attention to planning and may exclude necessary partners. Allowing sufficient time for the start-up phase of a project will likely prevent problems during implementation. Evaluation of the Nursing Centre demonstration project, for example, noted that the demonstration period was far too short to allow for assessment of its true impact and that the grant application should have taken into account the time required to work with the community before opening the centre. This is not a unique insight in demonstration project evaluation, and it is hoped that funding bodies will seriously consider and provide for these concerns in future projects.

Partnerships

Although the RNABC has facilitated several successful partnership projects, each one has brought challenges in the initial phase. Finding common ground and methods for overcoming differences among partner organizations is always an issue when coalitions are being formed. Again, taking the time to listen to each partner as issues arise helps the coalition to function effectively in the long term. This may be a frustrating period to live through, as one partner is ready to "get on with" the project while another needs to resolve an underlying issue before proceeding. In the case of the Health Centre Working Group, it took more than 6 months for the 10 partners to agree on the project's goals and methods. Hours were spent debating the direction of the

project. One important partner withdrew during that period because its views seemed incompatible with those of the majority. In hindsight, the group may have been able to keep that organization if more time had been spent listening to its concerns. It is quite remarkable that the 10 partner organizations have sustained the coalition through the challenges of the first 2 and a half years and have been able to meet their objectives.

Commitment to Primary Health Care

It remains a constant struggle to raise and maintain the profile of PHC in Canada. Indeed the meaning of the term *primary health care* is frequently misunderstood and equated with primary care or primary medical care. The RNABC has spent more than 10 years clarifying the concept through visible projects, thoughtful policy analysis, and communication strategies to exchange ideas. This has occurred against a backdrop of changing governments (with corresponding changes in ministers of health and senior officials) and political and economic uncertainty at local, regional, and provincial levels. In addition, the government's good intentions to implement PHC often become lost due to the latest "crisis" in health care, political sensitivity to the concerns of the medical profession, and public demand for services, including new technologies. On a positive note, we have observed growing enthusiasm among health authority governors for adoption of broad PHC approaches in their communities. These governors volunteer their time to serve on regional health boards and councils because they want to bring about changes in health services and to act on determinants of health.

Conclusion

Although not an empirical study or formal case study, this paper has analyzed and reflected on earlier evaluations of aspects of the RNABC's work. It has illustrated that the RNABC developed, in the public interest, a comprehensive policy program to demonstrate and influence changes in health care. From its early explorations of the PHC approach, the RNABC developed a solid foundation, which informed subsequent initiatives. In building this policy program, the Association chose specific objectives and used a wide array of strategies to meet its goals, always taking into account the valuable lessons learned from past projects. A strong emphasis on evaluation of the major initiatives was evident throughout this period; both process and outcomes were examined thoroughly and results disseminated. The most visible achieve-

ments came from demonstration projects and solid partnerships. These projects added substance to the policy papers, in themselves an important legacy of the RNABC's work to advance PHC. Although there were remarkable accomplishments from this policy work, keeping PHC on everyone's agenda will require further collaborative efforts using multiple strategies.

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Authors' Note

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Happenings

New Opportunities for Nurses in Primary Health Care and Population Health

Nancy C. Edwards

Primary health care (PHC) has been soundly adopted by the nursing profession as both an approach to service delivery and a basis for intriguing research questions. Over the past 25 years, several significant events have provided momentum for research in the field of PHC: the *Alma-Ata Declaration* of 1978, the *Ottawa Charter for Health Promotion*, and, more recently, initiatives in the field of population health.

The *Alma-Ata Declaration* gave us pause to examine approaches to health-care delivery that ensure diverse populations access to basic health-care services. The tenets of the *Alma-Ata Declaration* continue to be put in place with international initiatives led by Canadian nurses. Current examples include a PHC training initiative in Vietnam led by Memorial University of Newfoundland; training for renewal in PHC being undertaken through a partnership between the Mozambican Health Ministry and the University of Saskatchewan; preparing the next generation of community health nurses in Ghana, an initiative led by the University of Alberta; PHC training programs in Pakistan and in a rural area of South Africa, initiatives led by faculty at McMaster University; and participatory training for grassroots maternal and child health-care workers in China and the design of decision support tools for PHC in Chile, projects led by nursing faculty at the University of Ottawa. These international projects funded by the Canadian International Development Agency provide opportunities for the involvement of Canadian nurses in innovative PHC design and evaluation. It may be timely to consider how we might better use these

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important initiatives as a base for research and as a means of bringing lessons learned from the South to the North.

Health promotion emerged as a tour de force in the 1980s, marked by release of the *Ottawa Charter for Health Promotion* in 1986. The Canadian Consortium for Health Promotion Research has emerged as a strong voice for health promotion, with representation from many Canadian regions. It is composed of 14 research centres, all of which have been in existence for at least 6 years. Partners for individual centres include Health Canada, universities, provincial health ministries, non-governmental organizations, community groups, and service delivery agencies. The Consortium supports the work of member centres by providing opportunities for networking and information exchange, facilitating opportunities for collaborative research, and advancing health promotion research in Canada. It also serves as a conduit for health promotion expertise and knowledge at the national level. Working groups of the Consortium reflect innovative research underway in Canada. Examples of such groups include those tackling issues of health promotion and health reform, intersectoral collaboration, and poverty and health. Nurses are key members of these groups, providing leadership on health promotion research teams.

The Canadian Public Health Association conference, to be held in Ottawa in October 2000, will provide opportunities for dialogue on PHC and what it means for research and service delivery at the turn of the century. A forum on the Evaluation of Health Promotion Initiatives, to be hosted by the Canadian Consortium for Health Promotion Research in conjunction with the conference, is expected to stimulate discussion of key evaluation issues.

The debate on population health currently underway (Edwards, 1999; Hayes & Dunn, 1998; Raphael & Bryant, 2000) encourages us to deepen our understanding of health promotion and population health approaches and to question their relative contributions to the issues of health-care reform. Nursing input into this dialogue is essential. Fundamentally, the population health debate is about better understanding the determinants of health and tackling inequities in health status (Green, 1994; Hertzman & Hayes, 1992; Ross et al., 2000). These issues have also fuelled the PHC and health promotion movements. They remain a critical source of research questions. Nurses in Canada are well positioned to join and lead multidisciplinary teams tackling these challenging research questions as they bring together the traditions of qualitative and quantitative research.

Exciting opportunities are being created and will support the full participation of Canadian nurses in leading-edge population health initiatives. Examples include the establishment of nursing research chairs by the Canadian Health Services Research Foundation; proposals to the interim governing council of the Canadian Institute of Health Research suggesting a slate of institutes that embrace population health; the availability of population health research funds from provincial and federal agencies; and the creation of new positions for post-doctoral fellows and visiting scholars to prepare the next generation of researchers in the fields of health promotion and population health. Examples of the latter can be found at the Institute of Health Promotion Research at the University of British Columbia, which has a well-established visiting scholar program, and the University of Ottawa, which is establishing new post-doctoral fellowship awards within its recently launched Institute for Population Health.

Each of these opportunities promises to enrich these fields of study (PHC, health promotion, and population health). They will also help to ensure that nurses are front and centre in the design, implementation, evaluation, and dissemination of new knowledge and insights as we wend our way through the current era of health-care reform.

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A Review of the Research on the Health of Low-Income Canadian Women

**Linda Reutter, Anne Neufeld,
and Margaret J. Harrison**

La diminution des iniquités sur le plan de la santé liées à la pauvreté constitue un rôle important pour la profession infirmière exercée dans le domaine de la santé publique. Cet article décrit l'étendue de la recherche sur la santé des Canadiennes à faibles revenus. Les recherches qui ont fait l'objet de cette étude ont été publiées dans des revues de langue anglaise dont les articles étaient révisés par des pairs, entre 1990 et 1997. Les 26 articles sélectionnés sont résumés selon l'objet de l'étude et la composition de l'échantillonnage. La plupart se penchaient sur les pratiques de santé personnelles et l'état de santé. Une seule étude d'intervention a été identifiée. Les études et les résultats de cette analyse font l'objet d'une discussion en fonction de trois recommandations portant sur la recherche et la santé des femmes : un accent sur le contexte social, y compris les conditions structurelles influant sur la santé des femmes; la participation active des femmes dans le processus de la recherche; et la reconnaissance de la diversité chez les femmes à faibles revenus. Les créneaux qui devraient faire l'objet d'une priorité pour la future recherche sont : les études portant sur l'intervention; les études se penchant sur le contexte structurel dans lequel vivent les femmes à faibles revenus; les stratégies de recherche qui favorisent la participation des femmes dans le processus de recherche; et une participation accrue de divers groupes de femmes, telles que les femmes sans abris et les femmes de divers antécédents ethniques, y compris les femmes des Premières nations.

Reducing health inequities associated with poverty is an important public health nursing role. This article describes the scope of research on the health of low-income Canadian women. The research included was published in English-language peer-reviewed journals between 1990 and 1997. The 26 articles retrieved are summarized according to the focus of the study and the composition of the sample. Most addressed personal health practices and health status. Only one intervention study was identified. The studies and the findings of this analysis are discussed in relation to three recommendations for research on women's health: an emphasis on social context, including the structural conditions affecting women's health; active participation of women in the research process; and recognition of diversity among low-income women. Suggested priority areas for future research are: intervention studies; studies addressing the structural context of the lives of low-income women; research strategies that enhance the participation of women in the research process; and increased involvement of diverse groups of women such as homeless women and women of varied ethnic backgrounds, including First Nations women.

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Reducing health inequities is increasingly viewed as an important nursing role (American Public Health Association, 1996; Canadian Public Health Association [CPHA], 1990), which requires a focus on social and political determinants of the health of populations and communities. One determinant that is a continuing source of poor health is income inadequacy, including income inequity. Public health nurses have been challenged not only to support individual families in poverty but also to advocate for structural changes that ameliorate poverty.

Public health nursing initiatives to address health issues among low-income Canadian women are influenced by trends in health policy and evolving perspectives on women's health. In Canada, policy-influencing bodies (e.g., Advisory Committee on Population Health [ACPH], 1994, 1996; CPHA, 1997a; National Forum on Health, 1997) and health sectors of government (e.g., Alberta Health, 1993; Epp, 1986; Office of the Provincial Health Officer, 1995; Régie régionale de la santé et des services sociaux de Montréal-Centre, 1998) have recently given priority to reducing health inequities related to socio-economic factors. The shift to an emphasis on health inequities is rooted in a socio-environmental view of health. This perspective on health, which places importance on social context, is also congruent with the recent discourse on women's health (Cohen & Sinding, 1996; Walters, Lenton, & McKeary, 1995). In particular, structures of social disadvantage are acknowledged as important determinants of women's health (Cohen & Sinding; Kaufert, 1996; National Forum on Health; Walters et al.). At the Fourth World Conference on Women, held in Beijing, women's health was defined as involving emotional, social, and physical well-being and as determined by the biological, social, political, and economic contexts of women's lives (Cohen & Sinding; Lefebvre, 1996).

The purpose of this article is to describe the scope of research published between 1990 and 1997 on the health of low-income Canadian women. We will discuss the identified studies in relation to recommendations for research on women's health that have been given priority on Canadian and international agendas: an emphasis on social context, including structural conditions affecting women's health; the active participation of women in the research process; and recognition of diversity among low-income women. We will conclude with implications for public health nursing research.

Background

Increasing awareness of the broad range of psychosocial factors and socio-environmental conditions that influence health has led scholars to

articulate a public health nursing mandate that challenges social, economic, and political factors that determine health (Butterfield, 1990; Drevdahl, 1995; Kuss, Proulx-Girouard, Lovitt, Katz, & Kennelly, 1997; Reutter, 1995; Stevens & Hall, 1992; Sword, 1997). The CPHA (1990) statement on public health nursing roles describes the advocacy role of public health nursing as one of helping the socially disadvantaged to become aware of issues relevant to their health and promoting the development of resources that will result in "equal access to health and health-related services." Changing conceptualizations of health and health determinants as well as rising poverty rates (National Council of Welfare, 1998) have contributed to the renewed interest among policymakers and public health professionals in reducing health inequities related to socio-economic status. There has been a shift from an individualistic (behavioural) perspective on health to a social (socio-environmental) view that gives primacy to the influence of material and social conditions in which people live on a daily basis. A contextual approach to health places greater emphasis on the root causes of health and health behaviours (Link & Phelan, 1995) and provides an "upstream" approach to achieving health. Concern for health inequities rooted in social structures is based on a critical social theory perspective directed to developing knowledge that will free people from oppressive social conditions that, in turn, limit their health potential (Reutter, 1995; Reutter & Williamson, in press; Stevens & Hall, 1992).

In Canada, women face a significantly higher risk of poverty than men. In 1996, 19% of women, compared with 14% of men, were living in poverty (National Council of Welfare, 1998). The *circumstances* that lead to poverty may be different for men and women (Burt & Cohen, 1989; Montgomery, 1994). The gender differences can be explained in part by the increased poverty rate in three groups: unattached women under 65 years of age, unattached women over 65 (the age group with the greatest gender discrepancy), and single women with children, 61% of whom are poor (National Council of Welfare). Also, First Nations women and visible minority women are twice as likely to be living in poverty (Kaufert, 1996). In addition, the *effects* of poverty on health may be gender-sensitive because of the intersection of socio-economic status (SES) with work and family roles (Gijsbers van Wijk, Kolk, van den Bosch, & van den Hoogen, 1995).

The need to attend to women's health has been recognized in Canada. A Federal/Provincial/Territorial Working Group on Women's Health (1990) highlights women's health priorities in the paper *Working together for women's health: A framework for the development of policies and programs*. Subsequent initiatives include the creation of a Women's

Health Bureau, the establishment, in 1994, of the McMaster Research Centre for the Promotion of Women's Health, and the funding by Health Canada, in 1996, of five Centres of Excellence for Women's Health across the country. These initiatives indicate support for research on women's health and women's response to the determinants of health, such as SES. The establishment of these centres has also facilitated research with First Nations and immigrant women. Nevertheless, research on the health of low-income women continues to be a priority. It is important to conduct research within a Canadian context to determine the impact of Canadian social structures and Canadian economic, political, and social policies on health. This information could form a basis for determining how the health of low-income women in Canada compares with that of low-income women in other countries. Such comparative information contributes to our understanding of how social context influences health (Walters et al., 1995).

Method

We analyzed research articles published in peer-reviewed journals between 1990 and 1997 that addressed a Canadian population of women. We used MEDLINE, CINAHL, PSYCHLIT, and SOCIOFILE databases and did a manual search of key journals for the years 1993–97, including *Advances in Nursing Science*, *American Journal of Public Health*, *Canadian Journal of Nursing Research*, *Canadian Journal of Public Health*, *Gender and Society*, *Health Care for Women International*, *Health Promotion International*, *Health Reports*, *Journal of Advanced Nursing*, *Journal of Community Health Nursing*, *Journal of Women's Health*, *Nursing Research*, *Public Health Nursing*, *Qualitative Health Research*, *Research in Nursing and Health*, *Western Journal of Nursing Research*, *Women and Health*, and *Women's Health Issues*. Search terms included *poverty*, *female*, *health*, *women*, *socioeconomic status*, *health behavior*, and *low-income*. To ensure credibility of the research retrieved, we included only studies that employed acceptable research designs. To be selected for the review, an article had to report a research study using a Canadian sample, include a measure of SES, and address some aspect of women's health. We selected only English-language publications. We excluded studies in which the primary focus was child or infant health. We also excluded chapters of books, government documents not accessible through computerized databases, and studies that consisted of descriptions of programs for low-income women, without a research component.

Our literature search resulted in 26 articles that met the criteria. A summary of the articles is presented in Table 1. We classified the articles

according to the primary focus of the study (personal health practices, use of health-care services, and health status), criteria for SES, and sample characteristics. Our intent was to identify areas that have been addressed, as well as gaps, in the retrieved research. Because of the varied foci of the studies, no attempt is made to present an integrated summary of findings.

Criteria for SES

In studying the influence of SES on health it is important to consider the indicators that have been used to measure SES. Different indicators may result in inclusion of different subgroups of women. The SES indicators selected may also differentially influence outcome measures such as health practices or utilization of health-care services (Gazmararian, Adams, & Pamuk, 1996). We found that some studies included multiple indicators of SES while others relied on a single measure. The range of measures of SES included: family or household income, census tract income quintiles, receipt of social assistance or unemployment insurance, labour-force status, living in subsidized housing, index of possessions, life circumstances index, perceived purchasing ability, education, occupation, and social class (e.g., using the Hollingshead and Blishen indices). Of particular interest is the measure of life circumstances used by Locker, Jokovic, and Payne (1997), which incorporates material and social attributes of individuals as well as the environments in which they live. Increasingly, use of composite indices, which include both individual-level data and characteristics of the area of residence, is being advocated in Canada (Mustard & Frohlich, 1995).

Composition and Size of Samples

The samples varied in composition and size (see Table 1). Six studies focused exclusively on low-income women (Browne et al., 1997; O'Loughlin, Paradis, Renaud, Meshefedjian, & Bennett, 1997; Stewart et al., 1996; Tarasuk & Maclean, 1990; Travers, 1996). Three included participants from minority cultures: immigrant women (Anderson, Blue, Holbrook, & Ng, 1993; Franks & Faux, 1990) and Inuit men and women (Young, 1996). Only one study consisted of disabled as well as able-bodied individuals (Hammond & Grindstaff, 1992). We included one study in which the sample comprised only men (Lupri, Grandin, & Brinkerhoff, 1994), because it explored wife abuse from the perspective of the perpetrator. Other studies focused on specific age groups, including teenagers (Turner, Grindstaff, & Phillips, 1990) and older adults (Krause, 1993; Locker et al., 1997).

Table 1 *Summary of Canadian Studies on Health of Low-Income Women***PERSONAL HEALTH PRACTICES**

Authors	SES Criteria	Sample	Focus of Study
Anderson et al. (1993) ^a	Employment sector	EuroCanadian and Chinese employed women (N = 30)	Management of chronic illness
Campbell & Horton (1991)	Social assistance recipient Income decile	Urban households (N = 4,777) 23.5% female-headed	Nutrient intake
Ford-Gilboe (1997)	Family income	Female-headed Single parent (N = 68) 2-parent families (N = 70)	Health behaviours
Horton & Campbell (1990)	Per capita income	Urban households (N = 4,777)	Food expenditure
Krause (1993)	Perception of financial strain	Adults over 55 years (N = 640)	Social ties
Millar & Stevens (1993)	Education	Men and women (N = 11,000 [1985], 12,000 [1991]) 25 years and over	Smoking, physical activity, weight
Locker et al. (1997) ^b	Life-circumstances index	Men and women 53+ (N = 498)	Numerous health practices

Table 1 (cont'd)**PERSONAL HEALTH PRACTICES (cont'd)**

Authors	SES Criteria	Sample	Focus of Study
Mustard & Roos (1994) ^b	Income quintile (geographic area)	Pregnant women (N = 12,646)	Smoking
O'Loughlin et al. (1997) ^c	Low-income geographic area	Women (N = 122)	Smoking
Stewart et al. (1996) ^a	Family income	Low-income rural women (N = 138)	Smoking
Tarasuk & Maclean (1990) ^a	Subsidized housing Family income	Sole-support mothers (N = 8 interviews, N = 54 participant observation)	Problems obtaining food
Travers (1996) ^a	Social assistance recipient Low-income geographic area	Mothers from low-income families (N = 33)	Food and nutrition practices
Young (1996)	Education Personal income	Inuit men and women (N = 434)	Obesity, smoking, physical activity

Table 1 (*cont'd*)**USE OF HEALTH-CARE SERVICES**

Authors	SES Criteria	Sample	Focus of Study
Browne et al. (1997) ^b	Social assistance	Sole-support mothers (<i>N</i> = 101)	Use of health and social services
Eyles et al. (1993)	Household income Employment status	Adult men and women (<i>N</i> = 13,000)	Nursing contacts
Katz & Hofer (1994)	Family income Education	Adult women 18 years and over (<i>N</i> = 23,521 Canada, <i>N</i> = 23,932 U.S.)	Clinical breast exam, mammogram, pap test
Lin et al. (1996)	Social assistance	Men and women 15–64 years (<i>N</i> = 8,116)	Use of mental health services
Lipman et al. (1997) ^b	Household income	Mothers with dependent children (<i>N</i> = 1,540)	Use of mental health services
Maxwell et al. (1997)	Household income	Women 40 years and over	Mammography screening
Mustard & Roos (1994) ^b	Income quintile (geographic area)	Pregnant women (<i>N</i> = 12,646)	Prenatal care

Table 1 (cont'd)**HEALTH STATUS**

Authors	SES Criteria	Sample	Focus of Study
Browne et al. (1997) ^b	Social assistance	Sole-support mothers (N = 101)	Depressive disorders
Frands & Faux (1990)	Family income Occupation Employment status	Immigrant Chinese, Vietnamese, Portuguese, and Latin-American women (N = 212)	Depression
Hammond & Grindstaff (1992)	Occupation Household income Employment status Education	Men and women 15-54 years (N = 1,692 disabled, N = 1,692 able-bodied)	Life satisfaction
Lipman et al. (1997) ^b	Household income	Mothers with dependent children (N = 1,540)	Chronic physical problem, physical disability; psychiatric disorders
Locker et al. (1997) ^b	Life circumstances index	Men and women 53+ (N = 498)	Oral health status
Lupri et al. (1994)	Income; Education; Occupation	Adult men (N = 471)	Wife physical and psychological abuse

Table 1 (cont'd)			
HEALTH STATUS (cont'd)			
Authors	SES Criteria	Sample	Focus of Study
Murphy et al. (1991)	Index of possessions	Rural adults (<i>N</i> = 593)	Depression, anxiety
Mustard & Roos (1994) ^b	Income quintile (geographic area)	Pregnant women (<i>N</i> = 12,646)	Pregnancy complications
Russell & Love (1992)	Median income (geographic area)	Women 14–50 years (<i>N</i> = 2,749)	Pelvic inflammatory disease
Smith (1990)	Family income Occupation Education Employment status	Adult women (<i>N</i> = 604)	Wife physical abuse
Turner et al. (1990)	Father or mother occupation	Pregnant teenagers (<i>N</i> = 268)	Depression
a = qualitative study b = study addressing multiple components c = intervention study			

With regard to sample size, 40% of the studies used large data sets from national or provincial surveys (Campbell & Horton, 1991; Eyles, Birch, & Newbold, 1993; Hammond & Grindstaff, 1992; Horton & Campbell, 1990; Katz & Hofer, 1994; Krause, 1993; Lin, Goering, Offord, Campbell, & Boyle, 1996; Maxwell, Kozak, Desjardins-Denault, & Parboosingh, 1997; Millar & Stevens, 1993; Young, 1996). All but two of these studies (Katz & Hofer; Maxwell et al.) included both men and women.

Focus of Studies

All but one of the retrieved articles focused on understanding the links between SES and women's health. The remaining study (O'Loughlin et al., 1997) determined the effectiveness of an intervention program. Almost equal numbers of studies focused on personal health practices (13) and health status (11). Seven studies explored the use of health-care services. Only one study (Mustard & Roos, 1994) examined all three areas: personal health practices, use of health-care services, and health status.

Of the 13 studies addressing *personal health practices*, most addressed either smoking (5) or nutrition (4). One (Millar & Stevens, 1993) focused on smoking, physical activity, and weight control among adult women and men over time, while another (Young, 1996) explored these behaviours in a population of Inuit men and women. The only intervention study in our review evaluated the impact of a smoking cessation program on women in a low-income community (O'Loughlin et al., 1997). Other studies investigated smoking among low-income pregnant women (Mustard & Roos, 1994) and low-income rural women (Stewart et al., 1996).

Of the four studies that addressed nutrition, two examined food expenditure and nutrient intake (Campbell & Horton, 1991; Horton & Campbell, 1990), while two investigated the problems that low-income women encounter in obtaining food (Tarasuk & Maclean, 1990; Travers, 1996). The remaining studies that addressed personal health practices focused on patterns of social interaction (Krause, 1993), immigrant women's management of diabetes in the context of job insecurity (Anderson et al., 1993), and various health behaviours (Ford-Gilboe, 1997; Locker et al., 1997).

In the group of studies that identified predictors of the *use of health-care services*, two focused on preventive screening. Katz and Hofer (1994) employed large data sets to compare the association of SES and

preventive screening rates (clinical breast examination, mammogram, pap test) in Ontario and the United States, while Maxwell et al. (1997) utilized the 1994–95 National Population Health Survey data to explore correlates of mammography screening. Other studies focused more generally on health and social services. For example, one study explored the use of a variety of health and social services among social assistance sole-support mothers (Browne et al., 1997), and two others (Lin et al., 1996; Lipman, Offord, & Boyle, 1997) explored utilization of mental health services. Mustard and Roos (1994) examined the effect of SES on prenatal care in Winnipeg, Manitoba, using administrative health-care data such as physician reimbursement claims and hospital discharge abstracts. The final study in this group (Eyles et al., 1993) was based on the Aday and Andersen (1974) model of health-care utilization and explored nursing contacts in the previous 12 months using the 1985 Canada General Social Survey.

Eleven studies addressed the relationship between SES and *health status*, using a range of health status indicators. Mental health indicators included depression (Browne et al., 1997; Franks & Faux, 1990; Lipman et al., 1997; Murphy et al., 1991; Turner et al., 1990) and anxiety (Lipman et al.; Murphy et al.). Four studies addressed physical health status, including physical disabilities, pregnancy complications, pelvic inflammatory disease, and dental health (Lipman et al.; Locker et al., 1997; Mustard & Roos, 1994; Russell & Love, 1992). Social dimensions of health such as wife abuse (Lupri et al., 1994; Smith, 1990) and life satisfaction (Hammond & Grindstaff, 1992) were incorporated into the remaining three studies. Two studies tested theoretical issues related to the relationship between poverty and health status. Murphy et al. used a prospective design to explore competing explanations (social drift and social causation) of the relationship between mental health and SES, while Locker et al. explored the relative contributions of circumstances and lifestyle to the relationship between dental health status and SES.

Issues and Challenges in Research

We discuss the research retrieved in relation to three recommendations for research on women's health that have been given priority on both Canadian and international research agendas: emphasis on social context, including structural conditions affecting women's health; active participation of women in the research process; and recognition of diversity among low-income women. In our discussion we identify congruence with these recommendations as well as direction for future research. Throughout, the terms *contextual* and *structural* are used inter-

changeably to refer to the social, political, economic, and environmental conditions of women's lives.

Structural Context of Women's Health

Public health nurses who understand the structural context of behaviour will be more sensitive to the sociopolitical issues that shape the life circumstances of low-income women (Reutter, 1995; Sword, 1997). Studies that incorporate a contextual approach to individual behaviours will help to dispel myths about low-income women. A popular myth is that the source of unhealthful behaviours is individual inadequacy; structural characteristics that limit individual options are ignored or unacknowledged. If research is to benefit public health nurses and, ultimately, low-income women, it must illuminate the context of personal health practices, use of health services, and health status. In our review, the studies varied in the manner and degree to which they reflected a contextual approach.

Several qualitative studies explored the structural context of personal health practices, utilization of health-care services, or health status. Four studies used ethnographic methods, in which the social circumstances that influence individual behaviour are elucidated by providing understanding of the meanings of these behaviours in the lives of low-income women. For example, pervasive financial insecurity and competing priorities for food often dictated the diet of sole-support low-income mothers and their families, rather than their knowledge of what constitutes an adequate diet (Tarasuk & Maclean, 1990). Information of this type leads us to question the appropriateness of individualistic nutrition education strategies, and to consider instead strategies that advocate for structural changes, such as increased social assistance allowance. These qualitative findings complement the quantitative work of Horton and Campbell (1990), which details the food expenditures and nutrient intake of low-income families.

Travers (1996) used institutional ethnography to identify the structural forces that influence the nutritional practices of low-income mothers. Institutional ethnography goes beyond an understanding of the individual's everyday experiences to an "analysis of social relations structuring those experiences" (Travers, p. 546). Such an approach makes explicit the social policies that influence health and health behaviours, and is the basis for advocating healthy public policy, an important public health nursing role. Travers found that social policies at a variety of levels influenced the ability (or, more accurately, inability) of women to meet the nutritional needs of themselves and their families.

For example, the women's ability to purchase low-cost groceries was limited by lack of access to inexpensive stores as well as by welfare policies that resulted in frequent lack of funds. The implication of this finding for public health nurses is the relative importance of advocating for changes in income-support policies and addressing inequities in food pricing, as opposed to providing women with knowledge and skills.

An institutional ethnography incorporating a critical feminist perspective (Anderson et al., 1993) identified the influence of race and class oppression in immigrant women's management of diabetes in the context of job insecurity. This study also offered insights into how life circumstances influence access to health care. Its findings can be used to sensitize nurses who provide health education to immigrant women to the fact that working conditions, such as inflexible scheduling, can influence the feasibility of recommended strategies for diabetes management.

Stewart et al. (1996) used a feminist analysis to elucidate the intersection of gender and class in understanding the social determinants of smoking behaviour. This study supports others conducted in the United Kingdom (Graham, 1994) and the United States (Lacey et al., 1993) that identified smoking as a coping mechanism for managing stress in the face of limited resources and decreased personal control. An appreciation of the reasons why women smoke and the barriers to quitting will enable nurses to use more effective approaches in setting up smoking cessation programs. For example, the women could be invited to help plan the programs, child care could be provided, and steps could be taken to ensure that programs are culturally, financially, and geographically accessible.

Studies using quantitative methods also contribute information about the context of women's health, complementing the insights gained from qualitative research. Krause (1993) used structural equation modelling to examine the structural correlates of social isolation among older people in a nationwide sample. The study explored how distrust of others (which leads to social isolation) is influenced by the interplay of socio-economic factors and neighbourhood characteristics. Neighbourhood characteristics comprised physical features such as housing, buildings, and streets, as well as environmental stressors such as noise level, air quality, and safety from crime. Findings indicated that distrust and social interaction were influenced by physical deterioration of the neighbourhood.

In summary, the above studies help us to understand the experiences of low-income women in the context of their daily lives and, to a lesser extent, the social and political structures that inhibit health. Studies that focus on the contextual aspects of individual behaviours help to dispel the myths that perpetuate an individualistic approach to what are really structural influences requiring change. Such studies point to the need for nursing strategies that go beyond helping individual women in poverty to advocating for public policy that challenges social structures. Researchers with a critical social perspective (Anderson et al., 1993; Stewart et al., 1996; Tarasuk & Maclean, 1990; Travers, 1996) emphasize the need to change health-inhibiting conditions. Anderson et al. express this perspective eloquently:

Once we recognize that health and illness are socially produced, it is obvious that the boundaries of nursing should expand to identify and address social and political issues. We should not accept social injustice as a given; instead, we should accept the challenge to work toward social justice for all people. (p. 120)

Several of the studies highlighted the resiliency and innovative coping strategies of low-income women. These studies found that, contrary to popular belief, women possess adequate knowledge, skills, and motivation to engage in health-enhancing behaviours, and that their health-inhibiting behaviours result from struggles to meet conflicting health priorities in the face of decreased resources. A focus on strengths and capacity-building is an inherent principle of health promotion and an important emphasis in feminist perspectives on women's health (Reutter, Neufeld, & Harrison, 1995).

Participation of Women in the Research Process

Participation is a key concept on women's health agendas and in health promotion and feminist literature (Lefebvre, 1996). In research with vulnerable populations, it is particularly important that participants' voices are heard and that action results in improved conditions for health. This principle requires an empowering form of research that acknowledges and explores the experiences of low-income women and enables them to use the research process to effect change. Although women's health-research agendas call for a mix of qualitative and quantitative methodologies, recently there has been a call for more qualitative methodologies that allow women's own voices to be heard. Researchers should enter into dialogue with women concerning not only their perceived needs but also the structural changes they believe will lead to improved health (Sword, 1997). Qualitative methods such as ethnography give

participants a voice (Anderson et al., 1993; Stewart et al., 1996; Tarasuk & Maclean, 1990). Moreover, by directly asking women to identify, for example, the types of smoking cessation programs that would be helpful to them, Stewart et al. acknowledge the need for changes at the system level that might foster a more supportive environment for low-income women who wish to stop smoking. Although several studies ascertained women's views in relation to researcher-identified topics such as smoking or nutrition, no study elicited women's opinions on their priority health issues.

Travers (1996) employed a participatory research approach, which allowed participants to voice their concerns, served to increase participants' awareness of social constraints to access to food, and empowered participants to change barriers to health. This method is most congruent with a socio-environmental view of health and health promotion, as it is based on a critical social theory perspective that links understanding with action. The women in her study critiqued the corporate control of food and initiated a campaign to reduce pricing inequities between inner city and suburban supermarkets; critiqued welfare policies and lobbied the government for improvements in food allowances; and critiqued public and professional perceptions of low-income people and media portrayal of stereotypes.

Obtaining the participation of vulnerable populations such as low-income women is not without its problems. Walters et al. (1995) discuss the difficulty of accessing the "authentic" voice of women. Recruiting and retaining low-income research participants requires considerable effort. Interviews can be conducted at sites accessible (and preferably known) to the women, and child care and transportation can be provided (Stewart et al., 1996; Travers, 1996). Other means of encouraging participation include maintaining cultural sensitivity by employing interviewers of the same background, providing monetary return in exchange for participation, and being alert to cues that women may be responding from a sense of coercion rather than participating freely (Demi & Warren, 1995). The use of focus groups as a means of data collection has been advocated for vulnerable populations, as group participation facilitates consciousness-raising, acknowledges participants' expertise, and encourages participants to view their issues as shared (Stevens, 1996; Sword, 1997). Stewart et al. (1996) used focus groups to elicit recommendations for potential programming; Travers (1996) involved women in developing and carrying out recommendations.

Recognition of Diversity

An important principle inherent in women's health research agendas is the need to recognize and address diversity among women. Low-income women are not a homogeneous group. Nevertheless, we found limited evidence of the inclusion of women of diverse backgrounds in studies.

Although Canada's cultural composition is rapidly becoming more diverse, only three studies directly addressed ethnic diversity (Anderson et al., 1993; Franks & Faux, 1990; Young, 1996). Franks and Faux found that immigrant women are at high risk for depression but that different variables predict depression in different ethnic groups. Anderson et al. compared workplace and health-service factors that influenced management of diabetes, and found variation among different ethnic groups. Young's findings on determinants of obesity in an Inuit population can be used to provide more meaningful programs for addressing obesity among a group that is frequently overlooked in research. In Canada, women from First Nations communities have an average life expectancy 7 years lower than women in the general population (ACPH, 1996), and 33% live in poverty (Kaufert, 1996). Only one study (Young) included First Nations women. The reasons for limited research with minority cultures are unknown, but may relate to barriers such as researchers' inability to be sensitive to cultural variations or lack of fluency in the language of the minority culture.

In addition to cultural diversity, another indication of the degree to which diversity has been addressed is the omission of groups of women who vary on other characteristics. While several studies included women on social assistance, there were no studies with the homeless, despite the rapid growth in the number of homeless women and children in Canada (CPHA, 1997b). There were few studies with older women or adolescent girls. Both of these groups have age-specific health issues. Moreover, these groups are particularly vulnerable to the effects of poverty (National Council of Welfare, 1998). Variation in family makeup was addressed by several studies with sole-support mothers.

Establishing research teams that include women of diverse backgrounds may facilitate development of pertinent research questions and bring sensitivity to interpretation of data. Such research is complex and will require extensive human and financial resources.

Limitations

There are challenges in conducting a review of published research. The small number of studies reviewed is likely due in part to our inability to locate all the relevant literature. Not all relevant published research includes, in the title, keywords, or abstract, the search terms that we used. For example, research that addresses the health of low-income immigrant or First Nations women may not include the terms *low-income* or *poverty* and therefore would not be captured in our search. In addition, our review was limited to English-language publications. Although some of the studies retrieved included francophone women, studies published in French were not included, hence issues important to francophone women may have been inadvertently omitted.

To address these limitations, we carried out some manual searches of relevant journals, used a variety of search terms, searched specifically for populations poorly represented (e.g., age), and referred to related discussion papers to inform the search. The difficulties we experienced were not unique (Lefebvre, 1996). Adequate retrieval methods should be used to identify research on Canadian low-income women. For example, researchers should include determinants of health, such as low income, in their lists of keywords, and research teams should include a member able to review research published in French.

Implications for Public Health Nursing Research

Given the limited number of studies retrieved, it is difficult to discuss "gaps" in the research literature. Clearly, more studies are needed in each of the three focus areas: health status, health practices, and health-care utilization. Nevertheless, some omissions, alluded to in the previous sections, are particularly obvious. A glaring omission is the lack of studies on homelessness. Homelessness is becoming an important public health issue, of concern to public health nurses, and in some jurisdictions is reaching crisis proportions. Another obvious omission is the lack of intervention studies. We retrieved only one intervention study (O'Loughlin et al., 1997), and this study measured the effects of a smoking cessation program. More studies are needed that evaluate the effectiveness of programs that are directed towards improving the health of low-income women, particularly evaluation studies of population-focused approaches such as community development and public policy initiatives (Dookhan-Khan, 1996; Ploeg et al., 1995). Future research should include women from diverse groups such as older women, First Nations women, and immigrant women.

Only one study incorporated policy analysis and structural change affecting women's health (Travers, 1996). Research on the *structural context* of women's health provides direction for policy change to modify the social, economic, and political structures that create ill health. Change in these structures may be difficult, as they are sustained by powerful economic interests (Walters et al., 1995). Nevertheless, because advocating healthy public policy is the most effective strategy for reducing health inequities, there is an urgent need for research to inform this initiative.

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La communication interculturelle en contexte clinique : une question de partenariat

Bilkis Vissandjée et Sophie Dupère

This article is intended to promote reflection on the intercultural competence of nurses and other health professionals. It discusses the different types of interpretation used to communicate with patients who do not speak English or French, legal and ethical consequences, and impact on health-care quality. The authors offer recommendations for both research and clinical nursing, as well as the health-care system in general, and highlight the challenges faced by nurses in a pluralist society. The literature review reveals an inherent complexity in the use of diverse types of interpreters. Finally, the authors argue that the intricacy of the cross-cultural communication trio is intensified by a lack of adequate preparation of nurses and other health professionals and interpreters regarding cross-cultural communication.

Le but de cet article est de contribuer à promouvoir une réflexion sur la compétence interculturelle des infirmières et autres professionnels de la santé. Différents types d'interprétiariats servant à entrer en communication avec un patient de langue autre que le français et l'anglais et les conséquences sur le plan légal, éthique ainsi que de la qualité des soins sont discutés. Des pistes de recherche en sciences infirmières et des recommandations sur la pratique infirmière et le système de santé en général sont ensuite offertes. Cet article vise surtout à faire ressortir les défis qui se posent aux infirmières dans le contexte actuel de notre société pluriethnique. La revue des écrits fait ressortir la complexité inhérente aux types d'interprètes. N'est pas bon interprète qui veut ! Finalement, nous argumentons que la complexité de la triade en communication interculturelle est accrue par le manque de préparation des infirmières, des autres professionnels de la santé et des interprètes en matière de communication interculturelle.

Introduction

L'univers canadien s'est grandement diversifié avec l'arrivée soutenue d'immigrants et de réfugiés, ce qui a contribué à 26 % de la croissance de la population du pays (Chen et Wilkins, 1996). La transformation du contexte canadien engendrée par ces vagues d'immigration requiert que prestation des services sur le plan de l'accessibilité sociale et cul-

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turelle soit repensée pour ces populations, lesquelles sont souvent constituées de groupes vulnérables de gens récemment arrivés et démunis. En plus de l'accessibilité socioculturelle, l'accessibilité linguistique demeure un facteur important qu'il faut considérer. D'après le recensement de 1991, 50 000 résidents (soit 1,5 % de la population totale) du Montréal métropolitain ne peuvent accéder pleinement aux services publics à cause de leur connaissance insuffisante du français ou de l'anglais. Les personnes âgées représentent 30 % d'entre eux et les femmes près des deux tiers (Hemlin et Mesa, 1997). Les chiffres rapportés ci-dessus reposent sur les déclarations des immigrants et peuvent ainsi masquer le portrait réel de la réalité linguistique. Pour les immigrants qui possèdent l'une ou l'autre des langues officielles, l'écart culturel et les charges émotionnelles provoquées par certaines situations inhérentes à la condition immigrante exigent de plus en plus le recours à un interprète culturel lors des interactions avec les professionnels de la santé (Hemlin et Mesa).

La diversification du profil linguistique et le nombre grandissant d'allophones (en cinq ans le nombre d'allophones a augmenté de 31 %; Hemlin, 1997) posent ainsi un défi de taille au réseau de la santé et des services sociaux qui se doit d'offrir des services de qualité appropriés et équitables. Plusieurs études font ressortir les barrières linguistiques comme un obstacle important pour les allophones en ce qui a trait à l'accès aux services de santé (D'Avanzo, 1992; Heneman, Legault, Fortin et Alvarado, 1994), ceux-ci retardant souvent leur consultation jusqu'à ce que la situation soit jugée grave (Mesa, 1997).

Les infirmières reconnaissent l'importance de la communication dans le processus de soins (Giger et Davidhizar, 1995). De plus, l'éducation aux patients est une des responsabilités principales de l'infirmière pour maintenir et augmenter les comportements de santé, encourager l'autoprise en charge et inciter la participation des patients dans leurs soins. Or, dans le contexte actuel de restructuration des soins, de la diminution des temps de séjour hospitalier, du mouvement des soins vers la communauté, les patients et leurs familles sont appelés à se prendre en charge. Afin de responsabiliser les familles et d'inciter celles-ci à participer pleinement aux soins des patients, une communication adéquate entre les infirmières et ces familles est une condition essentielle de rétablissement (Baker et al., 1996; Buchwald, 1993; Murphy et Clark MacLeod, 1993; Vissandjée, N'tétu, Courville, Bourdeau et Breton, 1998).

Le but de cet article est de contribuer à promouvoir une réflexion sur la compétence interculturelle des infirmières et autres profession-

nels de la santé. Différentes façons d'entrer en communication avec un patient de langue autre que le français et l'anglais et les conséquences de ces stratégies sur le plan légal, éthique et sur la qualité des soins sont discutées. Des pistes de recherche en sciences infirmières et des recommandations sur la pratique infirmière et le système de santé en général sont ensuite offertes. Cet article vise surtout à faire ressortir les défis que les infirmières ont à relever dans le contexte actuel de notre société pluriethnique. La revue des écrits fait état de la complexité inhérente aux types d'interprètes. Des enjeux légaux et éthiques se doivent d'être considérés dans le choix de ces derniers. Avant d'aborder les différents types d'interprétariats, une revue des éléments de la communication humaine est présentée, notamment ceux de la communication interculturelle engageant au moins trois personnes. Cette revue vise à faire ressortir les raisons sous-jacentes au choix et par le fait même, le rôle de la troisième personne qui assurera la traduction de l'information.

Filtrage lors d'une communication

Plusieurs ouvrages en sciences infirmières examinent les différentes composantes de la communication et les barrières potentielles associées aux langages verbal et non verbal (comme le toucher, les expressions faciales, le contact visuel, les gestes et la posture du corps) lorsque des personnes de différentes ethnies se rencontrent (Giger et Davidhizar, 1995; Lea, 1994).

L'attribution d'un sens aux messages émis et reçus est étroitement liée à l'intégrité cérébrosensorielle de chaque individu et contribue à un certain degré de filtrage. La culture propre à chaque interlocuteur ainsi que les statuts sociaux incluant les connaissances et les expériences antérieures de chaque interlocuteur colorent le contenu et la forme des messages émis et reçus. Une dissonance entre les valeurs, les croyances, les attitudes et par ailleurs, les intentions des individus et la perception du contenu des messages reçus, entraîne de part et d'autre des comportements de modification ou d'évitement par rapport à ces messages, ainsi qu'une volonté d'exprimer ou de retenir de l'information (Kreps et Kunimoto, 1994). En plus, le temps utilisé pour s'assurer d'une compréhension mutuelle des messages ainsi que le lieu physique de la communication ont un impact libérateur ou inhibiteur sur chacun des interlocuteurs selon les perceptions individuelles, ce qui constitue un autre niveau de filtrage. Chaque séquence doit être appropriée pour obtenir une communication réussie. Ainsi, l'interprète détient une position considérable de pouvoir sur ce que Kaufert et Putsch (1997) nomme le *linguistic black box*, qui n'est généralement pas accessible aux deux

autres acteurs (Hatton, 1992; Hatton et Webb, 1993). L'interprète peut faciliter l'échange entre deux interlocuteurs ou amplifier certaines difficultés de communication, de façon accidentelle ou délibérée, synonymes d'insatisfactions chez les clients et les intervenants face à l'information obtenue (Cohen-Émerique, 1993; N'tétu et Fortin, 1995). Il est donc judicieux de se référer à un interprète officiel qualifié qui est conscient de ce processus de filtrage et qui a été formé pour minimiser les distorsions de l'information. Avant d'aborder les caractéristiques idéales d'un interprète officiel, les types d'interprétariats utilisés par les professionnels de la santé, dont les infirmières, et les conséquences particulières relatives à ces types d'interprétariats sont débattues dans les prochaines sections.

Types d'interprétariats informels

Le recours à un ami / membre de la famille

Le recours à la personne accompagnant le patient est fréquent puisque c'est une solution facile, rapide et peu coûteuse (Phelan et Parkman, 1995). Toutefois, cette personne, rassurante à plusieurs niveaux, ne peut s'empêcher de donner sa vision des choses en traduisant et ce, pour diverses raisons. Vissandjée et al. (1998) notent une tendance à exagérer les propos du client dans le but d'attirer l'attention de l'infirmière, d'accélérer le service ou bien d'obtenir une information spéciale. Un triage de l'information donnée par les intervenants a également été constaté lorsqu'un interprète informel est utilisé. L'interprète informel peut retenir de l'information afin de protéger les patients en évitant de leur annoncer de mauvaises nouvelles ou éviter de futurs problèmes personnels (Phelan et Parkman; Rechtman, 1992; Vissandjée et al., 1998). Déclarer à une personne qu'elle va mourir n'est pas toujours acceptable pour certaines cultures qui croient fermement qu'une telle nouvelle peut être irrespectueuse ou risquer de réduire le temps de survie de l'individu (Beyene, cité par Kaufert et Putsch, 1997). L'interprète informel peut ne pas vouloir mentionner les effets secondaires des médicaments à son épouse de peur que celle-ci refuse de les prendre (Phelan et Parkman). Le désir de cacher une vérité est assez classique, comme par exemple dans le cas d'un époux qui a physiquement violenté sa conjointe et qui agit comme interprète lorsqu'ils se présentent à l'urgence (Gany et Thiel de Bocanegra, 1996; Phelan et Parkman). De plus, l'interprète informel n'est pas tenu au secret professionnel; il n'y a alors aucune assurance qu'il y ait un respect de la confidentialité (Bibeau, Chan-Vip, Lock, Rousseau et Sterlin, 1992; Gany et Thiel de Bocanegra). Certaines personnes peuvent se sentir inconfortables dans

l'expression des détails intimes devant un membre de la famille. Comme dans le cas rapporté par Haffner (1992), une dame latino-américaine ne se sentant pas à l'aise de parler de sa fistule rectale devant son fils adulte agissant comme interprète consultait très souvent et inventait des symptômes en espérant que le médecin finisse par comprendre. C'est finalement en l'absence du fils qu'une interprète professionnelle exprima correctement la situation. Dans les cultures asiatiques, il n'est pas admis que les enfants en sachent plus que les parents. Des responsabilités disproportionnées sont alors imposées à l'enfant et un bouleversement des rôles familiaux peut en découler (Gany et Thiel de Bocanegra).

*Le recours à un interprète issu de la communauté
(travailleur communautaire)*

Le recours à un bénévole issu de la communauté est également assez courant, peu cher et rassurant pour le patient. Étant souvent issu de la même culture, le bénévole fait le pont entre les deux cultures. Toutefois, la confidentialité est encore à considérer (Plunkett et Quine, 1996). Si le bénévole n'a pas reçu une formation adéquate le préparant à interpréter, le risque de filtrage d'information reste présent. Ce recours n'est pas nécessairement une solution systématique puisqu'il existe des disparités au sein même d'une communauté culturelle (Gany et Thiel de Bocanegra, 1996).

Le recours à la liste d'employés au sein de l'institution

La plupart des établissements détiennent des listes d'employés qui sont prêts à agir bénévolement comme interprètes. Certains établissements soutiennent financièrement des cours de langues pour leurs employés ou encore encouragent l'embauche de personnes trilingues. Cette solution est assez répandue puisqu'elle permet un accès rapide à l'interprète et représente une économie de frais d'interprétariat (Marshall et White, 1994). Cependant, peu d'études ont procédé à de réelles analyses de coûts (Mesa, 1997). La question de la formation préparant à un travail d'interprétariat reste entière ainsi que l'évaluation des coûts relatifs au retrait de ces personnes de leurs tâches habituelles (Gany et Thiel de Bocanegra, 1996). Par ailleurs, les politiques d'embauche de personnel qui exigent que les employés maîtrisent plus que les deux langues officielles sont remises en question par certains. L'hôpital chinois de Montréal est en attente d'une décision de la Cour supérieure concernant la possibilité d'offrir quelques postes d'infirmières à des personnes parlant couramment le cantonnais ou le toisonnais. Il

s'agit d'offrir un service de qualité puisque les deux tiers des patients s'expriment en chinois. Toutefois, l'embauche d'employés uniquement trilingues n'est pas réaliste.

En somme, le recours à un interprète non officiel menant à un interprétariat douteux et peu fidèle influe sur la qualité des soins (Hornberger et al., 1996). Un échange d'information insuffisant empêche l'instauration d'une relation de *caring* et de soins adéquats (Giger et Davidhizar, 1995), influe sur la collecte de données et l'évaluation de la situation clinique et entraîne des diagnostics erronés, des traitements peu appropriés (Gany et Thiel de Bocanegra, 1996; Marshall et White, 1994) ainsi que des tests coûteux et inutiles (Shah, 1997), de l'insatisfaction (Gany et Thiel de Bocanegra) et une diminution de la participation (Hornberger et al., 1996). De plus, les professionnels de la santé et les patients éprouvent frustration et stress lors des échanges d'information limités (N'tétu et Fortin, 1995). La qualité réduite des soins qui découle d'une communication déficiente provoque des situations où les patients risquent de ne pas se conformer aux traitements, aux plans de soins et aux visites de contrôle (Gany et Thiel de Bocanegra).

Sur le plan juridique, certaines de ces stratégies peuvent compromettre les droits des usagers tel que le consentement libre et éclairé. À travers une barrière linguistique et sans un interprétariat adéquat, le consentement libre et éclairé est peu probable et la responsabilité déontologique du professionnel de la santé d'informer le client devient cruciale. Pour pallier ces difficultés et favoriser une communication interculturelle optimale, le recours à un interprète officiel et qualifié est recommandé (Shah, 1997).

Type d'interprétariat officiel

La Banque interrégionale d'interprètes de la région régionale de la santé et des services sociaux de Montréal-Centre (RRSSS)

Afin de garantir une traduction de qualité et un accès équitable aux immigrants allophones ne connaissant pas suffisamment la langue française, et à la demande du ministère de la Santé et des Services sociaux, la RRSSS de Montréal-Centre a créé la Banque interrégionale d'interprètes. Cette banque met à la disposition des établissements 82 interprètes sensibilisés à la culture québécoise et au fonctionnement des institutions, offrant des services en 50 langues. Après une sélection rigoureuse fondée sur les compétences linguistiques et les aptitudes de communication, ces interprètes reçoivent une formation qui les sensibilise à l'aspect culturel de la communication. Les interprètes ainsi

formés répondent plus adéquatement aux critères d'un interprète « modèle » suggéré dans les écrits. Ces critères sont examinés dans la section suivante. Malgré une évolution importante de la demande, soit de 220 % de 1993 à 1996, cette banque n'est pas suffisamment utilisée par les institutions dispensant des soins de santé et des services sociaux (Hemlin et Mesa, 1996).

Responsabilités de l'interprète officiel

Dans son rôle de traducteur mot à mot, c'est-à-dire qui rapporte les mots le plus fidèlement possible dans l'autre langue, l'interprète est invisible, son attitude peut être passive et il ne doit pas participer activement à la triade. Hornberger et al. (1996) privilégient ce type de traduction car cette méthode favorise, entre autres, l'instauration d'une relation efficace entre l'intervenant et son patient et évite les interprétations subjectives de la part des interprètes. Kaufert et Putsch (1997) soulignent que ce type de traduction littérale contribue aux malentendus, suggérant de réfléchir plutôt aux possibilités offertes par le partenariat lors du processus de traduction. Cet auteur privilégie une traduction visant à restituer un sens plutôt qu'une traduction mot à mot, par le biais d'un médiateur. L'interprète devrait donc détenir non seulement une compétence linguistique mais aussi une certaine compétence socioculturelle afin d'agir en tant que traducteur et médiateur des discours socioculturels (Gany et Thiel de Bocanegra, 1996). Il devra également avoir certaines connaissances dans le domaine de la santé (Vissandjée et al., 1998), de la terminologie médicale, des tests cliniques et des procédures d'évaluation (Smart et Smart, 1995) et enfin, être soumis à un code d'éthique strict (Solomon, 1997).

À la suite de la révision d'une vingtaine de codes d'éthiques élaborés à l'intention des interprètes au États-Unis et au Canada, Kaufert et Putsch (1997) constatent l'importance de l'objectivité et de la neutralité de l'interprète en milieu clinique, dont le rôle s'apparente à celui de l'interprète en milieu juridique. La plupart de ceux qui prônent l'objectivité et la neutralité des interprètes ne sont pas conscients de l'influence non négligeable qu'exercent la classe sociale, l'éducation, les rôles liés à l'appartenance à un sexe, les croyances et le manque d'équivalence sémantique. Le but de la traduction n'est donc pas uniquement de maintenir une position neutre mais plutôt de construire une compréhension mutuelle (Solomon, 1997), le risque associé étant une possibilité d'interprétations subjectives dans la traduction. Toutefois, à l'aide de règles de « transparence », les interprètes signalent les ajouts, les retraits et les modifications. Les interprétations subjectives peuvent

donc être minimisées, ce qui permet une rencontre plus congruente sur le plan culturel.

Toutefois, le recours à un interprète officiel n'offre qu'une solution partielle au problème de communication interculturelle déficiente en situation clinique comportant trois personnes. Il faut également que les intervenants sachent travailler avec un interprète et surtout que tous soient conscients des différences culturelles présentes et des effets découlant d'une communication déficiente.

Implication pour les sciences infirmières

Les résultats de quelques études indiquent encore la présence de comportements d'indifférence, un manque de connaissances, des soins incomplets et des attitudes peu congruentes dans un contexte de communication interculturelle en présence d'interprètes (Murphy et Clark MacLeod, 1993; Samovar et Porter, 1991). Murphy et Clark MacLeod ont étudié chez les infirmières les comportements de « caring » envers des populations ethniques minoritaires. La lacune la plus importante identifiée était la communication, suivie du manque de connaissances culturelles et l'absence de ressources d'interprétariat. Dans certains cas, la communication était si mauvaise que les infirmières n'ont pu identifier les problèmes du client. De façon déconcertante, certaines de ces infirmières ont démontré une impassibilité face à une communication déficiente.

Jones et Van Amelsvoort-Jones, cités par Lea (1994), démontrent que les infirmières passent moins de temps avec les patients qui sont d'origine ethnique autre. Les besoins des personnes de ces groupes sont alors peu satisfaits et cela accuse la présence de stéréotypes et d'attitudes dérogatoires (Murphy et Clark MacLeod, 1993). Bien que peu documenté, l'ethnocentrisme médical en tant que barrière de communication est présent chez les infirmières. Les stéréotypes et les préjugés perçus comme des obstacles à la communication modifient l'échange de renseignements essentiels (Barette, Gaudet et Lemay, 1993). Ceux-ci forment un écran qui suscite des distorsions, des malentendus et peuvent mettre en échec le processus d'aide. Ces préjugés sont en réalité les paravents de nos peurs (Vissandjée, 1996) et la conscience de la question interculturelle n'est pas encore suffisamment vive chez les professionnels de la santé en général.

Les résultats de ces études démontrent d'une part le besoin urgent de continuer à développer les connaissances par l'entremise de la formation de base en sciences infirmières, des formations pour l'éducation

continue des infirmières soignantes et cliniciennes et de la recherche vers une meilleure adéquation culturelle des soins prodigués. Comprendre l'influence de la culture sur le processus de soins n'est pas une nouvelle donne en sciences infirmières. Les soins infirmiers transculturels examinent cette question depuis plus de trente ans et en ont souligné l'importance afin de donner des soins spécifiques à la culture, congruents et sensibles (Leininger, 1995). Les infirmières sont de plus en plus conscientes des différences culturelles, de l'effet d'une communication déficiente sur la qualité des soins et les coûts liés à la santé, de l'existence de l'inégalité dans les traitements et de l'ethnocentrisme au sein de la profession.

Recommandations

Raffiner les connaissances en matière de codes culturels

Il est essentiel de sensibiliser les individus à la relativité de ces derniers en tant qu'interface essentielle entre le patient et l'infirmière (Cohen-Emérique, 1993; Vissandjée, Carignan et Bourdeau, 1999). Les infirmières qui prodiguent des soins aux patients provenant de différentes cultures doivent accorder une attention particulière à certains facteurs tels que l'espace, la communication, l'organisation sociale, le temps et l'environnement. Leininger (1995) suggère de se pencher sur les connaissances relatives aux valeurs, aux croyances et aux pratiques de diverses cultures. Cet apprentissage peut se faire par l'entremise d'un examen de la structure sociale, des valeurs, de la langue et des contextes environnementaux des divers groupes. L'importance de comprendre et de respecter l'universalité et les diversités culturelles, au-delà des aptitudes de communication avec des membres de groupes culturels, a souvent été soulignée, pour que soient assurés des soins efficaces et congruents (Kreps et Kunitomo, 1994; Nance, 1995).

Nance (1995) propose : (1) d'adopter une perspective multiculturelle qui reconnaît que les cultures diverses se valent, qu'elles ont un sens et reflètent les expériences de vies des personnes; (2) d'adopter une perspective historique qui éclaire le sens des comportements culturels des personnes; et (3) d'envisager l'unicité de la personne plutôt que de se fonder sur des généralisations, étant donné que les connaissances sur un groupe en particulier ne constituent pas une prémisse de connaissance de la personne issue de ce groupe.

Plusieurs guides en sciences infirmières tentent de fournir de l'information culturelle spécifique sur diverses cultures. Bien que ces guides répondent généralement à un besoin exprimé par les infirmières

soignantes qui se sentent démunies face à certaines situations cliniques, ces guides peuvent nuire à une pratique congruente et risquent de renforcer des catégorisations, des généralisations et des préjugés (Kaufert, 1990; Vissandjée et al., 1999).

Développer une attitude appropriée

La communication avec des amis ou des membres de la famille diffère de la communication interculturelle en terrain clinique et peu familier (Lea, 1994). Dans ce cadre, les buts de la communication interculturelle sont de diminuer l'incertitude potentielle entre les acteurs et de développer une confiance mutuelle afin de créer un climat favorisant l'interaction interculturelle. Il ne s'agit pas simplement de trouver les mots justes mais plutôt de découvrir un terrain commun de communication. Ce terrain commun n'est créé que lorsque les acteurs participants ont le désir réel de comprendre l'autre et de se faire comprendre de l'autre. L'infirmière doit également être sensible au fait qu'une tierce personne influence la dynamique d'une relation avec le patient, notamment la dimension affective (N'tétu et Fortin, 1995).

Apprendre à travailler avec un interprète

Hatton et Webb (1993), après avoir effectué une étude qualitative auprès des infirmières et des interprètes, ont découvert plusieurs styles de traduction : (1) *voice box*, où l'interprète traduit « mot à mot »; (2) le substitut, où l'interprète agit en tant que substitut; et (3) le collaborateur, où l'interprète collabore à la prestation des soins. La traduction mot à mot est appréciée par plusieurs infirmières puisque ce style élimine les interprétations subjectives et donne de l'information détaillée et précise, particulièrement dans les cas de violence ou de négligence envers des enfants. Le substitut est généralement utile lors des premières visites à domicile, l'interprète servant de porte d'entrée. Dans cette situation particulière, les infirmières tendent à encourager l'interprète à participer activement. Enfin, le collaborateur est un style qui est apprécié par les infirmières ayant plusieurs années d'expérience. Ces interactions de collaboration permettent aux infirmières et aux interprètes d'établir des liens plus efficaces avec les clients, facilitant l'évaluation, la planification et la prestation des soins.

Solomon (1997) propose un entretien avant et après la rencontre avec l'interprète afin de discuter du but, des thèmes qui seront abordés et du temps approximatif prévu, des sujets potentiellement délicats, ainsi que du code d'éthique à respecter. Vissandjée et al. (1999) sug-

gèrent de mettre à profit l'expertise de l'interprète et de lui laisser une marge de manœuvre suffisante lors de la collecte des données et de la transmission de l'information. Des ateliers avec des jeux de rôles entre infirmières et interprètes permettraient de déceler les lacunes et les forces de chacun, favorisant ainsi l'apprentissage de la collaboration. Un réseau de soutien pour les infirmières qui prennent soin de personnes issues de cultures différentes serait indiqué afin de permettre à celles-ci de discuter de leurs sentiments et de les partager (Murphy et Clark MacLeod, 1993).

Pour qu'un partenariat solide s'installe entre les infirmières et les interprètes, l'amélioration du statut d'interprète est essentielle. Une reconnaissance ne sera possible que lorsque tous les interprètes recevront une formation et une rémunération adéquates. La collaboration interdisciplinaire est fondée sur l'appréciation de la spécificité de chacun s'appuyant sur l'équité des compétences et sur la parité (Kérouac, Pépin, Ducharme, Duquette et Major, 1994). Il est également important d'obtenir du soutien administratif afin d'uniformiser les politiques de soins favorisant une collaboration efficace entre les interprètes et les infirmières. Cette dynamique triadique est influencée par des forces globales institutionnelles, professionnelles et structurelles telles que les directives de programmes de l'hôpital, le financement et le niveau de représentation des programmes d'interprétariat sur le plan de la gestion.

Un partenariat vers des soins congruents

En plus de raffermir la collaboration entre les interprètes et les infirmières, il est impératif d'engager les patients et leurs familles d'une façon culturellement appropriée dans le processus de décision concernant les soins. Il est indispensable de développer des stratégies synergiques entre les formateurs des infirmières et des interprètes, les infirmières et les interprètes, les organismes ethnoculturels pertinents, le réseau de la santé et des services sociaux et les patients venant d'ailleurs, le regard de ces derniers sur leurs conditions de vie étant essentiel à la qualité optimale des soins.

Les communautés ethnoculturelles devraient jouer un plus grand rôle dans la conception des programmes et l'élaboration de solutions qui conviennent à leur culture. Ce partenariat permettrait, d'une part, de mobiliser les ressources et les compétences des communautés ethnoculturelles déjà existantes et, d'autre part, d'assurer des stratégies congruentes et durables qui répondent réellement aux besoins diversifiés.

La situation particulière des immigrants peu lettrés, pour qui l'apprentissage de la lecture et de l'écriture d'une deuxième langue peut être doublement difficile car ils ne détiennent pas ces aptitudes dans leur propre langue maternelle, doit être considérée (Brown, 1995). De plus, une attention particulière devrait aussi être portée aux populations immigrantes hautement qualifiées pour lesquelles la reconnaissance des acquis scolaires et professionnels représente un réel enjeu. De façon similaire, les groupes qui vivent des difficultés spécifiques liées à une faible scolarisation, à une plus grande distance culturelle de la société d'accueil ou encore au statut de réfugié sont encore peu compris.

Il serait souhaitable de déterminer le bien-fondé d'un appariement entre l'interprète et le patient. Peut-être serait-il préférable d'assurer un appariement entre personnes de même sexe dans les cas de problèmes gynécologiques cliniques. Le débat sur l'appariement comme stratégie de développement de connaissances culturelles appropriées tente de favoriser les identités partagées entre les divers intervenants (Sawyer et al., 1995; Vissandjée et al., 1999; Weinfeld, 1998) sans négliger les connaissances culturelles, la sensibilité et la collaboration.

Enfin, la question des coûts, de la qualité, du type d'interprétariat et du recours à un interprète mérite des analyses économiques plus approfondies. Les contextes de soins requérant des interprètes officiels et ceux nécessitant plutôt des interprètes non officiels ou même encore une comparaison des besoins de part et d'autre n'ont pas été systématiquement étudiés, l'objectif étant d'élaborer des recommandations claires pour les divers niveaux de pratique et de décision.

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Book Reviews

Primary Health Care: Concepts and Challenges in a Changing World — Alma-Ata Revisited

E. Tarimo and E.G. Webster

Geneva: World Health Organization — Division of Analysis, Research & Assessment, 1997, 118 pp. (Current Concerns Paper 97.1, Order #1930090)

Reviewed by Heather F. Clarke

Over 20 years ago, in 1978, the Alma-Ata conference defined and gave international recognition to the concept of primary health care (PHC). This approach embodies explicit principles, including: universal accessibility and coverage on the basis of need, community and individual involvement and self-reliance, intersectoral action for health, and appropriate technology and cost-effectiveness. It has major implications for the entire health-care system and for its interactions with broader economic and social development structures.

Chapter 1 of *Primary Health Care: Concepts and Challenges in a Changing World — Alma-Ata Revisited* summarizes the main features of the PHC approach and the implications of this approach for health-care systems. Of particular note are required changes related to redistribution of existing resources and to attitudes/misinterpretations. Six misinterpretations of PHC are addressed. Perhaps the most common of these is the misinterpretation of PHC as the first level of contact between individuals/communities and the health-care system — that is, primary care.

The next five chapters provide a critical review of the progress, or lack thereof, towards implementation of the specific recommendations of the Alma-Ata conference. Major obstacles to implementation are discussed with respect to: strategic approaches, health systems, program elements, human resources, and international support. Canada is praised for its progress in mobilizing health action and public debates. However, neither Canada nor any other country is praised for the outcomes. There have been few successes in advancing the PHC approach or in advancing towards the goal of health for all. Successes are mainly to be found in accepting the concept of PHC — promoting more equitable distribution of health resources and re-orienting services — but this has been more evident in developing countries than developed ones. Epidemiologically, childhood diseases such as poliomyelitis, measles, tetanus, and pertussis have decreased due to the rapid expansion of immunization. However, few developing countries have been able to maintain a high level of childhood vaccination without external support.

Failures relate primarily to a lack of the political commitment required to embrace PHC and a lack of coordination of activities, resources, priority-setting, and systems research. It is distressing to learn that social, ethnic, gender, and occupational inequities in health and health care have decreased little and sometimes have even increased. This finding is not restricted to developing countries.

Chapter 7 addresses important issues for the year 2000 and beyond. These are: partnership with a view to a social contract and a code of ethics, special efforts to reach the underprivileged in pursuit of equity, renewed attempts to improve the quality and effectiveness of health services, and rethinking of priorities.

What does this have to do with nursing? A great deal. The Canadian Nurses Association and many provincial and territorial nursing associations take the position that the Canadian health-care system should be founded on the principles of PHC and the *Canada Health Act*. Nurses believe that PHC is an essential approach, with significant roles for nurses. Nurses influence policy at many levels and provide leadership in health-care reform. They facilitate change in the social context of health. In a health promotion approach, they develop partnerships with others and contribute to new models of health care in practice, education, and research (Registered Nurses Association of British Columbia [RNABC], 1998a).

In their summary, Tarimo and Webster note: "[re]search and development is essential to improve the quality of priority setting processes" (p. 89). These are roles for nurses that have been recognized nationally (RNABC, 1998b).

Primary Health Care: Concepts and Challenges in a Changing World — Alma-Ata Revisited is a clear, concise, and well-referenced volume. It is a valuable resource for nurses in the areas of practice, education, research, policy, and management.

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Primary Health Care in Urban Communities

Beverly McElmurry, Cynthia Tyska, and Randy Spreen Parker

Sudbury, MA: Jones & Bartlett and National League of Nursing, 1999, 266 pp.

ISBN 0-7637-1010-5

Reviewed by Sheila M. Gallagher

Primary health care can integrate the activities of the medical, educational and economic sectors with those of individuals and communities. By strengthening local initiative and stimulating educational reform and greater communication and cooperation between health professionals and lay people, primary health care will not only allow better use of resources but ensure that community needs are met. (World Health Organization, 1985, p. 1)

This book details the collaborative efforts of health-care workers, community members, and university personnel in community-based primary health care (PHC) initiatives in Chicago, Illinois. The range of projects described illustrates the chameleon-like character of effective PHC initiatives. These initiatives embody PHC principles in a way that is acceptable and useful to local communities. The operational and philosophical link between PHC and community development is evident in these discussions.

Chapters 1 and 2 provide an introductory framework for the Chicago initiatives. A discussion on the role of public and private partnerships in health care in PHC strikes a familiar chord in light of current Canadian discussions. Chapters 3, 4, 5, and 7 highlight community health advocates (CHA) and nurse teams, CHA training, and reflections on the role of the CHA — with the work of Paulo Freire as a recurring theme. Chapter 6 provides theoretical, practical, and critical discussions on PHC evaluation and is thus an important resource for anyone undertaking a PHC project. Freire's (1973) discussions on literacy and popular education and Kretzman and McKnight's (1993) work on community capacity building inform Chapters 8, 9, and 10. Chapter 11 describes a PHC-inspired academic community health centre located in a medically underserved area where health-care professionals in training receive a true education. Chapters 12 and 14 discuss multicultural projects. Chapter 13, 15, and 16 highlight children's services and education/curriculum design. Chapters 17 and 18 explore contemporary community health, including innovative community-centred outcome measures and transformational leadership. Planners and evaluators should take note.

The initiatives presented in this book are examples of nursing in action. They can be beneficial for all health-care professionals but particularly for nurses, as they are celebrations of the practice and art of nursing.

Front-line health-care professionals, students, and educators will benefit from the breadth of the descriptions of PHC projects — projects that exemplify nursing innovation.

Additional strengths of *Primary Health Care in Urban Communities* include the format of the chapters and of the book itself. The chapters feature sections on research methodology; the generalizability of lessons learned from individual projects; and successes and challenges in planning, administering, and evaluating projects. These sections provide pearls of wisdom relative to these three stages in any PHC initiative. Increasing demand on health-care initiatives to demonstrate outcomes and to maximize efficacy and efficiency highlights the value of the lessons learned from the Chicago PHC projects.

The final chapter of the book, which mirrors the format of the preceding chapters, provides an analysis of the lessons learned from the various initiatives. This analysis offers conceptual insight on a macro level for researchers, educators, and policy-makers.

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***Promoting Health:
The Primary Health Care Approach (2nd edition)***

Andrea Wass

Toronto: Harcourt Saunders, 2000, 297 pp.

ISBN 0-7295-3425-1

Reviewed by Beverly D. Leipert

Health promotion workers increasingly find themselves operating in a political context that supports economic rationalism, "new right" thinking, and decreased government commitment to the principles of primary health care. Andrea Wass has written a valuable book on PHC and health promotion principles and practice. Intended primarily for nurses but of value to other health promotion workers as well, this book, now in its second edition, presents historical, theoretical, and practical information designed to empower health-care workers and advance health promotion in these politically challenging times. Although *Promoting Health* focuses on PHC in Australia, all of its 10 chapters have been updated and expanded to address international perspectives as well.

Chapter 1 examines the principles of PHC from a historical perspective and describes the new public health movement. Here, the author reviews barriers to the implementation of PHC approaches, such as political and economic restructuring and interconnections, and highlights national and World Health Organization commitments to PHC. This chapter also uniquely examines what PHC is *not* as well as what it *is*. The second half of the chapter looks at Australian health policy in some depth and critically examines the extent to which this policy incorporates PHC principles.

The second chapter presents key concepts and values in health promotion and raises issues and questions that health workers face as they contemplate and use health promotion ideas and approaches. Definitions of health, community health, family health, health promotion, and other concepts are discussed, and issues attendant to such health promotion concepts as client participation, power, and responsibility are addressed. Interesting and controversial health promotion projects, such as the Australian program "Life: Be in It With a Cat," are critically discussed.

The next two chapters of *Promoting Health* examine needs assessment and evaluation. Wass contends that these two areas have a great deal in common, as both require research skills as the basis of their

processes. Chapter 3 examines major issues in community assessment, such as the types of research skills, data sources, and health indicators that are used to determine needs. In Chapter 4 the author approaches the evaluation of health promotion programs from participatory and empowerment perspectives.

Chapters 5 to 9 explore a number of strategies useful in health promotion work — using the mass media, employing community development approaches, working for healthy public policy, working with groups, and using education as a health promotion strategy. Throughout these chapters, the author presents examples, advice, and tips to assist the reader in implementing each health promotion strategy.

Chapter 10 considers how to put health promotion approaches and strategies together to produce an effective health promotion practice for individuals or teams. In her conclusion, Wass provides suggestions to further develop skills and expertise in health promotion and primary health care. The book has five appendices: the *Alma-Ata Declaration*, the *Ottawa Charter*, the *Jakarta Declaration*, an annotated bibliography, and some Internet sites.

Promoting Health: The Primary Health Care Approach is a practical resource for nurses and other health promotion workers. It will also be of interest to students of health promotion in nursing, community health, and other education programs. Articulation of historical highlights of the health promotion movement and of its commitment to the principles of social justice, equity, community participation, intersectoral action, and sustainable, balanced health-care systems provides a solid foundation for students of PHC in general and health promotion in particular. Although the book focuses on health promotion as it pertains to Australia, the international audience may not necessarily consider this a limitation. Many of Wass's examples and discussions do seek to articulate health promotion principles for a wider audience. The combination of historical, theoretical, and practical information in one volume, and the empowerment approach evident throughout the book, make this a comprehensive, accessible, and timely resource for health promotion students and practitioners in these times of political retrenchment.

Beverly D. Leipert, RN, PhD (cand.), is Assistant Professor, Nursing Program, University of Northern British Columbia, Prince George, and a Killam Scholar, University of Alberta.

**CJNR 2000–2004:
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Abuse and Violence

March 2001 (vol. 32, no. 4)

In nursing and other disciplines, research on violence and abuse and their health consequences has increased rapidly over the past decade. This issue will focus on all aspects of this phenomenon as it intersects with nursing practice in the entire range of health-care settings. We are interested in both the perpetration of violence and its victimization, family and non-family violence, abuse across the lifespan, physical and mental health outcomes, and prevention and intervention. We are particularly interested in areas that have received insufficient recent nursing research attention such as child and elder abuse, youth violence, rape and sexual assault (especially against males), cultural and cross-cultural influences in the perpetration of violence and the responses to it, and the testing of nursing interventions. We hope to publish mainly research reports but will also consider papers on theory development and testing. We welcome investigations that use qualitative or quantitative data or a combination of the two.

Guest Editor: Dr. Jacquelyn C. Campbell

Submission Deadline: July 15, 2000

Economics of Nursing Care

June 2001 (vol 32, no. 1)

Research on the economics of nursing care focuses on the cost implications of nursing services. These may take the form of cost-minimization, cost-benefit, cost-utility or cost-effectiveness analyses. Economic evaluation in nursing is still relatively recent. Papers are sought which examine the economic aspects of nursing care which may include the use of system resources such as length of stay or emergency visits. Priority will be given to papers that examine the effects and expense of nursing care from multiple points of view.

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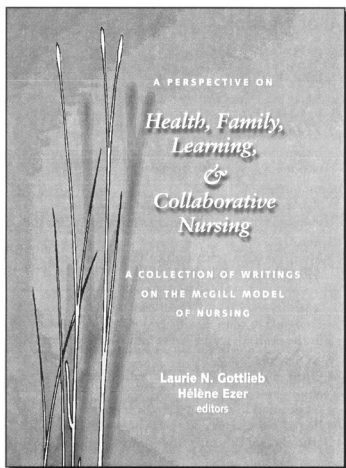
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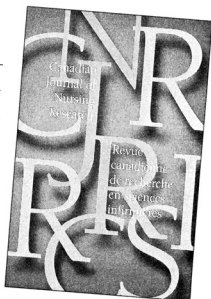
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