

Guest Editorial and Discourse

Incorporating Culture and Gender into Multiple Intervention Programs

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The first issue of *CJNR* that focused on Culture and Gender was published in 1996. In her guest editorial, Dr. Joan Anderson reminded readers that culture and gender are socially constructed. She also presented important theoretical challenges related to the multi-layered context of people's lives and the complex interrelationships of race, class, and gender. Dr. Anderson called for a new discourse based on these theoretical insights. The challenges of multi-layered context and complex interrelationships are still highly relevant for researchers addressing matters of culture and gender. In this issue of *CJNR*, the contributors advance the dialogue initiated by Dr. Anderson by incorporating culture and gender considerations into the development of theory, the choices of methodologies and methods, and the design of interventions. We argue for the development of multiple intervention programs¹ that integrate gender and culture as key determinants of health.

Theory Development

The papers in this issue of the Journal pose important challenges for researchers in relation to theory development. Are theory and knowledge universally relevant or culturally specific? Does this depend on the context? Jakubec and Campbell highlight the dangers inherent in the indiscriminate export of knowledge to countries with a different worldview from the one where the knowledge was developed. Their thoughtful analysis of the use of a World Health Organization mental health survey in The Gambia brings into sharp focus the relationship between theory and worldviews: theory is embedded in a particular worldview, and the two are inextricably linked. The underlying assumptions of a theory must be examined before it is used in another setting. Questions

¹ Multiple intervention programs use a combination of intervention strategies that target multiple levels of the socio-ecological system (e.g., individual, family, community, organization, and policy) to address health issues. These programs are sometimes referred to as comprehensive programs.

to consider when contemplating the use of a theory in different settings and cultures include: How do worldviews related to health differ among cultures? What are the different contextual features that may influence the utilization of theory? How might cultural differences influence the measurement of concepts within the theory?

Researchers investigating culture and gender must guard against the tendency to adopt their most comfortable philosophical position related to theory development. They must be willing to risk considering an alternative philosophical stance to transform the way research questions are framed. The thoughtful analysis of gender and stress-related disorders provided by Carter-Snell and Hegadoren offers an interesting perspective in relation to the development of gender-sensitive theory. Their review of the differential contribution of physiological and psychosocial variables in the development of stress disorders in men and women challenges readers to critically review their own presuppositions in relation to theory development generally and theory development in stress disorders specifically. Carter-Snell and Hegadoren raise concerns regarding potential biases inherent in the use of “categories” outlined in the *Diagnostic Services Manual, 4th Edition* (DSM-IV) to assess the prevalence of stress disorders. They argue that, instead of relying on groups of symptoms, we must identify and validate distinct concepts underlying stress disorders to determine their causal influences and relationships. The authors also challenge the notion of gender-sensitive theory as limited to the experience of women. They advocate for the development of a theory on stress disorders that is sensitive to the voice of both men and women.

Methodology and Methods

Conducting research within culturally, racially, and linguistically diverse communities is the reality in Canada today. The heterogeneity of communities demands the use of diverse methodologies and methods to tease out the influence of culture and gender on health and to develop interventions to mediate this influence. A diversity of methods and methodologies is reflected in the papers featured in this issue. Institutional ethnography (Jakubec & Campbell), ethnography (Banister, Jakubec, & Stein), grounded theory (Gage-Rancoeur & Purden), longitudinal survey (Secco & Moffatt), and retrospective, correlational survey (Dahinten) designs were chosen to explore a range of problems, while interviews (Gage-Rancoeur & Purden), focus groups (Banister, Jakubec, & Stein), participant observation (Banister, Jakubec, & Stein; Gage-Rancoeur & Purden), and standardized questionnaires (Dahinten; Secco & Moffatt)

were used to collect data in order to answer questions related to these problems.

A gendered analysis of an experience or phenomenon may also influence the choice of research design. For example, Gage-Rancoeur and Purden's knowledge that adult daughters were more likely than sons to provide care to parents led them to focus their study on the caregiving experiences of daughters of cardiac patients. Banister, Jakubec, and Stein argue that a critical feminist perspective was required for their exploration of power inequalities in the dating relationships of adolescent girls. Furthermore, they suggest that the use of focus groups provided the adolescents with a safe environment in which to share their concerns about their dating relationships and to begin reflecting on the power imbalances within these relationships.

The use of diverse methods and methodologies to explore health issues among different cultural and linguistic populations is not without challenges. Some of the difficulties related to the translation and adaptation of psychometric instruments in cross-cultural or cross-linguistic settings are expertly summarized in the Designer's Corner feature article prepared by Kristjansson, Desrochers, and Zumbo. These authors provide a critical overview of common problems and pitfalls encountered by researchers during the translation of instruments that may lead to bias. They review problems related to lack of conceptual equivalence, lack of semantic equivalence, and differences in cultural norms regarding behaviour. Furthermore, Kristjansson and colleagues detail strategies to assist with the development of reliable and valid measurement instruments for cross-cultural or cross-linguistic research.

Secco and Moffatt's exploration of the home environment of Canadian adolescent mothers highlights some of the challenges associated with measuring the influence of ethnicity on health. They suggest that some of the differences in quality noted in the home environment of Caucasian and Métis/First Nations adolescents may be attributable to the confounding influence of poverty rather than mothering. Secco and Moffatt also point out that the explanatory power of the ethnicity variable may be compromised due to the ability to delineate only two broad ethnic categories, Caucasian and Métis/First Nations, thereby overlooking the diversity within each group.

Interventions

Health is determined by a complex interaction of factors, including culture and gender. For optimal efficacy and efficiency, intervention programs must focus simultaneously on the multiple determinants of health, rather than on a single determinant. A multiple intervention approach,

based on a social-ecological framework (Smedley & Syme, 2000), is advocated for the design of health interventions. Multiple intervention programs address not only the individuals at risk, but also risk-producing environments and policies, by focusing on the individual, social, cultural, educational, political, and economic determinants of health. Ideally, multiple intervention programs are integrated across several settings such as home, workplace, and community. Programs must also ensure optimal sequencing of interventions to maximize the synergy between intervention strategies.

Research has explored and substantiated culture and gender as a determinant of health. Considerably less progress has been made, however, in incorporating this knowledge into the design of health interventions. What is the basis for this omission? Perhaps it is related to culture and gender being considered “non-modifiable” risk factors. Many researchers acknowledge the influence of these factors but believe that little can, or should, be done to modify them. This may be an accurate assessment if gender is narrowly delineated as sex and culture is equated with ethnicity. However, the conceptualization of gender and culture as the socially constructed roles of men and women brings these concepts within the realm of “modifiable.” In addition, our desire to be culturally sensitive and politically correct and our reluctance to challenge the status quo may restrain our efforts to ensure that health interventions are designed to mitigate the influence of culture and gender. For example, culturally specific attitudes and practices may increase women’s vulnerability to HIV infection. Long-standing beliefs that limit women’s power in relation to men, practices that favour the education of boys over girls, and policies that result in higher levels of poverty among women have been documented in Sub-Saharan Africa (Aggleton, 1996; Campbell, 1997; Mill & Anarfi, 2002; United Nations Development Programme, 1997). These beliefs, practices, and policies increase women’s vulnerability to HIV infection. Although they are embedded in the complex fabric of a culture, it is essential that their impact be critically examined and if necessary challenged. The words of Mohandas Gandhi almost a century ago may be germane to the conundrum faced by researchers trying to balance respect for cultural differences with the responsibility to challenge those differences that have a negative impact on health: “It is good to swim in the waters of tradition, but to sink in them is suicide” (Editorial in *Navajivan*, June 28, 1925).

Several of the articles in this issue of the Journal have implications for health interventions that are based on a gendered analysis of an experience. Gage-Rancoeur and Purden’s exploration of the caregiving experience of the daughters of cardiac patients substantiates the growing

awareness of the significant contribution and commitment of women as caregivers. The compelling account of the health consequences of the unequal power dynamics in the dating relationships of adolescent girls provided by Banister, Jakubec, and Stein documents the need for health interventions that challenge mainstream culture and foster the empowerment of adolescent girls. Similarly, Dahinten's work supports the notion that the social construction of gender influences the perpetration of various forms of sexual harassment among males and females and by males and females. Furthermore, her finding that the coping strategies of girls, in response to sexual harassment, are different from and more varied than those of boys points to the need for differential prevention interventions. Dahinten's work increases our understanding of sexual harassment as a function of gender and reminds us that gendered analysis must include the experiences of boys and men in addition to those of girls and women.

The Future

The breadth and depth of the papers published in this issue demonstrate that a focus on culture and gender is alive and well on the landscape of nursing research in Canada today. The next generation of research on the influence of culture and gender on health must demonstrate the integration of mixed methodologies, merging the strengths and perspectives of qualitative and quantitative methods. In addition, there is a need for the testing of interventions that incorporate sensitivity to or modification of the impact of culture and gender on health.

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