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EDITORIAL

Nursing Research and Publishing Challenges as the Mantle Passes to a New *CJNR* Editor: Sean Clarke

After 84 issues, 43 editorials, collaborating with 64 guest editors on 69 focus issues, publishing two anniversary issues, and having *CJNR* host the International Academy of Nursing Editors conference, it is time for me to pass the baton to a new editor. This is my last issue as Editor-in-Chief. I will be assuming the position of Editor Emeritus — whatever that role will become.

As of volume 45, Dr. Sean Clarke will be taking over the editorship. Sean has been involved with *CJNR* for 18 years. During the past eight he has served as Associate Editor. Sean has recently returned to his alma mater as the first occupant of the Susan E. French Chair at the Ingram School of Nursing of McGill University and is the newly appointed director of the McGill Nursing Collaborative for Education and Innovation in Patient- and Family-Centred Care. He is an established researcher, a prolific author, and editorial board member for several Canadian and US nursing publications. We have worked closely together over these many years and have penned a number of editorials together. Sean is extremely well qualified to carry the torch, to look at the Journal with fresh eyes while appreciating its history. He has the skills to lead *CJNR* into the brave new world of publishing.

When I was invited to assume the editorship 21 years ago, I could not have foreseen that I would be occupying this position for so long, nor could I have predicted the changes that have transpired in nursing, nursing research, and publishing. It was another time, another era — truly another world.

Other than belonging to the second wave of Canadian nurse scholars and researchers and being relatively well published for the time, I lacked the qualifications to warrant appointment as editor. Yet appointed I was — naïve on everyone's part, including my own. I learned on the job how to be an editor. I surrounded myself with able colleagues and had the support of the Canadian nursing academic community. It was a time when all researchers in Canada knew one another, for ours was a small community of scholars. This was before Canada had doctoral programs in nursing and few PhD-prepared nurses. Master's-prepared nurses formed the backbone of our research community. Our main support was the Canadian Association of University Schools of Nursing. I made a yearly pilgrimage to the CAUSN annual meeting of Deans and Directors of University Schools of Nursing, which had about 37 members, for emotional and financial support. The executive director of CAUSN, the late Wendy McBride, and the deans and directors across the country never let me down.

When I was appointed to this position, I was faced with the reality that we had few manuscripts to publish, an erratic publishing schedule, and a list of just a handful of reviewers. Nevertheless, I believed that Canadian scholars needed a journal in which to publish their research and that nurse clinicians, educators, researchers, and students needed a journal with Canadian content to guide them. The challenge was how to ensure *CJNR*'s survival, then how to envisage it, and finally how to realize the vision.

Necessity is the mother of invention is one of those clichés that is a cliché because of its time-proven wisdom and truth. I'm not sure where the idea for focus issues came from, but I knew I couldn't do this alone. I needed the expertise of many to ensure the Journal's survival and growth. What better way to do so than to draw on the experience and expertise of my many friends and colleagues across Canada? The time was right, as nurse scholars were beginning to move from individual studies to programs of research. I respected my colleagues and knew that they were privy to what was happening in their respective fields and the major players in those fields; I believed that they were in a better position than I to know about ongoing, planned, and nearly completed research projects. I needed them to find authors, convince these authors that *CJNR* was a bona fide place to publish, and help me improve the quality of manuscripts through a more rigorous review process. At the same time, I wanted *CJNR* to continue to be a general journal. Eureka! Why not combine the two missions? This proved to be one of my best decisions. Inviting my colleagues to become guest editors served to transform *CJNR* from a McGill University journal into a national journal that was housed at McGill University. It has been an honour to work with so many talented, knowledgeable, and above all generous guest editors. Collaborating with them as well as with our authors and reviewers has been the most gratifying aspect of this position.

We are at a most exciting juncture in the development of both nursing and publishing. Advances in technology, a critical mass of seasoned nursing scholars, and the emergence of nursing as a mature and respected science are some of the forces transforming the health-care landscape. Yet there are many new challenges that editors will need to address in this evolving and changing landscape. Some of the challenges are specific to nursing while others are related to how best to disseminate information and research in this information, digital age. I will highlight just a few of these challenges.

Challenges for Developing Nursing Science

Challenge #1

Many have concluded that nurses can be a force in transforming health care by virtue of our sheer numbers and nursing's mandate in health and healing. They believe that nurses just need to be given the opportunity to practise to the full scope of their knowledge and skills (Institute of Medicine, 2010). Study after study has shown that when nurses provide *nursing* care, not just medical care, to groups requiring their skills and services, such as the elderly, those with chronic conditions, and those requiring palliative care, nurses can deliver safe, effective, comprehensive care that is also cost-effective for the system (Browne, 2012). Nursing research needs to continue to document the nature and effects of nursing practice, describe innovations to practice, identify specific groups who benefit most from professional nursing care, document a broad range of outcomes beyond mortality and morbidity, and identify the qualities and workplace conditions that are needed to ensure that nurses practise to their full capacity.

Challenge #2

There is a growing gap between different groups of nurses. This is disheartening and discouraging. Over 40 years ago, the late Dr. Helen Mussallem predicted the emergence of the technical nurse and the professional nurse. Her prophecy has come true. The profession of nursing has reaffirmed its mandate of promoting health, facilitating healing, and alleviating suffering. In keeping with this mandate, nursing research has focused on understanding these phenomena and how nurses fulfil their social contract through the nurse-patient relationship and preserving the public's trust. Yet far too many nurses subscribe to the idea of nursing as a set of technical activities and tasks rather than as a relational/moral/social profession practised on a technical foundation (Steele & Harmon, 1979). Anyone who has been a patient in hospital knows that a significant number of nurses have discounted the centrality of the patient-nurse relationship. Spending time with patients and using basic communication skills have been devalued and in some cases rendered almost non-existent. Tasks have trumped the relationship and the need to take the experiences of patients and families into account. For many, nursing is a nine-to-five job rather than a vocation. Nursing education, service, and research need to bring these different camps in line and reclaim and recommit to nursing as a relational profession with a technical-task base. Nursing research needs to explore the reasons for the widening gap and address the factors responsible, including who is selected into nursing and how our educational and workplace environments contribute to professional identity and support or sabotage professional practice.

Challenge #3

Let us examine the nature of nursing itself. Nursing is the nexus of many activities and complex roles that require the integration of biological, psychosocial, and context-specific phenomena with underpinnings of holism and embodiment. Nursing research needs to pay more attention to explicating the biological basis and mechanisms of specific nursing phenomena. In this era of neurobiology and technological advances, we are beginning to understand the whole, integrated person. Our research questions and designs must reflect what we profess to be nursing values and nursing's focus.

Challenge #4

The trend towards interprofessional/interdisciplinary collaboration will continue to grow. Some nurses have been voicing a belief that interprofessional work means that professions have a convergent focus and speak the same language. This indicates that some nurses have adopted the medical model, assuming more medical tasks and devoting more of their studies to the medical issues of diagnosis and treatment. I would argue that this is the wrong path to be taking. Evolutionary theory has taught us that for a species to survive it must occupy its own niche (Gottlieb & Gottlieb, 1998). In a professional context, this means that nursing must have its own set of knowledge and skills and must play a role that no other profession can. Nursing needs to have its own framework of practice, rooted in the traditional values of holism, embodiment, uniqueness, and collaborative partnership, with a focus on strengths rather than on deficits and problems. We need more research to demonstrate nursing's effectiveness in empowering patients and families to take charge of their own healing and make their own health-care decisions.

In addition to the challenges of developing nursing science, there are those related to information dissemination.

Challenges for Information Dissemination

Challenge #1

The issue of impact factor (IF) will need to be reconsidered and revisited. Publishers, scholars, readers, and the academy have become more concerned about a journal's IF than about the impact that a particular article or study has on practice, education, management, and research. When one asks those preoccupied with IF what it is, most will state that a high IF is good but will have little understanding of what it is and how it is derived. IF reflects the journal, not the impact of a specific article. Few understand what is involved in calculating a journal's IF (Gottlieb & Clarke, 2005). Many so-called IF articles are actually low impact (as reflected in the number of citations) but because they are published in high-impact journals readers assume they are significant. The focus should be the quality of the article and its impact in directing clinical decisions and inspiring creative, person-focused practice, rather than its impact on tenure committees. *CJNR* is too small to be awarded an IF. Yet our impact is high if measured according to the number of articles that are downloaded. Among more than 16,200 journals, *CJNR* consistently ranks high for full downloads on ingentaconnect.com. For example, in February 2012 *CJNR* ranked 39th, with 2,814 downloads, and in March 2012 it ranked 36th, with 3,031. In September 2012 it ranked 26th, with 3,034 downloads, and in October 2012 it ranked 23rd, with 3,576! And so forth. The idea of increasing impact is a good one, but a question that needs to addressed is how best to measure impact.

Challenge #2

A major trend in this new information age is the democratization of information. Democratization plays out in different debates and is reflected in discussions on open access and open content, the role of social media in academic publishing, online publications, self-publications, and the like. Some of the discussions centre on having free access to all scholarly journals at little or no cost, based on the principle of open access. The bottom line is that diffusion of information is a costly venture, with many hidden costs, such as those incurred in creating more sophisticated platforms, in editing, and so on. Although different models have been tried — with varying degrees of success — no one standard model has yet emerged.

Along with open access come open content, online publishing, and self-publishing. The underlying issue in these debates is how to control the quality and veracity of what is published. We are living in an era of clever schemes for plagiarism, duplicate publication, salami publication, and the like. Sophisticated computer programs are being used to detect plagiarism and duplicate publication. In terms of quality, different models have been used to judge the quality and accuracy of an article, almost all employing the widely accepted peer-review process. Although other models have been tried, none has proved superior to the scrutiny of one's peers. Nonetheless, the peer-review approach will be challenged, new models tried, or articles published without the benefit of review. Editors will need to become hypervigilant and even more sceptical if they are to fulfil their role as gatekeepers of knowledge and ensure the integrity of information that is published on their watch. As part of their role, editors will require a more sophisticated arsenal and will need reviewers who are knowledgeable and up-to-date, to ensure the veracity and validity of what they are publishing. Only then will their readership be well served and the public safeguarded from reports that have been falsified or data that have been distorted.

Challenge #3

Since Johannes Gutenberg introduced the printing press to the Western world, scientific information has been communicated in one medium — the written word. Now, however, visuals, audiorecordings, and media that make use of our other senses to communicate information are being tried, because each communicates different slices of information about the same phenomenon. In a similar vein, information dissemination will continue to move from the unidirectional relationship of author to reader to increasing interactivity and all that it entails. Blogs and online commentaries are the precursors of this trend.

Moreover, traditionally articles have reported on the outcomes of research. The article of the future will be concerned as well with how the results were derived — in other words, the research process per se.

As we move from print to electronic forms of communication, from personal to social media, from one-medium (auto-media) to multimedia formats, from passive, non-connected interactions (e.g., writer and reader) to interactive dialogue and discourse, journals will need to become relevant, responsive, and adaptive. Only those journals that are able to do so will survive. Whereas in the past, content changed while the format remained constant, the brave new world of publishing will require authors, publishers, and readers to adapt to new content presented in many different formats.

Parting words: *CJNR* has been able to evolve because we have anticipated future trends in nursing and health care and in the world of publishing, and planned accordingly. Its publication has required and will continue to require vision, knowledge, commitment, creativity, courage, versatility, adaptability, a modicum of chutzpah, and above all imagination and integrity.

We are in a time of transition — moving from one form of communication to another that is not yet fully developed. Yet we should never forget that human beings are wired to think and not be hoodwinked into believing that technology can ever replace human imagination, vision, and thought. In this brave new world where publishing is driven by technology, we would do well to remember the wisdom of Albert Einstein, who is reported to have cautioned: "Computers are incredibly fast, accurate, and stupid. Humans are incredibly slow, inaccurate, and brilliant. Together they are powerful beyond imagination." Thus, *machines should work; people should think.*

These are exciting times filled with opportunities and endless possibilities. *CJNR* will continue to develop while respecting its mission to disseminate high-quality nursing research with a Canadian orientation. I for one can hardly wait to see what lies ahead. Bonne chance, Sean!

Laurie N. Gottlieb
Editor-in-Chief

References

Browne, G. (2012). *Better care: An analysis of nursing and healthcare system outcomes.* Ottawa: Canadian Health Services Research Foundation.

Gottlieb, L. N., & Clarke, S. P. (2005). Impact factors and the law of unintended consequences. *CJNR, 37*(4), 5–10.

Gottlieb, L. N., & Gottlieb, B. (1998). Evolutionary principles can guide nursing's future development. *Journal of Advanced Nursing, 28,* 1099–1105.

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health.* Washington: National Academy of Sciences.

Steele, S. M., & Harmon, V. M. (1979). *Values clarification in nursing.* New York: Appleton-Century-Crofts.

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GUEST EDITORIAL

Nursing Scholarship in Global Health

Linda Ogilvie, Judy Mill

In the call for papers for this Global Health issue of *CJNR,* we stated that "global health perspectives transcend the local (and national) level and target health issues and challenges at a more interdependent and world-wide level." It is therefore fitting that Lisa Merry's article, "Global Health for Nursing . . . and Nursing for Global Health," be included. In her piece, Merry articulates what a meaningful definition of global health for nurses and nursing should encompass and suggests what nurses and nursing could contribute to global health. Advocacy for social justice, caring in the process of promoting healing and alleviating suffering, and enhancement of nursing capacity globally are her suggestions for nursing roles. This is an important article, as we need more clarity on what we as nurses can offer in our work to promote health equity for individuals and populations locally, nationally, and globally. We also need to voice our strengths and contributions to the larger interdisciplinary health and social science community in order to fulfil our potential as partners in health-care and health-system development.

Two important matters arose as we reviewed manuscripts. First, how should we as Canadians define or classify countries as belonging to particular groups? Second, what is the state of current nursing scholarship in global health? Each of these matters will be discussed briefly.

While these terms were not used, articles referred to countries in terms that in the past correlated with the First, Second, and Third worlds. Country classifications in the submitted manuscripts included developed/developing, industrialized/industrializing, North/South, and high/low/middle income. We have chosen to use the terms "high-income countries" (HICs) and "low-and-middle-income countries" (LMICs), as these are the terms that appear most accurate, are currently favoured by international agencies, and imply fewer value judgements than, in particular, "developed/developing."

In selecting manuscripts for inclusion, we evaluated and re-evaluated what we wanted to achieve in this Global Health issue of *CJNR.* For example, it was interesting that many of the submissions were not based on empirical or interpretive research but were, rather, discussion or literature review articles. Our vision of global health is broad, but we wanted depth and critique within each article that would move thinking about global health forward. Thus two articles offering critical analyses of existing studies and other literature appear in this issue. "Intimate Partner Violence: A Global Health Perspective," by Sepali Guruge, offers a sophisticated discussion of what is known about a worldwide phenomenon that nurses are well positioned to address. The concept of intersectionality is introduced and the connection to migration is highlighted. In the article "Tuberculosis and Common Mental Disorders: International Lessons for Canadian Immigrant Health," Amy Bender and colleagues review literature in order to better understand the synergies of tuberculosis, mental disorders, and underlying social conditions as they impact on the health of immigrants. TB and depression are recognized as significant causes of morbidity internationally, and both emanate from complex interactions of multiple social determinants of health. Nurses are at the forefront of primary health care in many parts of the world and are well positioned, both alone and in partnership with others, to make significant contributions through direct clinical practice; health worker and public education; program development, implementation, and evaluation; advocacy for health promoting policies; and research. Bender and colleagues synthesize the literature and draw attention to the strong connections between TB and depression and/or anxiety as co-morbidities, stigmatizing, and etiologically similar. Globalization contributes to the presence of co-morbidity through immigration and increased international travel, and these authors suggest that recognition of the potential for mental health disorder in the treatment of TB would improve health outcomes. Both of these articles are thought-provoking and could be useful in setting the context for innovative global health research projects and programs.

Fewer manuscripts emerged from completed research initiatives. In "Balancing Tensions in Anti-colonial Research: Lessons Learned by Collaborating With a Mining-Affected Indigenous Community," C. Susana Caxaj and colleagues report that over 75% of transnational mining companies are based in Canada. As Canadian nurses interested in global health, therefore, we should be concerned about environmental and other health risks in mining communities worldwide. Using a community-based research approach in a Guatemalan community, the authors studied the systematic impact that mining can have on the health of Indigenous communities and demonstrate that a community's resistance can be a resource for health promotion. Using an anti-colonial analysis lens, they were able to discern three central tensions in relation to community agency/community victimhood, common ground/distinct identities, and commitment to outcomes/awareness of limitations. The theoretical perspectives introduced in this article reveal the inequity, vulnerability, and marginalization present in many Indigenous communities. The authors suggest ways to build meaningful and productive research relationships that do not further disempower such populations.

The articles submitted for consideration revealed a strong interest by academic nurses in community-based and participatory action research. The Happenings contribution in this issue, prepared by Solina Richter and Annali Botha, introduces comparative interdisciplinary research on homelessness in South Africa and Canada. Thus attention is drawn to another recognizably at-risk population, including the need to include multisectoral decision-makers, health- and social-care providers, and other stakeholders to address complex global health-equity issues.

In "Leaving the Philippines: Oral Histories of Nurses' Transition to Canadian Nursing Practice," Charlene Ronquillo uses oral histories to look at the experiences of nurses educated in the Philippines as they transition to a new health-care context in Canada. Themes include family settlement as a priority, discrepancies between expectations and actual experiences, the need to constantly prove oneself, and perceptions of racism. This article is timely and speaks to the work of Salimah Valiani in her book *Rethinking Unequal Exchange: The Global Integration of Nursing Labour Markets,* which is reviewed by Jordana Salma in this issue of the Journal.

In the Discourse contribution, "Global Health Research as Seen Through a Health-Systems Lens," Nancy Edwards and colleagues highlight an important gap in global health research. The authors stress the importance of analyzing and comparing the sociopolitical context across settings and argue for the adoption of a health-system lens to enable researchers to explore issues within complex health systems. They suggest that a health-system orientation requires the strategic involvement of decision-makers and health-care providers on research teams. The authors conclude their Discourse piece with a critical, highly relevant, and thought-provoking question: Are we providing the next generation of nurse researchers with the skills required to make this paradigmatic shift in our approach to health research?

Collectively, the articles included in this issue of the Journal demonstrate the growing interest of nurses in global health research and the theoretical and methodological approaches commonly used in nursing research focused on health inequities. Edwards and colleagues challenge us to revisit our approach to research both as nurse researchers and as educators. As guest editors for this issue, we add a plea for recognition of the importance of interprofessional and interdisciplinary partnerships for increasing the sophistication and the comprehensiveness of our research. We also recognize the importance of contextualizing our research historically, theoretically, and socially. Global health research is complex both conceptually and methodologically. In differentiating global health from international health and public health, Koplan et al. (2009) make four points: global health has a focus on "issues that directly or indirectly affect health but that can transcend national boundaries" (p. 1994); addressing global health issues often requires global cooperation; both population and individual interventions are relevant; and interdisciplinary and multidisciplinary partnerships, including those beyond the health disciplines, are key.

As nurses, we need to make our voices heard and to have our current and potential research and practice contributions recognized. We need to become more politically sophisticated and contribute to policy development. There are challenges ahead. Our graduate programs should prepare nurses for leadership in health promotion and health-system research as well as for nursing research. We hope that this Global Health issue of *CJNR* moves us forward as partners in the search for health equity worldwide.

References

Koplan, K. P., Bond, C., Merson, M. H., Reddy, K. S., Rodriguez, M. H., Sewankambo, N. K., et al., for the Consortium of Universities for Global Health Executive Board. (2009). Towards a common definition of global health. *Lancet, 373,* 1993–1995.

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Discourse

Global Health Research as Seen Through a Health-System Lens

Nancy Edwards, Harriet Nakanyike,
John Moses Okomo, Mariatha Yazbek

Background

We recently participated in a research internship at Great Lakes University of Kisumu, Kenya, that brought together colleagues from five low- and middle-income countries. The question of how to meet the Millennium Development goal for maternal health was a recurring point of discussion. Interns observed that while some progress has been made, high maternal mortality ratios, late and infrequent antenatal visits, and a substantial proportion of deliveries being assisted by unskilled birth attendants in many parts of Sub-Saharan Africa indicate that much remains to be done (Crowe, Utley, Costello, & Pagel, 2012). We reflected on the state of the evidence, successes and gaps, and efforts being made to address what at times seems an intransigent problem. We asked ourselves: How can nurses and midwives use research to make a difference, and would a health-system lens provide a different orientation to our research approach?

We begin with three brief scenarios, each highlighting a critical dimension of the gap in maternal care. We then consider the value of using a health-system lens to guide research in this field.

Reducing Financial Barriers to Maternity Care in Kenya

In an effort to reduce high maternal and neonatal mortality rates, Kenya has introduced a national policy requiring that births be attended by skilled health workers. But this entails additional costs for the family, including the cost of getting to a health facility and the cost of care. Studies conducted in Kenya indicate that many clients report financial barriers to maternity care (Borghi, Ensor, Somanathan, Lissner, & Mills, 2006; Gamble Kelley, 2010).

This fact prompted the Kenyan government to introduce the Output Based Approach (OBA) program. Clients receive an OBA voucher for a fee of two hundred Kenyan shillings (approximately $2.50). This voucher ensures access to safe delivery at a Kenyan health facility of one's choice with no additional costs (Center for Health Market Innovations, 2012; Warren et al., 2011). It puts the decision about where to deliver in the hands of the consumer while providing an incentive system for health providers to improve the quality of maternity care.

Private and Public Partnerships for Maternity Care in Uganda

The goal of Uganda's National Health Policy on Public-Private Partnerships for Health (Ministry of Health, Government of Uganda, 2010) is to strengthen the health system by promoting collaboration between the two sectors. However, in practical terms this collaboration is characterized by service duplication in the midst of service gaps. Also, there are high rates of staff turnover in the public sector and poor co-ordination of services across the continuum of care. This leads to mothers seeking care from multiple health-service providers and an erosion of the public sector image.

Addressing Attitudes of Care Providers and TBA Policies in South Africa

Traditional Birth Attendants (TBAs) play a significant role in cultural competence, consolation, empathy, and psychosocial support in childbirth. Their role in caring for pregnant women and carrying out deliveries is acknowledged by the South African government, although generally TBAs are not trained to handle complications (Madhivanan, Kumar, Adamson, & Krupp, 2010). However, negative attitudes on the part of hospital staff towards TBAs and financial constraints that impede women's use of maternity services may encourage women to seek the services of these traditional providers. The knowledge and skills of the TBAs can be improved within permissible standards through sustained partnerships with skilled birth attendants. Such partnerships may lead to improved maternal and neonatal health outcomes.

Using a Health-System Lens to Guide Research

Each of these scenarios highlights an important dimension of maternity care. While studies that look at these elements in isolation offer important insights into discrete mechanisms of influence, an understanding of how the elements interrelate is also needed to inform effective programs. This requires a system-oriented approach to research (de Savigny & Adam, 2009).

A comprehensive overview of research in this field is well beyond the focus of this article. Nonetheless, we can offer a couple of observations about this realm of research.

Systematic reviews yield disparate conclusions about the effectiveness of maternity-care interventions targeting vulnerable and poor women, such as TBA training programs, identification of high-risk pregnant women, and incentives for deliveries by skilled attendants (Wilson et al., 2011). While initiatives such as Safe Motherhood and the Ministers' Leadership Initiative (Gamble Kelley, 2010) highlight the importance of a health-system approach to the problem, it is our contention that many researchers have not kept pace with this paradigmatic shift. The literature suggests that many research studies continue to focus on discrete intervention elements (training programs, financial incentives, provision of birthing kits, transportation in obstetric emergencies, identification of high-risk pregnant women, provision of drugs to treat postpartum hemorrhage), each examining a limited number of interventions — albeit within multidimensional health-system frameworks (de Savigny & Adam, 2009).

This pattern of research is not surprising. Determining which individual interventions are effective requires focused research, but in making choices about policies, programs, and resource allocation, decision-makers also have to grapple with questions about the mix of interventions and the interactions between these interventions and their context. Synthesizing and integrating policy-relevant findings across studies requires more than a brief description of study settings. It also calls for an in-depth description of the sociopolitical context(s) for intervention research. Examples of contextually relevant characteristics include the predominant attitudes of health professionals towards TBAs; the evolution of country-level policies on maternal and child health and the current status of these policies in relation to the role, scope of practice, and accountability of maternal-health providers (professional and traditional; private and public sector) to government and to communities. Contextually rich descriptions are needed to inform a health-system orientation for both interpreting research findings and comparing better maternity-care systems across studies and settings.

Implications

So how do we bridge this gap? How do we move from an abundance of research examining discrete interventions to more research with a health-system orientation?

A shift to a health-system orientation in research is becoming more evident in requests for proposals and will help to stimulate research in this area. For instance, there have been recent funding calls for implementation research, issued by the Global Alliance on Chronic Disease and the Global Alliance for Health Policy and Systems Research (Global Health Workforce Alliance, 2012). These require the proactive and strategic involvement of decision-makers and health providers on research teams, to ensure that an intimate understanding of the day-to-day realities of implementing change in complex health systems is embedded within research plans. They also require in-depth contextual analyses and comparisons across settings. These methodological parameters will yield the types of data needed to examine system characteristics that influence outcomes. For example, how do the skill mix of private and public health providers and the involvement of non-governmental organizations in a district affect the uptake of enhanced maternity-care services, and how do local transportation services and agricultural patterns influence the cost-effectiveness of financial incentives when used in combination with TBA training and high-risk antenatal screening?

Achieving these aims requires development in a number of areas. We need knowledge-synthesis approaches that more fully take contextual influences into account. We need decision-maker input to identify key parameters for sociopolitical contextual analyses across studies. The expertise necessary to achieve depth and sophistication in the assessment of complex sociopolitical and economic realities of health-system change warrants careful consideration. Finally, funders need to support implementation science and provide mechanisms that encourage timely cross-fertilization of learning across teams working in comparative settings.

Conclusion

While the examples used in this article have been focused on maternity care in lower-income countries, the question of system-oriented research is equally applicable to other vexing issues in Canada and internationally. We must ask ourselves whether we are adequately preparing the next generation of nurse researchers for this challenging arena of inquiry and how we might contribute to the development of the integrative methods, contextual analytical approaches, and synthesis techniques that are essential for this work. Working with colleagues who are in resource-poor settings and grappling with acute and chronic service delivery challenges would yield fruitful dialogue and insights with broad applicability.

References

Borghi, J., Ensor, T., Somanathan, A., Lissner, C.. & Mills, A. (2006). Mobilizing financial resources for maternal health. *Lancet, 368*(9545), 1457–1465.

Center for Health Market Innovations. (2012). *Kenya Output Based Aid Voucher Program.* Washington: Author. Retrieved October 9, 2012, from http://healthmarketinnovations.org/program/kenya-output-based-aid-voucher-program.

Crowe, S., Utley, M., Costello, A., & Pagel, C. (2012). How many births in Sub-Saharan Africa and South Asia will not be attended by a skilled birth attendant between 2011 and 2015? *BMC Pregnancy and Childbirth, 12,* 4–12.

de Savigny, D., & Adam, T. (Eds.). (2009). *Systems thinking for health systems strengthening.* Geneva: World Health Organization Press.

Gamble Kelley, A. (2010, September). *Reducing financial barriers to reproductive health care: Experiences with free care and health insurance.* Ministerial Leadership Initiative. Washington: Aspen Global Health and Development. Retrieved October 9, 2012, from http://www.aspeninstitute.org/sites/default/files/content/docs/pubs/mli_issue_brief_reducing_financial_barriers_to_reproductive_health_care.pdf.

Global Health Workforce Alliance. (2012). *Call for proposals – implementation research for health MDG 4, 5 and 6.* Geneva: Author. Retrieved October 9, 2012, from http://www.who.int/workforcealliance/media/news/2012/callmdg456/en/index.html.

Madhivanan, P., Kumar, B., Adamson, P., & Krupp, K. (2010). Traditional birth attendants lack basic information on HIV and safe delivery practices in rural Mysore, India. *BMC Public Health, 10,* 570–575.

Ministry of Health, Government of Uganda. (2010). *Health Sector Strategic Plan III: 2010/11-2014/15.* Retrieved October 9, 2012, from http://www.health.go.ug/docs/HSSP_III_2010.pdf.

Warren, C., Abuya, T., Obare, F., Sunday, J., Njue, R., Askew, I., et al. (2011). Evaluation of the impact of the voucher accreditation approach on improving reproductive health behaviors and status in Kenya. *BMC Public Health, 11,* 177–185.

Wilson, A., Gallos, I., Plana, N., Lissauer, D., Khan, K., Zamora, J., et al. (2011). Effectiveness of strategies incorporating training and support of traditional birth attendants on perinatal and maternal mortality: Meta-analysis. *British Medical Journal, 343.*

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Résumé

La santé mondiale pour la profession infirmière… et la profession infirmière pour la santé mondiale

Lisa Merry

Cet article puise dans la documentation pour présenter une conceptualisation de la santé mondiale (SM) qui correspond à la profession infirmière et définit les apports de la pratique infirmière à la SM. Selon l'auteure, la « santé » doit être définie et abordée sous une perspective holistique afin de mettre en évidence le fait que la SM va au-delà de l'éradication de la maladie et que le droit fondamental à la santé, dont tout être humain doit bénéficier, doit être exprimé de façon explicite. Le mot «mondiale» fait référence aux liens supraterritoriaux entre les déterminants sociaux présents partout dans le monde, dans un contexte international. La SM met l'accent sur les déterminants supraterritoriaux et a pour objectif ultime l'équité en matière de santé pour toutes les nations et tous les peuples. Les infirmières peuvent défendre les droits, prodiguer des soins, soulager les souffrances et œuvrer à augmenter la capacité des services infirmiers à l'échelle mondiale. Les priorités en matière de SM ne peuvent être véritablement mises en œuvre qu'en établissant un nouvel ordre mondiale dans le cadre duquel les décisions politiques seront guidées par des principes fondés sur une humanité commune.

Mots clés: santé mondiale (SM), perspective holistique, liens supraterritoriaux, déterminants sociaux, équité en matière de santé

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Global Health for Nursing . . . and Nursing for Global Health

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This article draws on the literature to present a conceptualization of global health (GH) that corresponds with the discipline of nursing and defines the contributions of nursing to GH. The author's perspective is that "health" should be defined and considered holistically to reflect the fact that GH involves more than the eradication of disease and that health as a fundamental right of every human being must be made explicit. "Global" refers to the supraterritorial links among the social determinants of health located at points anywhere on earth within a whole-world context. The focus of GH is the supraterritorial determinants and its ultimate objective is health equity for all nations and all people. The contributions of nurses are advocacy, healing and alleviating suffering through caring, and increasing nursing capacity globally. To truly advance the GH agenda, a new world order is needed, one in which political decision-making is guided by our shared humanity.

Keywords: global health, nursing theory, holistic nursing, social determinants of health

Action for social justice and equity worldwide has never been more apparent than it is today. The Occupy Wall Street movement and uprisings across the Middle East are evidence that there is a will to eradicate oppression, poverty, and economic inequality. Simultaneously, environmental degradation, largely due to humans living in excess, and economic policies that value profit over human/environmental health and well-being are warning signs that a shift in values and a change in how we live are necessary for the survival of the human race (Labonte, 2003).

The 1990s ushered in an era of globalization and the world is now more interconnected than ever before. With the international flow of information, goods, services, and people, a new economic, political, and social space has emerged (Kickbusch, 2005). The implications for the health of people worldwide, particularly in low- and middle-income countries (LMICs), are significant. Global health (GH) has also come into existence as an academic field (Brown, Cueto, & Fee, 2006), attracted the attention of governments, non-governmental organizations (NGOs), and private foundations, and led to public-private partnerships in a spirit of hope for global equity. Academics, including nurses, have been writing about this new field: what it is, what it encompasses, who is involved in it, and what it means for education and research.

In this article I present a conceptualization of GH that corresponds with the discipline of nursing. I then explicate how GH is relevant for nursing and its purpose. I next consider, based on the literature, what nursing has to offer GH, including advocacy for global social justice, healing and alleviating of suffering through caring, and increased nursing capacity globally. I conclude by briefly discussing the implications for research and education.

What Is Global Health?

The debate on how best to define GH is of great importance. As pointed out by Koplan, Bond, and Merson (2009), consensus on the meaning of GH is imperative so that there is agreement on what is to be achieved, what skills are required, and in what ways researchers, policy-makers, caregivers, and educators should go about meeting the objective. GH is an interdisciplinary field (Koplan et al., 2009), and nursing, which represents the majority of health-care providers worldwide, is critical to the GH initiative (Dickenson-Hazard, 2004). It therefore seems appropriate that nursing weigh in on the debate.

A number of definitions of GH have been proposed, one of the most commonly cited being that put forth by Koplan et al. (2009): "an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide" (p. 1995). The purpose of GH is health equity *among* nations and for *all* people, rather than *within* a nation (or community), as with public health. It is also more than one nation helping another, as with *inter*national health. GH is achieved through prevention or treatment and care of individuals and/or populations and through the sharing of knowledge, resources, and experience *across* cultures, societies, and international borders.

The work of Koplan et al. (2009) is a seminal contribution to the field, as it expands on earlier definitions of GH (Her Majesty's Government, 2008; Kickbusch, 2006) and has stimulated further discussion. Beaglehole and Bonita (2010), for example, call for a shorter and sharper definition, claiming that the one proposed by Koplan et al. is wordy and uninspiring. Stemming from that definition, Beaglehole and Bonita define GH as "collaborative trans-national research and action for promoting health for all" (p. 5142). Conversely, Fried et al. (2010) argue that GH is global public health and that there should be no distinction between the two fields.

What Definition of Global Health Fits With Nursing?

A thoughtful discussion by Bozorgmehr (2010) is a useful place to begin to answer this question. The author provides an in-depth analysis of how "global" has been defined, including "transcending national boundaries," "worldwide," and "holistic" — the last referring to anything and everything that impacts health — and offers a new approach to defining the term. He also considers how "health" should be defined, a rarity in the debate on how to define GH.

Health. From the viewpoint of Bozorgmehr (2010), health refers to more than just the absence of disease; it includes physical, mental, and social well-being (World Health Organization [WHO], 1947). Bozorgmehr also considers health to be a social, economic, and political issue, as well as a fundamental human right. He claims that this conceptualization sets a foundation for GH on two fronts. First, it implies that GH research, education, and practices go beyond biomedical approaches — thus GH entails more than addressing the eradication of disease. Second, health as a human right puts normative objectives (i.e., equitable access to health) at arm's length in the debate about GH, not attached directly to its definition. Since there are multiple GH communities, each with its own set of motivations and values, from Bozorgmehr's perspective GH should be described as what it is rather than what it should be.

For nursing, defining health is key given that good health is the goal of the discipline (Smith, 2008). A definition that goes beyond the absence of disease and that is holistic also aligns with definitions of health within nursing. In fact, a definition with greater emphasis on quality of life and well-being would be more inclusive (e.g., populations living with chronic illness, disability, or mental health issues) and therefore more suited to GH and the goals of nursing (i.e., health promotion and healing). An emphasis on quality of life and well-being is further justified when one considers the limitations of traditional medicine in curing many of the world's ailments, the growing interest in alternative/complementary therapies, and the existence of and widespread use of non-medical healing approaches all around the world. Also, high-income countries (HICs) might have much to learn from LMICs regarding social well-being.

The World Health Organization (WHO) (1947) considers health a fundamental right of every human being. This view is shared by the International Council of Nurses (ICN) (2011a), which represents more than 130 national nursing bodies. Although *health as a human right* is a shared philosophy across many countries, it often gets diluted in health-care policies. Furthermore, for many nurses a human rights frame of reference does not explicitly guide nursing practice (Easley & Allen, 2007). I believe that, to reinforce a human rights perspective in health and health-care discourse, health as a human right should be made explicit in the definition of health (as in global health). In contrast to Bozorghmehr (2010), however, I would argue that normative objectives should not be separated and that equity ("absence of systematic disparities in health between groups with different levels of underlying social advantage/disadvantage — that is, wealth, power, or prestige" [Braveman & Gruskin, 2003, p. 254]) should be included in the overall definition of GH.

While political influence is unavoidable in GH, we must not bury social justice objectives within layers of its definition. Even if there is agreement on the detachment of normative objectives, associations with "doing good" will still be made. Furthermore, I would argue that proponents of GH must engage in debate in order to set priorities and must strive to include input across and within countries. A critical or feminist perspective of social justice may be the most appropriate for framing such debate (Pauly, MacKinnon, & Varcoe, 2009). As noted in the literature, justice is not simply a matter of distribution — the focus should be differences that exist along the lines of gender, ethnicity, class, and social positioning and that constrain freedom and impact well-being (Pauly et al., 2009).

Greater transparency and accountability for GH initiatives are imperative if GH is about "doing good." Nurses and other health-care providers need to advocate for global equity (i.e., health for every human being) as the objective and to not let politics bully the GH agenda. GH also needs an independent governing body, such as the WHO, to ensure that its standards are met. The WHO should not only provide leadership on GH matters but also have financial and legal authority; our shared humanity (via the WHO) should be steering political decision-making rather than the reverse. A similar idea is proposed by Labonte and Spiegel (2003), who advocate for the assessment of world trade agreements with human rights and environmental sustainability goals. This would be congruent with the need and the call for a shift in values and power, as reflected in recent movements, and would ensure that GH missions are not predominately driven by the financial and security interests of the more powerful nations.

Global. "Globality," as Bozorghmehr (2010) calls it, in the context of health refers to "supraterritorial links between the social determinants of health located at points anywhere on earth within a whole-world context" (p. 6). "Supraterritorial" refers to a social space that represents the connectedness of the world due to globalization. It is a spatial unit in itself but converges with territorial and transterritorial or interterritorial spaces. In this definition, "global" is more than the sum of its parts and the focus of GH is the supraterritorial determinants that impact people and their health through complex pathways.

In Bozorgmehr's (2010) definition of "global," GH is more than public health or international health. It clarifies the object of focus (the supraterritorial determinants) and positions GH squarely in the context of globalization. It avoids the issues inherent in defining "global" as merely worldwide or holistic, neither of which fully captures the focus or essence of GH. In the supraterritoritorial conceptualization, populations of interest may include Aboriginal people or migrants or women — groups that are not always thought of in terms of GH — and the level of action may be local or global. For example, maternal mortality in Africa is a concern in GH not because more women die during childbirth in Africa than elsewhere, or because it is a significant issue affecting millions of women, but because the causes of maternal mortality are linked to supraterritorial influences such as the shortage of health workers and the world financial crisis (Bozorgmehr, 2010). Furthermore, humanitarian aid, although necessary in crisis situations (e.g., the Horn of Africa drought or the earthquake in Haiti), would not necessarily be considered GH in this framework. Actions must be sustainable, not short-term fixes, and health promotion and illness prevention must be the primary goal.

Bozorgmehr's (2010) definition also corresponds with the principle of wholeness in nursing science. Leuning (2001) draws on the nursing theories of Leininger, Rizzo Parse, Watson, and Newman to present eight principles, including wholeness, that she believes are required for a global perspective. Wholeness is characterized by the view that the world is unitary and indivisible and that human beings are in rhythmical interchange with their environments. A global perspective requires a focus on patterns of the whole and a recognition that the betterment of humankind is intrinsically linked with the health of persons, the environment, nations, the universe, and the galaxy. Therefore, the complex pathways between the supraterritorial social space and people and their social determinants are patterns that affect the whole. Seeing the patterns occurs through a continual process of zooming in and out from the parts to the whole and through a recognition of uniqueness and diversity, connectedness and meaning. As described by Newman (2002) "the data of pattern are the stories of people and their connectedness with their environment, reflecting the complexity of continuing change" (p. 6). Better understanding of the supraterritorial determinants and their patterns, which are reflected in people's daily lives and in their health, as an object of focus for GH, therefore fits within the nursing paradigm.

In summary, from a nursing perspective any definition of GH should include a sub-definition of health — to make it clear that GH concerns not only the eradication of disease but also quality of life and well-being, and that the means for achieving health are holistic. This sub-definition must also explicitly iterate that health is a fundamental right of every human being. A sub-definition of the global aspect of GH is also necessary. Globality as supraterritorial, as defined by Bozorgmehr (2010), is recommended so as to more clearly delineate the focus of GH (i.e., supraterritorial determinants). This description of global also aligns with the principle of wholeness, a core nursing value and a key concept in many nursing theories.

GH is a complex phenomenon that cannot be reduced to a few words. Its intentions and perspectives should not be assumed, but — to ensure clarity for all involved — the objectives of health as a human right and health equity (i.e., the absence of systematic disparities) need to be made explicit. The conferring of greater power to the WHO as a governing body of GH could help to ensure that these principles are upheld in GH initiatives.

Global Health and Nursing

There is an inherent fit between GH and nursing's theoretical and philosophical foundations. The substantive focus of the discipline of nursing is the person, environment, health, and caring (Smith, 2008). While there is some variation in how health is defined, depending on the particular nursing theory or model, health is viewed from a holistic perspective and involves harmony or balance between body, mind, spirit, and environment (i.e., wholeness). Also, nursing recognizes that each person is unique and that how health is defined by a person, group, or community is subjective. Healing captures the dynamic element of health: The person moves towards balance and wholeness within the self (Burkhardt, 1985). Nursing itself has been described as "the study of human health and healing through caring" (Smith, 2008, p. 3). Caring, or caring consciousness, is a way of being whereby one person is open to connecting with another; it is seeing and knowing a person holistically, which calls for acceptance, non-judgement, appreciation, recognition, sojourning, accompanying, partnering, exploring, dialoguing, and listening (Cowling, Smith, & Watson, 2008). The role of nurses is to enable people to move towards wholeness/health (i.e., healing) through the act of caring. With this frame of reference, nurses are positioned to work with people and communities to promote health, prevent illness, support, and provide care during times of sickness and normal life developments. Advocacy for healthy environments that support wellness/wholeness at macro levels — that is, nationally and globally (worldwide and supraterritorially) — is also within the scope of nursing and is congruent with nursing's unitary and caring conceptualizations.

Activism is deeply embedded in the profession of nursing. Florence Nightingale believed that it was nurses' duty to change conditions (social, political, environmental) for the betterment and health of humankind. Chinn and Kramer (2008) describe a form of knowing in nursing referred to as *emancipatory knowing,* a way of perceiving the world that grows out of critical analysis of the status quo and a vision of the changes that are needed to achieve equitable and just conditions under which all human beings can reach their full potential. Emancipatory knowing involves reflecting on how social and political forces and power dynamics shape knowledge. Taking action includes advocating for change, changing one's own way of behaving, and conducting research directed at effecting change.

In the spirit of Nightingale, nursing has recently renewed its commitment to this goal and has made GH a priority for the discipline. In 2010, the centennial of Nightingale's death, the International Year of the Nurse (Beck, Dossey, & Rushton, 2010) called on nurses worldwide to become engaged in promoting *health for all*. One of the main drivers of this event was the Nightingale Initiative for Global Health, a grassroots movement of nurses that aims to identify, share, and promote approaches for creating health globally and actively advocates that the United Nations and its member states make health a universal priority. The ICN and many national nursing associations have also explicitly expressed a commitment to GH (Hancock, 2004; Villeneuve, 2008). The ICN has taken action by issuing several position statements related to GH, working with the WHO and other policy-making bodies, and lobbying governments and intergovernmental agencies to implement policies that are environmentally conscious and people-centred. Clearly, GH is within the scope of nursing, and, more than that, nurses are well placed to advocate for and realize the goals of GH.

Nurses Must Reflect and Take Action

The issues that are considered inherently GH concerns are those related to environmental degradation and poverty (Labonte & Spiegel, 2003). They are reflected in the United Nations 2015 Millennium Development Goals (MDGs): eradicate poverty and hunger; achieve universal education; promote gender equality and the empowerment of women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria, and other diseases; ensure environmental sustainability; and form a global partnership for development (www.un.org/millenniumgoals/). Also considered GH concerns are the many non-communicable diseases and conditions such as cancer, cardiovascular disease, diabetes, injuries, and respiratory illness (Magnusson, 2009) that are linked to MDGs via their environmental and lifestyle determinants (diet, tobacco use, work environments, physical activity), the last being related to poverty and the exportation of Western culture. Mental health is also relevant to GH because of the effects of migration, conflict, natural disasters, and global trade policies on well-being (Patel & Prince, 2010). With these issues and the definition of GH in mind, the priority roles of nurses in

GH should be advocacy, healing and alleviating suffering through caring, and increasing nursing capacity globally.

Advocacy. Raising awareness and advocacy together make up the most important role of nursing in GH (Mill, Astle, Ogilvie, & Opare, 2005; Reutter & Kushner, 2010). The ICN has taken a position on many issues related to GH, including international trade agreements, climate change and health, environmental and lifestyle-related health risks, universal access to clean water, the elimination of weapons of war and conflict, child labour, and women's health (ICN, 2002, 2006b, 2007a, 2008a, 2008b, 2010, 2011b). These positions link directly with the supraterritorial determinants of health and speak to all of the MDGs as well as noncommunicable diseases and mental health.

Nursing must continue to participate in advocacy, not only at the international level but also nationally and locally, and to echo the statements issued by the ICN. The ICN (2011a) believes that nurses have a responsibility to call attention to human rights violations (including the right to health and health care) and to respect and promote human rights. Nurses work closely with individuals and communities and are therefore well placed to hear and collect stories about the impact of living conditions (and of policies) on people's lives. In Canada, for example, the Canadian Nurses Association (2012) recently opposed government cuts to the health insurance scheme for refugees and asylum-seekers, a federal measure that has resulted in reduced access to care for this population.

The eighth MDG, a global partnership for development, requires particular attention from advocates for GH, as it may be the most important goal. Sub-goals of this MDG include developing a trading and financial system that is open, rule-based, predictable, and non-discriminatory and addressing the debt problems of LMICs. Falk-Rafael (2006) speaks to this matter by detailing the harrowing effects of globalization on human health and urges nurses to advocate for a change in the global order. This includes advocating for debt cancellation (which the ICN has already done (Anderson, 2005), more democratic governance and application of global rules, and global policies that favour LMICs but are non-protectionist of HIC. Falk-Rafael takes it a step further and suggests that environmental protection and people need to be at the centre of all trade agreements and domestic practices. Profit can no longer be the driving force; a new world order is urgently needed.

Healing and alleviating suffering through caring. Primary health care has been deemed the key strategy for GH and for achieving *health for all* (WHO, 1978). It has also been said that many of the world's ailments could be addressed through nursing care (Villeneuve, 2008). Indeed, poor maternal health, child mortality, and HIV/AIDS, malaria, and other diseases, as well as mental disorders and non-communicable diseases, are all addressable by primary health care delivered by nurses. Primary health care focuses on health promotion (enabling people to improve their health) and illness prevention, mostly by tending to the social determinants of health (social, economic, and environmental factors that affect health). As frontline caregivers, nurses counsel individuals, families, and communities on health promoting behaviours (e.g., healthy eating, basic hygiene); support development over the lifespan (e.g., parenting, death and dying); and encourage illness-prevention activities (e.g., vaccination, general health screening). Primary health care may be provided by nurses in the community or in the context of primary care (e.g., chronic illness management, prenatal care). While advocacy is the approach for ultimately changing policies and social structures that underpin health inequities, in their work nurses maintain a stance of caring consciousness, view people and communities holistically, and tend to address social determinants with the resources at hand. More importantly, nurses accompany, sojourn, partner with, explore, converse with, and listen to individuals and families to make them more resilient to the ecological and social factors that affect their health. It is because of such compassionate care for humanity that people may begin to heal and suffering may be alleviated.

Increasing nursing capacity globally. The ICN (2007b) position statement on nurse retention and migration stipulates that quality health care depends on an adequate supply of qualified, committed nursing personnel. Certainly, the provision of nursing care requires basic resources, infrastructure, and nurses. For this reason, investing in primary health care and increasing nursing capacity globally must be a GH priority for nursing.

While the nursing shortage is a global problem, its effects are most severe in Africa and Asia. The ICN believes that nurses have the right to migrate as a function of choice but also that the international migration of nurses can negatively impact health-care systems by siphoning nursing personnel from the regions most in need. Additional concerns, in LMICs and HICs, are the poor treatment and working conditions of (migrant) nurses and the relaxing of training standards in order to fill nursing positions or to minimize health-care costs.

The nursing shortage requires socially responsible solutions (Tyer-Viola et al., 2009). A number of strategies have been proposed (Dickenson-Hazard, 2004; ICN, 2006a, 2007b; International Organization for Migration [IOM], 2006). These include investing in health-worker education, enhancing the image of the nursing profession, reducing barriers to education for vulnerable groups, ensuring proper regulation of nurses, improving working conditions, developing models for management, retention and resource allocation, and "brain circulation" — whereby nurses from LMICs migrate to HICs and then return home. Ethical recruitment and protection of migrants' rights are also essential (Dickenson-Hazard, 2004; ICN, 2007b; Tyer-Viola et al., 2009).

Mechanisms to improve the availability of human and material resources need to be identified (Dickenson-Hazard, 2004). Strategies for financing health-care systems in LMICs might be provisions in trade agreements — that is, conditions requiring countries to invest in health care (Labonte, 2003), recruitment/migration policies that offer financial incentives to health/education institutions in migration source countries, and cost-sharing mechanisms across borders.

Finally, qualifications and skill requirements must be improved across nations (IOM, 2006). This will not only serve to improve quality of care, but also help to retain nurses in LMICs and raise the status of women (Sullivan, 2000), which addresses the third MDG. Distance-learning initiatives (within LMICs or between HICs and LMICs) and knowledge and skill transfer via migrants returning to their home countries (Tyer-Viola et al., 2009) are examples of strategies that could be used to increase and improve nursing education in LMICs.

Implications

Education

GH programs have become commonplace, particularly in North America (Macfarlane, Jacobs, & Kaaya, 2008). Their emergence partly reflects the shift from international health to GH by the WHO as well as a growing demand by health professionals and students for education in GH. Numerous articles have been published on the topic of GH education, including several in nursing (Hodson-Carlton, Ryan, Ali, & Kelsey, 2007; Leuning, 2001; Mill & Astle, 2011; Mill, Astle, Ogilvie, & Gastaldo, 2010). Generally, there is agreement that GH education should include learning about interconnectedness and wholeness; justice, human rights, and social responsibility; social determinants and disparities; environmental issues; economics, demographics, and politics; respect and tolerance for difference and openness to learning from others; GH concerns (e.g., MDGs); and burden of disease. Current thinking, however, is that the core curriculum for all health professionals should educate them to be globally conscious and prepared to "participate in patient and population-centred health systems as members of locally responsive and globally connected teams" (Frenk et al., 2010, p. 1924).

GH training often includes clinical (and research) placements, mostly in international settings in LMICs. These may put an undue burden on already taxed health and education systems in host countries (Crump & Sugarman, 2010). Developing partnerships and identifying benefits for host institutions must be part of placement planning (Hickey, Gagnon, & Merry, 2010). Local GH placements (migrant or Aboriginal populations) may offer alternative training opportunities. Increased funding to develop GH programs is also needed (Kishore et al., 2011), as stronger, sustained programs may help to address theses issues (i.e., long-term partnerships and money to develop innovative ways to accrue benefits to host institutions).

Research

Global health research (GHR) is essential for guiding health-care providers and other stakeholders in developing policies and appropriate interventions. GHR objectives must be oriented towards locating the upstream drivers (supraterritorial determinants) — political, social, cultural, economic, and environmental — of health and/or developing approaches that increase resiliency with regard to these factors (Stephen & Daibes, 2010). Interdisciplinary teams, including partnerships of decision-makers, care providers, and communities affected by the policies/interventions, are necessary to ensure that the knowledge developed is relevant and can be implemented. A long-term vision, adequate time, and funding are also essential, to ensure that partnerships and knowledge translation/transfer will be achieved and to account for unforeseen disruptions or a change of course in research (due to input from partners or newly identified needs). Funding may be a particular challenge, as nursing research is not recognized in GHR (Jairath, 2007); this not only limits access to funds but also diminishes the role of nursing in GH.

Other points of consideration for GHR include methods and ethics. To more comprehensively answer GHR questions, a variety of methods and approaches are needed (Stephen & Daibes, 2010). Since the use of diverse methods is a strength of nursing, the discipline has much to contribute to GHR. Empirical methods as well as other modes of inquiry, such as phenomenology, ethnography, and even aesthetic forms (hermeneutics), that might more effectively communicate experiences, feelings, and struggles are part of the research tradition in nursing. Regarding ethics, GHR is itself a budding field of research (Stephen & Daibes, 2010). The ethical issues are numerous — for example, the potential for exploitation, unequal power between HIC and LMIC partnerships, and the application of Western bioethics (Crigger, 2008; Harrowing, Mill, Spiers, Kulig, & Kipp, 2010; Ijsselmuiden, Kass, Sewankambo, & Lavery, 2010; Powell, Gilliss, Hewitt, & Flint, 2010; Stephen & Daibes, 2010) — and are beyond the scope of this article.

Conclusion

The body of literature on GH and nursing is expanding rapidly. Nursing has a fundamental role to play in GH and the perspective and unique contributions that nurses make to the field need more visibility within and outside of the discipline. This article has addressed conceptual issues in GH as they relate to nursing, with the objective of advancing nursing-specific knowledge in this area. Nurses engaged in research, education, or GH work must continue to write about and conceptually describe GH in order to further define the field and its relevancy to nursing. This could serve to maintain clarity on what constitutes GH and whether we are achieving our objectives as we move forward and the global perspective becomes more integrated into everyday nursing practice. Most importantly, it will provide a foundation for improving the education of nurses so that they will be better prepared to participate in patient- and population-centred health-care systems as members of locally responsive and globally connected teams.

References

Anderson, K. (2005). Debt relief is key to better health in Africa. *Nursing Standard, 19*(18), 5.

Beaglehole, R., & Bonita, R. (2010). What is global health? *Global Health Action, 3,* 5142.

Beck, D. M., Dossey, B. M., & Rushton, C. H. (2010). The 2010 International Year of the Nurse: 21st-century Nightingales and global health. *Nursing Economics, 28*(3), 215–216.

Bozorgmehr, K. (2010). Rethinking the "global" in global health: A dialectic approach. *Globalization and Health, 6*(1).

Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health, 57*(4), 254–258.

Brown, T. M., Cueto, M., & Fee, E. (2006). The World Health Organization and the transition from "international" to" global" public health. *American Journal of Public Health, 96*(1), 62–72.

Burkhardt, M. A. (1985). Nursing, health and wholeness. *Journal of Holistic Nursing, 3*(1), 35–36.

Canadian Nurses Association. (2012). *CNA open letters: CNA and partners urge Minister Kenney to reverse decision to reduce health benefits for refugees.* Ottawa: Author. Retrieved August 10, 2012, from http://www2.cna-aiic.ca/CNA/documents/pdf/publications/IFHP_Open_Letter_e.pdf.

Chinn, P. L., & Kramer, M. K. (2008). Emancipatory knowledge development. In P. L. Chinn & M. K. Kramer, *Integrated theory and knowledge development in nursing* (7th ed.) (pp. 76–107). St. Louis: Mosby Elsevier.

Cowling, R. W., Smith, M. C., & Watson, J. (2008). The power of wholeness, consciousness, and caring: A dialogue on nursing science, art and healing. *Advances in Nursing Science, 31*(1), E5141–E5148.

Crigger, N. J. (2008). Towards a viable and just global nursing ethics. *Nursing Ethics, 15*(1), 17–27.

Crump, J. A., & Sugarman, J. (2010). Ethics and best practice guidelines for training experiences in global health. *American Journal of Tropical Medicine and Hygiene, 83*(6), 1178–1182.

Dickenson-Hazard, N. (2004). Global health issues and challenges. *Journal of Nursing Scholarship, 36*(1), 6–10.

Easley, C. E., & Allen, C. E. (2007). A critical intersection: Human rights, public health nursing, and nursing ethics. *Advances in Nursing Science, 30*(3), 367–382.

Falk-Rafael, A. (2006). Globalization and global health: Toward nursing praxis in the global community. *Advances in Nursing Science, 29*(1), 2–14.

Frenk, J., Chen, L., Bhutta, Z. A., Cohen, J., Crisp, N., Evans, T., et al. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *Lancet, 376*(9756), 1923–1958.

Fried, L. P., Bentley, M. E., Buekens, P., Burke, D. S., Frenk, J. J., Klag, M. J., et al. (2010). Global health is public health. *Lancet, 375*(9714), 535–537.

Hancock, C. (2004). Meeting today's global health care challenges: The ICN vision. *Imprint, 51*(2), 57–59.

Harrowing, J., Mill, J., Spiers, J., Kulig, J., & Kipp, W. (2010). Culture, context and community: Ethical considerations for global nursing research. *International Nursing Review, 57*(1), 70–77.

Her Majesty's Government. (2008). *Health is global: A UK government strategy 2008–13*. London: Author.

Hickey, J., Gagnon, A. J., & Merry, L. (2010). Partnering with migrant friendly organizations: A case example from a Canadian school of nursing. *Nurse Education Today, 30*(1), 67–72.

Hodson-Carlton, K., Ryan, M., Ali, N. S., & Kelsey, B. (2007). Integration of global health concepts in nursing curricula: A national study. *Nursing Education Perspectives, 28*(3), 124–129.

Ijsselmuiden, C., Kass, N., Sewankambo, K., & Lavery, J. (2010). Evolving values in ethics and global health research. *Global Public Health, 5*(2), 154–163.

International Council of Nurses. (2002). *Women's health*. Geneva: Author. Retrieved December 16, 2011, from http://www.icn.ch/images/stories/documents/publications/position_statements/A19_Womens_Health.pdf.

International Council of Nurses. (2006a). *The global nursing shortage: Priority areas for intervention*. Geneva: Author.

International Council of Nurses. (2006b). *Towards elimination of weapons of war and conflict*. Geneva: Author. Retrieved December 16, 2011, from http://www.icn.ch/images/stories/documents/publications/position_statements/E14_Elimination_Weapons_War_Conflict.pdf.

International Council of Nurses. (2007a). *Child labour*. Geneva: Author. Retrieved December 16, 2011, from http://www.icn.ch/images/stories/documents/publications/position_statements/E02_Child_Labour.pdf.

International Council of Nurses. (2007b). *Nurse retention and migration.* Geneva: Author. Retrieved December 16, 2011, from http://www.icn.ch/images/stories/documents/publications/position_statements/C06_Nurse_Retention_Migration.pdf.

International Council of Nurses. (2008a). *Nurses, climate change and health.* Geneva: Author. Retrieved December 16, 2011, from http://www.icn.ch/images/stories/documents/publications/position_statements/E08_Nurses_Climate_Change_Health.pdf.

International Council of Nurses. (2008b). *Universal access to clean water.* Geneva: Author. Retrieved December 16, 2011, from http://www.icn.ch/images/stories/documents/publications/position_statements/E15_Universal_Access_Clean_Water.pdf.

International Council of Nurses. (2010). *International trade agreements.* Geneva: Author. Retrieved December 16, 2011, from http://www.icn.ch/images/stories/documents/publications/position_statements/C05_International_Trade_Agreements.pdf.

International Council of Nurses. (2011a). *Nurses and human rights.* Geneva: Author. Retrieved December 16, 2011, from http://www.icn.ch/images/stories/documents/publications/position_statements/E10_Nurses_Human_Rights.pdf.

International Council of Nurses. (2011b). *Reducing environmental and lifestyle related health risks.* Geneva: Author. Retrieved December 16, 2011, from http://www.icn.ch/images/stories/documents/publications/position_statements/E11_Reducing_Environmental_Health_Risks.pdf.

International Organization for Migration. (2006). *Migration and human resources for health: From awareness to action.* Geneva: Author. Retrieved December 16, 2011, from http://www.iom.ch/jahia/webdav/site/myjahiasite/shared/shared/mainsite/microsites/IDM/workshops/Migration_and_HR_23240306/MHCW_final_report.pdf.

Jairath, N. (2007). Global health: The role of nursing research. *Nursing Research, 56*(6), 367–368.

Kickbusch, I. (2005). Action on global health: Addressing global health governance challenges. *Public Health, 119*(11), 969–973.

Kickbusch, I. (2006). The need for a European strategy on global health. *Scandinavian Journal of Public Health, 34*(6), 561–565.

Kishore, S., Siegel, K. R., Kelly, B., Vedanthan, R., Ali, M. K., Koplan, J., et al. (2011). Preparing the university community to respond to 21st century global public health needs. *Global Heart, 6*(4), 183–190.

Koplan, J., Bond, T., & Merson, M. (2009). Towards a common definition of global health. *Lancet, 373*(9679), 1993–1995.

Labonte, R. (2003). *Dying for trade: Why globalization can be bad for our health.* Toronto: CSJ Foundation for Research and Education. Retrieved December 16, 2011, from http://www.socialjustice.org/uploads/pubs/DyingforTrade.pdf.

Labonte, R., & Spiegel, J. (2003). Setting global health research priorities. *British Medical Journal, 326*(7392), 722–723.

Leuning, C. J. (2001). Advancing a global perspective: The world as classroom. *Nursing Science Quarterly, 14*(4), 298–303.

Macfarlane, S. B., Jacobs, M., & Kaaya, E. E. (2008). In the name of global health: Trends in academic institutions. *Journal of Public Health Policy, 29*(4), 383–401.

Magnusson, R. (2009). Rethinking global health challenges: Towards a "global compact" for reducing the burden of chronic disease. *Public Health, 123*(3), 265–274.

Mill, J., & Astle, B. (2011, November 13–15). *Global citizenship in nursing education.* Paper presented at the Global Health Conference: Advancing Health Equity in the 21st Century, Montreal.

Mill, J., Astle, B., Ogilvie, L., & Opare, M. (2005). Global health and equity. Part 1: Setting the context. *Canadian Nurse, 101*(5), 22–24.

Mill, J., Astle, B. J., Ogilvie, L., & Gastaldo, D. (2010). Linking global citizenship, undergraduate nursing education, and professional nursing: Curricular innovation in the 21st century. *Advances in Nursing Science, 33*(3), E1–E11.

Newman, M. A. (2002). The pattern that connects. *Advances in Nursing Science, 24*(3), 1–7.

Patel, V., & Prince, M. (2010). Global mental health: A new global health field comes of age. *Journal of the American Medical Association, 303*(19), 1976–1977.

Pauly, B. M., MacKinnon, K., & Varcoe, C. (2009). Revisiting "who gets care?": Health equity as an arena for nursing action. *Advances in Nursing Science, 32*(2), 118–127.

Powell, D. L., Gilliss, C. L., Hewitt, H. H., & Flint, E. P. (2010). Application of a partnership model for transformative and sustainable international development. *Public Health Nursing, 27*(1), 54–70.

Reutter, L., & Kushner, K. E. (2010). "Health equity through action on the social determinants of health": Taking up the challenge in nursing. *Nursing Inquiry, 17*(3), 269–280.

Smith, M. C. (2008). Disciplinary perspectives linked to middle range theory. In M.-J. Smith & P. R. Liehr (Eds.), *Middle range theory for nursing* (pp. 1–12). New York: Springer.

Stephen, C., & Daibes, I. (2010). Defining features of the practice of global health research: An examination of 14 global health research teams. *Global Health Action, 3,* 5188.

Sullivan, E. J. (2000). Enhancing global health through nursing. *Journal of Professional Nursing, 16*(1), 1–2.

Tyer-Viola, L., Nicholas, P. K., Corless, I. B., Barry, D. M., Hoyt, P., Fitzpatrick, J. J., et al. (2009). Social responsibility of nursing. *Policy, Politics, and Nursing Practice, 10*(2), 110–118.

Villeneuve, M. J. (2008). Yes we can! *Policy, Politics, and Nursing Practice, 9*(4), 334–341.

World Health Organization. (1947). *Constitution of the World Health Organization.* Geneva: Author. Retrieved December 16, 2011, from http://www.opbw.org/int_inst/health_docs/WHO-CONSTITUTION.pdf.

World Health Organization. (1978). *Primary health care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR.* Geneva: Author.

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Résumé

La violence perpétrée par un partenaire intime : une perspective de la santé mondiale

Sepali Guruge

La violence perpétrée par un partenaire intime est une grave violation des droits de la personne et un problème de santé important à l'échelle mondiale. Les infirmières et les infirmiers, qui constituent la catégorie de professionnels de la santé comptant le plus d'effectifs dans le monde, sont bien placés pour s'attaquer à cette problématique. S'appuyant sur une documentation provenant de divers pays, cet article présente un résumé des documents traitant des conséquences sur la santé, des coûts, de la prévalence, des facteurs de risque, des perceptions et des manifestations de la violence perpétrée par un partenaire intime, et de la réactions des femmes à cette problématique. Puis, utilisant comme assise le programme de recherche de l'auteur sur la violence perpétrée par un partenaire intime, l'article met en lumière plusieurs implications à l'endroit de la profession infirmière : l'intersectionnalité; les échelles micro, meso et macro; la violence sociale; la violence que subit une femme au cours de sa vie; le contexte et le processus de migration. Pour terminer, l'article présente des recommandations à l'intention du personnel infirmier en matière de recherche et de pratique et propose des collaborations et un renforcement des capacités Nord-Sud dans le but de faire face à la nature complexe de ce fléau mondial.

Mots clés : santé à l'échelle mondiale, intersectionnalité, violence perpétrée par un partenaire intime, violence sociale, violence que subit une femme au cours de sa vie, processus de migration

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Intimate Partner Violence: A Global Health Perspective

Sepali Guruge

Intimate partner violence is a serious violation of human rights and a significant global health problem. As the largest health workforce worldwide, nurses are well positioned to address this health issue. Based on literature from various countries, this article presents a summary of the literature on health consequences, costs, prevalence, risk factors, perceptions, and manifestations of intimate partner violence, and women's responses to it. Next, building on the author's program of research on intimate partner violence, the article highlights a number of implications for nursing: intersectionality; micro, meso, and macro levels; social violence; violence throughout a woman's lifespan; and the migration context and process. Finally, the article presents research and practice recommendations for nurses and proposes North–South collaborations and capacity-building to address the complex nature of this global health problem.

Keywords: ecosystemic frameworks, global health, intersectionality, intimate partner violence, social violence, violence against women, violence throughout a woman's lifespan, violence throughout the migration process

Introduction

Intimate partner violence (IPV) is defined as a pattern of physical, sexual, and/or emotional abuse by a current or former spouse or a non-marital partner in the context of coercive control (Tjaden & Thoennes, 2000). The overwhelming majority of victims of IPV worldwide are women. At a global level, IPV occurs in epidemic proportions (Heise et al., 1994). IPV has been consistently linked to a wide range of physical and mental health problems that may persist long after the abuse has ended (Campbell, 2002). Thus, women who have experienced IPV tend to use health services more frequently than women who have no history of IPV (Campbell, 2002). These health-care visits present an opportunity for nurses to provide care and support to women who have experienced IPV. However, due to the unprecedented population mobility from rural to urban settings and across international borders, nurses can no longer focus solely on their own locality. In the context of global health, they must take into account the diversity of women as well as the complex ways in which the social, economic, gender, geographic, ethnic, cultural, and political contexts of women's lives shape their experiences of, perceptions about, and responses to IPV. Certain factors, experiences, and concerns transcend borders but others are unique to specific contexts. Drawing from my own program of research on IPV throughout the migration process (i.e., pre-migration, border crossing, and post-migration) and the literature, in this article I present a summary of the current knowledge about IPV and a number of implications and recommendations for nursing research and practice in this area.

What Do We Know? A Summary of the Literature

Health Consequences of IPV

Women living with IPV are often injured in the face, head, back, neck, thorax, breast, or abdomen (Muellman, Lenaghan, & Pakieser, 1996). Chronic physical health conditions linked with IPV include neck and back pain, arthritis, headaches and migraines, hypertension, peptic ulcers, and irritable bowel disease (Breiding, Black, & Ryan, 2008; Campbell & Lewandowski, 1997; Coker, Smith, Bethea, King, & McKeown, 2000; Lesserman & Dorssman, 2007; Letourneau, Holmes, & Chasedunn-Roark, 1999). Common mental health problems linked with IPV include depression, anxiety, post-traumatic stress disorder, substance use and dependence, and thoughts of suicide (Devries et al., 2011; Eby, Campbell, Sullivan, & Davidson, 1995; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Fischbach, & Herbert, 1997; Heise & Garcia-Moreno, 2002; Humphreys, Lee, Neylan, & Marmar, 1999; Ishida, Stupp, Melian, Serbanescu, & Goodwin, 2010; Plitcha, 2004; Roberts, Auinger, & Klein, 2005; Roberts, Klein, & Fisher, 2003; Varma, Chandra, & Thomas, 2007; Vizcarra et al., 2004). Reproductive health problems can include sexually transmitted disease, unwanted pregnancy, and chronic pelvic pain (Coker, 2007; Emenike, Lawolo, & Dalal, 2008; Letourneau et al., 1999; Silverman, Decker, Kapur, Gupta, & Raj, 2007; Stephenson, Koenig, & Ahmed, 2006). IPV during pregnancy is also associated with increased risk of miscarriage, premature delivery, malnutrition, and low birth weight (Ackerson & Subramanian, 2008; Campbell, Garcia-Moreno, & Sharps, 2004; El Kady, Gilbert, Xing, & Smith, 2005; Janssen et al., 2003). The type, length, and severity of IPV experienced over a woman's lifespan increase her risk for various and severe health problems (Scott-Storey, 2011).

Costs of IPV

IPV has a greater cumulative impact on morbidity and mortality than some more common public health problems (Garcia-Moreno & Watts, 2011). For example, in Mexico City IPV and rape have been estimated as the third most frequent cause of morbidity and mortality, accounting for approximately 6% of all disability-adjusted life years lost (Ascensio, 1999). In Victoria, Australia, IPV accounts for approximately 8% of the overall disease burden among women of reproductive age — more than high blood pressure, smoking, or obesity (Vos et al., 2006). IPV also creates a financial burden for the family. Not all IPV-related services are freely available worldwide. For example, women in Ethiopia are expected to pay for a medical card in order to report IPV to the police (Guruge, Bender, et al., 2012). In some countries, out-of-pocket expenditure on IPV-related services can be as high as 75% of a household's average weekly income (International Center for Research on Women, 2009). In the United States, women who are unemployed, have no health insurance, and/or are undocumented often cannot access IPV-related services (Sokoloff, 2005).

IPV also generates huge costs for health-care systems. For example, in Uganda the cost of "domestic" violence in 2007 was estimated at US$2.5 million (Economic Policy Research Center, 2009). Health Canada (2002) estimated that the direct medical cost of violence against women (including IPV) in 2002 in Canada was CDN$1.1 billion. A study conducted in the United States estimated the related annual costs for medical and mental health services at US$4.1 billion (National Center for Injury Prevention and Control, 2003). The extent of IPV-related social costs (such as poverty and homelessness) and economic costs (such as those related to social services, criminal justice, and loss of employment) has not been documented in most countries.

Prevalence of IPV

Studies from Australia, Canada, Israel, South Africa, and the United States report that 30–70% of all women murdered are killed by their husbands or boyfriends (Aldridge & Browne, 2003; Fox & Zawitz, 2006; World Health Organization [WHO], 2002b). At a global level, non-fatal (i.e., non-femicide) IPV rates are comparable to those for cancer, HIV/AIDS, and cardiovascular diseases (Heise et al., 1994). Based on 48 population-based surveys from developing and developed countries, the World Health Organization (WHO) (2002a) found that 10–70% of women reported being physically assaulted by a male partner at some point in their lives. However, country-to-country comparisons cannot be carried out based on these data due to differences in types of violence (e.g., physical/psychological), participant inclusion/exclusion criteria (all women, ever-partnered, etc.), sampling (convenience/random), sample sizes, geographical locations (rural/urban), time frames (e.g., lifetime, previous 12 months), and the wording of questions (Guruge, Tiwari, & Lucea, 2010). A WHO (2006) multi-country study that attempted to address some of these inconsistencies found that 15–71% of ever-partnered women had experienced physical or sexual IPV, 1–28% of ever-pregnant women reported being abused during a pregnancy, and 20–60% of women had never before told anyone about experiencing IPV.

Risk Factors for IPV

IPV is shaped by a set of interacting factors at the individual, micro (family), meso (community) and macro (societal) levels. *Individual-level* factors include age differences between partners, marital status, and the abuser's mental health status and use/abuse of alcohol (Heise, 1998). A history of childhood abuse and witnessing parental IPV have emerged as risk factors in studies conducted in Brazil, Cambodia, Canada, Chile, Colombia, Costa Rica, El Salvador, Indonesia, Nicaragua, Spain, the United States, and Venezuela (WHO, 2002a, 2002b). At the *family level,* changing family dynamics and gender roles (e.g., women working outside the home or postponing marriage and children, or men being away from home for long periods due to work) are known to strain family relations and contribute to IPV (Garcia-Moreno, 2000; Jewkes, Penn-Kekana, Levin, Ratsaka, & Schrieber, 2001; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Raj & Silverman, 2002), particularly if these changes challenge "traditional" gender norms (Guruge, Tiwari, et al., 2010). At the *community level,* reduced access to social safety nets, increased geographical isolation, or higher rates of other types of violence, for example, may increase a woman's risk for IPV (Abraham, 2002; Guruge, 2007; Heise, 1998; Maclean & Sicchia, 2004). Literature from a range of countries indicates that poverty acts as a "marker" for a variety of individual and social conditions (e.g., overcrowding, hopelessness, frustration, sense of inadequacy, and stress); together, these can increase a woman's risk for IPV (Guruge, Tiwari, et al., 2010). *Societal-level* factors may include armed conflict or political instability; rigid gender roles; a sense of male entitlement, authority, and ownership over women; religious approval of chastisement of women; and a cultural ethos that condones violence as a means of settling interpersonal disputes (Brownridge & Halli, 2002; Heise, 1998).

Perceptions and Manifestations of IPV

IPV is socially constructed and is therefore shaped by cultural, religious, socio-economic, educational, and political factors (Guruge, Tiwari, et al., 2010). Thus, differently situated women may disagree about (1) what constitutes IPV, (2) what leads to IPV, (3) acceptable/unacceptable levels of violence, (4) women's roles in perpetrating IPV, and (5) how to deal with individuals who commit IPV (Vickers, 2002). For example, a WHO multi-country study (WHO, 2006) revealed that an overwhelming percentage of women from some study sites agreed that it was "acceptable" for a husband to beat his wife under certain circumstances. The type of IPV is also shaped by context: In the post-migration context, IPV may involve not allowing women to access language training, taking away their immigration documents, and threatening deportation (Agnew, 1998; Guruge, 2010; Raj & Silverman, 2002). For women living in rural settings, IPV may take the form of partner-enforced isolation, such as being denied transportation or a telephone (Bosch, & Schumm, 2004; Hornosty & Doherty, 2002). "Mail-order brides" may be subjected to forms of IPV that incorporate racial, ethno-cultural, and religious domination (Glodava & Onizuko, 1994; Langevin & Belleau, 2000).

Women's Responses to IPV

Women's responses to IPV are individually and socially shaped and depend on available supports and services within a couple's community and society, as well as the pressure and control they assert on the couple (Guruge & Humphreys, 2009). Family members, neighbours, and co-workers often have a strong influence on the couple (Guruge & Humphreys, 2009). In collectivist communities where family ties, harmony, and order are given priority, women are taught to subordinate their own interests to those of their family (Abraham, 2002), so a woman may feel pressured to keep her family together. In contrast, in some low-to-middle-income countries in South Asia and Africa the abuser may be physically punished or shunned by other women and/or men in the family or the community (Guruge, 2007; Guruge, Ford-Gilboe, et al., 2012; Vickers, 2002). Worldwide, many women are reluctant to seek help for IPV due to shame or fear of being stigmatized and/or having their children taken away or being pressured to leave their husbands (WHO, 2006). Societal response (i.e., supports, resources, and services) can also influence women's responses. For example, only one shelter is currently available to abused women in all of Sri Lanka, a country with approximately 9 million girls and women and an estimated IPV rate of 60–80% (Guruge, Ford-Gilboe, et al., 2012). In some areas in Hilo, Hawaii, the distance from the police station and the extended time needed for police to reach women following 911 calls deter women from calling the police (Guruge & Morrison, 2012). In Canada, immigrant women's interest and/or willingness to seek help is often negatively shaped by Canadian immigration policies, which prioritize men as primary applicants and pose threats of deportation for abusive husbands and/or other family members (Guruge, 2007; Guruge, Kanthasamy, et al., 2010; Guruge, Khanou, & Gastaldo, 2010).

Implications for Nursing

Based on my program of research, this section identifies a number of interrelated implications for nurse educators, researchers and policy-makers, and nurses in various practice settings.

Attention to Intersectionality

To clarify the nature of IPV in the global context, research, practice, and policy must focus on diversity within and between groups, shared experiences within and across groups, and the intersections of multiple sites of privilege and oppression. "As Yuval-Davis (1997) argues, 'not all women are oppressed and/or subjugated in the same way or to the same extent,' and violence against women and its impact are not borne equally by all groups of women" (Hankivsky & Varcoe, 2007, p. 485). The intersectionality perspective helps to capture the complexity of multiple dimensions of social identity (such as gender, race, class, and immigration status), how these intersect to influence health and well-being, how they come together in distinct ways to affect health outcomes for individuals and groups (Guruge & Khanlou, 2004), and why certain individuals and groups are disproportionately more vulnerable to IPV. It also helps to clarify "the broader issues such as racism, sexism, ageism, and classism as well as various institutional and structural elements that continue to create inequalities" between/among different groups of women and men (Guruge & Khanlou, 2004, p. 42). In other words, the intersectionality perspective enables the consideration of shared meanings within groups and shifting identities and realities, while incorporating diversity within and between groups, without contributing to existing power inequities. From this perspective, the production of, experiences of, and responses to IPV are seen as being influenced profoundly by the intersections of multiple sites of oppression and privilege that women experience within the family, the community and society, and the world.

Attention to Micro, Meso, and Macro Levels

As noted earlier, risk factors for and women's responses to IPV can be explored on micro, meso, and macro levels; strategies to address and prevent IPV can also be organized along these levels. Thus, an ecosystemic framework can help clarify how individuals are situated within and influenced by family, community, and society. Ecosystemic frameworks can promote critical inquiry into the determinants of IPV by locating them within complex socio-economic, historical, political, and institutional structures and dynamics that often impede changes at system levels (Guruge & Khanlou, 2004). Use of an ecosystemic framework can help nurses reconsider their frames of reference for practice and ensure that nurses move beyond the individual (and individual blame) to examine how factors at the micro, meso, and macro level affect women's responses to IPV. For example, a woman's response to IPV is shaped by micro-level factors, including financial stresses, isolation of the couple, and loss of family support; meso-level factors, including available education, employment, and settlement opportunities; and macro-level factors, including the policies and practices of various institutions such as departments of education, health, labour, justice, and immigration (Guruge & Gastaldo, 2008).

Attention to Social Violence

To understand the nature of IPV in the global context, nurses must consider how urbanization, globalization, cultural imperialism, ethnocentrism, and marginalization create various forms of overt and/or subtle forms of social violence: the growing gap between the rich and poor within the same country, among ethno-racial groups, and between countries; cheap (often female) labour resulting from global factories, economic instability, and financial crises; and increased use of alcohol and illicit drugs and increased trading of legal and illegal arms, fuelling new or existing conflicts (Barrientos & Barrientos, 2002; Guruge & Gastaldo, 2008; International Labour Organization, 2002; Standing, 1999). These processes and situations (re)create inequities that determine who has access to information, resources, and support and that disproportionately and adversely affect the health of children, women, and the poor (Chatterjee & Jeganathan, 2000; Giles, de Alwis, Klein, & Silva, 2003; Giles & Hyndman, 2004). Furthermore, local cultures are being flooded by Western (mainly American) culture (Maclean & Sicchia, 2004), eroding long-established local cultural and religious values and practices and contributing to family fragmentation and loss of social networks and support (Guruge & Gastaldo, 2008). These processes, which began under colonialism, have continued as neocolonial relations with new players, new rules, and a new pace of change generate more subtle ways of maintaining economic, political, and cultural imperialism and domination (Guruge & Gastaldo, 2008). Over the years, globalization has enforced gender inequalities in a number of ways: Women are often employed in poorly regulated informal sectors with little or no disability, pension, or maternity benefits; earn lower wages than men for the same job; face doubled and tripled work burdens with unpaid work and caregiving in the home and community; and are exposed to hazardous working conditions, including workplace harassment (Bennett & Tomossy, 2006; Bonder et al., 2004; Kawadi & Wamala, 2006; Lee, 2003; Maclean & Sicchia, 2004; Maki, 1993; Mehra & Gammage, 1999; Standing, 1999). These processes and conditions increase women's vulnerability to violence and limit their ability to respond to IPV in a manner that is appropriate for them. They have a disproportionately greater influence among women in the South.[1]

Attention to Experiences of Violence Throughout a Woman's Lifespan

IPV must be understood within the context of other forms of violence against women throughout their lifespan. For example, more than 8,000 dowry-related deaths were reported in India in 2007 (United Nations, 2012); more than 15,000 women annually are sold into sexual slavery in China (Hankivsky & Varcoe, 2007); 50% of all women in Canada have experienced at least one episode of physical or sexual violence (Statistics Canada, 1993); in the United States, 83% of girls between 12 and 16 years of age experience some form of sexual harassment in public schools (United Nations, 2012); globally, an estimated 150 million girls under the age of 18 experienced some form of sexual violence in 2002 alone (United Nations, 2012); and each year, approximately 2 million girls between the ages of 5 and 15 are trafficked, sold, or coerced into prostitution (Lederer, 1996). In some countries (e.g., Ethiopia), IPV is shaped by early/underage marriage, female genital cutting, rape, sexual assault, abduction, and trafficking (Guruge, Bender, et al., 2012). In one of my recent (pilot) studies in Canada (Guruge, Roche, & Catallo, 2012), immigrant women from Iran and Sri Lanka reported experiencing multiple forms of violence: childhood abuse, witnessing violence as a child, sexual or physical assault before the age of 15, sexual or physical assault after the age of 15 by someone other than an intimate partner, and IPV. With the recent focus on the world's increasing aging population, the extent of the abuse and neglect of older women by family members is also being exposed. Thus, IPV cannot be addressed in isolation.

Global to Local: Attention to the Migration Context and Process

Women make up approximately half of all international migrants (DeLaet, 1999) and approximately half of all asylum-seekers, refugees, and immigrants to Canada (Citizenship and Immigration Canada, 2010). Emerging evidence suggests that the complex processes of migration and (re)settlement, which may include shifts in power dynamics, may leave women vulnerable to IPV (Guruge, Refaie-Shirpak, et al., 2010). In the

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[1] The South or the global South refers to "developing" or low-to-middle-income countries. The North–South as such is based on a socio-economic and political division rather than necessarily a geographical one. The global South includes 85% of the world's population and only 3% of its wealth. However, this situation is changing; as nations become wealthy or "developed" they may become part of the North even if they are located in the Southern Hemisphere (http://en.wikipedia.org/wiki/North–South_divide; http://www.slideshare.net/pvanleeuwen/kegley-chapter-5).

post-migration and (re)settlement context, social and economic barriers such as social isolation, poor access to employment and fair wages for women (and their husbands), linguistic barriers, difficulty accessing safe housing, social and geographical adjustments, welfare surveillance, and systemic racism embedded within health and social services contribute to stress, marital conflict, and IPV (Guruge & Gastaldo, 2008). As nurses provide care for women dealing with IPV, they must go beyond each woman's present experience in the post-migration context and consider her experiences during the pre-migration and border-crossing contexts. For example, my previous work (Guruge, 2007; Guruge, Roche, et al., 2012) revealed that women experience various forms of threat, abuse, and violence at the hands of authorities such as police and asylum/immigration officials. Pre-migration conflict and forced migration can have various physical, mental, economic, and social consequences. Some of these are associated with poverty and deprivation; others are associated with more extreme difficulties such as war-related injuries, torture, and sexual violence (Gushulak & MacPherson, 2011; Kirmayer et al., 2011). Pre-migration experiences during civil unrest and war often result in increased violence against women (United Nations, 2012). Women who are displaced, who travel alone, who use "illegal" means of migration, or who are trafficked are often subjected to detention, rape, and various other forms of trauma during border crossing (Guruge & Gastaldo, 2008). Thus, nurses must focus on how pre-migration, border-crossing, and post-migration processes and contexts act together to shape women's vulnerabilities and resiliencies with regard to IPV.

Where to From Here?

Drawing from my own research and current global knowledge about IPV, I have developed some recommendations for nursing research and practice; these are intended to serve as a starting point.

Research

Despite the substantial contributions made by health science research to the field of IPV, many gaps remain. Most research has focused either on IPV as an isolated entity or on the combination of childhood abuse and IPV. Researchers need to consider women's exposure to many other forms of violence throughout their lifespans, including social violence, the compounding effects of violence on women's physical and mental health, and the kinds of care, support, and services that women may require. Research is urgently needed to further understand women's exposure to and experiences of pre-migration, border-crossing, and post-migration violence. Such research could provide important insights to guide the provision of care, support, and services to immigrant and refugee women living in the global North.

Most health research in the area of IPV focuses on screening for and assessment of IPV, management of its health consequences, and identification of risk factors. Researchers have begun to focus on health interventions to improve care for women living with IPV and/or its aftermath; however, these interventions are often reactive and tend to focus on the individual. Attention to prevention interventions, especially ones that are theory- and community-based, collaborative, and multidisciplinary, is urgently needed. Given the multi-level nature of IPV risk factors, prevention interventions should incorporate multi-level strategies. Such work can be guided by ecosystemic approaches. Additionally, incorporating intersectionality approaches might yield more effective prevention strategies for differently situated groups of women in the North and the South. Mixed-method studies (involving both qualitative and quantitative methods) may be required to clarify the range and depth of issues that have already been identified. Interventions to prevent violence have yielded promising results in Brazil, South Africa, Nicaragua, Uganda, and Tanzania (Foshee et al., 2004; Guedes, 2004). Such knowledge could benefit countries in the global North. Studies incorporating multiple sites within and across countries are also more likely to provide additional insights about commonalities/similarities and diversities/differences within and between groups and across settings and countries and the context-specific nature of prevention strategies. Findings from this kind of research will likely become a priority for health-care administrators and policy-makers.

Forging North–South and South–South links will be crucial to ensure effective research collaboration and capacity-building across international boundaries. By sharing and pooling experiences, expertise, data, methods, and resources, researchers can gain new perspectives about existing practices, programs, and initiatives and generate multidisciplinary interventions that can be applied across multiple populations simultaneously. Such links will require a greater investment by major research funding bodies such as the Canadian Institutes of Health Research to promote health science research on IPV in low-income countries, enhance local capacity, build strong research institutions, and support more equitable collaborations between researchers in the North and the South.

Practice

Addressing IPV in the context of other forms of violence throughout a woman's lifespan can provide important insights about more effective care and support for women affected by IPV. Nurses need to move beyond focusing on the individual "victim" and "perpetrator" and the micro–macro dichotomy and seek to understand the continuous and reciprocal interaction between micro, meso, and macro levels of society and what takes place at home (Guruge, 2007). Additionally, nurses must move beyond the current focus on screening and identifying IPV victims and on encouraging every woman to leave her abuser, as some women may not consider this to be an option, or may prefer not to leave, depending on their individual/family/community/country situation. Thus, innovative approaches and solutions are needed to provide care for women living with IPV.

Nurses play a vital role in various settings worldwide; they provide immediate care, safety, and support for women and their children affected by IPV through identification, documentation, risk assessment, safety planning, reporting, and care and referral. Without diminishing this contribution, I propose that nurses can further their role as advocates within and beyond the health-care system, providing structural solutions. They may advocate for affordable and increased public housing, shelters, and long-term transitional housing for women and children, linguistically and culturally appropriate services, coordinated services offered under one roof, reducing piecemeal approaches to services, addressing service eligibility criteria (such as proof of citizenship), and finding ways for women to update their employment skills and obtain quality and affordable child care and employment (Guruge & Gastaldo, 2008; Guruge & Humphreys, 2009).

Nurses' roles in health promotion and primary prevention of violence must include early education about healthy relationships, promoting public awareness about the effects of violence against women and children, life-skills development, safety and support programs for women, engaging men in violence-prevention programs, and developing capacity-building and community-based programs to enable women's decision-making (Guruge, 2012; Guruge & Gastaldo, 2008). These programs may include job counselling, literacy and language training, and resources to address child-care, transportation, and financial needs (Guruge, 2012; Guruge & Gastaldo, 2008). These strategies will require the incorporation of components from within and beyond the health sector, as well as collaboration between and among women and men, their families, their communities, and service providers and policy-makers within and across borders. Working across sectors and borders, nurses can also facilitate/coordinate global campaigns and petitions to gain political commitment to address this important global health issue.

Conclusions

Efforts to eradicate IPV must address the inequalities that shape the lives of women in their home countries and beyond. This will require understanding differences among women and between groups of women, questioning generalized notions of gender relations, and critically examining the processes that sustain a multitude of inequalities. Women will be freed from oppression in general, and IPV in particular, only when the North and the South work together to address the economic, political, and social circumstances of women in the South and their various counterparts in the North, because IPV is connected to and shaped by social violence, which fuels and sustains violence against women. By taking this kind of approach, nurses can play a leading role in improving the health of women worldwide.

References

Abraham, M. (2002). *Speaking the unspeakable: Marital violence among South Asian immigrants in the United States.* New Brunswick, NJ: Rutgers University Press.

Ackerson, L. K., & Subramanian, S.V. (2008). Domestic violence and chronic malnutrition among women and children in India. *American Journal of Epidemiology, 167,* 1188–1196.

Agnew, V. (1998). *In search of a safe place: Abused women and culturally sensitive services.* Toronto: University of Toronto Press.

Aldridge, M. L., & Browne, K. D. (2003). Perpetrators of spousal homicide: A review. *Trauma, Violence and Abuse, 4,* 265–276.

Ascensio, R. L. (1999). The health impact of domestic violence: Mexico City. In A. R. Morrison & M. L. Biehl (Eds.), *Too close to home: Domestic violence in the Americas* (pp. 81–101). New York: Inter-American Development Bank.

Barrientos, A., & Barrientos, S. W. (2002). *Extending social protection to informal workers in the horticulture global value chain.* Washington: World Bank.

Bennett, B., & Tomossy, G. F. (Eds.). (2006). *Globalization and health: Challenges for health law and bioethics.* Dordrecht: Springer.

Bonder, G., Maclean, H., McGregor, B., Oldham, G., Randriamaro, Z., & Sichia, S. (2004). *Globalization and health: The gender dimension.* Retrieved August 1, 2008, from http://www.crwh.org/PDF/consensus.pdf.

Bosch, K., & Schumm, W. R. (2004). Accessibility to resources: Helping rural women in abusive partner relationships become free from abuse. *Journal of Sex and Marital Therapy, 30,* 357–370.

Breiding, M. J., Black, M. C., & Ryan, G. W. (2008). Chronic disease and health risk behaviours associated with intimate partner violence – 18 US states/territories, 2005. *Annals of Epidemiology, 18,* 538–544.

Brownridge, D. A., & Halli, S. S. (2002). Culture variation in male partner violence against women. *Violence Against Women, 8,* 87–115.

Campbell, J. (2002). Health consequences of intimate partner violence. *Lancet, 359,* 1331–1421.

Campbell, J., Garcia-Moreno, C., & Sharps, P. (2004). Abuse during pregnancy in industrialized and developing countries. *Violence Against Women, 10,* 770–789.

Campbell, J., & Lewandowski, L. (1997). Mental and physical health effects of intimate partner violence on women and children. *Psychiatric Clinics of North America, 20,* 353–374.

Chatterjee, P., & Jeganathan, P. (2000). *Community, gender, and violence.* Sublatern Studies xi. New York: Columbia University Press.

Citizenship and Immigration Canada. (2010). *Facts and figures: Immigration overview.* Ottawa: Author. Retrieved December 15, 2010, from http://www.cic.gc.ca/english/resources/statistics/facts2010/index.asp.

Coker, A. L. (2007). Does physical intimate partner violence affect sexual health? A systematic review. *Trauma Violence Abuse, 8,* 149–177.

Coker, A. L., Smith, P. H., Bethea, L., King, M. R., & McKeown, R. E. (2000). Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine, 9*(5), 451–457.

DeLaet, D. L. (1999). Invisibility of women in scholarship on international migration. In G. A. Kelson & D. L. DeLaet (Eds.), *Gender and immigration* (pp. 1–17). New York: NYU Press.

Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L. B., Deyessa, N., et al. (2011). Violence against women is strongly associated with suicide attempts: Evidence from the WHO Multi-country Study on Women's Health and Domestic Violence Against Women. *Social Science and Medicine, 73*(1), 79–86.

Eby, K., Campbell, J., Sullivan, C., & Davidson, W. (1995). Health effects of experiences of sexual violence for women with abusive partners. *Health Care for Women International, 16,* 563–576.

Economic Policy Research Center. (2009). Kampala IPV: Estimating its cost and effect in Uganda. In *Intimate partner violence: High costs to households and communities* (pp. 1– 12). Washington: International Center for Research on Women and United Nations Population Fund.

El Kady, D., Gilbert, W. M., Xing, G., & Smith, L. H. (2005). Maternal and neonatal outcomes of assaults during pregnancy. *Obstetrics and Gynecology, 105*(2), 357–363.

Ellsberg, M., Jansen, H. A. F. M., Heise, L., Watts, C. W., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO Multi-country Study on Women's Health and Domestic Violence: An observational study. *Lancet, 371*(9619), 1165–1172.

Emenike, E., Lawolo, S., & Dalal, K. (2008). Intimate partner violence and reproductive health of women in Kenya. *International Nursing Review, 55,* 97–102.

Fischbach, R., & Herbert, B. (1997). Domestic violence and mental health: Correlates and conundrums within and across cultures. *Social Science and Medicine, 45,* 1161–1176.

Foshee, V. A., Bauman, K. E., Ennett, S. T., Linder, G. F., Benefield, T., & Suchindran, C. (2004). Assessing the long-term effects of the Safe Dates program and a booster in preventing and reducing adolescent dating violence, victimization, and perpetration. *American Journal of Public Health, 94*(4), 619–624.

Fox, J. A., & Zawitz, M. W. (2006). *Homicide trends in the United States.* Washington: US Department of Justice. Retrieved August 1, 2008, from http://www.ojp.usdoj.gov/bjs/homicide/homtrnd.htm.

Garcia-Moreno, C. (2000). Violence against women: International perspectives. *American Journal of Preventive Medicine, 19*(4), 330–333.

Garcia-Moreno, C., & Watts, C. (2011). Violence against women: An urgent public health priority. *Bulletin of the World Health Organization, 89*(2), 2–3.

Giles, W., de Alwis, M., Klein, E., & Silva, M. (2003). *Feminists under fire: Exchanges across war zones.* Toronto: Between the Lines.

Giles, W., & Hyndman, J. (2004). *Sites of violence and gender conflict zones.* Berkeley: University of California Press.

Glodava, M., & Onizuko, R. (1994). *Mail-order brides: Women for sale.* Fort Collins, CO: Alaken.

Guedes, A. (2004). *Addressing gender-based violence from the reproductive health/HIV sector: A literature review and analysis.* Washington: POPTECH.

Guruge, S. (2007). *The influence of gender, racial, social, and economic inequalities on the production of and responses to IPV in the post-migration context.* Unpublished dissertation, University of Toronto.

Guruge, S. (2010). Perceptions of and responses to IPV: Findings from a study in the Sri Lankan Tamil community in Toronto. In J. S. F. Fong (Ed.), *Out of the shadows: Woman abuse in ethnic, immigrant, and Aboriginal communities* (pp. 264–283). Toronto: Canadian Scholars Press.

Guruge, S. (2012). Nurses' role in caring for women experiencing intimate partner violence in the Sri Lankan context. *ISRN Nursing* [online], article ID 486273: http://www.hindawi.com/isrn/nursing/2012/486273/.

Guruge, S., Bender, A., Hyman, I., Aga, F., Tamiru, M., Hailemariam, D., et al. (2012). Towards a global interdisciplinary evidence-informed practice: Intimate partner violence in the Ethiopian context. *ISRN Nursing* [online], article ID 307271: http://www.hindawi.com/isrn/nursing/2012/307271/.

Guruge, S., Ford-Gilboe, M., Varcoe, C., Ganesan, S., Vithanarachchi, S., Sivayogan, S., et al. (2012). *Factors that influence the production of and responses to IPV in the Sri Lankan context.* Unpublished report (available from the first author).

Guruge, S., & Gastaldo, D. (2008). Violencia en la pareja e inmigración? Cómo ser parte de la solución? *Presencia, 4*(8). http://www.index-f.com/presencia/n8/p8801.php.

Guruge, S., & Humphreys, J. (2009). Barriers that affect abused immigrant women's access to and use of formal social supports. *Canadian Journal of Nursing Research, 41*(3), 64–84.

Guruge, S., Kanthasamy, P., Jokajasa, J., Sathananthan, S., Wan, Y. W. T., Chinchian, M., et al. (2010). Violence against older immigrant women in an urban context. *Women's Health and Urban Life, 9*(2), 16–41.

Guruge, S., & Khanlou, N. (2004). Intersectionalities of influence: Researching the health of immigrant and refugee women. *Canadian Journal of Nursing Research, 36*(3), 32–47.

Guruge, S., Khanlou, N., & Gastaldo, D. (2010). The production of intimate male partner violence in the migration process: Intersections of gender, race, and class. *Journal of Advanced Nursing, 66*(1), 103–113.

Guruge, S., & Morrison, L. (2012). *Intimate partner violence among women in Hilo, Hawaii.* Unpublished report (available from the first author).

Guruge, S., Refaie-Shirpak, K., Zanchetta, M., Gastaldo, D., Hyman, I., & Sidani, S. (2010). A meta synthesis of post-migration changes and their effects on marital relationships in Canada. *Canadian Journal of Public Health, 101*(4), 327–331.

Guruge, S., Roche, B., & Catallo, C. (2012). Violence against women: An exploration of the physical and mental health trends among immigrant and refugee women in Canada. *Nursing Research and Practice* [online], article ID 434592. http://www.hindawi.com/journals/nrp/2012/434592/.

Guruge, S., Tiwari, A., & Lucea, M. B. (2010). International perspectives on family violence. In J. Humphreys & J. Campbell (Eds.), *Family violence and nursing practice* (2nd ed.) (pp. 411–436). Philadelphia: Lippincott Williams & Wilkins.

Gushulak, B. D., & MacPherson, D. W. (2011). Health aspects of the pre-departure phase of migration. *PLoS Med, 8*(5), e1001035.

Hankivsky, O., & Varcoe, C. (2007). From local to global and over the rainbow: Violence against women. In M. Morrow, O. Hankivsky, & C. Varcoe (Eds.), *Women's health in Canada: Critical theory and policy* (pp. 477–506). Toronto: University of Toronto Press.

Health Canada. (2002). *Violence against women: Impact of violence on women's health.* Ottawa: Author.

Heise, L. L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women, 4,* 262–291.

Heise, L., & Garcia-Moreno, C. (2002). Violence by intimate partners. In E. Krug, L. Dahlberg, J. A. Mercy, B. Zwi, & R. Lozano (Eds.), *World report on violence and health* (pp. 87–121). Geneva: World Health Organization.

Heise, L. L., Pitanguy, J., & Germain, A. (1994). *Violence against women: The hidden health burden.* Washington: International Bank for Reconstruction and Development/World Bank.

Hornosty, J., & Doherty, D. (2002). *Responding to wife abuse in farm and rural communities: Searching for solutions that work.* Regina: Saskatchewan Institute of Public Policy.

Humphreys, J., Lee, K., Neylan, T., & Marmar, C. (1999). Sleep patterns of sheltered battered women. *Image: Journal of Nursing Scholarship, 31,* 139–143.

International Center for Research on Women. (2009). *Intimate partner violence: High costs to households and communities.* Washington: International Center for Research on Women and United Nations Population Fund. Retrieved April 2, 2012, from http://www. icrw.org /publications.intimate-partner-violence-high-cost-household-and-communities.

International Labour Organization. (2002). *Decent work and the informal economy.* Geneva: Author.

Ishida, K., Stupp, P., Melian, M., Serbanescu, F., & Goodwin, M. (2010). Exploring the associations between intimate partner violence and women's mental health: Evidence from a population-based study in Paraguay. *Social Science and Medicine, 71,* 1653–1661.

Janssen, P. A., Holt, V. L., Sugg, N. K., Emanuel, I., Critchlow, C. M., & Henderson, A. D. (2003). Intimate partner violence and adverse pregnancy outcomes: A population based study. *American Journal of Obstetrics and Gynecology, 188,* 1341–1347.

Jewkes, R., Penn-Kekana, L., Levin, J., Ratsaka, M., & Schrieber, M. (2001). Prevalence of emotional, physical and sexual abuse of women in three South African provinces. *South African Medical Journal, 91,* 421–428.

Kawadi, I., & Wamala, S. (2006). *Globalization and health.* New York: Oxford University press.

Kirmayer, L. J., Narasiah, L., Muñoz, M., Rashid, M., Ryder, A. G., Duzder, J., et al. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal, 183*(12), E959–E967.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). *World report on violence and health.* Geneva: World Health Organization.

Langevin, L., & Belleau, M.-C. (2000). Chapter 2: "Mail-order brides" in Canadian law. In L. Langevin & M.-C. Belleau, *Trafficking in women in Canada: A critical analysis of the legal framework governing immigrant live-in caregivers and mail-order brides.* Ottawa: Status of Women Canada. Retrieved August 25, 2011, from http://www.childtrafficking.com/Docs/langevin_2000__trafficking_.pdf.

Lederer, L. J. (1996, August). *National legislation on child pornography and international trafficking.* Unpublished document. Minneapolis: Centre on Speech, Equality, and Harm, University of Minnesota Law School.

Lee, K. (2003). *Health impacts of globalization: Toward global governance.* New York: Palgrave.

Lesserman, J., & Dorssman, D. A. (2007). Relationship of abuse history to gastrointestinal disorders and symptoms. *Trauma, Violence and Abuse, 8,* 331–343.

Letourneau, E., Holmes, M., & Chasedunn-Roark, H. (1999). Gynecologic health consequences to victims of interpersonal violence. *Women's Health Issues, 9,* 115–120.

Maclean, H., & Sicchia, S. R. (2004). *Gender, globalization and health.* Background paper. Ottawa: Canadian Institutes of Health Research–Institute of Gender and Health. Retrieved September 1, 2008, from http://www.womensresearch.ca/PDF/Stonehouse-Abridged.pdf.

Maki, O. (1993). Gender and the labor market. *Journal of Japanese Studies, 19*(1), 79–102.

Mehra, R., & Gammage, S. (1999). Trends, countertrends, and gaps in women's employment. *World Development, 27*(3), 533–550.

Muellman, R. L., Lenaghan, P. A., & Pakieser, R. A. (1996). Battered women: Injury locations and types. *Annals of Emergency Medicine, 28*(5), 486–492.

National Centre for Injury Prevention and Control. (2003). *Costs of intimate partner violence against women in the United States.* Atlanta: Centers for Disease Control and Prevention.

Plitcha, S. B. (2004). Intimate partner violence and physical health consequences: Policy and practice implications. *Journal of Interpersonal Violence, 19*(11), 1296–1323.

Raj, A., & Silverman, J. (2002). Violence against immigrant women. *Violence Against Women, 8*(3), 367–398.

Roberts, T. A., Auinger, P., & Klein, J. D. (2005). Intimate partner abuse and the reproductive health of sexually active female adolescents. *Journal of Adolescent Health, 36*(5), 380–385.

Roberts, T. A., Klein, J. D., & Fisher, S. (2003). Longitudinal effects of intimate partner abuse on high-risk behaviour among adolescents. *Archives of Pediatric and Adolescent Medicine, 157*(9), 875–981.

Scott-Storey, K. (2011). Cumulative abuse: Do things add up? An evaluation of the conceptualization, operationalization, and methodological approaches in the study of the phenomenon of cumulative abuse. *Trauma, Violence, and Abuse, 12*(3), 135–150.

Silverman, J. G., Decker, M. R., Kapur, N. A., Gupta, J., & Raj, A. (2007). Violence against wives, sexual risk and sexually transmitted infection among Bangladeshi men. *Sexually Transmitted Infections, 83*(3), 211–215.

Sokoloff, N. J. (with Pratt, C.) (Ed.). (2005). *Domestic violence at the intersections of race, class, and gender.* Piscataway, NJ: Rutgers University Press.

Standing, G. (1999). *Global labour flexibility: Seeking distributive justice.* Basingstoke: Macmillan.

Statistics Canada. (1993). The Violence Against Women Survey. *The Daily,* November. Ottawa: Ministry of Industry.

Stephenson, R., Koenig, M. A., & Ahmed, S. (2006). Domestic violence and symptoms of gynecologic morbidity among women in north India. *International Family Planning Perspectives, 32,* 201–208.

Tjaden, P., & Thoennes, N. (2000). *Extent, nature and consequences of intimate partner violence: Findings from the National Violence Against Women Survey.* Washington: Office of Justice Programs, US Department of Justice.

United Nations. (2012). *Fast facts: Statistics on violence against women and girls.* Virtual Knowledge Centre to End Violence Against Women and Girls. Retrieved August 1, 2012, from http://www.endvawnow.org/en/articles/print/id/299/.

Varma, D., Chandra, P. S., & Thomas, T. (2007). IPV and sexual coercion among pregnant women in India: Relationship with depression and PTSD. *Journal of Affective Disorders, 102*(1), 227–235.

Vickers, J. (2002). Thinking about violence. In V. Dhruvarajan & J. Vickers (Eds.), *Gender, race, and nation: A global perspective* (pp. 222–246). Toronto: University of Toronto Press.

Vizcarra, B., Hassan, F., Hunter, W. M., Muñoz, S. R., Ramiro, L., & De Paula, C. S. (2004). Partner violence as a risk factor for mental health among women from communities in the Philippines, Egypt, Chile, and India. *Injury Control and Safety Promotion, 11*(2), 125–129.

Vos, T., Astbury, J., Piers, L. S., Magnus, A., Heenan, M., & Stanley, L. (2006). Measuring the impact of IPV on the health of women in Victoria, Australia. *Bulletin of the World Health Organization, 84,* 739–744.

World Health Organization. (2002a). *Child abuse and neglect by parents and other caregivers.* Geneva: Author.

World Health Organization. (2002b). Violence by intimate partners. In *World report on violence and health.* Geneva: Author.

World Health Organization. (2006). *Multi-country Study on Women's Health and Domestic Violence Against Women.* Geneva: Author.

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Résumé

La tuberculose et les troubles mentaux courants : des leçons d'autres pays applicables à la santé des immigrants au Canada

Amy Bender, Sepali Guruge,
Ilene Hyman, Martyn Janjua

La tuberculose est un problème de santé urgent d'ampleur mondiale. Son impact sur d'autres infections et maladies et sur des facteurs sociaux, y compris l'immigration, est bien connu. Toutefois, peu de recherches ont été menées sur les liens entre la tuberculose et les troubles mentaux, particulièrement chez les immigrants au Canada. Les auteurs font état d'un examen de portée qu'ils ont réalisé pour mieux comprendre les synergies entre la tuberculose, les troubles mentaux et les conditions sociales sous-jacentes touchant la santé des immigrants. Ils mettent en lumière les articles qui traitent de la cooccurrence entre tuberculose et dépression/anxiété. Après avoir décrit leur approche et leur stratégie, ils présentent des catégories thématiques clés : la prévalence; la présentation clinique; et les effets des stigmates et de la pauvreté. Inscrivant la recherche dans un contexte mondial, ils estiment que la migration contribue à ces conditions synergétiques. L'étude démontre que les Canadiens ont beaucoup à gagner en apprenant des expériences vécues par les pays à faible et moyen revenus en regard de ce qui constitue les meilleures données probantes à recueillir pour gérer des problèmes de santé mondiaux complexes.

Mots clés : tuberculose, troubles mentaux, immigrants, synergies, conditions sociales, stigmates, pauvreté

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Tuberculosis and Common Mental Disorders: International Lessons for Canadian Immigrant Health

Amy Bender, Sepali Guruge,
Ilene Hyman, Martyn Janjua

Tuberculosis is a pressing global health issue. Its association with other infections, illnesses, and social factors, including immigration, is well known, yet comparatively little research has examined the connections between tuberculosis and mental disorder, particularly among immigrants in Canada. The authors report on a scoping review conducted to better understand the synergies of tuberculosis, mental disorders, and underlying social conditions as they affect immigrants' health. They highlight the articles that focused on the co-occurrence of tuberculosis and depression/anxiety. After describing their approach and strategy, the authors present key thematic categories: prevalence, clinical presentation, and effects of stigma and poverty. Examining the research within the global context, they argue that migration contributes to these synergistic conditions. The review shows that Canadians stand to gain much by learning from low- and middle-income countries about what constitutes best evidence in approaching complex global health issues.

Keywords: care delivery, determinants of health, infectious diseases, mental health/psychosocial, psychosocial aspects of illness, vulnerable populations

Introduction

Tuberculosis (TB) is a pressing global health issue. Its current resurgence worldwide has been linked to globalization, migration, inconsistent or outdated treatments, and other, equally troubling, diseases, notably HIV/AIDS (World Health Organization [WHO], 2008). The World Health Organization's 2011 *Global Tuberculosis Control* report indicates that in 2010 almost 9 million new cases of TB were diagnosed worldwide and almost 1.5 million individuals died from the disease; although incidence rates and absolute numbers of cases have been falling since 2002 and 2006, respectively, multidrug-resistant TB (MDR-TB) remains a major concern, with fewer than 5% of new and previously treated TB patients being tested for MDR-TB in most countries in 2010 (WHO, 2011).

Social factors, such as poverty, inadequate housing, and stigma, also affect the activation, treatment, and spread of TB. These social factors are similarly significant determinants of mental disorder, and global statistics in this area are also of great concern. Estimates indicate that mental disorders account for 13% of the overall global burden of disease (WHO, 2004). Depression, alcohol addiction, and psychoses are among the 20 leading causes of disability, and depression alone ranks third worldwide, eighth in low-income countries, and first in middle- and high-income countries (WHO, 2004). According to a DSM-V working group, mental disorder refers to a behavioural or psychological pattern in an individual that reflects underlying psychobiological dysfunction; is not an expectable or culturally sanctioned response to common stressors, losses, or events; has clinically distressing or disabling consequences; and, debates about specific nomenclature notwithstanding, has clinical utility. Thus the term "mental disorder," when appropriately used, is more than a descriptive label (Stein et al., 2010).

There have been some investigations into the question of TB and mental disorders as co-occurring health problems, but Canadian research on the topic is lacking. Additionally, although immigrants are over-represented in Canadian TB rates and experience particular pressures that affect mental health, the synergies of TB and mental disorders in this group have not been studied in depth. Therefore, we undertook a scoping review to identify how these health problems and their underlying social conditions are framed in the literature in relation to immigrant health. A scoping review, one of several types of systematic literature synthesis, is typically defined as a technique of mapping out literature addressing a specific topic in a broad sense so that the range of perspectives and approaches to the topic are captured (Arksey & O'Malley, 2005). We therefore scoped both TB best practice documents and empirical literature from a syndemics perspective, which is theoretically premised on a critique of medicalization (Singer, 1994, 2004; Singer & Clair, 2003).

In this article we present only those publications addressing the relationship among TB, the common mental disorders of depression and anxiety, and social conditions that play a role in this co-morbidity, organized within the thematic categories of prevalence, clinical presentation, and effects of stigma and poverty.[1] In the Canadian context, newcomer populations bear unique stressors that are associated with both TB and common mental disorders. We thus argue that in a globalized world immigrant experiences represent an important point for consideration. We conclude with some lessons that stem from our reflections on the surprising lack of Canadian research in this area and offer suggestions for possible directions in Canadian TB programming.

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[1] For a full description of the review, see Bender, Hyman, Guruge, and Janjua (2012).

Background

Understanding TB as a global health issue means understanding that being born in or travelling in a country where TB is widespread represents one of the highest risk factors for contracting the disease (Public Health Agency of Canada [PHAC], 2009). This poses specific challenges to the provision of quality care in the Canadian context (Gardam et al., 2009). TB and immigration has been well studied and the research can be categorized into two main areas: (1) factors associated with latent TB and activation of the disease, and (2) barriers to detecting and treating the infection/disease in newcomers (Hyman, 2001). Over the past decade, 80% of immigrants (including refugees) arriving in Canada each year have originated from countries with a high incidence of TB (Long & Ellis, 2007). Despite a decline in the reported incidence rate of active TB (new and re-treatment cases) in immigrants, from 21.2 per 100,000 in 1998 to 13.7 per 100,000 in 2008, the annual number of newly reported TB cases has not changed substantially since 1970 (PHAC, 2010). Additionally, although the total number has remained stable, the proportion of immigrants in all active TB cases has increased significantly, from 18% in 1970 to 63% in 2008 (PHAC, 2010).

Increasing globalization brings with it the increased mobility of populations, or migration, which is a process of transition in terms of personal relationships, social networks, and socio-economic and cultural systems (DesMeules, Giri, & Grondin, 2010; Kirmayer et al., 2011). Unique to the migration experience itself, (re)settlement stress has been studied for its effect on the immune system and on the mental health of those who have migrated (Beiser, 2005; Hyman, 2001, 2004). Specific factors affecting mental health include pre-migration economic, educational, and occupational status; disruption in social roles, networks, and support; and political involvement and trauma (Hansson, Tuck, Lurie, & McKenzie, 2010; Kirmayer et al., 2011; Pottie et al., 2011). Post-migration stressors centre on issues of loss and uncertainty; disillusionment, demoralization, and depression are experienced when initial expectations are not met and when structural barriers and inequalities persist (Kirmayer et al., 2011, p. E961). Immigrants are generally less likely than their Canadian-born counterparts to use mental health services, even when levels of distress are comparable (Ganesan, Mok, & McKenna, 2011; Kirmayer et al., 2011); one of many reasons for this may be that mental disorders can involve considerable social stigma (Hansson et al., 2010).

Stigma can be conceptualized as a social phenomenon that is experienced subjectively, affecting one's cognitive and psycho-emotional processes. Layers of stigmatizing experiences therefore can compound such coping challenges as comprehending the disease/illness, self-doubt, and distrust of health professionals (Lekas, Siegel, & Leider, 2011; Mill et al., 2009). Specific to immigration and TB, stigma takes form in stereotypes of "foreigners" as the source of contagion or as those who "bring" diseases, which can cause immigrants to feel victimized by government screening protocols and border-control policy (Coker, 2004; Coreil et al., 2010; Littleton, Park, Thornley, Anderson, & Lawrence, 2008). The psychological and emotional effects of a contagious disease like TB, particularly for newcomers to a country, can lead to complex situations involving depression and anxiety, which call for more integrated approaches to population-focused disease management and individual mental health care.

Theoretical Perspective: Syndemics

Without diminishing Western medicine's central contribution to the successful treatment and eradication of TB, we recognize that medicalization can limit our understanding of health and illness. Therefore the review was guided by a syndemic approach, which stems from a critique of this phenomenon (Milstein, 2008; Singer, 2004). Medicalization is defined generally as a process of absorbing social conditions and behaviours into a biomedical arena, primarily by using pathologizing terminology to account for such concerns; it can serve "to mystify and de-politicize the social origins of personal distress" (Singer, 2004, p. 28). In short, it has profoundly shaped our understanding of the meaning of disease and the illness experience, the world over, thereby also often segregating treatment systems according to categories of disease. As Singer (2004) notes, diseases are more than simply the result of a pathogen or biochemical problem. They vary across locations and populations according to geographical conditions, systemic and institutional activities, resource distribution, and the living conditions that emerge from these arrangements. Similarly, the sufferer's experience, or "the manner in which an ill person manifests his or her disease or distress," is socially constructed as it is lived out between cultural meanings and the political-economic conditions of daily life (Singer, 2004, p. 27). Certainly this critique holds in the global context, when one considers the movement of people and diseases around the world.

A syndemic, as a refinement of the medicalized notion of epidemic, is defined as "a set of intertwined and mutually enhancing epidemics involving disease interactions at the biological level that develop and are sustained in a community/population because of harmful social conditions and injurious social connections" (Singer & Clair, 2003, p. 429). This kind of approach has gained a foothold in studies of HIV and its related conditions such as poverty (Singer, 1994) and financial crisis (Freudenberg, Fahs, Galea, & Greenberg, 2006); psychosocial problems

(Mustanski, Garofalo, Herrick, & Donenberg, 2007; Stall et al., 2003); and TB (Freudenberg et al., 2006; Littleton & Park, 2009), with several authors noting the marginalization of vulnerable populations, including immigrants, as an important aspect of the synergies of certain epidemics. From a global perspective on TB and mental disorders, it is important to incorporate pre- and post-migration locations, conditions, and experiences into our understanding of the mutually enhancing elements of TB (given its "contagious" label and demanding medication regime), mental disorders (manifested as "symptoms" that deeply affect one's sense of identity and reality), and immigration stress. For this reason, a syndemic perspective was useful for our scoping review.

Purpose and Search Strategy

Our purpose was to understand the synergies of TB, mental disorders, and underlying social conditions as they relate to immigration. The original guiding question was as follows: How are TB and mental disorders, along with social conditions, understood and addressed as intersecting issues for immigrant health? The peer-reviewed literature was searched using the following databases: MEDLINE, EMBASE, PsychINFO, PubMed, CINAHL, Social Science Abstracts, Sociological Abstracts, Web of Science, and Scopus. Articles were restricted to those published in English between 1960 and 2010. We included a range of journal articles, including case reports, clinical trials, evaluation studies, randomized control trials, and literature reviews. The search terms were organized into four categories: tuberculosis (TB), mental health (MH), social conditions (SC), and immigrant health (IH), and 23 variations of these terms served as keywords. Initially, a search was run for each keyword within separate categories, followed by crossing each category's results with the others, as follows: (1) all four categories (TB, MH, SC, and IH) and three respective combinations: (2) TB, MH, and SC; (3) TB, SC, and IH; (4) MH, SC, and IH. This yielded over 23,000 articles, so we eliminated the fourth combination, which did not include TB, and those articles not published within the last 25 years. The result was 1,397 articles. We further reduced the number of articles by removing those focused on TB among immigrants without explicit attention to mental health. We also excluded those on TB prevention rather than treatment, because treatment methods themselves have implications for mental health, and any effective prevention strategy must consider treatment of active disease. The titles and abstracts of the resulting 110 articles were scanned for relevance, leaving a total of 31 articles. Of these, 13 specifically identified the co-morbidities of TB and depression and anxiety, and only two of these articles identified immigrant populations.

Table 1 ***Articles Included in the Review***

Authors	**Location**	**Design and Year Conducted**	**Topic / Purpose**	**Immigrant Focus?**
Aamir & Aisha (2010)	Haripur, India	Survey using Hospital Anxiety and Depression Scale (HADS) (self-rating); over 6 months of treatment	To examine how detection of anxiety and depression levels in TB patients at an early stage can improve treatment adherence	No
Aghanwa & Erhabor (1998)	Ile-Ife, Nigeria: chest clinic of teaching hospital	Prospective controlled survey using 30-item General Health Questionnaire, Present State Examination (9th ed.), and demographics questionnaire; 1995–96	To examine the impact of TB on mental health status and to determine the relationship between psychopathology and sociodemographic characteristics	No
Bhasin et al. (2001)	East Delhi, India: 2 DOTS centres (hospital and dispensary)	Case-control study using Illness Behaviour Questionnaire (validated Hindi version); 2000	To understand illness perceptions and behaviours of TB patients	No
Deribew et al. (2010)	Adama, Nekemet, and Jimma, Ethiopia: urban hospitals	Cross-sectional study using Kessler 10 Scale, Comprehensive Psychopathology Rating Scale (CPRS), adapted stigma questionnaire, and patient records for demographics; 2009	To compare occurrence of common mental disorders in TB patients and TB/HIV co-infected patients	No

Husain et al. (2008)	Karachi, Pakistan: urban hospital (rural-receiving)	Survey using HADS; no psychiatric interview to diagnose; n.d.	To determine the presence of depression and anxiety in TB patients and their perceptions of the illness	No
Macq et al. (2005)	5 municipalities in Nicaragua: health centres	Qualitative descriptive; focus group and in-depth interviews; 2003	To explore social stigma of TB to inform an intervention for a government health program	No
Manoharam et al. (2001)	Vellore, India: community hospital	Structured interviews using Revised Clinical Interview Schedule and Short Explanatory Model Interview and ICD-9 diagnostic criteria; n.d.	To examine factors linked with TB treatment non-adherence, including psychiatric morbidity and patient beliefs	No, but questionnaire translated into Tamil
Naidoo & Mwaba (2010)	Cape Metropole, South Africa: public health TB clinic	Cross-sectional study using Beck Depression Inventory (Xhosa translation) and Social Network Support Questionnaire; n.d.	To determine the prevalence and severity of depression in TB patients as well as presence and type of social support	No, but Xhosa identified as main ethnic group
Natani et al. (1985)	Jaipur, India: hospital for TB and chest diseases	Cross-sectional study using Beck Depression Inventory and sociodemographic questionnaire; n.d.	To determine rates of depression in TB patients and the relationship between depression and sociodemographic characteristics	No

(continued on next page)

Table 1 (cont'd)

Authors	**Location**	**Design and Year Conducted**	**Topic / Purpose**	**Immigrant Focus?**
Nolan et al. (1988)	Seattle, United States: urban hospitals; public health TB clinic	Case study using clinic records; 1984–85	To examine factors involved in intentional isoniazid overdose in 3 Southeast Asian refugees	Yes: Southeast Asian refugees
Trenton & Currier (2001)	United States	Commentary	To offer guidelines for the co-morbid treatment of TB and depression	Immigration mentioned as risk factor
Vega et al. (2004)	Lima, Peru: community-based NGO	Retrospective case series 1996–99, including DSM-IV psychiatric diagnoses	To examine "psychiatric complications" in MDRTB cases	No
Westaway & Wolmarans (1992)	Soweto, South Africa: national TB hospital	Pilot study; n.d.	To determine the reliability and validity of the Beck Depression Inventory and applicability for screening in Black TB patients with low literacy; Rosenberg Self-Esteem Scale also used	No

Results: Prevalence, Clinical Presentation, and Effects of Stigma and Poverty

The 13 selected articles, detailed in Table 1, share commonalities yet differ in terms of context, purpose, and approach. They have been thematically categorized according to the prevalence of depression and anxiety in TB patients, the clinical presentation, and the effects of stigma and poverty — social conditions that are inseparable from TB and mental disorders. Throughout the review we discovered encouraging examples of effective interventions yet found very little addressing the concerns of immigrants. However, we observed that the studies varied geographically across four continents and represented countries with a heavy TB burden that are also common sources of immigrants to Canada. The stated rationale for examining depression and anxiety in eight studies was to improve TB treatment adherence (Aamir & Aisha, 2010; Deribew et al., 2010; Husain, Dearman, Chaudry, Rizvi, & Waheed, 2008; Naidoo & Mwaba, 2010; Natani et al., 1985; Westaway & Wolmarans, 1992). This is important because the goal of treatment adherence reflects the strong public health underpinnings of TB programs and the unique dual concern of protecting the population and caring for the sick individual. Key themes identified across articles were the prevalence and clinical presentation of depression and anxiety in TB patients and stigma and poverty as contributors to these health problems.

The detection of depression and anxiety in TB patients and clarification of related clinical features is important in ensuring that their signs and symptoms as well as their risk factors are recognized and appropriately addressed in TB care. An important first step is screening for mental disorders in TB settings. Several authors addressed screening, drawing associations between certain demographic characteristics and the TB-depression co-morbidity. For example, Natani et al. (1985) found that of the 150 TB patients screened in Jaipur, India, almost half met the criteria for depression (49%), citing such related social concerns as illiteracy, low socio-economic status, and attitudes towards TB. In Vellore, India, Manoharam, John, Joseph, and Jacob (2001) examined factors associated with TB treatment non-adherence, including psychiatric illness and patients' beliefs. Of 52 consecutive patients in a TB clinic, 7 (13.5%) met the *International Classification of Diseases* (ICD-9) (2012) criteria for depression. In Pakistan, Husain et al. (2008) also found high rates of depression and anxiety (46% and 47.2%, respectively), and symptoms of depression were positively correlated with physical symptoms of TB. With the overall goal of improving care for Black hospitalized TB patients, Westaway and Wolmarans (1992) adapted the Beck Depression Inventory

(BDI) as a screening tool for the South African context, and found that 65 of 100 patients met criteria for depression.

Two studies highlight a possible link between ongoing concurrent therapy for depression and anxiety and TB cure. Aamir and Aisha (2010) found that 47 of 65 newly diagnosed TB patients (72%) scored in the moderate-to-severe category for depression and anxiety. At the point of usual treatment completion 6 months later, 14 of the 47 individuals (22%) had not fully adhered to medications and showed signs of MDR-TB. Interestingly, the remaining 33 had agreed to regular consultations with a psychiatrist and completed the full course of treatment. In Lima, Peru, psychiatrists conducted unstructured screening interviews with patients as part of a comprehensive MDR-TB management program, which continued on a monthly basis with the prescription of psychiatric medications as necessary (Vega et al., 2004). The baseline prevalence of depression in this clinic population was higher than that for the general population (50%), but this seemed to improve over the course of treatment, which included psychosocial and psychiatric care.

Several authors examined depression and anxiety in individuals with particular complications of TB. HIV is a significant co-morbidity, particularly in countries with high rates of both infections (Deribew et al., 2010; Naidoo & Mwaba, 2010). Deribew et al. (2010) note that while depression has been studied in relation to HIV and to TB separately, cases of TB-HIV co-infection have not received the same attention. Comparing depression and anxiety rates in HIV patients and TB-HIV co-infected patients in Ethiopia, the authors found higher rates in the co-infected group (46.7% for HIV alone, compared to 63.7% for TB-HIV), although 20% of this group was lost to follow-up.

Suicide was the focus in Nolan, Elarth, and Barr's (1988) review of six clinical cases of intentional overdose with the first-line TB medication isoniazid. The patients were South Asian refugee females in the Seattle area of the United States, aged 14 to 23 years. Psychiatric evaluations at the time of hospitalization indicated that two patients were experiencing depression, two had depressed mood as a result of relocation stress, and two were believed to have acted on impulse. Migration status is mentioned as a contributing factor, but, surprisingly, the links among TB, depression, and "relocation stress" are not explored. The only recommendation offered is to limit the supply of isoniazid for newcomers, thereby increasing the frequency of clinic visits and opportunities to evaluate treatment adherence and suicide risk. In their literature review, Trenton and Currier (2001) counsel caution regarding the problematic links between isoniazid and select serotonin reuptake inhibitor (SSRI) antidepressants in terms of the potential for serotonin syndrome (marked by such symptoms as hypertension, hyperthermia, and rigidity). Despite a dearth of published studies, clinical reports led them to conclude that since TB and depression often co-occur, sufficient preparation of both primary care practitioners and psychiatrists is required to prevent problematic interactions.

Shifting from diagnostic and treatment concerns alone, several authors have taken a broader, quality-of-life, approach to clarifying TB patients' clinical presentation. Arguing for a more holistic view of the psychosocial characteristics of TB, Bhasin, Mittal, Aggarwal, and Chadha (2001) identify depression and stress in a study of patients' perceptions and behaviours related to their illness. TB patients had statistically significant higher scores than a control group in the categories of affective disturbance/dysphoria (including depressed mood), affective inhibition (restricting expression of negative emotions), and general hypochondriasis. Thus, they argue that TB patients are more distressed and have more behavioural concerns. Given that TB has so many confounding psychosocial dimensions, individuals' perceptions and beliefs must be carefully incorporated into care in culturally appropriate ways (Bhasin et al., 2001; Manoharam et al., 2001).

Similarly, Naidoo and Mwaba (2010) investigated learned helplessness, social support, and depression, arguing that clarification of the relationships among them helps to determine the best ways of enhancing TB patients' quality of life. Helplessness and depression are typically thought to be insidiously linked and to have negative effects on health outcomes. Interestingly, however, 64% of study participants were diagnosed with clinical depression, yet 89% of those did not report feelings of helplessness. Notably, participants in the 89% group also discussed social support in positive ways.

Broader still, the social context of TB patients' lives is acknowledged. Several authors (Aghanwa & Erhabor, 1998; Deribew et al., 2010; Vega et al., 2004; Westaway & Wolmarans, 1992) spotlight the role that poverty and stigma play in depression, anxiety, and TB. For example, Aghanwa and Erhabor (1998) investigated possible links between psychopathology and sociodemographic characteristics of TB patients, including occupation and income. Comparing a TB patient group and two control groups matched for age and gender, the authors found that more than 30% of TB patients experienced mild depressive episodes, generalized anxiety, and adjustment disorder, and that these disorders were inversely associated with socio-economic position and linked to experiences of stigmatization. Deribew et al. (2010) found that the risk of depression and anxiety was higher in TB-HIV patients who had no income or low income and who perceived themselves to be stigmatized and in poor health. And 81% of Westaway and Wolmarans' (1992) participants were unemployed or underemployed, 51% were the family's primary income-earner, and yet only 5% earned income during hospitalization. This calls attention to poverty, not only as a pre-existing condition for many TB patients, but also as a condition exacerbated by TB management protocols themselves, such as lengthy hospitalization, and by depressive disorders that can impair one's ability to work.

Poverty is also implicated in Macq, Solis, Martinez, Martiny, and Dujardin's (2005) analysis of stigma in TB. Although specific psychiatric diagnoses were not identified, these authors cite the need to address the sadness, loss of confidence, and depression that TB patients experience as a result of the attitudes/reactions of others. Several sources of stigma are identified, including patients' and others' contradictory feelings and behaviours, relational power dynamics (including those with health-care providers), and the health information delivered by professionals. Macq et al. argue that TB-related stigma is compounded by low social status and poverty, opening the way for even further subjugation of patients by health professionals, which in turn negatively affects mental health. They suggest strengthening the psychosocial component of TB care through capacity-building with patients and frontline health workers and changing structural models of care delivery. Supporting this idea of the importance of system-level change, Vega et al. (2004) comment that although depression declined in their program over time, the stressors of poverty and stigma persisted.

In summary, the reviewed studies provide compelling evidence of the high correlation of TB and depression and anxiety along with related clinical and social issues. Validated screening and diagnostic tools were used (HADS, BDI, ICD-9, DSM) and psychiatric specialists were consulted. Yet, as Singer and Clair (2003) argue, such codifications conceptualize disease as "an objective, clinically identifiable, and hence boundable entity" (p. 424), which may lead researchers and decision-makers to use similarly bounded approaches that often minimize such contextual issues as culture, disparity, and stigma. Conversely, while studies focused on the social level, such as those addressing stigma,[2] contribute to an overall understanding of the complexity of conditions affecting health, this kind of research tends to remain detached from the biomedical concerns and bodily experiences of TB and depression. Additionally, immigration is generally absent as a focal point in these studies. Although the suicide case studies presented by Nolan et al. (1988) might tell important stories of the immigrant experience, the authors' analysis and recommendations remain strictly biomedical; the resettlement stress associated with

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[2] Note that those articles in the review that addressed stigma in more depth (e.g., Jimenez, 2003) were not included here because common mental disorders were not highlighted explicitly.

migration and its role in depression goes unacknowledged as an important area of intervention. This absence of an immigrant-health focus highlights the need for further research, particularly in Canada. For example, these articles collectively beg a question regarding the central notion of isolation: How best to integrate what we know about the physical isolation that TB requires, the often self-induced isolation that depression invites, and the social isolation that stigma engenders? This question becomes more complex in situations of migration, a process that can confound social and physical isolation. This review also complements, as described elsewhere (Bender, Hyman, Guruge, & Janjua, 2012), the guidelines recently published in the *Canadian Medical Association Journal* for working with immigrants and refugees (Pottie et al., 2011).

International Lessons for the Canadian Context

From a syndemic perspective, a strictly biomedical or traditional epidemiological approach is insufficient. Similarly, a social perspective is important but taken on its own can marginalize very real and pressing biological and population health concerns, and is therefore also insufficient. Thinking synergistically helps to generate interdisciplinary, intersectoral, multi-intervention strategies for improved health (including mental health) outcomes (see Edwards, Mill, & Kothari, 2004). Despite their lack of explicit attention to immigrants, the studies offer valuable lessons for Canadian TB professionals. There is a need to focus interventions on reducing the negative mental health consequences of TB for immigrants through appropriate screening and monitoring for mental disorders; use TB programs more comprehensively as an entry point for mental health services; and examine how poverty, stigma, and other social conditions contribute to depression and anxiety for these patients and then develop treatment models that are culturally and contextually consistent.

More specifically, the literature reflects the importance of treatment adherence in the management of TB and links successful adherence with engaging psychiatric services for TB patients with altered mental status or mood. However, an emphasis on this goal alone could shift providers' attention away from meaningfully exploring the synergistic effects of everyday stressors — interpersonal, social, and treatment-related — and limit the psychotherapeutic potential of their daily encounters with patients. Furthermore, emphasis on adherence as the primary population health mandate of TB professionals may sideline critical discussion of power dynamics reflected in personal attitudes towards patients.

Following from this, health education as a recommended strategy for reducing stigma (Aghanwa & Erhabor, 1998; Bhasin et al., 2001; Deribew et al., 2010) is challenged by Macq et al.'s (2005) articulation of healthcare providers' subjugation of the "ignorant" patient. Despite their best intentions, health professionals may inadvertently display belittling attitudes towards the recipients of their educative efforts. In the enthusiasm for transmitting knowledge to uninformed patients, other forms of stigma may be reinforced. Thus superficially applied education strategies are inadequate. The synergies of TB, depression and anxiety, and stigma demand comprehensive programming that allows sufficient time for trusting relationships to develop; promising initiatives in this vein have been reported (Macq et al., 2005; Vega et al., 2004).

Third, racialization is a relevant social phenomenon when contemplating who are most affected by TB in the world, yet this is not explored in the literature. For example, despite the identification of Black patients in the title and introduction of the study by Westaway and Wolmarans (1992), no rationale is given for this racial focus and the possible intersections of race, stigma, depression, and TB remain unacknowledged. Nolan et al. (1988) single out South Asian refugees in Seattle but, similarly, race is an invisible dimension of these "cases." And though race is not mentioned in the remaining studies, possibly because of the homogeneity of groups in these study locations, the confluence of racism, a particularly troubling form of stigma, is an important issue in mental disorders (Hyman, 2009) and TB (Farmer, 1997) and for places like Canada where racialized groups account for 75% of newcomers (Hyman, 2009).

The review indicates that research is needed to further examine TB standards and guidelines. In an era of evidence-based practice, how do TB practices incorporate evidence regarding mental health and how might such programs be structured? For example, the article by Toth, Fackelmann, Piggott, and Tolomeo (2004) is one of the very few published in Canada that focuses directly on TB nursing. It highlights the establishment of trust as central when issues such as culture and mental illness affect treatment. Still, while establishing trust is vital, it is only the first step in planning for and intervening in complex situations of migration, TB, and mental disorders. The real challenge for practising nurses lies in translating biomedical and epidemiological knowledge into culturally appropriate action and introducing tailored, tested psychotherapeutic interventions to improve mental health and ameliorate or prevent mental disorders.

Finally, this review has shown that Canadians have much to gain by taking a more global position on what constitutes best evidence around the world. There can be a tendency in high-income countries to pass over research carried out in low- and middle-income countries as not relevant for "our" context. Yet this review demonstrates that information and innovations originating in these countries hold promise for the

Canadian context. The synergies of infectious diseases like TB and mental disorders like depression greatly affect the world's population and therefore must be understood across geographical, cultural, and sociopolitical contexts to ensure that local treatment and support strategies are relevant for those receiving care.

References

Aamir, S., & Aisha. (2010). Co-morbid anxiety and depression among pulmonary tuberculosis patients. *Journal of the College of Physicians and Surgeons Pakistan, 20*(10), 703–704.

Aghanwa, H. S., & Erhabor, G. E. (1998). Demographic/socioeconomic factors in mental disorders associated with tuberculosis in southwest Nigeria. *Journal of Psychosomatic Research, 45*(4), 353–360.

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19–32.

Beiser, M. (2005). The health of immigrants and refugees in Canada. *Canadian Journal of Public Health, 96,* 30–44.

Bender, A., Hyman, I., Guruge, S., & Janjua, M. (2012). Addressing the intersections of tuberculosis, mental disorder, and their underlying social conditions in immigrant health: A scoping review from a syndemics perspective. In A. Sobrun-Maharaj, S. Parackal, F. Rossen, S. Nayar, E. Ho, J. Hand, et al. (Eds.), *Social environment, migration and health: Proceedings of the Fifth International Asian and Ethnic Minority Health and Wellbeing Conference* (pp. 160–169). Auckland: University of Auckland. Retrieved August 5, 2012, from http://www.fmhs.auckland.ac.nz/soph/centres/cahre/_docs/2012_Conference_Proceedings.pdf.

Bhasin, S. K., Mittal, A., Aggarwal, O. P., & Chadha, R. K. (2001). Illness behaviour of tuberculosis patients undergoing DOTS therapy: A case-control study. *Indian Journal of Tuberculosis, 48,* 81–85.

Coker, R. (2004). Compulsory screening of immigrants for tuberculosis and HIV. *British Medical Journal, 328*(7435), 298–300.

Coreil, J., Mayard, G., Simpson, K. M., Lauzardo, M., Zhu, Y., & Weiss, M. (2010). Structural forces and the production of TB-related stigma among Haitians in two contexts. *Social Science and Medicine, 71*(8), 1409–1417.

Deribew, A., Tesfaye, M., Hailmichael, Y., Apers, L., Abebe, G., Duchateau, L., et al. (2010). Common mental disorders in TB/HIV co-infected patients in Ethiopia. *BMC Infectious Diseases, 10,* 201–201.

DesMeules, M., Giri, N., & Grondin, D. (2010). Migration health: Emerging perspectives. *Health Policy Research Bulletin* (Health Canada), 7(December), 3–6.

Edwards, N., Mill, J., & Kothari, A. R. (2004). Multiple intervention research programs in community health. *Canadian Journal of Nursing Research, 36*(1), 40–54.

Farmer, P. (1997). Social scientists and the new tuberculosis. *Social Science and Medicine, 44*(3), 347–358.

Freudenberg, N., Fahs, M., Galea, S., & Greenberg, A. (2006). The impact of New York City's 1975 fiscal crisis on the tuberculosis, HIV, and homicide syndemic. *American Journal of Public Health, 96*(3), 424–434.

Ganesan, S., Mok, H., & McKenna, M. (2011). Perception of mental illness: Preliminary exploratory research at a cross-cultural outpatient psychiatric clinic. *International Journal of Social Psychiatry, 57*(1), 81–89.

Gardam, M., Verma, G., Campbell, A., Wang, J., & Khan, K. (2009). Impact of the patient-provider relationship on the survival of foreign-born outpatients with tuberculosis. *Journal of Immigrant and Minority Health, 11,* 437–445.

Hansson, E., Tuck, A., Lurie, S., & McKenzie, K., for Task Group of the Services Systems Advisory Committee, Mental Health Commission of Canada. (2010). *Improving mental health services for immigrant, refugee, ethno-cultural and racialized groups: Issues and options for service improvement.* Retrieved February 2, 2011, from http://www.mentalhealthcommission.ca/SiteCollection Documents/Key_Documents/en/2010/Issues_Options_FINAL_English% 2012Nov09.pdf.

Husain, M. O., Dearman, S. P., Chaudhry, I. B., Rizvi, N., & Waheed, W. (2008). The relationship between anxiety, depression and illness perception in tuberculosis patients in Pakistan. *Clinical Practice and Epidemiology in Mental Health, 4*(4), 1–5.

Hyman, I. (2001). *Immigration and health.* Working paper 01-05, Health Policy Working Paper Series. Ottawa: Health Canada. Retrieved February 2, 2011, from http://courseweb.edteched.uottawa.ca/pop8910/Notes/Immigrant %20health%20in%20Canada.pdf.

Hyman, I. (2004). Setting the stage: Reviewing current knowledge on the health of Canadian immigrants. *Canadian Journal of Public Health, 95*(3), 4–8.

Hyman, I. (2009). *Racism as a determinant of immigrant health.* Ottawa: Public Health Agency of Canada and Metropolis Canada. Retrieved February 2, 2011, from http://canada.metropolis.net/pdfs/racism_policy_brief_e.pdf.

International Classification of Diseases (ICD-9). (2012). Bethesda, MD: National Library of Medicine, National Institutes of Health. Retrieved February 2, 2011, from http://icd9cm.chrisendres.com/index.php?srchtype=mesh&srchtext=mental+disorders&Submit=Search&action=search.

Jiminez, A. D. (2003). Playing the blame game: Casting guilt and avoiding stigma during a tuberculosis health crisis. *International Journal of Sociology and Social Policy, 23*(6/7), 80–114.

Kirmayer, L. J., Narasiah, L., Muñoz, M., Rashid, M., Ryder, A. G., Guzder, J., et al. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal, 183*(12), E959–E967.

Lekas, H. M., Siegel, K., & Leider, J. (2011). Felt and enacted stigma among HIV/HCV-coinfected adults: The impact of stigma layering. *Qualitative Health Research, 21*(9), 1205–1219.

Littleton, J., & Park, J. (2009). Tuberculosis and syndemics: Implications for Pacific health in New Zealand. *Social Science and Medicine, 69,* 1674–1680.

Littleton, J., Park, J., Thornley, C., Anderson, A., & Lawrence, J. (2008). Migrants and tuberculosis: Analysing epidemiological data with ethnography. *Australian and New Zealand Journal of Public Health, 32*(2), 142–149.

Long, R., & Ellis, E. (2007). *Canadian tuberculosis standards* (6th ed.). Ottawa: Public Health Agency of Canada and Canadian Lung Association/Canadian Thoracic Society.

Macq, J., Solis, A., Martinez, G., Martiny, P., & Dujardin, B. (2005). An exploration of the social stigma of tuberculosis in five "municipios" of Nicaragua to reflect on local interventions. *Health Policy, 74*(2), 205–217.

Manoharam, E., John, K. R., Joseph, A., & Jacob, K. S. (2001). Psychiatric morbidity, patients' perspectives of illness and factors associated with poor medication compliance among the tuberculous in Vellore, South India. *Indian Journal of Tuberculosis, 48,* 77–80.

Mill, J., Edwards, N., Jackson, R., Austin, W., MacLean L., & Reintjes, F. (2009). Accessing health services while living with HIV: Intersections of stigma. *Canadian Journal of Nursing Research, 41*(3), 168–185.

Milstein, B. (2008). *Hygeia's constellation: Navigating health futures in a dynamic and democratic world.* Atlanta: Syndemics Prevention Network, Centers for Disease Control and Prevention. Retrieved February 2, 2011, from http://www.uic.edu/sph/phtpg/Content/Reading%20Room/Articles/Hygeia's_constellation_Milstein.pdf.

Mustanski, B., Garofalo, R., Herrick, A., & Donenberg, G. (2007). Psychosocial health problems increase risk for HIV among urban young men who have sex with men: Preliminary evidence of a syndemic in need of attention. *Annals of Behavioral Medicine, 34*(1), 37–45.

Naidoo, P., & Mwaba, K. (2010). Helplessness, depression, and social support among people being treated for tuberculosis in South Africa. *Social Behaviour and Personality, 38*(10), 1323–1334.

Natani, G. D., Jain, N. K., Sharma, T. N., Gehlot, P. S., Agrawal, S. P., Koolwal, S., et al. (1985). Depression in tuberculosis patients: Correlation with duration of disease and response to anti-tuberculosis chemotherapy. *Indian Journal of Tuberculosis, 32,* 195–198.

Nolan, C. M., Elarth, A. M., & Barr, H. W. (1988). Intentional isoniazid overdosage in young Southeast Asian refugee women. *Chest, 93*(4), 803–806.

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., et al. (2011). Guidelines: Evidence-based clinical guidelines for immigrants and refugees. *Canadian Medical Association Journal, 183*(12). Retrieved September 10, 2011, from http://www.cmaj.ca/content/183/12/E824.full.pdf+html.

Public Health Agency of Canada. (2009). *Notifiable diseases on-line: Tuberculosis.* Retrieved February 2, 2011, from http://dsol-smed.phac-aspc.gc.ca/dsol-smed/ndis/diseases/tubr_e.html.

Public Health Agency of Canada. (2010). *Tuberculosis in Canada 2008 – Pre-release.* Ottawa: Minister of Public Works and Government Services Canada. Retrieved February 2, 2011 from http://www.phac-aspc.gc.ca/tbpc-latb/pubs/tbcan08pre/index-eng.php.

Singer, M. (1994). AIDS and the health crisis of the US urban poor: The perspective of critical medical anthropology. *Social Science and Medicine, 39*(7), 931–948.

Singer, M. (2004). Critical medical anthropology. In C. R. Ember & M. Ember (Eds.), *Encyclopedia of medical anthropology: Health and illness in the world's cultures* (pp. 23–30). New York: Kluwer Academic/Plenum.

Singer, M., & Clair, S. (2003). Syndemics and public health: Reconceptualising disease in bio-social context. *Medical Anthropology Quarterly, 17*(4), 423–441.

Stall, R., Mills, T. C., Williamson, J., Hart, T., Greenwood, G., Paul, J., et al. (2003). Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men. *American Journal of Public Health, 93*(6), 939–942.

Stein, D. J., Phillips, K. A., Bolton, D., Fulford, K. W., Sadler, J. D., & Kendler, K. S. (2010). What is a mental/psychiatric disorder? From DSM-IV to DSM-V. *Psychological Medicine, 40,* 1759–1765.

Toth, A., Fackelmann, J., Pigott, W., & Tolomeo, O. (2004). Tuberculosis prevention and treatment: Occupational health, infection control, public health, general duty staff, visiting, parish nursing or working in a physician's office – All nursing roles are key in improving tuberculosis control. *Canadian Nurse, 100*(9), 27–30.

Trenton, A. J., & Currier, G. W. (2001). Treatment of comorbid tuberculosis and depression. *Primary Care Companion to the Journal of Clinical Psychiatry, 3*(6), 236–243.

Vega, F., Sweetland, A., Acha, J., Castillo, H., Guerra, D., Fawzi, M. C. S., et al. (2004). Psychiatric issues in the management of patients with multidrug-resistant tuberculosis. *International Journal of Tuberculosis and Lung Disease, 8*(6), 749–759.

Westaway, M. S., & Wolmarans, L. (1992). Depression and self-esteem: Rapid screening for depression in Black, low literacy, hospitalized tuberculosis patients. *Social Science and Medicine, 35*(10), 1311–1315.

World Health Organization. (2004). *Global burden of disease.* Retrieved February 2, 2011, from http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf.

World Health Organization. (2008). *The stop TB strategy: Building on and enhancing DOTS to meet the TB-related Millennium Development Goals.* Retrieved February 2, 2011, from http://whqlibdoc.who.int/hq/2006/WHO_HTM_STB_2006.368_eng.pdf.

World Health Organization. (2011). *Global tuberculosis control.* Retrieved August 5, 2012, from http://www.who.int/tb/publications/global_report/2011/gtbr11_main.pdf.

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Résumé

Les tensions dans le cadre d'une recherche anticoloniale : les leçons tirées d'une collaboration avec une communauté autochtone touchée par l'industrie minière

C. Susana Caxaj, Helene Berman, Colleen Varcoe, Susan L. Ray, Jean-Paul Restoule

Les infirmières et les infirmiers qui font de la recherche communautaire visent à développer des partenariats de collaboration qui répondent aux priorités des participants en matière de santé et qui sont pertinentes à leurs réalités sociopolitiques. Dans un contexte d'iniquité mondiale, la dynamique entre les parties privilégiées et les parties opprimées façonne inévitablement le processus de recherche, générant des tensions, des contradictions et des défis auxquels il faut faire face. Cet article a trois objectifs : examiner le contexte politique dans lequel les entreprises minières opèrent; décrire les menaces à la santé et les défis courants que les communautés touchées par l'industrie minière doivent affronter; et réfléchir sur la recherche effectuée en collaboration avec une communauté autochtone touchée par des activités minières au Guatemala et dont la santé et la capacité de défendre ses droits subissent l'impact d'un héritage colonial. Utilisant une analyse anticoloniale, les auteurs discutent de trois tensions importantes : les organismes communautaires et la victimisation collective; les similitudes et les identités distinctes; et la volonté d'atteindre des résultats et de mettre en lumière les limites. Ils concluent avec des suggestions méthodologiques à l'intention des infirmières et des infirmiers chercheurs dont le travail est fondé sur une approche anticoloniale.

Mots clés : communautés autochtones, industrie minière, héritage anticolonial, iniquité mondiale, victimisation communautaire; identités distinctes

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Tensions in Anti-colonial Research: Lessons Learned by Collaborating With a Mining-Affected Indigenous Community

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Community-based nurse researchers strive to develop collaborative partnerships that are meaningful to the health priorities of participants and relevant to their sociopolitical realities. Within the context of global inequity, intersecting forces of privilege and oppression inevitably shape the research process, resulting in tensions, contradictions, and challenges that must be addressed. This article has 3 purposes: to examine the political context of mining corporations, to describe common health threats and challenges faced by mining-affected communities, and to reflect on research with a mining-affected Indigenous community in Guatemala whose health and capacity for self-advocacy are impacted by a legacy of colonialism. Using an anti-colonial lens, the authors discuss 3 central tensions: community agency and community victimhood, common ground and distinct identities, and commitment to outcomes and awareness of limitations. They conclude by offering methodological suggestions for nurse researchers whose work is grounded in anti-colonial perspectives.

Keywords: Indigenous health, anti-colonial, global inequity, mining, community-based research, research relationships, cross-cultural

Introduction

The past decade has seen the emergence of a body of nursing research focusing on peoples marginalized by broad contextual forces, including historical and ongoing colonization (e.g., Berman et al., 2009; Browne & Varcoe, 2006). Scholars engaging in such research must confront multiple tensions. In this article we reflect on strategies for addressing these issues, learned by conducting anti-colonial community-based research with a mining-affected Indigenous community. Research approaches such as these can be used to support nurses in meeting their obligations to safeguard and promote human life and dignity and to raise awareness about the root inequities that affect the health of communities globally (Canadian Nurses Association [CNA], 2009, 2011; International Council of Nurses, 1998).

The global dominance of the Canadian mining sector and its health implications underscore the importance of mining issues to both national and global nursing mandates. Research indicates that mining companies often threaten the well-being of host communities by violating Indigenous rights, operating without community consent, altering local ecosystems, triggering social conflicts and gendered violence, limiting access to food and water, and exacerbating poverty (Coumans, 2009; Gonzales-Parra & Simon, 2008; Imai, Mehranvar, & Sander, 2007; Simpson, 2009). The connections among environment, society, interpersonal relationships, and health are foundational to nursing knowledge (Chinn & Kramer, 2008). Therefore nurses are well positioned to address the threats that mining operations pose to well-being.

An anti-colonial lens is a way of theorizing, re-articulating, and challenging colonial relations (Dei, Hall, & Rosenberg, 2000). This perspective is important because the well-being of Indigenous communities is situated in historical and political landscapes (Alfred, 2009). Although employed for some time by academics (e.g., Fanon, 1963; LaDuke, 2005), anti-colonial thought has divergent origins stemming from a diversity of Indigenous knowledges embodied both physically and spiritually (Shahjahan, 2005). Thus, while an anti-colonial perspective shares the aims of counter-hegemony, social justice, and emancipation, it has unique histories, structures, and concepts that distinguish it from critical theories (Kovach, 2009). Key to an anti-colonial perspective is the acknowledgement that colonialism is a contemporary reality, not a thing of the past (Endres, 2009). Further, this perspective requires awareness that Indigenous people have always resisted colonization (Shahjahan, 2005). Anti-colonial approaches seek to emulate this spirit of resistance by articulating spaces of epistemological pluralism, particularly *indigenous ways of knowing,* critiquing and addressing colonial systems of oppression, *remembering* a legacy of colonialism, and honouring and respecting Indigenous self-determination (Castellano, 2000; Tuhiwai Smith, 1999). Anti-colonial research is a deeply politicized process that critiques, challenges, and employs Western knowledge (Tuhiwai Smith, 1999). Consequently, it requires ongoing contestation of power, privilege, and normative ontologies and epistemologies (Brunanski, 2009).

The purpose of this article is to analyze central tensions inherent in collaborative research from an anti-colonial stance based on our experience with mining-affected communities. By *collaborative research,* we mean a researcher-community partnership in which a project, from design to dissemination of results, develops through ongoing dialogue with communities about their priorities and their identified needs and objectives.

First, we review the political context that shapes the conduct of mining companies in general. Next, we discuss common health threats and challenges experienced by communities directly affected by mining operations. Finally, we reflect on our recent experiences conducting research with a mining-affected community.

Political Context

Over 75% of the world's transnational mining companies are based in Canada (Foreign Affairs and International Trade Canada, 2009). These companies have enjoyed increased rights through a pattern of liberalized trade and investor protection (Gordon & Webber, 2008; McCarthy, 2004). In some cases, lawyers and development agents sponsored by the Canadian government have been tied to the revision and reformulation of mining codes and laws in foreign countries (Gordon, 2010; Kuditshini, 2008). Under pressure from the World Bank and the International Monetary Fund, one half of the world's nations have changed their mining laws to make them more attractive to foreign investment (Gedicks, 2010; Munarriz, 2008). Such changes often involve corporate deregulation, removal of corporate taxes, and breaking down of trade restrictions with the promise of economic prosperity (Falk-Raphael, 2006; O'Connor & Montoya, 2010). Yet consistently low national royalties, frequent *maquila* (a Mexican term for industrial operations in free trade zones), and reports of exacerbated poverty in mining towns call into question the economic benefits of the industry (Gordon & Webber, 2008; Kuditshini, 2008). Transnational companies and allied government officials have sought to lower standards of safety and environmental protection, or "non-tariff barriers," in drawing up trade agreements under the rhetoric of "competitive" corporate practices (Grossman, 2000). Documented health impacts of such policies include malnutrition, treatment inaccessibility, increased health disparities, increased exposure to contaminants, food insecurity, and a weakening of public health systems (Gilmore et al., 2004; Labonte, 2004; Mann, 2011; Schäfer Elinder, 2003). As noted by Skjærseth et al. (2004), trade agreements are premised on a financial determinism that excludes the social or environmental indicators necessary to sustain the well-being of diverse communities.

Indigenous movements often articulate a rejection of this business model of development. Such struggles are historically connected to and are in opposition to colonial constructions of whiteness and superiority (Tuhiwai Smith, 1999). Lawrence (2002) notes that colonialism must be understood as a "concerted process of invasion and land theft" shaped by racist state policies that normalize violence against Indigenous peoples (p. 26). For instance, the appropriation of northern Ontario, largely fuelled by mineral and mining exploration, was enabled by the Department of Indian Affairs, which often forcibly relocated Indigenous peoples viewed as a hindrance to the establishment of exploration activities (Lawrence, 2002). *Resource colonialism* targets the homelands of Indigenous communities worldwide because they contain untapped resources for industrial development. It requires the ignoring of land ownership and other distinct rights through the legal/political construction of Indigenous communities as "dependent domestics," undermining Indigenous sovereignty and ownership (Endres, 2009; Gedicks, 2010).

Globally, colonial legacies of oppression continue to manifest in the everyday health experiences of Indigenous communities (Estrada, 2009) and thus are important to our understanding of the contemporary context of Indigenous communities affected by mining. Political persecution and violence (Fiddler & Peerla, 2009; O'Connor & Montoya, 2010; Vanderbroucke, 2008), lack of consultation with and respect for Indigenous leadership (Sherman, 2009), and threats to socio-cultural-spiritual structures (Alfred, 2009), as well as land dispossession and forced displacement (Gonzales-Parra & Simon, 2008; Whiteman, 2009), indicate that colonial mechanisms are still central to the imposition of mining operations worldwide. Mining operations are often backed by the Western rhetoric of development in which the economic systems and ways of life of local communities are portrayed as primitive and backward (Alfred, 2009; Endres, 2009). There are many reports of silencing, marginalization, and inferiorization of community views of economic development that are based on sustainability, spirituality, survival, and environmental conservation (Shriver & Webb, 2009; Whiteman, 2009). The acts may involve appropriation or misrepresentation of Indigenous cultures, reification of corporations as agents of "development," construction of Indigenous peoples as helpless (Endres, 2009; Gedicks, 2010), and criminalization and intimidation of Indigenous leaders (Holden, Nadeau, & Jacobson, 2011).

Community Health Implications

Mining poses environmental and human health risks to communities worldwide. Risks relate to industrial contamination (Obori, Dodoo, Okai-Sam, & Essumang, 2006; Sherman, 2009; Thomas, Irving, Lyster, & Beaulieu, 2005), water depletion, lack of corporate accountability (Grossman, 2000), and poor regulation. For some communities, mining may also have a direct negative impact on traditional/subsistence activities, such as hunting, fishing, and agriculture, thus threatening community food security (Pereira et al., 2009; Simpson, 2009; Tsuji et al., 2005). Mining operations can release high levels of heavy metals and toxins into the environment that endanger human health for decades (Colin, Villegas,

& Abate, 2012; Rodrigues et al., 2012). Even at low levels, synergistic/chronic exposure to these pollutants can introduce health harms that are not yet fully understood (Fowler, Whittaker, Lipsky, Wang, & Chen, 2004; Grandjean & Landrigan, 2006).

For many Indigenous communities affected by industrial megaprojects, psychological impacts are tied closely to economic, cultural, and social threats (Endres, 2009; Richmond & Ross, 2008). These close-knit relationships have been observed when considering the economic impact of mining operations on mining towns. The dependence of a community on mining operations makes it vulnerable to a volatile mining market with regular "boom and bust" cycles. This imposed dependence results in a community sense of vulnerability, uncertainty, and powerlessness that can manifest as anxiety, fear, or depression (Coumans, 2009). Further, the presence of mining operations can trigger psychological suffering expressed as grief, loss, fear, social division, increased alcohol abuse, and violence against women (Coumans, 2009; Gibson & Klinck, 2009; Munarriz, 2008) These mental health challenges, including substance abuse, have also been observed among mining workers in northern communities in Canada as a result of this same uncertainty as well as high-stress work demands (Glibson & Klinck, 2009).

Adding to these stressors are the militarization of Indigenous territory and the violent displacement of Indigenous peoples through mining concessions (Renfrew, 2011; Szablowski, 2002). Even if companies have relocation programs in place, residents often suffer from a loss of homes, productive lands, social supports, and self-determination, as well as a sense of powerlessness, alcoholism, gendered vulnerability, and a disruption of their spiritual practices (Ahmad & Lahir Dutt, 2006; Gonzales-Parra & Simon, 2008; Szablowski, 2002). This process, coined the "resettlement effect," is marked by a loss of social sustainability, or *new poverty* (Downing, 2002).

Whether mining can be conducted in a way that introduces little threat to the environmental health and well-being of residents is a matter of debate. Strategies identified for responsible corporate mining include recognizing land title, increasing job opportunities, timely environmental impact assessments, and proper/respectful application of traditional knowledge (Gibson & Klinck, 2009; Paci & Villebrun, 2005). Yet minimal environmental-social-corporate regulation, a global liberalized market that incentivizes a lowering of public health and safety standards, and limited state responsibility to communities may overshadow any community benefit (Howlett, Seini, McCallum, & Osborne, 2011; Kuditshini, 2008; Larmer, 2005).

Research Procedures

The aim of this research was to examine (1) the possible systemic impact of mining operations on the health of Indigenous communities, and (2) how resistance by communities is a resource for health promotion. In this research context, we understood resistance as an inherent or intuitive counterpoint to oppression (Sandoval, 2000; Shaw, 2001). The survival of Indigenous communities, in the face of systematic mechanisms devised for their extermination, is a testament to their diverse strengths and their tactics of resistance (Castellano, 2000). Viewed through an anti-colonial lens, resistance is enacted via reclamation of one's relationship to the land (Alfred, 2009), protection of community sovereignty (Sherman, 2009), anti-racist stances, demilitarization (Munarriz, 2008), and survival (Chrisjohn et al., 2002; Lawrence, 2002).

This research, conducted with Indigenous community members in San Miguel Ixtahuacán, San Marcos, Guatemala, constituted the first phase of a larger study. That study examined how global forces shape the experiences of unique Indigenous mining communities through conversations with Indigenous peoples within the nation-state borders of Canada as well as Guatemala. We wished to incorporate an analysis of transnational actors and determinants that operate across borders to shape the health of mining-affected communities.

The anti-colonial narrative study was developed through a 2-year process of dialogue and engagement with community leaders and well-established community groups working in the region. A narrative methodology facilitated the telling of community members' stories and was aimed at privileging marginalized narratives and their sociopolitical contexts (Finley, 2008; Kovach, 2009) and at co-constructing a space for creative agency, anti-colonial revisions, and Indigenous ways of knowing (Bishop, 1996; Brunanski, 2009; Castellano, 2000; Chadwick, 1997). We were also guided by principles of participatory action research such as reciprocity, relevance, addressing power and privilege, and working towards community ownership (Castleden, Garvin, & Huu-ay-aht First Nation, 2008; Freire, 1999).

With the participation of members of FREDEMI (Coalition for the Defence of San Miguel Ixtahuacán), local Catholic parish leaders and associations, and the Association for Holistic (Integral) Development in San Miguel Ixtahuacán, we were able to recruit 54 diverse participants. Included were men and women between the ages of 27 and 68 who collectively represented 14 villages within the municipality of San Miguel Ixtahuacán. During her 4-month stay, the first author, with the help of community leaders, visited each village three to five times. During the first visit, the study was introduced and its purpose described and any questions that community members had were addressed. While check-ins and soliciting of consent were ongoing, subsequent visits were more focused on health experiences and well-being, with groups of four to six individuals participating in each 60-to-90-minute interview. During each visit, the first author would report back on key issues and narrative themes that she had taken away from the previous interview in order for participants to challenge, elaborate on, or revise her accounts. This was a purposeful strategy designed to include community leaders in the first phases of analysis. The discussions continued following data collection, in formal meetings and telephone consultations.

Navigating Tensions: Reflecting on the Research Process

Here, we examine three central tensions encountered in the research that may be relevant for other scholars conducting research with anti-colonial intentions: (1) community agency and community victimhood, (2) common ground and distinct identities, and (3) commitment to outcomes and limitations. The pronoun "I" will be used — referring to the first author — as much of the discussion is based on her personal experiences and reflections.

Community Agency and Community Victimhood

Nurse researchers have stressed the need to capitalize on the initiatives and strengths of communities in order to work towards health objectives that are relevant and synergistic (Lind & Smith, 2011). Yet researchers have consistently observed that community health experiences are rooted in material and sociopolitical realities that are shaped by oppressive and systemic forces of inequity (Anderson et al., 2009; Gracey & King, 2009). Often, these perspectives have been constructed as distinct and dichotomous, obfuscating either the strengths of residents or the political inequities experienced by a community. For instance, collaborating residents stressed the need to illustrate both the impact of mining on community health and the social, political, and economic factors that enabled the company to impose its operations on the region. On the other hand, residents discussed agricultural projects and cultural and educational programs they were organizing to address the key health priorities of the community, explaining that support would be needed to ensure their success. One resident engaged in mining resistance said, "It can't be mining, mining, mining all the time; we also have to be thinking about . . . the future, alternatives."

These different perspectives were evident from the initial phases of the research. In one village meeting held to describe the project to a group of women, the women expressed frustration and concern that the proposed research would just be "another outsiders' project." The women explained that visitors often gathered information to develop media for a North American/Western European audience but in their view these projects had done little to benefit them or their community. They were reluctant to continue to volunteer information, as they felt betrayed in having shared personal and intimate stories with these outsiders.

While the problem appeared to be partly related to a lack of communication or transparency about the goal of a given project, from my perspective it also related to contradictory constructions of agency and victimhood. From watching a variety of media cover community members' experiences, I interpreted many of the documentarians or authors as purposefully and effectively shedding light on the "realities" of their situation. Yet the narrated experience of community members had been distanced from the community members themselves, as it stressed their victimization and subsequent reaction to the event. This rhetorical strategy, which placed an emphasis on women as symbols of victimization — in this case, gendered victimization — was intended to provide insights into particular injustices. Yet these accounts did not convey a true sense of the formal organization and planning in which the women were continuously engaged and did not incorporate the women's long-term visions. These omissions raise important questions. How do we balance the telling of an unjust experience without betraying the strength of participants?[1] And if victimhood is uniquely gendered and/or racialized, among other social intersections, how do we walk the line between reification of helplessness/inferiorization and acknowledgement of oppressive realities? For researchers seeking to address these tensions, the concern relates not only to silencing agency and subjectivity, but also, at the other extreme, romanticizing communities' experiences in the process of showcasing strengths and resilience (Bathum, 2007).

When some residents learned about the present research project, they stressed the urgency of their situation and the need for outsiders to draw attention to their suffering and the threats to their health. Receptivity to the research was often linked to the hope that I would bring a unique expertise and understanding to an issue that some community members, particularly those with little formal education, felt they were lacking. Being viewed as an authority was a challenge for me, because I wished to highlight the unique perspectives and knowledge of residents. If par-

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[1] We do not wish to convey the notion that agency and victimhood are the only possibilities here; on the contrary, we wish to illustrate their binary constructions, which researchers undertaking this type of work must address.

ticipants considered me the expert, there was a risk that their knowledge and experience would be devalued. On the other hand, many community members had experienced a multitude of health threats, including political persecution, gendered violence, and social exclusion, concurrent with the opening of the mine. Often, these individuals had a profound sense of obligation to be strong spokespersons for the resistance movement, while also facing threats to their own well-being and even their lives. In these cases, acknowledging victimhood became the focus as the interview became a relational process of sharing, *being believed,* and being supported. These frontline leaders clearly understood the political power inherent in claiming victimhood, and thus easily deconstructed the dichotomy of victimhood and agency.

Throughout my visits, I spoke with participants about the aims and intended audiences of the research. In communities where residents were aware of the limitations and potential of receiving international attention, talking openly about this possibility helped to ensure that the data collection and dissemination processes were not only acceptable to residents but also consistent with the long-term goals of the community. The conversations developed organically as participants grew confident that they understood how the data were to be used. This was apparent when residents would stress a particular event or issue, reminding me of the importance of including it in any report, or pointing out omitted themes when I would paraphrase or summarize earlier conversations. Interviews also served as an opportunity to "set things right." Participants reported that the mining company would often take credit, in its public relations campaigns, for work it had not been responsible for or would carry out a superficial initiative to boost its image without making a meaningful commitment to the community. Residents would exclaim, "Lies! That's not how we live" or "That happens, but not because of the mine — we do that ourselves."

As noted by Swadener and Mutua (2008), one of the aims of anticolonial research is to interrogate both the process and the outcome of the research in order to challenge hegemonic power relations inherent in research environments. Considering intended audiences, the long-term vision of community members, the emotional needs of participants, and transparency in the research process can shape how individuals in mining-affected communities negotiate agency and victimhood. Equally important to this process are positions of privilege, the role of community advocates, and corporate misrepresentations. Leaving room in group conversations for iterative meaning-making and purposeful planning with respect to intended audiences can facilitate an awareness and a cooperative approach in addressing these tensions.

Common Ground and Distinct Identities

The building of long-term, authentic relationships is at the core of community-based research (Estey, Kmetic, & Reading, 2008). Achieving this ideal involves constant scrutiny and questioning of the researcher's privilege and social position, which can shape the research process. The researcher must also genuinely engage with individuals' realities, moving past superficial curiosity to explore the reciprocal/personal in finding common ground. Yet identifying with a community's struggle can be problematic if it results in the appropriation or erasure of differences and inequity. On the other hand, placing an emphasis solely on privilege and difference can lead to missionary posturing whereby the researcher fails to grasp the interdependence of human beings and takes on the role of saviour or educator. The practice of research demands a joining together across differences towards "transformative solidarities," always aware of the constant risk of privileging certain perspectives while marginalizing others (Canella & Manuelito, 2008).

I sought to avoid the trappings of these two positions, a stance that challenged me to constantly revisit my own privileges, personal history, and identity. Throughout this reflective process, I found Noy's (2008) discussion of "tourist privilege" to be helpful. Tourist privilege refers to social advantages such as fluency in globally dominant languages, citizenship, money, and education, all of which facilitate access and mobility. I felt that these forms of privilege — my fluency in both Spanish and English, enrolment in a North American university, Canadian citizenship, and access to financial resources — had provided me with the ability to carry out this research, and indeed to initiate the project. More difficult to analyze was how these privileges informed my personal history as a racialized Mestiza woman and Guatemalan refugee.

During my time in the community I participated in some community events. One of these was a workshop on historical memory that was also attended by some of the research participants. The workshops sought to ensure nationwide awareness of the 36-year genocide in Guatemala's recent past. After one of the sessions I was approached by a participant. She had been particularly moved by a video account of a Q'uiche Mayan woman who had fled to Mexico during the years of state violence. The participant believed that this woman resembled me. Knowing that I was Guatemalan-born, she asked about my own history. I explained that my family had left the country after the state-ordered assassination of two of my uncles and death threats against my father, and that I was indeed of Q'uiche (and Kachiquel) descent. As a refugee raised in Canada — my identity constantly regulated/challenged — I was moved by the compassion shown by this woman, who felt connected to me and insisted that I should move back to Guatemala to "be in your home where you belong." I shared my history with many participants; it seemed to be an important step towards mutual understanding and a sense of common aims and struggles.

At other times I listened as community members told one another that I was of Q'uiche ancestry. I interpreted this re-telling as an expression of camaraderie and trust. Yet it was difficult for me to accept this identity, as I felt that my personal background was not in keeping with what a "Q'uiche background" — the Q'uiche were the most targeted Indigenous group in Guatemala during the genocide — seemed to signify for residents. My family had been targeted not because of their indigeneity per se but rather because of their participation in the progressive politics and community organizing that are viewed as a threat in any totalitarian regime. As is the case in most colonial states, my ancestors had been discouraged from learning their language and passing on their customs to their children. My family could offer little more than a sense of pride in our heritage. I wanted to reject a colonial and linear interpretation of indigeneity in which time ensures erasure or extinction (Tuhiwai Smith, 1999), yet my access to Western power made it difficult for me to feel secure in embracing an Indigenous identity. Other Mestiza authors have also documented contradictory identities and the implications for community research (Amado, 2012).

Some residents thought of me as solely Canadian. Often, thinking strategically, they were interested in how my position could bring about policy change or raise awareness in Canadian society about injustices inflicted upon their community. While this was a more comfortable identity for me, because it ensured acknowledgement of my position of privilege, it also implied the construction of "benevolent foreigner." Seeing me in this light, some community members were inclined to thank me for my "help," apparently construing my research project as a donation or a social investment. Other Western academics have noted that perceptions of their research are largely shaped by the political and economic contexts of inequity; if the research process is left unchecked, the research project runs the risk of becoming paternalistic (Batham, 2007; Moffat, 2006). I was mindful of ways in which my research could reify and reinforce hegemonic power relations. Consequently, I hoped that the research space would encourage a discussion of contexts/incidents of inequity/unfairness, the interdependent nature of the injustice(s), and the need for global accountability. Other nurse scholars have recommended dialogue as a strategy for developing collective consciousness about contextual inequities, an understanding of how they are relationally experienced, and a moral impetus for action (Anderson et al., 2009; Peter, 2011).

In group discussions I often reflected on my social position and privileges for the sake of transparency and reciprocity. For instance, if participants spoke of family members being forced to work in plantations abroad, their constant worry about deportation, and the dangers involved in crossing borders, I would disclose the ease with which I had entered their community. We would talk about the double standard whereby Canadian companies and workers could enter their community and stay as long as they liked while even visiting relatives in Canada or the United States was close to impossible for them. For me, it was important that community members know the specifics of my situation so that a sense of commonality or camaraderie would not camouflage the privilege in which my research project was situated. Awareness of one's multiple and intersecting identities, particularly as they change relative to space and time, is a way to maintain a personal sense of authenticity while addressing the context and privilege in which the research is being carried out (Hulko, 2009). Discussing universal needs and rights threatened by mining operations in relation to our different backgrounds and experiences allowed us to examine our distinct positions as well as our overlapping struggles.

Commitment to Outcomes and Awareness of Limitations

During conversations with active and potential participants, many were focused on how the research could be used and how it could be of benefit to the community. This outlook should be at the core of all community-based research, particularly research with Indigenous and racialized communities where health and social science research have a long history of exploitative and discriminatory practices (Tuhiwai Smith, 1999). Further, Indigenous communities often report being "over-researched" yet underserviced and overlooked, indicating that much research has failed to address key concerns or priorities of community members (Sunseri, 2007).

When research is conducted with communities facing a broad array of health challenges with limited health services and infrastructure and widespread poverty, it will inevitably fall short of comprehensively addressing the community's concerns. In mining-affected communities, if health concerns are connected to corporate misconduct, expectations for health research are high due to the extreme risks to health and human survival. This not only puts pressure on the research but also may introduce a coercive element into the research process. If community members believe that the research is needed, will they volunteer beyond their comfort level or with little attention to their own safety? If community members expect more of the research than it can deliver, has informed consent truly been obtained?

In any research process, practices of ongoing consent (Chih Hoong, 2005) and safety protocols (McCosker, Barnard, & Gerber, 2001) can be put in place to partially address these ethical issues. However, there is also an ideological tension that requires continuous engagement with research participants through adequate and ongoing communication as the research process evolves. As group interviews developed into rich and comprehensive stories, I tried to orient conversations towards an action focus. For instance, I would ask, What would you like to see happen with all the information that has been collected? If residents shared what they envisaged for dissemination, we would be able to work towards concrete first steps. I was also then able to be open about any practical limitations that I anticipated.

Other participants were more focused on the long-term goal and hence less interested in discussing incremental ways that the research could contribute. These participants articulated a bottom line: The mining company had to leave the community and cease its expansion activities. I had always anticipated that the project I was undertaking would be one of many, but I had not considered the extent to which the research would have to be linked to ongoing advocacy work and community projects and initiatives. The realization that community priorities were much more oriented towards long-term goals served as a reminder that my research, too, would need to have a long-term vision in order to be truly congruent with community priorities.

Following data collection, I have worked with community members to map out a research dissemination strategy considered relevant and beneficial to the community. Over one morning and afternoon, approximately 100 community members met to consider potential projects. Through a voting process, they decided to carry out a community-led health tribunal — a participatory and public forum to formally address and legitimize community health concerns (www.healthtribunal.org). Inspired by initiatives such as the Water Rights Tribunals in Mexico (Weaver, 2011), this event brought together scientists, journalists, activists, and community leaders. With a focus on community testimonials, an international jury considered (1) what impact Goldcorp, the mining company, has on the region; and (2) whether Goldcorp has the social licence to operate in the region. Momentum around the event exceeded expectations, as communities throughout MesoAmerica and Guatemala, where residents have expressed health concerns related to Goldcorp's mining operations, were able to participate. Residents are hopeful that the event will serve to bring greater international awareness about the health threats wrought by Goldcorp and, further, to provide a local source of support and capacity-building for community members. We are hopeful that this project, while not a simple process, will inform a collaborative and long-term struggle for global health and justice in Guatemala and beyond.

Conclusion

In anti-colonial research, the research environment is shaped by the same threats and challenges that face research participants. Mining operations introduce multiple threats and challenges for Indigenous communities throughout the world. Nurses must play a central role in both documenting and addressing this issue. Understanding community strengths and acts of resistance can help to both inform and articulate community priorities. Acknowledging privilege, finding common ground/shared histories, anticipating systemic barriers, coordinating with credible groups/institutions, and being cognizant of the tension between documenting oppression and community agency are important steps in building meaningful community-research relationships. Researchers should be mindful that there can be no short-term or easy resolution of systemic global injustices. Investigators must promote a transparent dialogue on the limitations, tensions, and potential of their study. Most importantly, researchers must remain present and committed to working with communities to achieve their long-term goals.

References

Ahmad, N., & Lahir-Dutt, K. (2006). Coal mining displacement and rehabilitation in India engendering mining communities. *Gender, Technology and Development, 10,* 313–339.

Alfred, A. T. (2009). Colonialism and state dependency. *Journal of Aboriginal Health,* 5(2), 42–60.

Amado, M. L. (2012). The "*New Mestiza*," the Old *Mestizos*: Contrasting discourses on *Mestizaje. Sociological Inquiry, 82,* 446–459.

Anderson, J., Rodney, P., Reimer-Kirkham, S., Browne, A., Khan, K. B., & Lynam, M. J. (2009). Inequities in health and healthcare viewed through the ethical lens of critical social justice. *Advances in Nursing Science, 32,* 282–294.

Bathum, M. E. (2007). Global health research to promote social justice: A critical perspective. *Advances in Nursing Science, 30*(4), 303–314.

Berman, H., Alvernaz Mulcahy, G., Forchuk, C., Edmunds, K., Haldenby, A., & Lopez, R. (2009). Uprooted and displaced: A critical narrative study of homeless, Aboriginal, and newcomer girls in Canada. *Issues in Mental Health Nursing, 30,* 418-430.

Bishop, R. (1996). *Collaborative research stories: Whakawanaungatanga.* Auckland: Dunmore.

Browne, A. J., & Varcoe, C. (2006). Critical cultural perspectives and healthcare involving Aboriginal peoples. *Contemporary Nurse, 22*(2), 155–167.

Brunanski, D. M. (2009). *Counselling with Aboriginal street youth: An Aboriginalizing narrative inquiry.* Unpublished master's dissertation, University of British Columbia.

Canadian Nurses Association. (2009). *Registered nurses, health and human rights.* Ottawa: Author. Retrieved July 30, 2012, from http://www2.cna-aiic.ca/CNA/documents/pdf/publications/PS116_Health_and_Human_Rights_2011_e.pdf.

Canadian Nurses Association. (2011). *Position statement: Global health and equity.* Ottawa: Author. Retrieved July 30, 2012, from http://www2.cna-aiic.ca/CNA/documents/pdf/publications/PS106_Global_Health_Equity_Aug_2009_e.pdf.

Canella, G. S., & Manuelito, K. D. (2008). Feminisms from unthought locations: Indigenous worldviews, marginalized feminisms, and revisioning an anticolonial social science. In N. K. Denzin, Y. S. Lincoln, & L. Tuhiwai Smith (Eds.), *Handbook of critical and Indigenous methodologies* (pp. 45–59). London: Sage.

Castellano, M. B. (2000). Updating Aboriginal traditions of knowledge. In G. J. S. Dei, B. L. Hall, & D. G. Rosenberg (Eds.), *Indigenous knowledges in global contexts: Multiple readings of our world* (pp. 21–36). Toronto: University of Toronto Press.

Castleden, H., Garvin, T., & Huu-ay-aht First Nation. (2008). Modifying photovoice for community-based participatory Indigenous research. *Social Science and Medicine, 66,* 1393–1405.

Chadwick, A. (1997). *Blood as narrative/narrative as blood: Constructing Indigenous identity in American Indian and New Zealand Maori literature and politics.* Unpublished doctoral dissertation, University of Arizona.

Chih Hoong, S. (2005). Seeking informed consent. *Sociology, 39,* 2277–2294.

Chinn, P. L., & Kramer, M. K. (2008). *Integrated theory and knowledge development in nursing.* New York: Mosby.

Chrisjohn, R. D., Wasacase, T., Nussey, L., Smith, A., Legault, M., Loiselle, P., et al. (2002). Genocide and Indian residential schooling: The past is present. In R. D. Wiggers & A. L. Griffiths (Eds.), *Canada and International Humanitarian Law: Peacekeeping and war crimes in the modern era.* Halifax: Dalhousie University Press.

Colin, V. L, Villegas, L. B., & Abate, C. M. (2012). Indigenous microorganisms as potential bioremediators for environments contaminated with heavy metals. *International Biodegradation, 69*(1), 28–37.

Coumans, C. (2009). Research on contested ground: Women, mining and health. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 3*(1), 9–32.

Dei, G. J. S., Hall, B. L., & Rosenberg, D. G. (Eds.). (2000). *Indigenous knowledges in global contexts: Multiple readings of our world.* Toronto: University of Toronto Press.

Downing, T. E. (2002). *Avoiding new poverty: Mining-induced displacement and resettlement.* Paper 58. London: International Institute for Environment and Development.

Endres, D. (2009). The rhetoric of nuclear colonialism: Rhetorical exclusion of American Indian arguments in the Yucca Mountain Nuclear Waste Siting Decision. *Critical/Cultural Studies, 6,* 39–60.

Estey, A., Kmetic, J., & Reading, J. (2008). Knowledge translation in the context of Aboriginal health. *Canadian Journal of Nursing Research, 40*(2), 24–39.

Estrada, A. L. (2009). Mexican Americans and historical trauma theory: A theoretical perspective. *Journal of Ethnicity in Substance Abuse, 8*(3), 330–340.

Falk-Rafael, A. (2006). Globalization and global health: Toward nursing praxis in the global community. *Advances in Nursing Science, 29*(1), 2–14.

Fanon, F. (1963). *The wretched of the earth.* New York: Grove Press.

Fiddler, A., & Peerla, D. (2009). The Kitchenuhmaykoosib Inninuwug and the struggle for the right to say no. *Journal of Occupational Science, 16*(1), 10–11.

Finley, S. (2008). Arts-based research. In G. J. Knowles & A. L. Cole (Eds.), *Handbook of the arts in qualitative research: Perspectives, methodologies, examples and issues* (pp. 71–81). Thousand Oaks, CA: Sage.

Foreign Affairs and International Trade Canada. (2009, March). Building the Canadian advantage: *A corporate social responsibility (CSR) strategy for the Canadian international extractive sector.* Ottawa: Author. Retrieved February 25, 2012, from www.international.gc.ca/trade-agreements-accords-commerciaux/ds/csr-strategy-rse-strategie.aspx?view=d.

Fowler, B. A., Whittaker, M. H., Lipsky, M., Wang, G., & Chen, X. Q. (2004). Oxidative stress induced by lead, cadmium and arsenic mixtures: 30-day, 90-day, and 180-day drinking water studies in rats. An overview. *Biometals, 1,* 567–568.

Freire, P. (1998). *Pedagogy of the oppressed.* New York: Continuum.

Gedicks, A. (2010). Resource wars against Native peoples in Colombia. *Capitalism Nature Socialism, 14*(2), 85–111.

Gibson, J., & Klinck, G. (2009). Canada's resilient north: The impact of mining on Aboriginal communities. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 3*(1), 115–139.

Gilmore, A., Österberg, E., Heloma, A., Zatonski, W., Delcheva, E., & McKee, M. (2004). Free trade versus the protection of health: The examples of alcohol and tobacco. In L. Maclehose, M. McKee, & E. Nolte (Eds.), *Health policy and European Union enlargement* (pp. 198–224). Milton Keynes: Open University Press.

Gonzales-Parra, C., & Simon, J. (2008). All that glitters is not gold: Resettlement, vulnerability and social exclusion in the Pehuenche Community Ayin Mapu, Chile. *American Behavioral Scientist, 51,* 1774–1789.

Gordon, T. (2010). Positioning itself in the Andes: Critical reflections on Canada's relations with Colombia. *Canadian Journal of Latin American and Caribbean Studies, 35,* 51–85.

Gordon, T., & Webber, J. R. (2008). Imperialism and resistance: Canadian mining companies in Latin America. *Third World Quarterly, 29*(1), 63–87.

Gracey, M., & King, M. (2009). Indigenous health. Part 1: Determinants and disease patterns. *Lancet, 374*(9683), 65–75.

Grandjean, P., & Landrigan, P. J. (2006). Developmental neurotoxicity of industrial chemicals. *Lancet, 368*(9553), 2167–2178.

Grossman, P. (2000). Corporate interest and trade liberalization: The North American Free Trade Agreement and environmental protection. *Organization and Environment, 13*(1), 61–85.

Holden, W., Nadeau, K., & Jacobson, R. D. (2011). Exemplifying accumulation by dispossession: Mining and Indigenous peoples in the Philippines. *Geografiska Annaler: Human Geography, 93,* 141–161.

Howlett, C., Seini, M., McCallum, D., & Osborne, N. (2011). Neoliberalism, mineral development and Indigenous people: A framework for analysis. *Australian Geographer, 42,* 309–323.

Hulko, W. (2009). The time- and context-contingent nature of intersectionality and interlocking oppressions. *Affilia, 24*(1), 44–55.

Imai, S., Mehranvar, L., & Sander, J. (2007). Breaching Indigenous law: Canadian mining in Guatemala. *Indigenous Law Journal, 6*(1), 101–129.

International Council of Nurses. (1998). *Nurses and human rights.* Geneva: Author. Retrieved July 30, 2012, from http://www.icn.ch/images/stories/documents/publications/position_statements/E10_Nurses_Human_Rights.pdf.

Kovach, M. (2009). *Indigenous methodologies.* Toronto: University of Toronto Press.

Kuditshini, J. T. (2008). Global governance and local government in the Congo: The role of the IMF, the World Bank, the multinationals and the political elites. *International Review of Administrative Sciences, 74,* 195–216.

Labonte, R. (2004). Globalization, health, and the free trade regime: Assessing the links. *Perspectives on Global Development and Technology, 3*(1/2), 47–72.

LaDuke, W. (2005). *Recovering the sacred: The power of naming and claiming.* Cambridge, MA: South End.

Larmer, M. (2005). Reaction and resistance to neo-liberalism in Zambia. *Review of African Political Economy, 32,* 29–45.

Lawrence, B. (2002). Rewriting histories of the land: Colonization and Indigenous resistance in eastern Canada. In S. Razack (Ed.), *Race, space, and the law* (pp. 21–46). Toronto: Between the Lines.

Lind, L., & Smith, D. (2011). Analyzing the state of community health nursing: Advancing from deficit to strengths-based practice using appreciative inquiry. *Advances in Nursing Science, 31*(1), 28–41.

McCarthy, J. (2004). Privatizing conditions of production: Trade agreements as neoliberal environmental governance. *Geoforum, 35,* 327–341.

McCosker, H., Barnard, A., & Gerber, L. (2001). Undertaking sensitive research: Issues and strategies for meeting the safety needs of all participants. *Forum: Qualitative Social Research, 2*(1), art. 1.

Moffat, C. (2006). Development unmoored. In G. J. S. Dei & A. Kempf (Eds.), *Anti-colonialism and education: The politics of resistance* (pp. 211–242). Toronto: Sense Publishers.

Munarriz, G. J. (2008). Rhetoric and reality: The World Bank development policies, mining corporations, and Indigenous communities in Latin America. *International Community Law Review, 10,* 431–443.

Noy, C. (2008). Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. *International Journal of Social Research Methodology, 11*(4), 327–344.

Obori, S., Dodoo, D. K., Okai-Sam, F., & Essumang, D. K. (2006). Non-cancer health risk assessment from exposure to cyanide by resident adults from the mining operations of Bogoso Gold Limited in Ghana. *Environmental Monitoring Assessment, 118,* 51–63.

O'Connor, D., & Montoya, J. P. B. (2010). Neoliberal transformation in Colombia's goldfields: Development strategy or capitalist imperialism? *Labour, Capital and Society, 43,* 85–118.

Paci, C., and Villebrun, N. (2005). Mining Denendeh: A Dene Nation perspective on community health impacts of mining. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 3,* 71–86.

Pereira, R., Marques, C. R., Silva Ferreira, M. J., Neves, M. F. J. B., Caetano, A. L., Antunes, S., et al. (2009). Phytotoxicity and genotoxicity of soils from an abandoned uranium mine area. *Applied Soil Ecology, 42*(3), 209–220.

Peter, E. (2011). Fostering social justice: The possibilities of a socially connected model of moral agency. *Canadian Journal of Nursing Research, 43*(2), 11–17.

Renfrew, D. (2011). The curse of wealth: Political ecologies of Latin American neoliberalism. *Geography Compass, 5,* 581–194.

Richmond, A. M., & Ross, N. A. (2008). Social support, material circumstance and health behaviour: Influences on health in First Nation and Inuit of Canada. *Social Science and Medicine, 67,* 1423–1431.

Rodrigues, S. M., Henriques, B., Reis, A. T., Duarte, A. C., Pereira, E., Romkens, P. F. A., et al. (2012). Transfer from contaminated soils to plants and animals. *Environmental Chemistry Letters, 10*(1), 61–67.

Sandoval, C. (2000). *Methodology of the oppressed.* Minneapolis: University of Minnesota Press.

Schäfer Elinder, L. (2003). *Public health aspects of the EU common agricultural policy.* Stockholm: National Institute of Public Health.

Shahjahan, R. A. (2005). Mapping the field of anti-colonial discourse to understand issues of Indigenous knowledges: Decolonizing praxis. *McGill Journal of Education, 40*(2), 213–240.

Shaw, S. M. (2001). Conceptualizing resistance: Women's leisure as political practice. *Journal of Leisure Research, 33,* 186–201.

Sherman, P. (2009). *Dishonour of the Crown: The Ontario resource regime in the Valley of the Kiji Sibi.* Winnipeg: Arbeiter Ring.

Shriver, T. E., & Webb, G. T. (2009). Rethinking the scope of environmental injustice: Perceptions of health hazards in a rural Native American community exposed to Carbon Black. *Rural Sociology, 74*(2), 270–292.

Simpson, L. (2009). Toxic contamination undermining Indigenous food systems and sovereignty. *Pimatiziwin: A Journal of Aboriginal and Indigenous Community Health, 1,* 129–134.

Skjærseth, J. R., Tangen, K., Swanson, P., Christiansen, A. C., Moe, A., & Lunde, L. (2004). *Limits to corporate social responsibility.* Lysaker, Norway: Fridtjof Nansen Institute.

Sunseri, L. (2007). Indigenous voice matters: Claiming our space through decolonising research. *Junctures, 9,* 93–106.

Swadener, B. B., & Mutua, K. (2008). Decolonizing performances: Deconstructing the global postcolonial. In N. K. Denzin, Y. S. Lincoln, & L. Tuhiwai Smith (Eds.), *Handbook of critical and Indigenous methodologies* (pp. 31–44). London: Sage.

Szablowski, D. (2002). Mining, displacement and the World Bank: A case analysis of Compañia Minera Antamina's operations in Peru. *Journal of Business Ethics, 39,* 247–273.

Thomas, P., Irving, J., Lyster, J., & Beaulieu, R. (2005). Radionuclides and trace metals in Canadian moose near uranium mines. *Health Physics, 88*(5), 423–428.

Tsuji, L. J., Manson, H., Wainman, B. C., Vanspronsen, E. P., Shecapio-Blacksmith, J., & Rabbitskin, T. (2005). Identifying potential receptors and routes of contaminant exposure in the traditional territory of the Ouje-Bougoumou Cree. *Environmental Monitoring and Assessment, 127*(1–3), 293–306.

Tuhiwai Smith, L. H. (1999). *Decolonizing methodologies: Research and Indigenous peoples.* London: Zed.

Vanderbrouke, E. (2008). *Environmental and socio-economic impacts of mining in Guatemala: The role of local communities and the ecological justice movement.* Unpublished thesis, Vrije Universiteit Brussel.

Weaver, M. A. (2011). El agua no se vende! Water is not for sale! The Latin American Water Tribunal as a model for advancing access to water. *Pepperdine Dispute Resolution Law Journal, 11*(3), art. 12.

Whiteman, G. (2009). All my relations: Understanding perceptions of justice and conflict between companies and Indigenous peoples. *Organization Studies, 30*(1), 101–120.

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Résumé

Quitter les Philippines : récits oraux sur la transition que vivent les infirmières dans le processus d'adoption de pratiques infirmières canadiennes

Charlene Ronquillo

Les infirmières philippines constituent le plus important groupe d'infirmières immigrantes au Canada. Bien qu'elles comptent pour une grande proportion de la main-d'œuvre infirmière, nous avons peu d'information sur les contextes dans lesquels s'inscrivent leurs expériences individuelles d'immigration et de transition. Cette étude se penche donc sur les expériences de transition d'infirmières philippines ayant immigré au Canada entre 1970 et 2000. Utilisant les récits oraux comme cadre et méthode de travail, elle établit un corpus de travaux en examinant l'histoire de ce groupe d'infirmières en contexte canadien. Des entrevues individuelles ont été réalisées auprès de neuf infirmières philippines qui occupent des emplois dans deux provinces canadiennes. L'étude met en lumière les raisons qui ont fait que certaines infirmières ont tardé à entamer les démarches qui leur permettaient de devenir une infirmière autorisée : elles accordaient la priorité à leur famille; elles constataient que l'ajustement que nécessitaient le rôle et la portée de la pratique infirmière canadienne exigeait du temps; elles se sentaient comme des « étrangères » et avaient l'impression de devoir prouver qu'elles étaient compétentes aux yeux de leurs collègues canadiennes.

Mots clés : infirmières immigrantes, Philippines, main d'œuvre infirmière, transition, récits oraux, contexte canadien

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Leaving the Philippines: Oral Histories of Nurses' Transition to Canadian Nursing Practice

Charlene Ronquillo

Filipino nurses are the leading group of immigrant nurses in Canada, making up a substantial portion of the nursing workforce, yet little is known about the contexts surrounding their immigration and transition experiences at the individual level. This study examines the transition experiences of Filipino nurses who immigrated to Canada between 1970 and 2000. Using oral history as the framework and method, it establishes a body of work in examining the history of this group of nurses in a Canadian context. Individual interviews were conducted with 9 Filipino nurses working in 2 Canadian provinces. Findings suggest that nurses may have delayed the process of becoming a Registered Nurse because the family was considered a priority, they found that adjusting to the role and scope of Canadian nursing practice required time, and they felt "foreign" and sensed a need to prove their competence to Canadian nurses.

Keywords: immigration, migration, transition, Philippines, history of nursing, Canada, oral history, culture

Background

The Philippines is often identified as the leading producer of nurses for global export (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Bach, 2003; Lorenzo, Galvez-Tan, Icamina, & Javier, 2007). It has been identified as one of the main source countries of Registered Nurse (RN) immigrants for the Canadian workforce (Baumann, Blythe, Kolotylo, & Underwood, 2004; Canadian Institute for Health Information [CIHI], 2011). Recent statistics show that nurses from the Philippines make up Canada's largest group (31%) of RNs who graduated from an international nursing program in 2010 (CIHI, 2011). Considering the predicted shortage of nurses in North America in the coming years (Bach, 2003), the general trend of nurses migrating from the global South to the global North (Kaelin, 2011), and an overall increase in the immigration of health professionals, Canada continues to grow as an important destination country for Filipino nurses (Goode, 2009). To gain insight into the immigration and transition experiences of Filipino nurses in Canada and implications of these experiences, an important initial step is to explore the roots of this phenomenon. Therefore employing a historical lens to examine the context surrounding their experiences is timely.

The work of the historian Catherine Choy on the history of immigrant Filipino nurses in the United States highlights the importance of the colonial relationship between the United States and the Philippines and shows that the seemingly recent popularity of immigration and of nursing as a career choice for Filipinos is in fact deeply rooted in their country's colonial history. These roots lie in US efforts in the 1940s to popularize and promote immigration of Filipino nurses to the United States as a move towards educational and professional advancement (Choy, 2003). The US establishment of an Americanized model of nursing training and education in the Philippines in the early 20th century included the use of American textbooks focused on Western medical knowledge and with a substantial English-language component (Choy, 2003). The Westernized training model facilitated the initial migration of Filipino-trained nurses to the United States and arguably served as an important precondition for the mass emigration of Filipino nurses in the last decades of the 20th century (Choy, 2003; Kingma, 2006). Choy's seminal work emphasizes the importance of an oral history perspective in obtaining a detailed look at the life histories of this group. This approach provides a complementary perspective to dominant economic and policy discourses and also mitigates the common depiction of migrant health professionals as faceless workers (Choy, 2003, 2010).

> By bringing attention to the lived experiences of foreign-trained nurse migrants and immigrants, the theme of international immigration complements two new approaches to nursing history: the agenda to internationalize its frameworks and the call to move away from "great women, great events" and toward the experiences of seemingly "ordinary" nurses of nursing. (Choy, 2010, p. 15)

This study is part of a larger study providing a regional and personal picture of immigration as voiced by those who have experienced it first-hand. The larger study examines two distinct temporal periods: (1) the motivation surrounding the choice to pursue immigration and leave the Philippines, and (2) the transition experience and the process of integrating into the Canadian nursing workforce and Canadian life. The present study focuses on the transition period, the part played by social, cultural, and historical influences in the transition experiences of the group, and how these influences have coalesced at the individual level. The research question for the part of the study presented here was as follows: *How are the motivations behind the decision to migrate and the transition to the Canadian workforce and Canadian life remembered by RNs who have emigrated from the Philippines?*

Global Transition of Nurse Migrants

An increasingly globalized world is facilitating the rapid movement and growth in numbers of migrant nurses. With some countries taking in a larger number of immigrant nurses each year, there is an increased focus on immigrant nurses' transition experience — the process of acculturating to work and life in the host country. A systematic review of transitional programs for internationally educated nurses (IENs) in the United States found that many studies focus on the effectiveness of transitional programs (Zizzo, 2009). A number of studies have explored the experiences of migrant nurses employed by the National Health Service in the south of England (Alexis, Vydelingum, & Robbins, 2007; Allan, Larsen, Bryan, & Smith, 2004; Daniel, Chamberlain, & Gordon, 2001; Withers & Snowball, 2003). Some of these studies report contradictory findings on support received by Filipino nurses from their British counterparts (Alexis et al., 2007; Daniel et al., 2001; Matiti & Taylor, 2005). A meta-synthesis of the experiences of immigrant Asian nurses working in Western countries found four overarching themes in the literature: the daunting challenges of communication; marginalization, discrimination, and exploitation; cultural differences; and differences in nursing practice (Xu, 2007).

Studies discussing the transition experiences of IENs in Canada are emerging. Early work reveals challenges similar to those reported in the British and American literature, such as language and communication barriers to workplace integration (Blythe & Baumann, 2009). Canadian studies similarly reveal difficulty becoming registered in Canada as a significant challenge for IENs, including a tendency to underestimate the amount of time and effort required to complete the process (Blythe, Baumann, Rheaume, & McIntosh, 2009).

Nurse Immigration History: Race, Gender, and Identity

The exploration of nursing immigration history in Canada has been analyzed within the frameworks of gender, identity, and race, in an attempt to understand the experiences of immigrants. Caribbean nurses are one of the few groups of immigrant nurses for whom there exists a historiography in Canada. Calliste (1993) and Shkimba, Flynn, Mortimer, and McGann (2005) discuss the roles played by race, class, and gender in controlling Canadian immigration in the post–World War II period. Nursing historians have argued that a perceived shortage of nurses in Canada in the mid-20th century prompted changes in immigration policies to facilitate immigration of foreign nurses and their incorporation into the Canadian workforce (Calliste, 1993; Shkimba et al., 2005). Notably, race played a prominent role in shaping the recruitment of foreign nurses.

Calliste (1993) explores the different immigration policies based on the nurses' race and country of origin. For example, in the 1950s and early 1960s Caucasian nurses' general admissibility was sufficient for them to be admitted as permanent settlers. In contrast, Caribbean nurses were admitted only "as cases of exceptional merit," and it is argued that Canadian immigration policies were subsequently changed to further Canada's trade interests in the British Caribbean (Calliste, 1993).

Establishment of nursing education and practice in the Philippines is influenced heavily by its colonial ties with the United States in the mid-20th century. Therefore a historical context is essential to any analysis of Filipino nurses' experiences (Choy, 2003, 2010). Analyses of the global immigration of nurses often focus on economic- and health-policy issues as the dominant contextual frameworks (Calliste, 1993; Choy, 2003, 2010; Connell, 2008; Damasco & Knowles, 2008; Kelly, 2003, 2006; Kelly & D'Addario, 2004; Kingma, 2006, 2009; Lorenzo et al., 2007; Yeates, 2010). Recent work examining the contexts of Filipino nurses' immigration to Canada from a historical perspective solidifies the importance of the historical colonial US-Philippines relationship as well as the cultural and societal pressures that come into play in the nurses' immigration decision (Ronquillo, Boschma, Wong, & Quiney, 2011). The present study adds to this historical perspective through an analysis of oral histories in order to complement ongoing work with respect to Filipino nurses.

Oral History Study

Method and Framework

Oral history research involves interviews with a select group of individuals — those with firsthand knowledge of the event or period under study — and a narrative of each individual's experiences in the context of the topic under study (Boschma et al., 2008). As both a method and a framework, oral history provides a bottom-up view, highlighting the everyday experiences of ordinary people (Boschma et al., 2008; Burke, 2001; Thompson, 2000). Experiences are captured in oral history research as they are presented by participants, complete with their possible ambiguities, disorganization, complexities, and inconsistencies (Boschma et al., 2008). Instead of a chronological and concrete telling of history, the focus is on how events are experienced, interpreted, and remembered by individuals (Sugiman, 2004). Oral history does not focus on the events themselves but instead explores the meaning that speakers give to their own experiences and how they view their relationship to their history (Boschma et al., 2008; Portelli, 1998). By examining how events are recollected over time, we gain insight into how they have shaped and coloured the individuals' perspectives on their experiences.

Sampling and Recruitment

This study examined the experiences of nine female Filipino nurse immigrants residing in the provinces of Alberta and British Columbia. Health-care structures in Canada are governed provincially and this study provides a regional look at the experiences of Filipino nurse immigrants in western Canada. Alberta and British Columbia have seen rapidly increasing numbers of new RN registrants from abroad, with numbers doubling in British Columbia and increasing fivefold in Alberta between 1999 and 2002 (Baumann et al., 2004).

Participants were recruited through purposive and snowball sampling, as the study called for individuals who had had particular experiences and were willing and able to share them. Volunteer third parties from the author's professional and personal networks initiated contact with potential participants and facilitated the recruitment process.

Ethics approval was granted by the University of British Columbia's Behavioural Research Ethics Board in the fall of 2009. The study was carried out from December 2009 to May 2010 inclusive.

Data Collection and Analysis

Written informed consent was obtained from all participants and interviews were conducted individually in person or by phone. Face-to-face interviews were conducted in locations convenient for participants. Some locations were public (coffee shops and restaurants) and others private (participants' homes). Participants were encouraged to speak freely and openly so that the nuances of their experiences could be captured. An open-ended script was used to guide the interviews. Consistent with oral history research methodology (Boschma et al., 2008), a semi-structured interview guide was used, but precedence was given to the stories that participants wished to tell.

All interviews were conducted by the author, digitally audiorecorded, and stored on a secure drive on the author's password-protected personal computer. All recordings were transcribed by the author and de-identified during transcription. Quotes that appeared unclear were checked with the interviewee for clarification. All participants were assigned pseudonyms.

Transcripts were analyzed and concepts related to motivations for migrating to Canada, and experiences related to the transition to becoming an RN in Canada, were identified. Sub-themes were identified across the transcripts, facilitated by continuous comparison between narratives as they were produced. The oral historian Alice Hoffman (1974) describes validity in oral history methodology as "the degree of conformity between the reports of the event and the event itself as recorded by other primary resource material such as documents, photographs, diaries, and letters" (p. 29). Using Hoffman's description as a guideline, the study employed continuous comparison between the oral history narratives and the literature on the events. In this way, participants' experiences could be contextualized and placed within the historical, social, and cultural influences that ultimately shaped their experiences. Broad themes were identified from the data as a whole.

Results

Participant Demographics

Of the nine participants, eight were practising as RNs at the time of the interview and one was on medical leave. All nine women had completed their nursing education in the Philippines. They ranged in age from early thirties to late fifties. Seven participants had a baccalaureate degree in nursing and two had graduated from hospital-based schools of nursing. Dates of departure from the Philippines ranged from 1974 to 2004. Five participants had lived and worked as RNs in other countries (Austria, Saudi Arabia, United Arab Emirates, United Kingdom, United States) prior to arriving in Canada. Five migrated with other family members and four as individuals. Seven migrated with the aid of a sponsor and two entered Canada through the Live-In Caregiver Program. Two nurses migrated independently, without aid from a sponsoring person or agency. Five of the nine participants indicated that they provided financial support to family members in the Philippines, either regularly or according to their family's needs.

Family First, Nursing Later

The concept of the loyal, cohesive family is central to the Filipino identity (Wolf, 1997). The narratives revealed that, for these nurses, family cohesiveness often took priority over any professional goals they may have had upon arrival in Canada and the need to provide immediate financial support and other familial responsibilities often took precedence. One consequence of putting the family first was a delay in obtaining RN registration in Canada. Often, this was coupled with being unaware of the amount of additional time and education required in order to register and work as a nurse in Canada. RNs who had worked in other countries where their Filipino nursing education and experiences were deemed equivalent were particularly frustrated by these delays.

Many recalled that their entry to Canada coincided with a period in their lives when they began to raise a family. To contribute to the financial support of their families, many nurses first worked for a number of years as care attendants or nurse's aides until they were able to obtain RN registration. Participants recalled that it became "comfortable" to continue working as aides or assistants indefinitely; they valued a guaranteed income over their career pursuits. (All names presented hereafter are pseudonyms.) Carmen was sponsored upon entering Canada by her grandparents and arrived at a time when nursing standards and reciprocity for IENs in Canada were beginning to change. Upon her arrival in 1974, she was able to obtain a graduate nurse position in a small town in Alberta. After taking time off to start a family, she found that the situation for IENs in Canada had changed:

> *When I'm ready to come back, I can't come back as a graduate nurse any more . . . I worked as a nursing aide. And actually I worked for a long time as a nursing aide. I was really comfortable . . . having a family . . . you never really think of [going back to school]. Until I got a call from [the registrar in] Edmonton, and they're saying: What are you going to do? Are you going to still take your exam, or what?*

Carmen recalled the registrar's persistence in encouraging her to pursue nursing registration in Canada. After working as a graduate nurse and nurse's aide for 16 years, she obtained her RN licence in 1991. She emphasized that she had wanted to complete the registration process immediately after re-entering the workforce but the demands of her new family took priority. Carmen's story mirrors the experiences of many of the nurses: Starting a family and establishing a nursing career in Canada came to be at odds.

A number of nurses explained that familial relationships were an important reason for choosing to immigrate to Canada versus another country. Nurses who actively chose Canada as a destination country often did so in order to bring their families together. Lydia recalled:

> *My husband got his immigrant visa here [in Canada]. He applied when he was single and I was waiting to be a citizen back in the States. It would take at least 3 more years before we can be together. Because we have a son . . . I have to sacrifice [US citizenship] . . . basically because of my husband. That's why I came here.*

For Alida, similarly, the hope of joining her sister was what she recalled as the reason for migrating to Canada. Alida was working as a nurse in the United Kingdom when both she and her sister in the Philippines decided to apply for immigration to Canada. Other than the wish to join her sister, Alida made no mention of any personal desire to come to Canada. While Alida was in the midst of the immigration process, her sister opted to remain in the Philippines to be with her own family. Alida shared the trade-off and challenges she faced in choosing to immigrate:

> *Being away from the family. Alone. Loneliness. You can never handle it. I've been away but you never get used to loneliness, I guess. It's always going to be there. Also [pause] depression. I got depression when I got here . . . [The] loss is not being able to be there for your family. But the gain is being able to financially support them. And, yeah, the loneliness too. Being away and being alone.*

In Filipino culture the cohesive and loyal family is of utmost importance (Oxman-Martinez, Hanley, & Cheung, 2004; Wolf, 1997). The participants in this study often brought up the concept of sacrifice. They put their family before their own wishes and either postponed pursuing their RN career in Canada or came to Canada based on a family decision.

Nursing in Canada: Different Expectations

Expectations and experiences of autonomy varied between those nurses who immigrated to Canada directly and those who first worked in another country. Nurses who immigrated to Canada directly indicated their need for a period of adjustment to new expectations of them as nurses, with additional decision-making responsibilities, as well as a significant difference in their working relationships with physicians. Some, like Patricia, who arrived in Canada in 1999, had initial reservations:

> *Back home, doctors, they're like gods. You can't even talk to them . . . you can't be on a first-name basis there. Here, oh my gosh! The doctors, they treat the nurses better . . . they treat nurses here with respect. They acknowledge that nurses have good knowledge of what they are doing, and they [nurses] are not just there saying yes to whatever they [doctors] want. They accept suggestions and you know you could tell them what you're thinking. Back home, we can't do that . . . I never go on a first-name basis with the doctor even though I know them. I can't help it. I'm never comfortable, even though they treat you nice and all that. I never assume we're equal because I was always taught that you were always . . . one step under them.*

Despite initial reservations, however, the increased expectations and less hierarchical relationships between nurses and physicians were described as a welcome change. Lonnie reflected:

> *Oh, Philippines and Dubai is almost the same. You're just following what the doctor said. We cannot decide. Unlike here, [where] we can decide on our own. We have our own nursing . . . I enjoy [here in Canada] because you can decide before calling a doctor . . . You have your own judgement, instead of calling the doctor right away . . . because they [doctors] don't like it also. I like that you have independence here.*

Lucita, who graduated from nursing school in the Philippines in 1974, also described a positive change in the relationship between nurses and doctors:

> *It's quite different [in Canada]. Once you know the doctor, they want you to call them by their first name. You never call them, back home, with their first name. And, you know, back home, like, when the doctor comes around, you stand up. But here it's different. And the thing I like here too is that the doctor listens to you. If you say something to the doctor, like, "This patient has a problem," they listen to you. And if patients complain about nurses . . . the doctor is going to back you up too. So I like that.*

The consistency of the nurses' perceptions of the physician–nurse relationship in the Philippines, whether they attended nursing school in the 1970s or in the 1990s, was notable. Nurses expressed feelings of being valued and respected by physicians in Canada, contrasting with their experiences in the Philippines. This change was described as giving them the confidence necessary for the increased autonomy as well as encouraging critical thinking and interdisciplinary teamwork. The participants needed a period of acclimatization to fully accept the increased expectations of nurses. Despite the period of adjustment, they believed that the sharing of their knowledge and expertise was not only valued but expected and contributed to a remarkable and rewarding nursing experience in Canada.

Alida shared a different story about her transition to nursing in Canada, where she felt her autonomy was decreased. Alida worked as an RN in the United Kingdom prior to arriving in Canada and recalled the challenges in her transition:

> *Work is, way, way too different from the UK . . . Everything will be under the nurse's discretion. We don't have RTs [respiratory therapists] there. If the patient is bubbly and chesty, put a naso tube down, suction through the nose . . . I think because of the nursing autonomy you do more for the patient there, in a way. Like the ECG — patients complaining of chest pain, you do the ECG right then and there . . . Here, you have to call the technician.*

Although Alida's story was unique in that she experienced a decrease in autonomy, it similarly illustrates the challenges of transitioning to a different nursing culture.

Being Foreign: Proving Oneself and Perceptions of Discrimination

Experiences of adapting to work in Canadian hospitals and integrating into Canadian nursing culture varied among individuals. Some remembered being supported by nursing colleagues upon their entry to RN practice in Canada, while others recalled much more challenging experiences. The theme of having to prove oneself was consistent within the narratives. Lydia worked in the United States for a number of years and upon arriving in Canada was struck by the fact that she was the only Asian person attending the regional orientation. Lydia described feeling that she was constantly being tested because she had not received her education in Canada:

> *Most of them try to kind of test you, how good you are . . . so I have to prove myself to them by saying . . . "Yeah, I'm a graduate nurse for now, but I have experience back in the States. I've been a nurse back home [in the Philippines]." They try to test your abilities, I think, but when they see . . . how you work, then they will try to be more accepting. That's what I feel . . . Even in this unit, the first time I started, most of the senior ones, they're saying . . . "Oh, Filipino nurses are different because their curriculum is not the same" as the one that they have here . . . I can still feel it. But most of us Filipino nurses, we kind of get the respect of the people working there because they know how hard-working we are . . . Well, you're working in a foreign country, hey, so what do you expect? You have to live [up] to their expectations . . . You have to prove yourself all the time because you're not a graduate here.*

The choice of phrases like "how hard-working we are" seems to be an attempt to legitimize Filipino nurses as just as competent as their Canadian counterparts. Lydia later noted that although her initial experiences were unsettling, they were not surprising. Lonnie revealed a similar perspective:

> *Yes, there is discrimination. That is everywhere. Even in Dubai there's discrimination. Because you are a foreigner. For me, so far, I didn't experience. But I can observe . . . For example, here in Canada if you work in your unit they will ask you where you're from, you're graduated from Philippines, how you got an RN right away. Then they will expect you more. That's what I observed. They expect you more. Just to prove to them that you are an RN.*

The narratives as a whole indicate that, for these nurses, proving oneself meant being competent, experienced, qualified, and, most importantly, worthy of the respect of their colleagues. For many, the feeling of being foreign influenced the perception that colleagues did not view them as equal. It is notable that although most participants did not explicitly identify discrimination as an important transition issue, "feeling foreign" was consistently identified as an issue. Tess's comments illustrate this:

> *In [name of hospital] I felt like I was a foreigner. I felt like an outsider. I felt most of them are the older Caucasian group. So I really felt like, not that I'm not welcome, but I'm just different from all of them. I'm young, and then I'm not Canadian. But I didn't feel any discrimination.*

Although Tess described a sense of isolation as a result of feeling foreign initially, she also spoke at length of feeling welcomed and supported in her workplaces. Describing the workplace as a source of support was common in the narratives. Lucita remembered being unjustly treated by a patient, which she perceived as discriminatory:

> *I'm in tears and this patient giving me a hard time. And the next day my supervisor backed me up. . . . She talked to the patient. She said, "Do you know that she's the best nurse I have? And you're giving her a bad time and she's threatened to quit . . . because of you . . ." [laughing] So that's the only thing. They give you lots of support here. They don't let it just go by.*

The narratives reveal the participants' acknowledgement that discrimination was an unavoidable issue that would arise at one point or another. Despite claims that discrimination was not an issue upon their transition to practice, narratives consistently illustrated the significance of "feeling foreign" as an issue in transition.

Discussion

The goal of this study was to employ an oral history method and framework to explore how the transition experiences of a group of immigrant Filipino nurses in Canada were remembered. Familial responsibility and sacrifice, shifting expectations of what it means to be a nurse in Canada, and perceptions of "feeling foreign" and the need to prove oneself were common themes. The first theme of needing to put family first and the concept of sacrifice described in the narratives link with women's historical roles in the family, the cultural constructions of Filipino women, and the expectations associated with those ideals. Historically, it is well established that women's roles have been shaped by their need to successfully manage domestic, reproductive, and economic responsibilities (D'Antonio, 1999), and it has been suggested that gendered expectations of women will likely persist in the coming decades (Kan, Sullivan, & Gershuny, 2011). The ideological roots of Western cultural norms that define "good mothering" are based on the model of intensive mothering in the context of the nuclear family (Arendell, 2000). A core value of the social construct of what makes a "good mother" is the expectation that women will sacrifice personal gains for the good of the family and that familial responsibilities take priority (Liamputtong, 2006; Milkie & Peltola, 1999; Mintz &

Kellogg, 1988; Mottarella, Fritzsche, Whitten, & Bedsole, 2009; Vincent, Ball, & Braun, 2010). Personal sacrifice for the good of the family can be seen in several of the participants' stories. In the context of nursing, researchers have found that female Caribbean immigrant nurses are expected to provide for their families despite any personal sacrifices (Flynn, Feldberg, Ladd-Taylor, Li, & McPherson, 2003; Flynn & Henwood, 2000). Cultural values in which the family is of central importance reinforce the expectation that individuals, especially women, will put the needs of their family above their own. These cultural and gendered expectations may have contributed to the postponement of the interviewees' pursuit of RN registration in Canada in order to devote themselves to their families. Participants were expected to juggle multiple roles as a wife, mother, and nurse while prioritizing family cohesiveness.

The second theme is the unexpected shift in understanding of what it means to be a nurse in Canada. The disconnect between expectations and the reality of working as a nurse overseas is discussed in several studies (Dicicco-Bloom, 2004; Matiti & Taylor, 2005; McGonagle, Halloran, & O'Reilly, 2004), which illustrates that the issue is not unique to Filipino immigrants. The narratives suggest that the autonomy and professional relationships expected of Filipino nurses were often at odds with their education, training, and nursing experience in the Philippines. There is a paucity of information on the structure of nursing education and development of the nursing curriculum in the Philippines since the establishment of the US-based educational model in the early 1900s. Western nursing education has undergone transformations over recent decades (Elliott, Stuart, & Toman, 2008; McPherson, 1996; Mortimer & McGann, 2005). From custodial care provided by untrained and uneducated matrons to the professionalization of nursing, contemporary nursing baccalaureate programs emphasize the importance of developing critical thinking skills (Boychuk Duchscher, 1999; Profetto-McGrath, 2003; Simpson & Courtney, 2002) and actively contributing unique nursing knowledge within interdisciplinary teams (Baldwin, 2007; Heller, Oros, & Durney-Crowley, 2000; Larson, 1995). The narratives describe a seemingly dated nurse-physician relationship in the Philippines, a hierarchical one with the physician in charge. The contrast between nurses' training environments and the nursing culture they encountered in Canada was identified as an important aspect of acculturation to Canadian nursing. Participants identified this shift in power dynamics as a process that they continued to adjust to, as evidenced in the example of being free to "call a doctor by their first name." Although the nursing education system in the Philippines is modelled on Western standards, the narratives illustrate this important difference in nurses' professional relationships at the time when these individuals were educated.

Notably, one nurse's comparison of her experiences working as an RN in the United Kingdom and in Canada is consistent with descriptions by Caribbean nurses working in Canada. A historical study in which researchers explored Caribbean nurses' entry to Canadian practice in the 1950s revealed that challenges in transition to nursing practice included restrictions on nursing autonomy and scope of practice in the host country (Flynn, 1998; Shkimba et al., 2005). Caribbean nurses were one of the first immigrant groups to enter Canada after World War II, with most having first worked in the United Kingdom (Calliste, 1993; Flynn, 1998; Shkimba et al., 2005). Indeed, the transition from the United Kingdom to Canada for foreign-trained nurses is not a new phenomenon. Concurrent comparison of participant narratives to nursing education and immigration history revealed that the transition experiences were products of social constructs with deep historical roots.

The third theme — the distinction between racial experiences and simply feeling different — remained vague throughout the study. Although participants denied experiencing discrimination, a sense of being judged and having to prove oneself were consistently attributed to being "foreign." This suggests that the nurses often did not realize they were experiencing discrimination, similar to Caribbean immigrant nurses who recognized discriminatory behaviour only after recalling their experiences decades later (Flynn, 1998). Arguably, Caribbean nurses entered Canada during a period when there was less diversity and tolerance in the country on the whole (Calliste, 1993; McPherson, 1996). Filipino migrants did not begin to arrive in large numbers until decades later, in the 1980s (Kelly, 2006). Additionally, Canadian society and professional culture have grown more diverse in recent decades and diversity is now a distinguishing ideological characteristic of the country. This aspect of Canadian culture — the embrace and growth of "multiculturalism" — may have contributed to the more subtle experiences of discrimination described by the participants, along with the vagueness and uncertainty in their recollection of discriminatory behaviour. The narratives reveal that despite feeling foreign and having to prove themselves, these nurses were generally accepted as fellow RNs and that their reception was conducive to successful integration into Canadian nursing practice.

The number of emerging studies that focus on transition programs for foreign nurses suggests a preoccupation with the integration of IENs in the host country. This preoccupation is evidenced by the large number of transition programs for IENs as part of hospital work orientation or specialty education programs in colleges and universities in recipient countries. Arguments for implementing such programs include addressing gaps in knowledge and training of foreign nurses in the host country and facilitating smooth integration into the health-care system and daily life, particularly considering the growing numbers of migrant nurses (Edwards & Davis, 2006; Ryan, 2003). In Canada, commitment to the smooth workplace integration of migrant nurses includes prior learning assessment and recognition (PLAR) programs such as that of the College of Registered Nurses of British Columbia (2006), the Creating Access to Regulated Employment (CARE) program for nurses (Centre for Internationally Educated Nurses, 2006), and education programs especially designed for immigrant nurses. Although the focus on evaluating transition programs is less evident in Canada than in the United States or the United Kingdom, it is reasonable to expect that Canada will see a similar phenomenon. Given current trends in nursing immigration, the focus on the transition of foreign nurses will continue to increase and has the potential to reach the national policy level in Canada.

Limitations

In oral history research, particular attention must be paid to the interpretation of the life histories shared by participants (Borland, 1998; Bornat, Henry, & Raghuram, 2009; Boschma, 2007). Although the interpretation is in theory guided primarily by the literature and knowledge of the historical background, the potential for introducing personal biases should always be considered. Being a fellow Filipino and a fellow nurse, I had an intimate connection with the topic. In this regard, it was especially important for me to maintain reflexivity during the interviews, in analyzing the narratives, and in connecting themes that arose from the narratives with available knowledge on corresponding topics (Sugiman, 2004). Recording field notes of my thoughts, ideas, and perceptions of each interview, written immediately after the interview, and reviewing these prior to the next interview was one way in which reflexivity was maintained (Anderson & Jack, 2006; Boschma et al., 2008). Discussing the interviews and emerging themes with my thesis committee was another means by which reflexivity was maintained. This allowed for the exploration of ideas surrounding the interviews that were outside of my own perceptions and provided alternative perspectives from which to view and analyze the narratives.

Due to time constraints and some participants' inability to meet in person, a number of interviews were conducted by phone, possibly imposing a limitation on the richness of the narratives. It can be argued that, in the absence of a person-to-person connection during the interview, the memories shared by the participants may be limited; in addition, the researcher misses non-verbal cues to an individual's feelings about a subject, which can add richness and can sometimes contradict the person's oral statements.

Conclusions

This investigation can be viewed as a case study, providing a snapshot of the transition history of a growing and significant group of nurse migrants in Canada. It is the first historical study of the experiences of immigrant Filipino nurses in Canada in the context of societal, cultural, and historical influences. This research reflects a growing scholarship in global nursing immigration and touches on issues that will increase in relevance with Canada's diversifying nurse population. It is also an important addition to the Canadian nursing and immigration historical literature.

The use of oral history as the primary method and framework directed this study towards a specific course. In addition to illustrating the themes that arose from the narratives, as in many qualitative studies, the oral history framework called for the presentation of results in the context of the historical background and social and cultural influences. By examining not only what memories were recalled, but how, the study was able to gain insight into the influences that were important to the participants at different points in their immigration journey. In sharing these memories in their own words, the nurses were censored only by their own thoughts and reservations, providing further clues to the significance of the events they experienced and the influences surrounding them. The nuances and richness of the stories were captured through the nurses' detailed storytelling, an advantage afforded by oral history.

Throughout their immigration journey, the Filipino nurses encountered a number of challenges in the transition process, but they also met with a number of successes. The challenges that came with the transition process were numerous, yet the focus on family loyalty and cohesiveness, shaped by cultural and societal constructs, remained a central value in their stories. The narratives describe a seemingly unchanged hierarchical relationship between physicians and nurses in the Philippines, a welcome challenge in the transition to Canadian nursing culture's greater focus on autonomy and interdisciplinary and collaborative care. Another notable issue in the transition was that of discrimination, often subtle and unrecognized by participants.

This study places in historical context the experiences of a group of immigrant Filipino nurses and adds to the literature on migrant nursing history in Canada.

References

Aiken, L. H., Buchan, J., Sochalski, J., Nichols, B., & Powell, M. (2004). Trends in international nurse migration. *Health Affairs, 23*(3), 69–77.

Alexis, O., Vydelingum, V., & Robbins, I. (2007). Engaging with a new reality: Experiences of overseas minority ethnic nurses in the NHS. *Journal of Clinical Nursing, 16*(12), 2221–2228.

Allan, H. T., Larsen, J. A., Bryan, K., & Smith, P. A. (2004). The social reproduction of institutional racism: Internationally recruited nurses' experiences of the British health services. *Diversity in Health and Social Care, 1*(2), 117–125.

Anderson, K. J., & Jack, D. C. (2006). Learning to listen: Interview techniques and analysis. In R. T. Perks (Ed.), *The oral history reader* (2nd ed.) (pp. 129–142). London: Routledge.

Arendell, T. (2000). Conceiving and investigating motherhood: The decade's scholarship. *Journal of Marriage and the Family, 62*(4), 1192–1207.

Bach, S. (2003). *International migration of health workers: Labour and social issues.* Working paper 209. Geneva: International Labour Office.

Baldwin, D. C. (2007). Some historical notes on interdisciplinary and interprofessional education and practice in health care in the USA. *Journal of Interprofessional Care, 21*(S1), 23–37.

Baumann, A., Blythe, J., Kolotylo, C., & Underwood, J. (2004). *Immigration and emigration trends: A Canadian perspective.* Ottawa: Nursing Sector Study Corporation.

Blythe, J., & Baumann, A. (2009). Internationally educated nurses: Profiling workforce diversity. *International Nursing Review, 56*(2), 191–197.

Blythe, J., Baumann, A., Rheaume, A., & McIntosh, K. (2009). Nurse migration to Canada: Pathways and pitfalls of workforce integration. *Journal of Transcultural Nursing, 20,* 202–210.

Borland, K. (1998). "That's not what I said": Interpretive conflict in oral narrative research. In R. Perks & A. Thomson (Eds.), *The oral history reader* (pp. 320–332). London: Routledge.

Bornat, J., Henry, L., & Raghuram, P. (2009). "Don't mix race with the specialty": Interviewing South Asian overseas-trained geriatricians. *Oral History, 37,* 74–84.

Boschma, G. (2007). Accommodation and resistance to the dominant cultural discourse on psychiatric mental health: Oral history. *Nursing Inquiry, 14*(4), 266–278.

Boschma, G., Scaia, M., Bonifacio, N., Roberts, E., Lewenson, S. B., & Herrmann, E. K. (2008). Oral history research. In S. B. Lewenson & E. K. Herrmann (Eds.), *Capturing nursing history: A guide to historical methods in research* (pp. 79–98). New York: Springer.

Boychuk Duchscher, J. E. (1999). Catching the wave: Understanding the concept of critical thinking. *Journal of Advanced Nursing, 29*(3), 577–583.

Burke, P. (2001). History of events and the revival of narrative. In P. Burke (Ed.), *New perspectives on historical writing* (2nd ed.) (pp. 283–300). Cambridge: Polity Press.

Calliste, A. (1993). "Women of exceptional merit": Immigration of Caribbean nurses to Canada. *Canadian Journal of Women and the Law, 6*(1), 85–103.

Canadian Institute for Health Information. (2011). *Regulated nurses: Canadian trends, 2006 to 2010.* Ottawa: Author.

Centre for Internationally Educated Nurses. (2006). *History of CARE Centre for IENs.* Toronto: Author. Retrieved July 26, 2010, from http://www.care4nurses.org/history/.

Choy, C. (2003). *Empire of care: Nursing and migration in Filipino American history.* Durham, NC: Duke University Press.

Choy, C. (2010). Nurses across borders: Foregrounding international migration in nursing history. *Nursing History Review, 18*(1), 12–28.

College of Registered Nurses of British Columbia. (2006). *Prior learning assessment and recognition framework for assessing nurse practitioners.* Vancouver: Author. Retrieved July 26, 2010, from http://www.crnbc.ca/downloads/440.pdf.

Connell, J. (Ed.). (2008). *The international migration of health workers.* New York: Routledge Taylor & Francis.

Damasco, V. G., & Knowles, J. G. (2008, March 7). *Life history research and discovery of a newfound history through emotions: The immigration of Philippine-trained healthcare professionals to Canada.* Paper presented at conference of the ESREA Life History and Biographical Research Network.

Daniel, P., Chamberlain, A., & Gordon, F. (2001). Expectations and experiences of newly recruited Filipino nurses. *British Journal of Nursing, 10*(4), 254–256, 258–265.

D'Antonio, P. (1999). Revisiting and rethinking the rewriting of nursing history. *Bulletin of the History of Medicine, 73*(2), 268–290.

Dicicco-Bloom, B. (2004). The racial and gendered experiences of immigrant nurses from Kerala, India. *Journal of Transcultural Nursing, 15*(1), 26–33.

Edwards, P. A., & Davis, C. R. (2006). Internationally educated nurses' perceptions of their clinical competence. [Feature.] *Journal of Continuing Education in Nursing, 37,* 265–269.

Elliott, J., Stuart, M., & Toman, C. (2008). *Place and practice in Canadian nursing history.* Vancouver: UBC Press.

Flynn, K. (1998). Proletarianization, professionalization and Caribbean immigrant nurses. *Canadian Women's Studies Journal, 18*(1), 57–60.

Flynn, K., Feldberg, G., Ladd-Taylor, M., Li, A., & McPherson, K. (2003). Race, the state, and Caribbean immigrant nurses, 1950-1962. In G. Feldberg, M. Ladd-Taylor, A. Li, & K. McPherson (Eds.)., *Women, health and nation: Canada and the United States since 1945* (pp. 247–263). Montreal and Kingston: McGill-Queen's Unversity Press.

Flynn, K., & Henwood, C. (2000). Nothing to write home about: Caribbean Canadian daughters, mothers and migration. *Association for Research on Mothering Journal, 2*(2), 118–129.

Goode, A. (2009). Global economic changes and the commodification of human capital: Implications of Filipino nurse migration. *East Asia: An International Quarterly, 26*(2), 113–131.

Heller, B. R., Oros, M. T., & Durney-Crowley, J. (2000). The future of nursing education: Ten trends to watch. *Nursing and Health Care Perspectives, 21*(1), 9–13.

Hoffman, A. M. (1974). Reliability and validity in oral history. *Today's Speech, 22*(1), 23–27.

Kaelin, L. (2011). A question of justice: Assessing nurse migration from a philosophical perspective. *Developing World Bioethics, 11*(1), 30–39.

Kan, M.Y., Sullivan, O., & Gershuny, J. (2011). Gender convergence in domestic work: Discerning the effects of interactional and institutional barriers from large-scale data. *Sociology, 45*(2), 234–251.

Kelly, P. (2003). Canadian-Asian transnationalism. *Canadian Geographer, 47*(3), 209–218.

Kelly, P. (2006). *Filipinos in Canada: Economic dimensions of immigration and settlement.* Working paper 48. Toronto: Joint Centre of Excellence for Research on Immigration and Settlement.

Kelly, P., & D'Addario, S. (2004). *Understanding labour market segmentation: Filipina healthcare workers in transnational Toronto.* Paper presented at the Atlantic Metropolis Conference, November 18–19, Halifax.

Kingma, M. (2006). *Nurses on the move: Migration and the global health care economy.* Ithaca, NY: Cornell University Press.

Kingma, M. (2009). The international workplace: Challenges and solutions. *Nursing Workforce: A Special Issue, 46*(7), 879–883.

Larson, E. L. (1995). New rules for the game: Interdisciplinary education for health professionals. *Nursing Outlook, 43*(4), 180–185.

Liamputtong, P. (2006). Motherhood and "moral career": Discourses of good motherhood among Southeast Asian immigrant women in Australia. *Qualitative Sociology, 29*(1), 25–53.

Lorenzo, F. M. E., Galvez-Tan, J., Icamina, K., & Javier, L. (2007). Nurse migration from a source country perspective: Philippine country case study. *Health Services Research, 42*(3P2), 1406–1418.

Matiti, M. R., & Taylor, D. (2005). The cultural lived experience of internationally recruited nurses: A phenomenological study. *Diversity in Health and Social Care, 2*(1), 7–15.

McGonagle, C., Halloran, S. O., & O'Reilly, O. (2004). The expectations and experiences of Filipino nurses working in an intellectual disability service in the Republic of Ireland. *Journal of Learning Disabilities, 8*(4), 371–381.

McPherson, K. (1996). *Bedside matters: The transformation of Canadian nursing, 1900-1990.* Toronto and New York: Oxford University Press.

Milkie, M. A., & Peltola, P. (1999). Playing all the roles: Gender and the work-family balancing act. *Journal of Marriage and Family, 61*(2), 476–490.

Mintz, S., & Kellogg, S. (1988). *Domestic revolutions: A social history of American family life.* New York: Free Press.

Mortimer, B., & McGann, S. (2005). *New directions in the history of nursing.* New York: Routledge.

Mottarella, K., Fritzsche, B., Whitten, S., & Bedsole, D. (2009). Exploration of "good mother" stereotypes in the college environment. *Sex Roles, 60*(3/4), 223–231.

Oxman-Martinez, J., Hanley, J., & Cheung, L. (2004). *Another look at the Live-In Caregivers Program: An analysis of an action research survey conducted by PINAY, the Quebec Filipino Women's Association with the Centre for Applied Family Studies.* Montreal: Centre de recherche interuniversitaire de Montréal sur l'immigration, l'intégration et la dynamique urbaine.

Portelli, A. (1998). What makes oral history different. In R. Perks & A. Thomson (Eds.), *The oral history reader* (pp. 63–74). New York: Routledge.

Profetto-McGrath, J. (2003). The relationship of critical thinking skills and critical thinking dispositions of baccalaureate nursing students. *Journal of Advanced Nursing, 43*(6), 569–577.

Ronquillo, C., Boschma, G., Wong, S. T., & Quiney, L. (2011). Beyond greener pastures: Exploring contexts surrounding Filipino nurse migration in Canada through oral history. *Nursing Inquiry, 18*(3), 262–275.

Ryan, M. (2003). A buddy program for international nurses. *Journal of Nursing Administration, 33*(6), 350–352.

Shkimba, M., Flynn, K., Mortimer, B., & McGann, S. (2005). In England we did nursing: Caribbean and British nurses in Great Britain and Canada 1950–1970. In B. Mortimer & S. McGann (Eds.), *New directions in the history of nursing: International perspectives* (pp. 141–157). London: Routledge Taylor & Francis.

Simpson, E. R. N., & Courtney, M. R. N. (2002). Critical thinking in nursing education: Literature review. *International Journal of Nursing Practice, 8*(2), 89–98.

Sugiman, P. (2004). Memories of internment: Narrating Japanese Canadian women's life stories. *Canadian Journal of Sociology, 29*(3), 359–388.

Thompson, P. (2000). *The voice of the past: Oral history*. Oxford: Oxford University Press.

Vincent, C., Ball, S. J., & Braun, A. (2010). Between the estate and the state: Struggling to be a "good" mother. *British Journal of Sociology of Education, 31*(2), 123–138.

Withers, J., & Snowball, J. (2003). Focus. Adapting to a new culture: A study of the expectations and experiences of Filipino nurses in the Oxford Radcliffe Hospitals NHS Trust. *NT Research, 8*(4), 278–290.

Wolf, D. L. (1997). Family secrets: Transnational struggles among children of Filipino immigrants. *Sociological Perspectives, 40*(3), 457–482.

Xu, Y. (2007). Strangers in strange lands: A metasynthesis of lived experiences of immigrant Asian nurses working in Western countries. *Advances in Nursing Science, 30*(3), 246–265.

Yeates, N. (2010). The globalization of nurse migration: Policy issues and responses. *International Labour Review, 149*(4), 423–440.

Zizzo, K. A. (2009). Post-hire transitional programs for international nurses: A systematic review. *Journal of Continuing Education in Nursing, 40*(2), 57–64.

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Happenings

New Research Initiatives: Addressing Global Homelessness

Solina Richter, Annali Botha

Homelessness is a global social issue that affects both industrializing and industrialized countries. Increasingly, researchers are indicating that problems related to social injustice and poverty are linked cross-nationally, requiring us to look for answers beyond our borders (Cross, Seager, Erasmus, Ward, & O'Donovan, 2010). We must become aware of the global impact of homelessness and share knowledge about best practices that can address this critical social issue in various countries. Kemeny and Lowe (1998) argue that there are underlying similarities in homelessness issues among all countries and that "awareness of varied experiences of other societies, cultures and jurisdictions in dealing with the housing issue facilitates a more informed assessment of our own national experience and priorities and can help confront assumptions" (p. 162).

In 2007 an interdisciplinary global homelessness research group was formed, with participants from South Africa and Canada. Researchers from Germany joined in 2011. On close examination, Canada and South Africa have more similarities related to homelessness than might be expected. The two countries are rich within the context of their continent. Both are classified as middle- to high-income countries yet present various housing and homelessness situations and degrees of poverty. Although South Africa is classified as a middle- to high-income country, its income disparities are among the most extreme in the world (Homeless International, 2012). South Africa and Canada have multicultural populations in which immigrant and migrant workers account for an increasing proportion of the labour force. Both countries encounter challenges meeting the demand for affordable and/or subsidized housing. Homelessness issues are more visible on the political agenda in Canada. South Africa, as a new democratic state, has other urgent problems (HIV/AIDS, poverty, crime and violence) that are higher on the priority list of politicians. Strategies and policies to address homelessness are related to political, economic, religious, societal, or public forces that influence the priorities of and pressures faced by governments and decision-makers. This is true for South Africa and Canada but the extent of homelessness and strategies to address it are different in each country. As researchers and humanitarians, we have much to learn from one another. A collaborative and comparative research agenda is warranted.

While meaningful, high-quality, multi-country global research is difficult to coordinate, especially when engaging interdisciplinary or cross-sectoral research teams (Freshwater, Sherwood, & Drury, 2006), such research is needed. It is critical that we explore issues in vulnerable populations such as low income, homelessness, and challenges related to equitable access to health and social services (Global Forum for Health Research, 2007). Evidence is needed not only to compare countries as to the strengths or weaknesses of health outcomes, health services, and other factors related to health, but also to provide validated knowledge on best practices, programs, and other factors that could be used to guide policy recommendations or decisions.

Our global homelessness research agenda includes exploration of partnership development. A partnership assessment tool (Afsana, Habte, Hatfield, Murphy, & Neufeld, 2009) is implemented yearly to assess and ensure equitable development of the partnership. Based on the stages involved in building sustainable collaborative partnerships, the South African, Canadian, and German team has established a process to strengthen itself and its capacity for collaborative work (Richter, Kovacs Burns, & Botha, 2012). The research group decided that an essential first step in addressing homelessness was not only to develop a common understanding of homelessness in the different countries, but also to show the inequities and injustice of the present situation and make "explicit the values on which proposed action is based" (Whitehead, 2001, para 4). We have strived to understand health inequities and disparities in each country, including the country-specific interplay between poverty and homelessness and the intersections with age, gender, sexual orientation, ethnicity, diseases, geography, various policies and programs, historical events, and other determinants. To this end, we have undertaken a range of national and international initiatives. The studies have focused on street youth in South Africa (Prinsloo & Richter, 2003), ethical issues related to conducting research with street youth (Richter, Groft, & Prinsloo, 2007), how homelessness intersects with gender and more specifically homeless women (Richter & Chaw-Kant, 2008, 2010), media discourses and the framing of homelessness (Calder, Richter, Kovacs Burns, & Mao, 2011; Richter, Kovacs Burns, & Chaw-Kant, 2010; Richter et al., 2011), and social reality and media ownership and how they influence news coverage of homelessness (Mao, Richter, Kovacs Burns, & Chaw-Kant, 2012). A direct result of the media studies was the development of a project to address homelessness within a university population. Other research projects will focus on developing a common definition of homelessness, an analysis of policies related to housing and homelessness, the specific needs and experiences of homeless people related to their geographic location, and health-care providers' perceptions and experiences delivering care to homeless people.

Ruger (2006) argues that an important step in global actions to redress inequalities related to homelessness is to develop guiding principles. Our team has developed the following set of guiding values for our collaborative research:

- Inclusion of multidisciplinary and multisectoral decision-makers, health and social care providers, and other stakeholders (e.g., faith-based organizations) within and across countries. We have developed terms of reference for the establishment of a global homelessness advisory group.
- Inclusion of homeless people. It is the people who are homeless who will benefit from the improved policies and practices based on knowledge gained from the projects and the program of research.
- Development and implementation of capacity-building and mentorship programs in research on homelessness. The team currently includes a PhD student and a postdoctoral fellow.
- Development of a shared integrated theoretical framework that incorporates a wide range of theories for changing individual behaviour, developing policy, driving collective global action, and enhancing knowledge translation (http://www.miptoolkit.com/). A philosophical discussion group has been established to advance our thinking.
- Acknowledgement of the need for multi-method research on homelessness. Exploratory and Community-Based Participatory Research with mixed-method designs is perceived as the most appropriate approach for within- and across-country studies on homelessness (Padgett, 2009).

Community engagement and ownership is a key principle in our research on homelessness, as it emphasizes community participation and methods that promote community ownership. Rich and Clark (2005) state that a "one size fits all" approach is inappropriate in this kind of research and subsequent program development.

Our focus is the generation of new ideas that support capacity-building internationally and across academic disciplines. Our hope is that this will promote active brokering of community partners and collaborators to address homelessness at a global level. In 2003 the World Social Forum adopted the slogan "Another world is possible" (Burchardt, 2008). It is essential that this slogan become increasingly visible in our research on global homelessness.

References

Afsana, K., Habte, D., Hatfield, J., Murphy, J., & Neufeld, V. (2009). *Partnership assessment toolkit.* Ottawa: Canadian Coalition for Global Health Research. Retrieved September 5, 2012, from www.ccghr.ca?Resources/Documents/.../PAT_Interactive_e.pdf.

Burchardt, T. (2008). Thinking globally [editorial]. *Journal of Poverty and Social Justice, 16*(3), 211–212.

Calder, M., Richter, S., Kovacs Burns, K., & Mao, Y. (2011). Framing homelessness for the Canadian public: The news media and homelessness. *Canadian Journal of Urban Research, 20*(2), 1–19.

Cross, C., Seager, J., Erasmus, J., Ward, C., & O'Donovan, M. (2010). Skeletons at the feast: A review of street homelessness in South Africa and other world regions. *Development Southern Africa, 27*(1), 5–20.

Freshwater, D., Sherwood, G., & Drury, V. (2006). International research collaboration. *Journal of Research in Nursing, 11*(4), 295–303.

Global Forum for Health Research. (2007). *Equitable access: Research challenges for health in developing countries.* Paper presented at A Report on Forum 11, October 29–November 2, Beijing.

Homeless International. (2012). *South Africa.* Coventry: Author. Retrieved September 10, 2012, from http://www.Homeless-international.org/standard.

Kemeny, J., & Lowe, S. (1998). Schools of comparative housing research: From convergence to divergence. *Housing Studies, 13*(2), 161–176.

Mao, Y., Richter, M. S., Kovacs Burns, K., & Chaw-Kant, J. (2012). Homelessness coverage, social reality, and media ownership: Comparing a national newspaper with two regional newspapers in Canada. *Journal of Mass Communication and Journalism, 2(119),* 7. Retrieved September 5, 2012, from http://dx.doi.org/10.4172/2165-7912.1000119.

Padgett, D. (2009). *Qualitative and mixed methods in Community-Based Participatory Research.* Presentation at NIH Summer Institute on Community-Based Participatory Research Targeting the Medically Underserved, August 2–7, New Orleans.

Prinsloo, L., & Richter, M. S. (2003). Perception of the health of children living and working on the streets of Sunnyside. Part 2: Methodology, interpretation and recommendations. *Curationis, 26*(3), 78–87.

Rich, A. R., & Clark, C. (2005). Gender differences in response to homelessness services. *Evaluation and Programme Planning, 28,* 69–81.

Richter, M. S., & Chaw-Kant, J. (2008). A case study: Retrospective analysis of homeless women in a Canadian city. *Women's Health and Urban Studies,* 7(1), 7–19.

Richter, M. S., & Chaw-Kant, J. (2010). Canadian homeless women: Gaps in the research agenda. *International Journal of Child Health and Human Development, 3*(1), 7–15.

Richter, M. S., Groft, J. N., & Prinsloo, L. (2007). Ethical issues surrounding studies with vulnerable populations: A case study of South African street children. *International Journal of Adolescent Medical Health, 19*(2), 117–126.

Richter, M. S., Kovacs Burns, K., & Botha, A. D. H. (2012). Planning for global homelessness research: A joint Canadian-South African initiative. *Online Journal of Social Sciences Research, 1*(3), 85–91. Retrieved September 5, 2012, from http://www.onlineresearchjournals.org/JSS.

Richter, M. S., Kovacs Burns, K., & Chaw-Kant, J. (2010). Analysis of newspaper journalists' portrayal of the homeless and homelessness in Alberta, Canada. *International Journal of Child Health and Human Development, 3*(1), 125–136.

Richter, M. S., Kovacs Burns, K., Mao, Y., Chaw-Kant, J., Calder, M., Mogale, S., et al. (2011). Homelessness coverage in Canadian newspapers: 1987 to 2007. *Canadian Journal of Communication, 36*(4), 619–636.

Ruger, J. (2006). Ethics and governance of global health inequalities. *Journal of Epidemiology, 60,* 998–1002.

Whitehead, A. (2001). *Trade, trade liberalisation and rural poverty in low-income Africa: A gendered account.* Background paper for the UNCTAD 2001 Least Developed Countries Report. Geneva: United Nations Conference on Trade and Development.

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Book Review

Rethinking Unequal Exchange: The Global Integration of Nursing Labour Markets

By Salimah Valiani
Toronto: University of Toronto Press, 2012, 208 pp.
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Reviewed by Jordana Salma

Questions continue to be raised about the global trend of nurse migration: its ethical implications, the professional challenges of cross-cultural nurse integration, and the socio-economic repercussions of migration for sending and receiving countries. A primary concern is the recruitment of nurses from the global South to temporarily fill labour deficits in the global North. Salimah Valiani, an associate researcher at the Centre for the Study of Education and Work at the University of Toronto and a policy analyst and advocate within the trade union movement, presents an in-depth historical and socio-economic analysis of this issue. She successfully addresses two research questions: *What accounts for the increased use of temporary migrant nursing labour in the global North, circa 1990, sparking the beginnings of the global integration of nursing labour markets? How can the dynamics of the global integration of caring labour markets be interpreted with regard to restructuring in the capitalist world economy?*

Valiani highlights the trend to substitute temporary labour migration for permanent migration in OECD (Organization for Economic Co-operation and Development) countries during the late 20th and early 21st centuries. Using temporary nurse migration as the exemplar, she analyzes the international, national, and local policies, processes, and practices that have created and that sustain this phenomenon. Valiani draws on Marxian economics, feminist theory, and the world historical approach to provide an alternative explanation to the traditional "push and pull" theorizations of global nurse migration. The Philippines, the first and largest exporter of nurses, and the United States and Canada, the largest receivers of migrant nurses, are used as examples to explain her theoretical perspective.

In the example of the United States, Valiani describes the relationship between the restructuring of nursing labour and the increasing reliance on medical technology. In her detailed historical analysis, she explores the pathways of commodification of medical technologies, health services, and drugs in the United States that have led to increased hospital costs for users. Hospital administrators cut costs by restructuring nursing labour using multiple approaches, such as the recruitment of temporary migrant nurses. In the example of Canada, Valiani combines a world historical lens and a socialist feminist lens to describe how undervaluing of female nursing labour has resulted in the high mobility of temporary nursing labour entering and exiting the Canadian health-care system. Interestingly, as Valiani points out, welfare state ideals in the Canadian instance have failed to overcome the capitalist logic of undervaluing female labour. In the final example of the Philippines, Valiani presents a pre- and postcolonial picture of the social and economic forces propelling the Philippines towards dependence on remittance of resources from exported labour. She describes the restructuring processes, at the national and global level, that ensured that the Philippines would supply the global labour market with a steady supply of temporary migrant nurses and thus solidify the exploitation and undervaluing of female labour.

In conclusion, Valiani states that the production of temporary migrant nursing labour leads to "absolute and deepened unequal exchange" within the world capitalist market. The bulk of this unequal exchange occurs between countries of the global South and the global North, exacerbating the social and economic inequities that already exist. This book is rich with evidence supporting Valiani's theoretical perspective. Overall, it is a great resource for anyone interested in expanding their knowledge of the macro-level processes and structures shaping global temporary nurse migration.

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Résumé

Un programme de gestion autonome culturellement spécifique à l'intention des Afro-américains atteints de diabète de type 2

Janice Collins-McNeil, Christopher L. Edwards,
Bryan C. Batch, Debra Benbow,
Camela S. McDougald, Daphne Sharpe

Une connaissance insuffisante de l'influence qu'exerce le mode de vie sur les résultats cliniques contribue aux difficultés que vivent de nombreux Afro-américains atteints de diabète de type 2 (DT2). Cette étude pilote axée sur une collectivité confessionnelle avait pour objet une intervention d'éducation à la gestion autonome du diabète (DSME) qui a été menée pendant une période de 12 semaines et qui ciblait des Afro-américains d'âge mûr et plus âgés atteints de DT2. Des données quantitatives ont été recueillies au début de l'étude et au bout de 12 semaines à l'aide de questionnaires et des mesures anthropométriques ont été prises. Des hausses importantes d'adhésion aux médicaments (p = ,006), à une alimentation saine (p = ,009) et aux soins des pieds (p = ,003) ont été relevées. L'intervention a produit un effet significatif du point de vue clinique sur la tension artérielle systolique, les lipides sanguins, l'activité physique et le tour de taille. Les interventions DSME axées sur une collectivité confessionnelle et culturellement spécifique menées auprès de personnes atteintes de DT2 peuvent donner de meilleurs résultats chez les Afro-américains souffrant de cette maladie. Les auteurs discutent de la valeur des interventions communautaires qui visent à changer les comportements de populations atteintes de maladies chroniques, particulièrement celles qui ont été historiquement exclues et/ou mal desservies.

Mots clés : diabète, gestion autonome, activité physique, culturellement spécifique

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A Culturally Targeted Self-Management Program for African Americans With Type 2 Diabetes Mellitus

Janice Collins-McNeil, Christopher L. Edwards,
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Camela S. McDougald, Daphne Sharpe

Inadequate knowledge of the influence of lifestyle on clinical outcomes contributes to the difficulties many African Americans experience with type 2 diabetes mellitus (T2DM). This pilot study examined a 12-week church-based culturally targeted diabetes self-management education (DSME) intervention for middle-aged and older African Americans with T2DM. Quantitative data were collected at baseline and at 12 weeks and included questionnaires and anthropometric measures. There were significant increases in medication adherence (p = .006), healthy eating (p = .009), and foot care adherence (p = .003). The intervention had a clinically significant effect on systolic blood pressure, blood lipids, physical activity, and waist circumference. Church-based culturally targeted DSME interventions may result in improved outcomes for African-American adults with T2DM. The authors discuss the value of community-based interventions that target behavioural changes in populations of chronically ill patients, particularly those who historically have been disenfranchised and/or underserved.

Keywords: diabetes, self-management, physical activity, culture

Introduction

Over three million African Americans in the United States have diabetes (Centers for Disease Control and Prevention [CDC], 2007), and African Americans are twice as likely as Caucasians to experience diabetes complications such as blindness (retinopathy), endstage renal disease, and lower-extremity amputations (Anderson-Loftin & Moneyham, 2000; Blank, Mahmood, Fox, & Guterbock, 2002; CDC, 2007). In the southern United States, African Americans with diabetes have poorer glycemic control and higher blood pressure than Caucasians and are at greater risk for diabetes-related complications and death (Cohen, Kamarck, & Mermelstein, 1983; Cohen & Williamson, 1988; Delamater et al., 2001). The disproportionately high rate of diabetes in African-American communities is similar to the disproportionately high rates of other chronic diseases in these communities.

The disparities draw attention to the need for accessible and efficacious programs to improve disease management and reduce the negative impact of chronic diseases like type 2 diabetes mellitus (T2DM) on African Americans (Faridi et al., 2009; Gaines & Weaver, 2006). This presents a challenge to clinicians and researchers who provide services to such populations. We need innovations in the administration and execution of interventional and research protocols that improve the effectiveness of treatments.

This article discusses an innovative approach to the treatment and management of T2DM among African Americans whereby a model is constructed to better serve underserved populations.

Effective self-management of T2DM typically involves a long-term, complex regimen of healthy eating, weight control, medications, blood glucose monitoring, exercise, and stress management (Gould, Kelly, Goldstone, & Gammon, 2001; van Tilburg et al., 2001). Interventions that combine dietary counselling, weight reduction, and physical activity are pivotal in reducing the morbidity associated with T2DM (Gregg et al., 2001).

A published review of 16 community-based interventions found that only half (8 studies) contained representative samples or discussions of populations that have been historically and disproportionately burdened by diabetes (African and Mexican Americans, American Indians, and Native Hawaiians) (Satterfield et al., 2003). The value of community-based, culturally tailored interventions has been demonstrated in international populations for many years (Long, 1978; Ockene et al., 2012) but has gained renewed popularity recently (Collins-McNeil, Holston, Edwards, Benbow, & Ford, 2009).

Diabetes self-management behaviours are influenced by culture and lifestyle, including food choices (Gould et al., 2001). In particular, impediments to self-management by African Americans with diabetes include poor understanding of the relationship between diabetes and diet; poor psychological adjustment; denial that diabetes is a serious condition; and lack of confidence, coping skills, and competence (Gould et al., 2001; Grey, Boland, Davidson, Li, & Tamborlane, 2000). In addition, negative attitudes and emotional distress such as depression and anxiety can contribute to poor diabetic control (Hill-Briggs et al., 2005; Houston, Martin, Williams, & Hill, 2006; Jiang et al., 2003).

In designing interventions for underserved populations such as African Americans with T2DM, it is important to draw on natural points of connection and sources of social support such as the church. From the time of slavery through the civil rights movement of the 1950s and 1960s to the local organizing that characterized the 1990s, the church has been a central institution in the African-American community (Markens, Fox, Taub, & Gilbert, 2002). African-American churches in the South now provide a wide range of prevention- and treatment-oriented programs that contribute to the psychological and physical well-being of their congregants (Blank et al., 2002; Sbrocco et al., 2005). Thus, church-based diabetes self-management programs may be an effective resource for African Americans.

The study reported on here examined the feasibility of conducting a church-based diabetes self-management education (DSME) program and its effects on the appraisal of diabetes self-management; level of self-care management; emotional distress; glycemic control (HbA1C); and blood pressure, lipid levels, waist circumference, and weight.

Methods

Setting and Sample

The 12-week DSME intervention was piloted with 12 African Americans (*n* = 10 women; *n* = 2 men) in the southeastern United States. Quantitative data were collected at baseline and at 12 weeks. Qualitative data were collected in a focus group at the conclusion of the study. Participants had to self-identify as African American, have a medical diagnosis of T2DM, demonstrate written or verbal comprehension, and sign or make a witnessed mark indicating consent. All had to provide a statement of medical clearance from their health-care provider and remain under the care of their provider for the duration of the study.

The study was approved by the Duke University Institutional Review Board. Incentives for participants consisted of payments of $20 at the initial and final assessment.

Intervention

The DSME intervention was developed by advanced practice registered nurses (RNs), nurse scientists, psychologists, physicians, and certified diabetes educators in collaboration with three local pastors. The program focused on seven areas of T2DM self-care: (1) healthy eating, (2) being active, (3) monitoring blood glucose, (4) taking medications, (5) problem-solving, (6) reducing risks, and (7) healthy coping. The program included both educational and behavioural strategies directed towards helping patients to achieve self-management goals.

DSME modules were adapted from the Duke University Outpatient Adult Diabetes Education Program, which is based on the standards of diabetes care recommended by the American Diabetes Association (ADA) and the American Association of Diabetes Educators. Sessions were held once a week for 2 hours over 6 weeks and were led by health-care providers and clerics. Culturally targeted written materials, videotapes, and presentations by racially concordant health-care providers and research staff were also provided. After the sessions were completed, participants were asked to practise self-management behaviours independently for 6 additional weeks.

The *healthy eating* module included education on the diabetes diet, label reading, meal planning, carbohydrate counting, controlling dietary fats, portion sizes, and keeping food logs to identify barriers to healthy eating. Culture-specific meals (participants selected the menu) were prepared using recipes from the *New Soul Food Cookbook for People With Diabetes* (Gaines & Weaver, 2006). Participants selected the appropriate portion sizes and documented their food intake using logs.

The *being active* module focused on aerobic exercises and overall fitness, weight management, and blood glucose control. Participants kept weekly exercise logs. Group discussions included barriers to being active, types of physical activity (walking, work-related exercise, recreational physical activities, group exercises, and community-based exercise programs), and cultural preferences for physical activity. Participants contracted with program staff and clergy to perform the physical activity of their choice for a minimum of 30 minutes three times a week. Participants also wore a standard pedometer.

The module on *self-monitoring of blood glucose* included education about equipment choice and selection, timing and frequency of testing, target values, and interpretation and use of results. Each participant received a new glucometer and two strips per day for the 12-week intervention period. Participants checked their glucose levels and blood pressure weekly under the guidance of an RN research assistant (RA). All readings were verified by the RA.

The *taking medications* module targeted diabetes-specific medications and their actions, side effects, and toxicity. One-on-one medication education sessions were also held with each participant to review prescribed medications and assess the participants' knowledge of their medications, the effects of missed or delayed doses, and proper storage of medications.

The module on *problem-solving* skills (Grey et al., 2000) was designed to help participants to choose healthy foods or establish an exercise regimen and make appropriate decisions about diet, physical activity, and medications on sick days or when they had high or low blood-glucose readings. Participants also discussed problem-solving strategies for issues such as family relationships, lack of support, budgeting for medications and food, the cost of glucometer strips, over-eating, and avoiding low and high blood sugar.

The *risk-reduction* module included ways to reduce risk behaviours such as smoking and the importance of regular eye, foot, and dental examinations. Participants were taught how to identify the need for a referral and how to make a list of their questions or concerns in order to improve communication with their providers. They received instruction in foot care and were required to perform demonstrations of proper foot care. Finally, participants had 1-hour sessions with the study's endocrinologist to ask questions about their personal health, fears, and various cultural mores and folk treatments for diabetes.

The *healthy coping* module included education on psychological distress and ways in which it directly affects health and influences motivation to keep diabetes under control. Participants received instruction in recognition of mood changes and on symptoms of anxiety and depression.

The emotion-focused coping modules included strategies to help participants reduce the emotional distress caused by stressful events and manage emotions that might result from stressors. Strategies included sharing personal stories and feelings related to diabetes self-management, deep breathing exercises, mental imagery, biblical stories and examples, scriptural readings, prayers, and songs. The stress-management modules included use of cognitive and behavioural skills to recognize and reduce stress and instruction in progressive muscle relaxation (PMR) (Surwit et al., 2002). A licensed clinical psychologist taught participants to consecutively tense and relax muscle groups in the body, starting with the feet and progressing to the head. PMR was also combined with techniques such as deep breathing and mental imagery specific to African-American culture.

Spiritual coping was integrated into all sessions. Participants were able to interact directly with clerics or trained spiritual counsellors regarding their feelings, beliefs, and attitudes about diabetes self-care practices and individual problem-solving. All intervention sessions opened and closed with prayer. Activities included reading of scriptures, praise and worship, prayer, meditation, and group exercises in faith, trust, and forgiveness.

Variables and Their Measurement

The Diabetes Self-Care Practices Measurement Questionnaire (DSCPM) (Skelly et al., 2000) was used to collect date of birth, marital status, years of education, race/ethnicity, gender, employment, annual income, and health-care payer. It also assessed healthy eating, medication-taking, physical activity, self-monitoring of blood glucose, and foot care.

Respondents were asked how frequently they engaged in these practices using five responses ranging from *never* (0%) *to all of the time* (100%). Physical activity was measured by self-reported frequency of the activity/week, duration, type of activity, and intensity (slow or brisk). Cronbach's alpha for the DSCPM has been reported to be 0.88 and test-retest reliability .95 measured at 2-week intervals (Skelly, Marshall, Haughey, Davis, & Dunford, 1995).

The Self-Appraisal Diabetes Self-Management Scale (SADSM) developed for this study was a visual analogue scale (VAS) with a horizontal line 100 mm in length. Participants marked on the line the point that represented their perception of their current state of diabetes self-management. The VAS score was determined by measuring the millimeters from the left-hand end of the line to the point marked by the participant (Gould et al., 2001). The VAS measured self-appraisal of diabetes self-management in the past month; scores ranged from 1 to 10, with 1 (10 mm) representing very poor self-management and 10 (100 mm) very good self-management.

The 20-item Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977) was used to assess depressive symptoms. CES-D scores can range from 0 to 60, with scores of 16 or higher indicating clinical depression (Jiang et al., 2003). The CES-D has been shown to be reliable for assessing the number, types, and duration of depressive symptoms across racial, gender, and age categories (Jiang et al., 2003; Radloff, 1977). Good internal consistency has been reported, with Cronbach's alpha coefficients ranging from .85 to .90 (Jiang et al., 2003). Concurrent validity and substantial evidence of construct validity have been demonstrated using clinical and self-report criteria (Jiang et al., 2003; Knight, Williams, McGee, & Olaman, 1997).

The Spielberger State Anxiety Subscale from the Spielberger State-Trait Anxiety Inventory (STAI) was used to measure anxiety symptoms (Patterson, O'Sullivan, & Spielberger, 1980). The STAI-State (STAI-S) is a 20-item self-administered scale that measures current general anxiety level. Responses to each item are scored from 1 to 4, with total scores ranging from 20 to 80 and higher scores indicating more anxiety. The STAI has been shown to have excellent psychometric properties for assessing anxiety in elderly persons and in African Americans (Knight, Silverstein, McCallum, & Fox, 2000; Patterson et al., 1980).

Perceived stress was measured using the Perceived Stress Scale (PSS) (Cohen et al., 1983), a validated 10-item global measure of the degree to which situations in one's life are perceived as stressful. Scores range from 0 to 16. This measure has been used successfully with diverse samples and is psychometrically sound (Cohen & Williamson, 1988).

Anthropometric measurements were taken at baseline and at 12 weeks by trained advanced practice nurses. Height was measured without shoes to the nearest 0.1 cm. Body weight was obtained on a balanced scale. Body mass index (BMI) was calculated by dividing body weight (in kilograms) by the square of height (in metres). Waist circumference was measured in duplicate using a measuring tape. Measurements were taken at the natural waist or at the midpoint between the bottom of the rib cage and 2 cm above the top of the iliac crest. Two measurements were made for each participant. Duplicate measurements were taken to the nearest 0.1 cm and repeated if they differed by more than 0.50 cm. The average of two or three readings was used for the analysis. Systolic and diastolic blood pressures were collected from an average of three sitting blood pressure readings done by RNs following standard procedures.

Participant logs were used to record anthropometric measures and labs during the study period, including total cholesterol (TC), low-density lipoproteins (LDL), high-density lipoproteins (HDL), triglycerides (TG), hemoglobin A1c (HbA1C), capillary blood glucose, BMI, systolic blood pressure (SBP), diastolic blood pressure (DBP), and waist circumference. RAs obtained all anthropometric measures except for capillary blood glucose. Participants measured glucose levels weekly under the supervision of RNs as part of the intervention.

Glycemic control was measured by fasting HbA1c levels at baseline and at 12 weeks. Using a standard finger-stick technique, capillary blood was collected into a capillary-collection vial (AccuBase A_{1c}Test Kit™), which was stored at 4°C. Blood samples were shipped for processing to Diabetes Technologies, Inc. (Thomasville, GA), a reference laboratory certified by the Clinical Laboratory Improvement Advisory Committee (CLIA) and Centers for Medicare and Medicaid Services. Fasting lipids (TC HDL, LDL, and TG) were measured using the Cholestech L-D-X System (CHOLESTECH Corp., Hayward, CA) at baseline and at 12 weeks; the Cholestech L-D-X is a CLIA-waived device.

Results

The participants were 12 adults aged 35 to 68 years (55.83 ± 9.62). Half were high-school graduates and one was a college graduate. Six were unmarried. Eight reported an annual household income of over $30,000.

At baseline, all 12 participants had TC levels within the recommended range (163.08 ± 57.81 mg/dL), with HDL levels (38.62 ± 11.54 mg/dL) below the recommended range and LDL (105.08 ± 46.21 mg/dL) levels above the recommended level of < 100 mg/dL. Mean BMI (35.92 ± 6.9kg/m^2) met the national diagnostic criterion for Class II Obesity

(BMI ≥ 34.9 kg/m^2) (NHLBI, NIH, 2000). Mean HgbA1c level at baseline was 7.56% ± 1.26, indicative of poor glycemic control. Mean waist circumference at baseline was 112 + 14.2 cm. Physical activity levels (days exercised, moving large muscle groups, for 30 minutes or more) were lower (2.76 + 2.0 days) than the 150 minutes per week recommended by the ADA (2007).

After the intervention, there was a mean change of 9mmHg in SPB, a reduction of 10 mg/dL in LDL, an increase of 4mg/dL in HDL, and a reduction of 26 mg/dL in TG. Participants also had an average reduction in waist circumference of 5.3 cm and an average weight loss of 2.2 pounds. Participants' physical activity increased (3.58 ± 1.62 days) and three participant logs indicated increases in brisk mall walking, up to 4 miles three times a week by week 9 of the intervention. There were no significant changes in physical activity or in the anthropometric measures (Table 1).

Table 1 ***Scores of Outcomes at Baseline and Post-intervention (N = 12)***

Variable	**Baseline**	**Post-intervention**
Hemoglobin A1C	7.56 ± 1.26%	7.73 ± 1.23%
Self-monitored blood glucose (non-fasting)	168 ± 70	128 ± 75
Total cholesterol	163.08 ± 57.81 mg/dL	199.42 ± 78.21 mg/dL
HDLs	38.62 ± 11.54 mg/dL	42.92 ± 15.13 mg/dL
LDLs	105.08 ± 46.21 mg/dL	96.42 ± 41.81 mg/dL
Triglycerides	258.83 ± 143.10 mg/dL	226.25 ± 143.99 mg/dL
SBP	132.77 ± 11.21 mmHg	123.67 ± 12.0 mmHg
DBP	72.46 ± 8.75 mmHg	73.58 ± 9.45 mmHg
BMI	36.0 ± 7.0 kg/m^2	35.6 ± 6.7 kg/m^2
Weight	211.2 ± 44.0 lb	209.0 ± 42.0 lb
Waist circumference	112 ± 14.2 cm	106.8 cm ± 13.1 cm
Physical activity days	2.76 ± 2.0 days	3.58 ± 1.62 days

$p = .05$

Based on CES-D scores, the participants did not meet the criteria for clinical depression at baseline (CES-D < 16; 10 ± 7.56) or post-intervention. Participants had lower depressive symptom scores post-intervention (CES-D < 16; 8.75 ± 8.49) but the difference was not significant. Participants had low anxiety scores both at baseline (STAI; 25.83 ± 4.69) and-post intervention (STAI; 24.08 ± 11.76). There was no significant difference between baseline and week 12 scores. Participants had moderately high perceived stress levels (PSS; 13.67 ± 7.57) at baseline. They had lower perceived stress levels post-intervention (PSS; 10.25 ± 7.87) but the difference was not significant.

At baseline, seven participants scored their diabetes self-management as very good (80–100 mm), two as fair (40–50 mm), and three as very poor (10–20 mm). At week 12, 10 participants scored their self-management as very good (80–100 mm), one as good (60–70 mm), and one as very poor (10–20 mm). There were no significant differences in perceived self-management.

At the conclusion of the study, participants showed significant improvements in adherence to diabetes self-management practices, including medication and insulin administration ($x^2 = 14.38$, $p = .006$; Cramer's V = .85, $p = .006$), diet ($x^2 = 26.67$, $p = .009$; Cramer's V = .94, $p = .009$), and foot care self-care practices ($x^2 = 25.57$, $p = .003$; Cramer's V = .83, $p = .003$). However, there were no significant differences in physical activity and glucose monitoring (Table 2).

Table 2 ***Self-Care Practices (*N *= 12) at Baseline and Post-intervention***

	Adherence (*n*)						
	Baseline			**Post-intervention**			
Self-care		***50-100%***	***0-25%***		***50-100%***	***0-25%***	***p***
Medicines	9	9	0	10	10	0	.006*
Diet	8	7	1	11	10	1	.009*
Foot care	12	10	2	12	11	1	.003*
Self-monitored blood glucose	12	7	5	12	10	2	.1
Physical activity	11	5	6	12	11	1	.5

* $p = .05$

Feasibility and acceptability of the intervention were assessed by examining recruitment, retention, and attendance rates. A total of 13 participants were recruited for the study but one left the study due to hospitalization. The retention rate was thus 87% (*n* = 12) for the 12-week study period. Eight participants had 100% attendance at study sessions. Reasons for absences were unrelated to the intervention (e.g., automobile accidents, birth of a premature grandchild, caregiver to sick aging parent, hospitalization).

Audiorecordings of focus groups indicated that the majority of participants were receptive and that they found the church-based culturally targeted diabetes management intervention acceptable. The collaborative work of minority health-care providers (advanced practice nurses, a clinical psychologist, certified diabetes educators, and a board-certified endocrinologist) and clergy was evaluated by asking participants what they liked or disliked about the program. One participant responded, "I liked that the program was just for me, you know, that it taught me about my diabetes and how it affects me as an African American and what changes I need to make in my life." Another participant commented, "I like the group setting at the church and I hope the church continues the program as a support group." Requests to continue the sessions were received from both study participants and church congregants with diabetes who were not able to enrol in the study. Additionally, the first author has received requests from other churches for the program. Thus, team members and clergy concluded that the church-based culturally targeted DSME was well received.

Discussion

This study tested the feasibility of a church-based culturally targeted diabetes self-management intervention for African-American adults with T2DM. The results indicate that interventions focused on DSME, physical activity, behavioural management, and emotional regulation can be implemented in the community and can lead to improvements in self-care management, emotional distress, and physical health in African-American adults with T2DM. The study also reaffirms a history of investigations that are indexed by published reviews demonstrating the value of tailored interventions for populations that are not well served by standard interventions implemented in traditional medical settings (Satterfield et al., 2003).

Although changes in participants' anthropometric measurements were not statistically significant, clinically relevant changes were noted in systolic blood pressure and lipid levels. To our surprise, we saw trends for increasing HbA1c from time 1 to time 2 evaluations. Previous studies have shown that in the general population a reduction in SBP as small as 5mmHg can lead to a 14% reduction in mortality due to stroke, a 9% reduction in mortality due to coronary heart disease (CHD), and a 7% decrease in all-cause mortality (Whelton et al., 2002). Multiple studies have shown that a reduction in LDL can lead to a decrease in mortality due to CHD (National Cholesterol Education Program Expert Panel, 2002). Thus if culturally targeted, church-based interventions such as this were shown to be successful with larger samples, the effects on SBP and lipids could have significant implications for reducing the risk of CHD and stroke in African Americans.

Changes in physical activity were not statistically significant. However, the majority of participants (n = 9) reported meeting their goal of performing physical activity at least 90 minutes a week (30 minutes 3 times/wk) at 12 weeks. Participants indicated that they preferred group physical activities to individual exercises. They also attributed their being active to the support they found in their DSME group meetings and the support they received from their church.

These middle-aged and older African-American adults with T2DM did not have clinically relevant anxiety or symptoms indicative of clinical depression, though they had moderately high levels of perceived stress at baseline. Their anxiety and depressive symptom scores and perceived stress were lower post-intervention. These findings are consistent with those of Steinhardt, Mamerow, Brown, and Jolly (2009), who found that African Americans with T2DM who participated in a church-based resiliency training intervention showed no significant changes in depressive symptoms and perceived stress scores but did report decreases in stress and depressive symptoms post-intervention. Additional prospective investigations are needed to better understand the role of culturally targeted, church-based interventions in managing psychological distress in African Americans with T2DM.

Surprisingly, at baseline the majority of participants in the study perceived themselves as managing their diabetes despite their high BMI and high glycemic and lipid indexes. This suggests that the perception of "good" self-management in African-American adults with T2DM may not fit with the outcome indices used by most health-care providers. Qualitative studies may be needed to explore perceptions of quality self-management in African Americans with T2DM.

The limitations of this study include the small, non-randomized sample, the limited range of demographics of the sample, and the lack of a control group. In addition, some of the data were based on self-report, and the SADSM scale did not have test-retest data. Further, some outcomes, including HbA1C, did not improve. However, in general the outcomes of this study are encouraging for the use of culturally tailored, community-based interventions to promote quality diabetes self-management behaviours among African-American adults with T2DM. We sacrifice external validity (generalizability to other populations) in this pilot study for high internal validity and the ability to build models directly for African Americans. It is particularly noteworthy that participants showed decreases in SBP, lipid levels, and waist circumference and an increase in physical activity. However, replication of the study with a larger sample and a control group are necessary to more definitively evaluate the effectiveness of this community church-based DSME intervention in improving diabetes self-management behaviours in African-American adults. In the meantime, the results clearly show the importance of collaborating with pastors or other recognized community leaders to ensure that interventions targeting behavioural change are feasible and acceptable to vulnerable populations such as African Americans with T2DM.

We lastly note that it is also important to replicate our findings with other disenfranchised and underserved national and international populations, with the goal of producing additional information for the development of culturally tailored, community-based interventions. The church, as we modelled it for African Americans in the present study, may be an appropriate venue for the promotion of health for some populations. We suggest that a temple, a mosque, a home, or an outdoor public space could be more appropriate for others. Studies conceptualized, conducted, and consumed in a cultural context are needed, to increase the effectiveness of such interventions for the multitude of populations that do not respond to generalized interventions.

References

American Diabetes Association. (2007). Standards of medical care in diabetes – 2006. *Diabetes Care, 29,* S4–42.

Anderson-Loftin, W., & Moneyham, L. (2000). Long-term disease management needs of Southern African Americans with diabetes. *Diabetes Education, 26,* 821–832.

Blank, M. B., Mahmood, M., Fox, J. C., & Guterbock, T. (2002). Alternative mental health services: The role of the Black church in the South. *American Journal of Public Health, 92,* 1668–1672.

Centers for Disease Control and Prevention. (2007). *National diabetes fact sheet: General information and national estimates on diabetes in the United States.* Atlanta: US Dept. of Health and Human Services, Centers for Disease Control and Prevention. Retrieved August 8, 2009, from http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2007.pdf.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24,* 385–396.

Cohen, S., & Williamson, G. (1988). Perceived stress in a probability sample of the United States. In S. Spacapam & S. Oskamp (Eds.), *The social psychology of health: Claremont Symposium on Applied Social Psychology* (pp. 31–67). Newbury Park, CA: Sage.

Collins-McNeil, J. C., Holston, E. C., Edwards, C. L., Benbow, J. C., & Ford, Y. (2009). Physical activity, depressive symptoms, and social support among African-American women with type 2 diabetes. *Canadian Journal of Nursing Research, 41*(3), 24–43.

Delamater, A. M., Jacobson, A. M., Anderson, B., Cox, D., Fisher, L., Lustman, P., et al. (2001). Psychosocial therapies in diabetes: Report of the Psychosocial Therapies Working Group. *Diabetes Care, 24,* 1286–1292.

Faridi, Z., Shuval, K., Njike, V. Y., Katz, J. A., Jennings, G., Williams, M., et al. (2009). Partners Reducing Effects of Diabetes (PREDICT): A diabetes prevention physical activity and dietary intervention through African American churches. *Health Education Research, 25,* 306–315.

Gaines, F. D., & Weaver, R. (2006). *New soul food cookbook for people with diabetes* (2nd ed.). Pikesville, MD: Port City Press.

Gould, D., Kelly, D., Goldstone, L., & Gammon, J. (2001). Examining the validity of pressure ulcer risk assessment scales: Developing and using illustrated patient stimulations to collect the data. *Journal of Clinical Nursing, 10,* 697–706.

Gregg, E. W., Geiss, L. S., Saaddine, J., Fagot-Campagna, A., Beckles, G., Parker, C., et al. (2001). Use of diabetes preventive care and complications risk in two African-American communities. *American Journal of Preventive Medicine, 21,* 197–202.

Grey, M., Boland, E. A., Davidson, M., Li, J., & Tamborlane, W. V. (2000). Coping skills training for youth with diabetes mellitus has long-lasting effects on metabolic control and quality of life. *Journal of Pediatrics*, *137,* 107–113.

Hill-Briggs, F., Gary, T. L., Bone, L. R., Hill, M. N., Levine, D. M., & Brancati, F. L. (2005). Medication adherence and diabetes control in urban African Americans with type 2 diabetes. *Health Psychology*, *24,* 349–357.

Houston, J. M., Martin, M., Williams, J. E., & Hill, R. (2006). The annual African American Conference on Diabetes: Evolving program evaluation with evolving program implementation. *Preventing Chronic Disease: Public Health Research, Practice, and Policy, 3*(1), A18.

Jiang, W., Babyak, M. A., Rozanski, A., Sherwood, A., O'Connor, C., Waugh, R., et al. (2003). Depression and increased myocardial ischemic activity in patients with ischemic heart disease. *American Heart Journal, 146,* 55–61.

Knight, B. G., Silverstein, M., McCallum, T., & Fox, L. (2000). A sociocultural stress and coping model for mental health outcomes among African American caregivers in southern California. *Journals of Gerontology. Series B: Psychological Sciences and Social Sciences,* 55*B,* P142–P150.

Knight, R. G., Williams, S., McGee, R., & Olaman, S. (1997). Psychometric properties of the Center for Epidemiologic Studies Depression Scale (CES-D) in a sample of women in middle life. *Behavior Research and Therapy, 35,* 373–380.

Long, T. P. (1978). The prevalence of clinically treated diabetes among Zuni reservation residents. *American Journal of Public Health, 68,* 901–903.

Markens, S., Fox, S. A., Taub, B., & Gilbert, M. L. (2002). Role of Black churches in health promotion programs: Lessons from the Los Angeles Mammography Promotion in Churches Program. *American Journal of Public Health, 92,* 805–810.

National Cholesterol Education Program Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). (2002). Third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) final report. *Circulation, 106,* 3143–3421.

Ockene, I. S., Tellez, T. L., Rosal, M. C., Reed, G. W., Mordes, J., Merriam, P. A., et al. (2012). Outcomes of a Latino community-based intervention for the prevention of diabetes: The Lawrence Latino Diabetes Prevention Project. *American Journal of Public Health, 102*(2), 336–342.

Patterson, R. L., O'Sullivan, M., & Spielberger, C. D. (1980). Measurement of state and trait anxiety in elderly mental health clients. *Journal of Behavioral Assessment, 2,* 89–97.

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurment, 1,* 385–401.

Satterfield, D. W., Volansky, M., Caspersen, C. J., Engelgau, M. M., Bowman, B. A., Gregg, E. W., et al. (2003). Community-based lifestyle interventions to prevent type 2 diabetes. *Diabetes Care, 26*(9), 2643–2652.

Sbrocco, T., Carter, M. M., Lewis, E. L., Vaughn, N., Kalupa, K. L., King, S., et al. (2005). Church-based obesity treatment for African-American women improves adherence. *Ethnicity and Disease, 15,* 246–255.

Skelly, A. H., Marshall, J. R., Haughey, B. P., Davis, P. J., & Dunford, R. G. (1995). Self-efficacy and confidence in outcomes as determinants of self-care practices in inner-city African-American women with non-insulin-dependent diabetes. *Diabetes Educator, 21,* 38–46.

Skelly, A. H., Samuel-Hodge, C., Elasy, T., Ammerman, A. S., Headen, S. W., & Keyserling, T. C. (2000). Development and testing of culturally sensitive instruments for African American women with type 2 diabetes. *Diabetes Educator, 26,* 769–774.

Steinhart, M. A., Mamerow, M. M., Brown, S. A., & Jolly, C. A. (2009). A resilience intervention in African American adults with type 2 diabetes. *Diabetes Educator, 35,* 274–284.

Surwit, R. S., van Tilburg, M. A., Zucker, N., McCaskill, C. C., Parekh, P., Feinglos, M. N., et al. (2002). Stress management improves long-term glycemic control in type 2 diabetes. *Diabetes Care, 25,* 30–34.

van Tilburg, M., McCaskill, C. C., Lane, J. D., Edwards, C. L., Bethel, A., Feinglos, M. N., et al. (2001). Depressed mood is a factor in glycemic control in type 1 diabetes. *Psychosomatic Medicine, 63,* 551–555.

Whelton, P. K., He, J., Appel, L. J., Cutler, J. A., Havas, S., Kotchen, T. A., et al. (2002). Primary prevention of hypertension: Clinical and public health advisory from the National High Blood Pressure Education Program. *Journal of the American Medical Association, 288,* 1882–1888.

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Résumé

Les interventions de lutte au tabagisme pratiquées par les infirmières des écoles postsecondaires en Ontario

Kelli-an G. Lawrance, Heather Elizabeth Travis, Sharon A. Lawler

Les interventions de cessation faites par les infirmières auprès d'étudiants de niveau postsecondaire pourraient s'avérer une stratégie efficace dans le cadre des efforts pour réduire le tabagisme chez les jeunes adultes. Cette étude se penche sur les méthodes que les infirmières œuvrant dans le milieu de l'enseignement utilisent pour identifier les fumeurs et offrir un soutien au sevrage tabagique. Des 108 infirmières travaillant dans 16 universités ontariennes, 83 ont rempli un questionnaire conçu par les chercheuses. De ce nombre : 8,2 pour cent ont interrogé presque tous leurs patients sur leur consommation de tabac; 27,4 pour cent ont posé très peu de questions; 83,1 pour cent ont conseillé aux fumeurs identifiés de cesser de fumer; 63,9 pour cent leur ont offert de l'aide; et 59 pour cent ont fixé des rendez-vous de suivis. La consommation de tabac était le plus souvent évaluée à l'occasion de consultations pour des problèmes respiratoires ou cardiovasculaires. Le plus souvent, l'aide aux fumeurs prenait la forme d'un aiguillage vers d'autres professionnels ou services. La mise en place d'une initiative de surveillance tabagique sur 10 des 16 campus, financée par le gouvernement, n'a exercé qu'une influence limitée sur les infirmières pour ce qui est de l'évaluation de la consommation de tabac et l'invitation à cesser de fumer. L'amélioration de la fréquence et de la qualité des interventions en matière de tabagisme faites par les infirmières d'établissements postsecondaires nécessitera peut-être un travail de sensibilisation et de soutien.

Mots clés : intervention de cessation, tabagisme, jeunes adultes, fumeurs, sevrage tabagique

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Tobacco Intervention Practices of Postsecondary Campus Nurses in Ontario

Kelli-an G. Lawrance, Heather Elizabeth Travis, Sharon A. Lawler

Cessation interventions offered by nurses to postsecondary students could represent an important strategy for reducing smoking among young adults. This study examines how nurses working in campus health clinics identify smokers and provide cessation support. Of 108 nurses working at 16 universities in the Canadian province of Ontario, 83 completed a researcher-designed questionnaire. Of these, 8.2% asked almost all patients about their tobacco use and 27.4% asked almost none; 83.1% advised identified smokers to quit, 63.9% offered them assistance, and 59.0% arranged follow-up visits. Smoking was most often assessed during patient visits for respiratory or cardiovascular concerns. Assistance most often involved referral of smokers to other professionals or services. A government-funded tobacco control initiative implemented on 10 of the 16 campuses had limited influence on whether nurses assessed tobacco use and advised cessation. Education and support may be needed to improve the frequency and quality of tobacco interventions provided by nurses working on postsecondary campuses.

Keywords: smoking cessation, young adult, clinical nursing research

Introduction

Despite successful efforts to reduce tobacco use in the Canadian population, the proportion of young adults smoking cigarettes has declined only modestly over the past decade, with 23% of those aged 20 to 24 still reporting current tobacco use (Health Canada, 2009). During the transition from adolescence to young adulthood, the prevalence of smoking and consumption of tobacco both rise substantially (Hammond, 2005; Lantz, 2003), as do the proportions of smokers intending and trying to quit (Hammond, 2005; Leatherdale & Shields, 2009; Patterson, Lerman, Kaufmann, Neuner, & Audrain-McGovern, 2004; Thompson et al., 2007). Thus, young adulthood is a period when smoking may either be rejected or become established as a long-term addiction with serious health risks (Backinger, Fagan, Mathews, & Grana, 2003; Biener & Albers, 2004; Hammond, 2005; Lantz, 2003).

In North America, more than half of the young-adult population pursues postsecondary education (Aud & Hannes, 2010; Drolet, 2005). Thus, smoking cessation interventions with students may be an especially important strategy for reducing tobacco use in this population.[1] In this regard, health professionals in campus health clinics may be ideally situated to offer brief tobacco interventions. Postsecondary students identify lifestyle issues, including addictions, among their top health concerns (Patterson & Kline, 2008) and perceive campus medical services as trusted sources of health information and assistance (American College Health Association [ACHA], 2009). Furthermore, there is convincing evidence that doctors (Lancaster & Stead, 2008), nurses (Rice & Stead, 2008), and other health professionals (Dent, Harris, & Noonan, 2009; Gordon et al., 2010) can increase smokers' chances of quitting by implementing a brief tobacco intervention protocol that includes asking about tobacco use, advising quitting, assessing readiness to quit, assisting with the quit attempt, and arranging follow-up. This evidence-based protocol is presented most comprehensively in the US Department of Health and Human Services 2008 document *Treating Tobacco Use and Dependence* (Public Health Service, 2008). It is mirrored with slight variations (such as the omission of the assessment step) in Australian, European, and Canadian best practice guidelines (Anonymous, 1997; Jackson et al., 2001; McIvor et al., 2009; Zwar et al., 2004), as well as the Registered Nurses Association of Ontario ([RNAO], 2007) guideline *Integrating Smoking Cessation Into Daily Nursing Practice* and the US *Tobacco Free Nurses* initiative (www.tobaccofreenurses.org).

While uptake of best practice guidelines for treating tobacco dependence has been relatively widespread among primary care physicians in the community (Crawford et al., 2005; Friend & Levy, 2001; Thorndike, Rigotti, Stafford, & Singer, 1998; Tong, Strouse, Hall, Kovac, & Schroeder, 2010; Tremblay, Cournoyer, & O'Loughlin, 2009; Tremblay et al., 2001) and on some postsecondary campuses (Lawrance & Lawler, 2008), it is unknown whether and the frequency at which nurses in campus clinics are intervening around tobacco. Burke (2008) reports that half of the health-care providers in a campus clinic spoke to their clients about smoking, and Fagan (2007) reports that more than two thirds did so, but neither study differentiated among physicians, nurses, or other health professionals. Studies comparing the cessation counselling practices of

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[1] Harm-reduction strategies that stimulate smokers to reassess their smoking behaviours, take steps to protect others from their tobacco smoke, reduce their tobacco consumption, and possibly even quit smoking may also be important with this age group and highly viable nursing interventions (*cf.* Logan & Marlatt, 2010). The current study, however, specifically addressed smoking cessation intervention.

physicians and nurses in community and hospital settings, on the other hand, have found that nurses intervene around tobacco less frequently than physicians (Tong et al., 2010; Tremblay et al., 2009). In a study with Canadian acute-care nurses, Schultz, Johnson, and Bottorff (2006) determined that nurses often assessed smoking status but rarely advised quitting or offered assistance with quitting. Given that Canadian young adults (aged 18–24) report seeing a nurse on average 6.6 times per year (Statistics Canada, 2010), and given the growing evidence that smoking cessation treatment offered by a variety of clinician types can increase both abstinence rates and quit attempts (An et al., 2008; Public Health Service, 2008), it is important to determine whether campus nurses are providing cessation counselling.

The primary goal of this study was to examine whether and to what degree nurses who work in campus health clinics at Ontario universities help students to stop smoking. At the time of the study, a comprehensive government-funded tobacco control initiative called Leave The Pack Behind (LTPB) was operating in approximately half of Ontario's 19 publicly funded universities. While the major component of LTPB was student-to-student education and programming, LTPB also involved campus health professionals in strategies to promote cessation. These strategies included stocking campus health clinics with age-tailored patient education materials, informing clinic staff of the availability of a trained team of students to support smokers trying to quit, and offering "brief, clinical tobacco intervention" training to all campus health professionals. The study also considered the influence of this initiative on nurses' provision of cessation counselling.

Methodology

Procedures

From the total of 19 universities in Ontario in 2004–05, a convenience sample of 16 universities was drawn. (One university was excluded because its health clinic was not overseen by campus administration and two were excluded because permission to distribute questionnaires could not be secured in time for the scheduled data collection.) Large and small commuter and residential universities were represented in the sample. Of the 16 universities, 10 were involved in the LTPB initiative.

With the agreement of the director of the campus health clinic, questionnaire packages were made available to all nurses who worked in the clinic. (Packages were either placed in nurses' mail slots or handed out at meetings.) All packages included an instruction sheet, a consent form, a confidential questionnaire, and two envelopes. Nurses choosing to participate in the study took about 5 minutes to complete the consent form and questionnaire, seal each document in a separate envelope, and return both envelopes to the clinic's administrative assistant. The assistant gave them a thank-you letter and $10 gift card redeemable at a local retailer. Study procedures were cleared by the Research Ethics Board at Brock University.

Participants

Of the 108 questionnaire packages distributed to nurses, 85 (76.9%) were returned. It was noted that 52 of the 75 nurses from universities implementing LTPB and 31 of the 33 nurses from universities not implementing LTPB returned questionnaires, $c^2(1, N = 107) = 7.47, p = .006$.

Measures

On the researcher-generated questionnaire, nurses were asked, "Of all the student patients/clients you see in a typical day, how many do you ask about their smoking status?" Response options were *almost none, some, about half, most,* and *almost all.* On seven-point scales, nurses also reported how often (1 = *never;* 7 = *always*) they asked about smoking at each of nine specific types of visit (annual physical, sexual health, etc.).

Nurses completed a checklist to describe all the actions they took with patients identified as smokers. Possible answers included *advise patient to quit, advise patient to call Smokers' Helpline* (the provincial quit line), *advise patient to find smoking cessation resources on the internet, suggest a follow-up appointment,* and *refer patient to another health professional or cessation service.* If nurses selected any of these options, they were considered to have advised the patient to quit. Those who selected any options beyond *advise patient to quit* were considered to have offered assistance. If they suggested a follow-up appointment or referred the patient to another health professional or cessation service, they were considered to have arranged follow-up. To further explore how assistance was offered, the questionnaire asked nurses how often they advised the use of self-help materials, nicotine patch, nicotine gum, or alternative cessation approaches (1 = *never;* 7 = *always*); whether smoking-related patient materials were kept in the clinic (*yes* or *no*); and where these materials were located (*waiting room, central storage/sample cupboard, examining rooms*). Finally, nurses at campuses with LTPB were asked whether they offered LTPB self-help materials to smokers (*yes* or *no*) and whether they referred smokers to LTPB peer-to-peer programming (*yes* or *no*).

Data Analyses

To account for the possibility of differences between nurses from universities that were and were not implementing LTPB, chi-square tests and mixed-model repeated measure designs (with presence of LTPB on campus as the between-subjects variable) were conducted. Results of these analyses are reported only where between-group differences were significant ($p < .05$). Otherwise, descriptive statistics were used to assess how often nurses asked patients about smoking; whether or not nurses advised cessation, offered cessation assistance, and arranged follow-up; and whether and where smoking-related patient materials were kept in the clinic. One-group repeated measure designs were used to assess how frequently nurses asked about smoking status at each of the specific types of visit and how frequently they advised the use of specific cessation aids. Use of LTPB materials and services by nurses at campuses implementing LTPB was examined with descriptive statistics. SPSS 18.0 was used for all analyses.

Results

Sample Characteristics

The average age of the nurses was 47.5 years ($sd = 8.8$) and 97.6% were women. Most (72.8%) identified themselves as non-smokers; 17.3% identified themselves as former smokers and 9.9% as smokers. They worked an average of 3.9 ($sd = 1.3$) days per week in the campus clinic. It was noted that 57.7% of the nurses at universities implementing LTPB had attended a 1-hour cessation-focused professional development session hosted by LTPB. No differences were observed between nurses at universities that were and were not implementing LTPB.

Asking About Tobacco Use

In the sample, 27.4% of the nurses reported typically asking *almost none* of their patients about tobacco use. On the other hand, 8.2% reported typically asking *almost all* of their patients about their smoking status. The remainder asked *most* (5.5%), *about half* (23.3%), or *some* (35.6%).

Analysis of the types of visit during which nurses were most likely to ask about smoking revealed the only between-group difference observed in the study: Compared to nurses at campuses with LTPB, those at campuses without LTPB asked more frequently about tobacco use, $F(1, 81) = 4.94, p = .029$. Of note, a significant main effect was also found for the within-subjects variable type of visit, $F(8, 74) = 59.42, p < .001$. As shown in Table 1, *post hoc* tests revealed that nurses were most likely to ask about patients' tobacco use during visits for upper and lower respiratory concerns and least likely to ask during visits for skin or musculoskeletal concerns.

Table 1 ***Nurses Asking About Smoking Status During Dedicated Patient Visits***

Reason for Visit	**Frequency of Asking**	
	M	***SD***
Lower respiratory	5.68^{a}	1.62
Upper respiratory	5.65^{a}	1.66
Cardiovascular	5.06	2.02
Substance abuse	4.54^{b}	2.26
Reproductive	4.53^{b}	2.23
Annual physical	4.17^{b}	2.42
Mental health	2.71	2.00
Skin	1.73^{c}	1.12
Musculoskeletal	1.65^{c}	1.00

Notes: Responses were measured on a 7-point scale (1 = *almost never*; 7 = *almost always*). Means sharing a superscript letter do not differ; all others differ significantly ($p < .05$, two-tailed, Sidak adjustment for multiple comparisons). Across all visits, nurses at campuses without LTPB more frequently asked about tobacco use: $F(1, 81) = 4.94, p = .029$ (main effect).

Advising and Helping Smokers to Quit

Overall, 83.1% of nurses advised identified smokers to quit and 63.9% offered them assistance. Although advising and helping patients to quit were each unrelated to the presence of LTPB on campus, nurses on campuses with LTPB did have the added option of offering LTPB self-help materials to smokers. When this option was included as a method of assistance, the proportion of nurses offering assistance to identified smokers increased to 73.5% from 63.9%. With respect to how nurses offered assistance, 83.6% referred patients to another health professional or cessation service, 9.8% advised calling the provincial quit line, 8.2% suggested looking for information on the Web, and 6.6% offered a follow-up appointment. On campuses with LTPB, 68.8% of the nurses gave patients LTPB self-help materials. (Percentages sum to greater than 100 because participants could check more than one option.)

Analysis of how frequently nurses suggested self-help cessation resources, nicotine gum, nicotine patch, or alternative approaches showed no between-group effect. The within-subjects effect for type of assistance offered was significant: $F(3, 79) = 50.92, p < .001$. *Post hoc* tests revealed that self-help cessation resources were suggested significantly ($p < .05$) more frequently ($M = 5.06, sd = 2.12$) than any of the other approaches. Nicotine gum ($M = 2.52, sd = 1.58$) and nicotine patch ($M = 2.42, sd =$

1.51) were both suggested more often than alternative approaches (*M* = 1.96, *sd* = 1.17).

All nurses reported that patient materials on smoking cessation were available in their clinics. Most (75.0%) reported that these materials were kept in a central location accessible to clinic staff; 77.5% reported that they were available in the waiting room; and 45.0% reported that they were kept in individual examining rooms.

Arranging Follow-up

Forty-nine nurses (59.0%) reported that they arranged follow-up for identified smokers. Virtually all of these (91.8%) referred smokers to physicians. As well, 18.5% referred smokers to counsellors, 9.3% referred them to pharmacists, and none referred them to another nurse. (Percentages sum to greater than 100 because participants could check more than one option.) Although arranging follow-up was unrelated to the presence of LTPB on campus, it was determined that 64.1% of the nurses on campuses with LTPB referred smokers to its peer-to-peer support. When this option was included as a method of referral, the proportion of nurses arranging follow-up increased to 66.3% from 59.0%.

Discussion

Regardless of practice setting, nurses can make a contribution to the health of individuals and society by incorporating health promotion and tobacco-reduction initiatives into their practice (Canadian Nurses Association, 2011; International Council of Nurses, 1999; Sarna et al., 2009; Underwood & Ryan, 2010; Whitehead, 2005).

In this study of the tobacco-intervention practices of nurses working in campus clinics across Ontario, 83% of those surveyed advised quitting and up to 73% offered cessation assistance to patients who were identified as smokers. Only 37.0% of the nurses reported that they asked the majority of their patients about their tobacco use, and fully 27.4% reported asking almost none of their patients about tobacco use. In studies with nurses working in hospitals or other acute-care settings, 50–90% reported asking a majority of their patients about tobacco use, 39–66% advised cessation, and 13–49% offered assistance (Sarna et al., 2009; Schultz et al., 2006; Tong et al., 2010; Tremblay et al., 2009). The present results suggest that nurses on campus ask fewer patients about tobacco use but provide quitting advice and assistance to a larger proportion of patients identified as smokers. The differences in results across studies may reflect heterogeneity in nurses' role expectations across settings. It has been suggested, for example, that health promotion activities such as brief tobacco intervention may be more consistent with the role expectations of nurses working in community settings than with those of nurses working in acute-care and hospital settings. The commitment to health promotion reflected in most services offered by campus clinics may help to explain the relatively high rates of cessation assistance offered by campus nurses. Their low rate of asking about tobacco use, however, appears at odds with this explanation. It may be that nurses in campus clinics respond to the demands made on their time by asking about patients' smoking status only when they expect to be able to provide advice and assistance. Similar practices and implications for care would likely be observed among nurses in other types of high-volume, walk-in clinic, where time pressures and limited opportunities for follow-up may inhibit them from addressing smoking cessation with patients. Alternatively, campus clinics may be structured such that brief tobacco intervention is regarded as the responsibility of physicians and thus is rarely initiated by nurses. This possibility is corroborated by the results of a study in which Lawrance and Lawler (2008) determined that virtually all physicians (96%) working in campus clinics advised identified smokers to quit, and most (72%) offered assistance. Other barriers not investigated here but previously found to interfere with health professionals' practice of brief tobacco intervention (e.g., feeling ill-equipped to intervene, prioritizing other health concerns over smoking cessation, anticipating hostility from the patient on the topic of smoking) may also explain why campus nurses ask so few patients about smoking. In any case, the findings suggest that there is room for improvement in terms of how often nurses in busy walk-in (campus) clinics inquire about and respond to patients' smoking status.

Unlike most investigations of nurses' brief tobacco intervention practices, this study looked explicitly at the type of appointment in which nurses asked about tobacco use, and determined that most often it was related to upper or lower respiratory concerns. Their frequency of asking was significantly greater in these types of visit than in visits for cardiovascular concerns, where asking was, in turn, significantly greater than in visits for substance abuse, reproductive issues, or an annual physical. Patients presenting with mental health, skin, or muscuoloskeletal concerns were very rarely asked about their tobacco use. Given the vast evidence indicating that tobacco use exacerbates respiratory and cardiovascular conditions (US Department of Health and Human Services, 2010), nurses might be expected to ask about tobacco use in visits for these conditions. What is surprising is how infrequently nurses asked about tobacco use during annual physicals. Visits for annual physicals represent an obvious opportunity to determine patients' smoking status and implement brief tobacco intervention. Not only is preventive advice expected in these appointments, but research has shown that patients who smoke are more likely to recall receiving cessation information during wellness visits than during visits for an acute illness (Flocke & Stange, 2004). Accordingly, this type of visit may be among the best opportunities for engaging smokers in discussions and interventions to promote cessation.

Among the 73% of nurses who provided assistance to identified smokers, more than 80% did so by referring patients to another health professional. Referrals were almost always made to physicians; only a small minority of nurses referred to counsellors or pharmacists, and none referred to another nurse. Other forms of assistance offered by the nurses included suggesting a follow-up appointment with themselves, encouraging patients to call the provincial quit line, and suggesting the Web as a source of information and support; however, no more than 10% of nurses reported offering any of these forms of assistance. Nurses' reports of how often they recommended specific quit aids clearly show that they encouraged the use of self-help materials far more often than they recommended nicotine replacement therapies (NRT), and that they very rarely suggested alternative remedies.

Overall, these findings suggest that nurses took steps to assist smokers with their efforts to quit, but these steps infrequently involved their directly delivering cessation interventions. Their proclivity to refer to physicians highlights the importance of ensuring that doctors in campus clinics are prepared and able to consistently and effectively intervene around tobacco use. Similarly, it raises the question of whether nurses are aware that their own advice and assistance to patients has the potential to synergistically augment any brief tobacco intervention provided by physicians and thus increase smokers' likelihood of successfully quitting (Public Health Service, 2008). Nurses' relatively infrequent recommendation of NRT mirrors similarly infrequent recommendations of NRT by campus physicians (Lawrance & Lawler, 2008). This suggests that students who smoke are getting very little information or encouragement to use NRT when they visit a campus clinic. While a few recent population studies have concluded that NRT is less effective when self-administered (Alpert, Connolly, & Biener, 2012; Pierce & Gilpin, 2002), a much larger body of clinical studies shows that NRT combined with support by a health professional meaningfully improves the chances of success (Hays et al., 1999; Shiffman et al., 2002; Shiffman & Sweeney 2008; Stead, Perera, Bullen, Mant, & Lancaster, 2008; Zhu, Lee, Zhuang, Gamst, & Wolfson, 2012). Furthermore, dialogue about NRT can engage patients in important conversations about their own strategies and motivations for quitting — regardless of whether they ultimately choose to use it. Given the effectiveness of NRT in clinical practice, it should be recommended more often.

The presence of the LTPB tobacco-control initiative on some of the campuses where the nurses worked had subtle but important effects on nurses' practice of brief tobacco intervention. For example, the total proportions of nurses who reported "assisting" smokers in their attempts to quit and "arranging" follow-up were greater when the definitions of these behaviours included options available through that initiative (e.g., "provide LTPB's self-help program" and "refer to LTPB peer team"). Indeed, 68.8% of nurses on campuses with LTPB reported offering its self-help program to patients and 64.1% said they referred patients to its peer support. While this study was not intended to examine the effectiveness of the initiative, the findings do suggest that the availability of pertinent, age-tailored resources and services may increase the likelihood of assistance being offered to smokers. In this regard, the findings support and extend those of Schultz et al. (2006), who determined that a supportive setting was associated with more widespread brief tobacco intervention by nurses working in hospitals. The data suggest that nurses in a variety of high-traffic, walk-in clinics might also be more inclined and better able to engage patients in tobacco interventions if the clinic structure and systems support this practice.

This study found that all campuses had smoking cessation materials on site and most (77.5%) kept these materials in the waiting room. Ideally, materials would be kept in the examining rooms where nurses (or other health professionals) can quickly hand them to smokers as they advise and help them to quit smoking. On the other hand, considering that many patients are not receiving smoking cessation advice or assistance during appointments, the availability of these materials in the waiting room may increase their accessibility to smokers.

Limitations

While the overall response rate for the study was just over 75%, the higher response rate among nurses on campuses not implementing LTPB suggests a possible bias in the results. The clinical training for LTPB may have made nurses on those campuses more aware of their own shortcomings relative to best practice. This may have led them to avoid completing a questionnaire that might reveal these weaknesses, or to report their tobacco intervention practices from a less optimistic perspective compared to nurses on campuses where LTPB was not implemented. This possible bias, along with the relatively small sample size and the use of unverified self-report, may limit the generalizability of the results. Nevertheless, given the paucity of research examining the tobacco intervention practices of nurses on university campuses, this study provides valuable preliminary data.

The possibility that nurses were following a harm-reduction approach when working with patients who smoked was not explored. Nurses may have been quietly encouraging smokers to take steps to reduce their smoking and limit its harmful effects (on themselves or others) rather than directly advising and urging smoking cessation. When abstinence is not the singular goal, both the nurse and the client can consider any positive behavioural changes as therapeutic successes. This empowers the client and reflects important values of client-centred nursing. This study specifically would have benefited, and the field in general would benefit, from more attention to how nurses use harm-reduction strategies when intervening with high-risk behaviours.

Implications

Fundamental similarities in the organization and delivery of health services on campuses across Canada and the United States imply generalizability of these results well beyond the provincial sample frame. Furthermore, given that clinics on university campuses typically operate like walk-in clinics in the community, it is not unreasonable to expect that many of the conclusions drawn from the present results would apply to other fast-moving outpatient clinics. With that in mind, the following practice implications are suggested.

The results of this study reveal poor adherence to best practice guidelines, including the RNAO (2007) guideline, which calls for nurses to ask every patient about tobacco use and provide cessation advice and assistance to all smokers. Given the high prevalence of tobacco use among young adults (Health Canada, 2009) and the interest of this group in quitting (Messer, Trinidad, Al-Delaimy, & Pierce, 2008), it is disconcerting that many nurses are not asking about tobacco use among visitors to campus health clinics. Patterns of tobacco use are highly changeable during young adulthood (Hammond, 2005; Lantz, 2003), and there is tremendous potential to prevent escalation and long-term use by helping smokers to quit (Fagan et al., 2007). Although it is possible that doctors working in campus clinics are implementing brief tobacco intervention (Lawrance & Lawler, 2008), optimal clinical practice would see nurses also asking all patients about tobacco use and following up accordingly.

To encourage more frequent implementation of brief tobacco intervention by nurses, it might be beneficial to provide nurses with efficient, effective ways to do so, and to offer evidence of the meaningful impact that their actions can make in supporting smoking cessation among young adults. For instance, nurses could be helped to find ways of tailoring tobacco- and cessation-related messages to patients' presenting concerns. There is evidence, for example, that smoking delays healing of injuries (Wong & Martins-Green, 2004), adversely affects male and female reproductive outcomes (Soares, 2009), exacerbates skin conditions (Metelitsa & Lauzon, 2010), and is highly co-morbid with poor mental health (Serras, Saules, Cranford, & Eisenberg, 2010). Recognition of these associations might help nurses to see ways to broach the topic of smoking with patients who present with these conditions. Given that tailoring health behaviour advice to the presenting concern is associated with a twofold to fourfold increase in patients' recall of the discussion (Flocke & Stange, 2004), this type of tailoring might also enhance the impact of nurses' advice to quit.

It might also be important for nurses to understand that brief tobacco intervention delivered repeatedly by a variety of health professionals increases smokers' odds of successfully quitting. Along similar lines, it may also help for nurses to know that students view the staff of their medical centre as a highly credible source of health information (ACHA, 2009; Kwan, Arbour-Nicitopoulos, Lowe, Taman, & Faulkner, 2010) and that smokers with whom campus health professionals discuss smoking are more satisfied with their visit than those with whom no discussion of smoking takes place (Burke, 2008). These data may assuage nurses' concerns that patients will respond negatively to inquiries and health advice related to their tobacco use.

Finally, the type of assistance that nurses provide requires attention. Despite clear evidence that telephone quit lines can boost smokers' odds of quitting (Stead, Perera, & Lancaster, 2009), only 1 in 10 nurses surveyed used this method to help smokers to quit. Whether the underuse of quit lines stems from a lack of awareness, a disinclination to refer to services off campus, or a perception that quit lines cater to older smokers, the results reveal the need to enhance nurses' understanding of the utility of quit lines as a cessation support. The same is true of nurses' very low frequency of recommending NRT as a form of assistance — especially given the population with whom they work. Many young adults are intermittent or "social" smokers (Hammond, 2005); are motivated to quit (Messer et al., 2008); and, compared to older adults, are less addicted to nicotine, with less entrenched smoking behaviour (Messer et al., 2008). These characteristics make them good candidates for NRT. Providing nurses with more and specific training about the pharmakinetics, indications, and clinical effectiveness of cessation aids may increase their likelihood of recommending them to patients who smoke. This type of information might be included both in professional training sessions on brief tobacco intervention and in nursing curricula. Additionally, because many nurses may not have an opportunity to attend training sessions, quarterly bulletins or newsletters distributed to clinics might be a valuable mechanism.

Conclusions

For many young adults, visits to campus health clinics represent their first opportunity to interact with health professionals without parental supervision or knowledge. Nurses working in campus health clinics have the opportunity to establish a standard of care that young patients might come to expect in their future interactions with health professionals. Assessment of smoking and advice and assistance with efforts to quit should be a regular feature of this care. More research is needed to understand both individual factors and characteristics of the campus and clinic environment that support and inhibit campus nurses' practice of cessation counselling.

References

Alpert, H. R., Connolly, G. N., & Biener, L. (2012). A prospective cohort study challenging the effectiveness of population-based medical intervention for smoking cessation. *Tobacco Control.* [Online.] Doi:10.1136/tobaccocontrol-2011-050129.

American College Health Association. (2009). National College Health Assessment, Spring 2008. *Journal of American College Health, 57*(5), 477–488.

An, L. C., Foldes, S. S., Alesci, N. L., Bluhm, J. H., Bland, P. C., Davern, M. E., et al. (2008). The impact of smoking-cessation intervention by multiple professionals. *American Journal of Preventive Medicine, 34,* 54–60.

Anonymous. (1997, June). *Guidelines on smoking cessation for general practitioners and other health professionals.* European Medical Association Smoking or Health (EMASH). *Monaldi Archives for Chest Disease, 52,* 282–284.

Aud, S., & Hannes, G. (Eds.). (2010). *The condition of education 2010 in brief* (NCES 2010-029). Washington: National Center for Education Statistics, Institute of Education Sciences, US Department of Education.

Backinger, C. L., Fagan, P., Mathews, E., & Grana, R. (2003). Adolescent and young adult tobacco prevention and cessation: Current status and future directions. *Tobacco Control, 12*(Suppl 4), iv46–53.

Biener, L., & Albers, A. B. (2004). Young adults: Vulnerable new targets of tobacco marketing. *American Journal of Public Health, 94,* 326–331.

Burke, M.V. (2008). Health care providers' discussions of tobacco use, advice to quit and patient satisfaction at college health centres. *Journal of Smoking Cessation, 3*(2), 77–80.

Canadian Nurses Association. (2011). *Tobacco: The role of health professionals in tobacco cessation: Joint statement.* Ottawa: Author. Retrieved June 2, 2012, from http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Joint_PS_Tobacco_Cessation_e.pdf.

Crawford, M. A., Woodby, L. L., Russell, T.V., Turner, T. J., Hardin, J. M., & Harrington, T. M. (2005). Tobacco use assessment and counseling practices among Alabama primary care physicians. *Quality in Primary Care, 13,* 163–70.

Dent, L. A., Harris, K. J., & Noonan, C. W. (2009). Randomized trial assessing the effectiveness of a pharmacist-delivered program for smoking cessation. *Annals of Pharmacotherapy, 43*(2), 194–201.

Drolet, M. (2005). *Participation in post-secondary education in Canada: Has the role of parental income and education changed over the 1990s?* Ottawa: Statistics Canada.

Fagan, K. A. (2007). Smoking cessation counselling practices of college/university health-care providers: A theory-based approach. *Journal of American College Health, 55*(6), 351–360.

Fagan, P., Augustson, E., Backinger, C. L., O'Connell, M. E., Vollinger, R. E., Kaufman, A., et al. (2007). Quit attempts and intention to quit cigarette smoking among young adults in the United States. *American Journal of Public Health, 97*(8), 1412–1420.

Flocke, S. A., & Stange, K. C. (2004). Direct observation and patient recall of health behaviour advice. *Preventive Medicine, 38*(3), 343–349.

Friend, K., & Levy, D. T. (2001). Smoking treatment interventions and policies to promote their use: A critical review. *Nicotine and Tobacco Research, 3,* 299–310.

Gordon, J. S., Andrews, J. A., Albert, D. A., Crews, K. M., Payne, T. J., & Severson, H. H. (2010). Tobacco cessation via public dental clinics: Results of a randomized trial. *American Journal of Public Health, 100*(7), 1307–1312.

Hammond, D. (2005). Smoking behaviour among young adults: Beyond youth prevention. *Tobacco Control, 14,* 181–185.

Hays, J. T., Croghan, I. T., Schroeder, D. R., Offord, K. P., Hurt, R. D., & Wolter, T. D. (1999). Over-the-counter nicotine patch therapy for smoking cessation: Results from randomized, double-blind, placebo-controlled, and open label trials. *American Journal of Public Health, 89,* 1701–1707.

Health Canada. (2009). *Canadian Tobacco Use Monitoring Survey (CTUMS) 2009: Summary of annual results.* Ottawa: Author. Retrieved July 18, 2011, from http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/_ctums-esutc_2009/ann_summary-sommaire-eng.php.

International Council of Nurses. (1999). *Tobacco use and health: Position statement.* Geneva: Author. Retrieved June 2, 2012, from http://www.icn.ch/images/stories/documents/publications/position_statements/A18_Tobacco_Use_Health.pdf.

Jackson, G., Bobak, A., Chorlton, I., Fowler, G., Hall, R., Khimji, H., et al. (2001). Smoking cessation: A consensus statement with special reference to primary care. *International Journal of Clinical Practice, 55*(6), 385–392.

Kwan, M. Y. W., Arbour-Nicitopoulos, K. P., Lowe, D., Taman, S., & Faulkner, G. E. J. (2010). Student reception, sources, and believability of health-related information. *Journal of American College Health, 58*(6), 555–562.

Lancaster, T., & Stead, L. F. (2008). Physician advice for smoking cessation. *Cochrane Collaboration, Issue 4, art. CD000165. Doi: 10.1002/14651858. CD000165.pub2.*

Lantz, P. M. (2003). Smoking on the rise among young adults: Implications for research and policy. *Tobacco Control, 12*(Suppl I), i60–70.

Lawrance, K. G., & Lawler, S. A. (2008). Campus physicians' tobacco interventions with university students: A descriptive study of 16 Ontario university clinics. *Patient Education and Counseling, 70,* 187–192.

Leatherdale, S. T., & Shields, M. (2009). *Smoking cessation: Intentions, attempts and techniques.* Health report 82-003-XWE. Ottawa: Statistics Canada.

Logan, D., & Marlatt, G. A. (2010). Harm reduction therapy: A practice-friendly review of research. *Journal of Clinical Psychology, 66,* 201–214.

McIvor, A., Kayser, J., Assaad, J. M., Brosky, G., Demarest, P., Desmarais, P., et al. (2009). Best practices for smoking cessation interventions in primary care. *Canadian Respiratory Journal, 16,* 129–134.

Messer, K., Trinidad, D. R., Al-Delaimy, W. K., & Pierce, J. P. (2008). Smoking cessation rates in the United States: A comparison of young adult and older smokers. *American Journal of Public Health, 98*(2), 317–322.

Metelitsa, A., & Lauzon, G. J. (2010). Tobacco and the skin. *Clinics in Dermatology, 28*(4), 384–390.

Patterson, F., Lerman, C., Kaufmann, V. G., Neuner, G. A., & Audrain-McGovern, J. (2004). Cigarette smoking practices among American college students: Review and future directions. *Journal of American College Health, 52,* 203–210.

Patterson, P., & Kline, T. (2008). *Report on post-secondary institutions as healthy settings: The pivotal role of student services.* Victoria: Health and Learning Knowledge Centre, School of Exercise Science, Physical and Health Education, University of Victoria.

Pierce, J. P., & Gilpin, E. A. (2002). Impact of over-the-counter sales on effectiveness of pharmaceutical aids for smoking cessation. *Journal of the American Medical Association, 288*(10), 1260–1264.

Public Health Service, US Department of Health and Human Services. (2008). *Treating tobacco use and dependence: 2008 update: Clinical practice guideline.* Rockville, MD: Author.

Registered Nurses Association of Ontario. (2007). *Integrating smoking cessation into daily nursing practice* (rev. ed.). Toronto: Author.

Rice, V. H., & Stead, L. F. (2008). Nursing intervention for smoking cessation. *Cochrane Database of Systematic Reviews,* Issue 1, CD 001188.

Sarna, L., Bialous, S. A., Wells, M., Kottlerman, J., Wewers, M. E., & Froelicher, E. S. (2009). Frequency of nurses' smoking cessation interventions: Report from a national survey. *Journal of Clinical Nursing, 18,* 2066–2077.

Schultz, A. S. H., Johnson, J. L., & Bottorff, J. L. (2006). Registered nurses' perspectives on tobacco reduction: Views from western Canada. *Canadian Journal of Nursing Research, 38*(4), 192–211.

Serras, A., Saules, K. K., Cranford, J. A., & Eisenberg, D. (2010). Self-injury, substance use, and associated risk factors in a multi-campus probability sample of college students. *Psychology of Addictive Behaviors, 24*(1), 119–128.

Shiffman, S., Rolf, C. N., Hellebusch, S. J., Gorsline, J., Gorodetzky, C. W., & Chiang, Y. K. (2002). Real-world efficacy of prescription and over-the-counter nicotine replacement therapy. *Addiction, 97,* 505–516.

Shiffman, S., & Sweeney, C. (2008). Ten years after the Rx-to-OTC switch of nicotine replacement therapy: What have we learned about the benefits and risks of non-prescription availability? *Health Policy, 86,* 17–26.

Soares, S. (2009). Cigarette smoking and fertility. *Reproductive Biology Insights, 2,* 39–46.

Statistics Canada. (2010). *Canadian Survey of Experience With Primary Health Care, 2007–2008 [DDI Codebook].* Ottawa: Data Liberation Initiative, Special Surveys Division, Statistics Canada.

Stead, L. F., Perera, R., Bullen, C., Mant, D., & Lancaster, T. (2008). Nicotine replacement therapy for smoking cessation. *Cochrane Database of Systematic Reviews,* Issue 1, art. CD000146. Doi: 10.1002/14651858.CD000146.pub3.

Stead, L. F., Perera, R., & Lancaster, T. (2009). Telephone counselling for smoking cessation. *Cochrane Database of Systematic Reviews* 2006, Issue 3, art. CD002850. Doi: 10.1002/14651858.CD002850.pub2.

Thompson, B., Thompson, L. A., Hymer, J., Zbikowsi, S., Halperin, A., & Jaffe, R. (2007). A qualitative study of attitudes, beliefs, and practices among 40 undergraduate smokers. *Journal of American College Health, 56*(1), 23–28.

Thorndike, A. N., Rigotti, N. A., Stafford, R. S., & Singer, D. E. (1998). National patterns in the treatment of smokers by physicians. *Journal of the American Medical Association, 279*(8), 604–608.

Tong, E. K., Strouse, R., Hall, J., Kovac, M., & Schroeder, S. A. (2010). National survey of US health professionals' smoking prevalence, cessation practices, and beliefs. *Nicotine and Tobacco Research, 12,* 724–733.

Tremblay, M., Cournoyer, D., & O'Loughlin, J. (2009). Do the correlates of smoking cessation counselling differ across health professional groups? *Nicotine and Tobacco Research, 11,* 1330–1338.

Tremblay, M., Gervais, A., Lacroix, C., O'Loughlin, J., Makni, H., & Paradis, G. (2001). Physicians taking action against smoking: An intervention program to optimize smoking cessation counselling by Montreal general practitioners. *Canadian Medical Association Journal, 165,* 601–607.

Underwood, S., & Ryan, T. (2010). Commentary on Sarna L, Bialous SA, Wells M, Kotlerman J, Wewers ME & Froelicher ES (2009), Frequency of nurses' smoking cessation interventions: report from a national survey. Journal of Clinical Nursing 18, 2066–2077. *Journal of Clinical Nursing, 19,* 294–296.

US Department of Health and Human Services. (2010). *How tobacco smoke causes disease: The biology and behavioral basis for smoking-attributable disease: A report of the Surgeon General.* Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

Whitehead, D. (2005). Health promoting hospitals: The role and function of nursing. *Journal of Clinical Nursing, 14,* 20–27.

Wong, L. S., & Martins-Green, M. (2004). Firsthand cigarette smoke alters fibroblast migration and survival: Implications for impaired healing. *Wound Repair and Regeneration, 12,* 471–484.

Zhu, S., Lee, M., Zhuang, Y., Gamst, A., & Wolfson, A. (2012). Interventions to increase smoking cessation at the population level: How much progress has been made in the last two decades? *Tobacco Control, 21,* 110–118.

Zwar, N., Richmond, R., Borland, R., Stillman, S., Cunningham, M., & Litt, J. (2004). *Smoking cessation guidelines for Australian general practice*. Canberra: Australian Government Department of Health and Ageing.

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