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Enhancing Nurses' Autonomous Caring Practices in Ukrainian Villages Affected by Chornobyl

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ABSTRACT

Enhancing nurses' autonomous caring practices

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Twenty years after the Chornobyl nuclear disaster of 1986, the people living in villages affected by Chornobyl in northern Ukraine suffer from poor health status. Compounding the biophysical effects of latent exposure to ionizing radiation, socio-economic instability and psychological stress increase their suffering. The nurses that serve these villages depend on inaccessible physicians to guide them and lack basic medical supplies. The purpose of this transcultural nursing practice project is two-fold: (1) to strengthen nursing caring practices used by village nurses to serve a socially, economically, and environmentally disadvantaged population in Ukrainian villages surrounding Chornobyl; and (2) to enhance village nurses' autonomous caring practices by implementing a theory-based transcultural nursing model. As a result, this transcultural nursing practice project will enhance nursing knowledge through praxis (learning through practice) and will improve health outcomes for Ukrainians while facilitating a contemporary understanding of the caring contributions of village nurses in Ukraine.

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Chapter 1: Introduction of transcultural nursing project

Purpose of project

Forbiddingly affected by the 1986 Chornobyl nuclear disaster and socio-economic instability, people living in Ukrainian villages surrounding Chornobyl suffer from poor health status. Twenty years after the Chornobyl nuclear disaster, the Ukrainians' well-being is still gravely affected by the latent effects of exposure to ionizing radiation. The mounting HIV/AIDS crisis exacerbates their dire situation. Additionally, mass unemployment and economic insecurity burden the people further. The nurses that live and work in these villages lack basic medical supplies and depend on inaccessible, outlying physicians to guide their community-based practice. Even the most basic medical equipment is antiquated and in need of repair. Public health services have deteriorated since the collapse of the former Soviet Union (FSU) and the subsequent disintegration of the country's centralized public health system. These factors combined provide a fertile setting for the HIV/AIDS epidemic.

Despite determined efforts, HIV/AIDS devastates societies globally at disturbing rates. Over 3.1 million people died of AIDS and an estimated 5 million people were newly infected with HIV in 2005, bringing the total of those affected to over 40 million world-wide (UNAIDS/WHO, 2005). Lesser known is that Ukraine is the country hardest hit by HIV/AIDS in Eastern Europe. An estimated 590,000 Ukrainians are living with HIV (World Health Organization, 2005). While the HIV/AIDS epidemic is still in the early stages in Ukraine, it has the opportunity to devastate an already suffering people of Ukraine.

The purpose of this transcultural nursing practice project is two-fold: (1) to strengthen nursing caring practices used by village nurses to serve a socially, economically, and environmentally disadvantaged population in Ukrainian villages surrounding Chornobyl; and (2) to enhance village nurses' autonomous caring practices by implementing a theory-based transcultural nursing model. As a result, this transcultural nursing practice project will enhance nursing knowledge through praxis (learning through practice) and it will improve health outcomes for Ukrainians while facilitating a contemporary understanding of the caring contributions of village nurses in Ukraine.

Significance of project to nursing practice

The Universal Declaration of Human Rights adopted on December 10, 1948 by the General Assembly of the United Nations proclaims all people have a basic human right to healthcare without distinction based on political status of countries. Furthermore, Article 25 states,

> (1) Everyone has the right to a standard of living adequate for the health and well-being of himself [herself] and of his [her] family, including food, clothing, housing, medical care, necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
>
> (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection (p. 13).

Nurses have a moral responsibility to promote and defend these rights in communities throughout the world. One of the cornerstones of public health nursing as it has evolved in the USA is a focus on social justice. Public health nursing in the USA focuses on promoting the health of the community. However, transcultural nurses are also focused on providing care to high-risk populations world-wide. Culturally competent community care is additionally based on caring, sensitivity, and cultural knowledge (Kim-Godwin, 2001).

Millennium Development Goals

In the year 2000, leaders of 189 countries, including Ukraine, came together to address the key challenges facing humanity world wide. The results of this global initiative are the Millennium Development Goals (MDGs). The MDGs have been set to improve global communication, increase the distribution of vital resources, and help governments achieve these action-oriented goals by the year 2015. The following MDGs are especially relevant to the health of high-risk populations: MDG #4) reduce the mortality rate of children less than five years of age; MDG #5) reduce the maternal mortality rate; MDG #6) reverse the spread of HIV/AIDS, tuberculosis, and other communicable diseases; MDG #7) ensure environmental stability and reduce by half the number of people without access to safe drinking water (United Nations, 2006).

Setting these critical MDGs and achieving them are quite different processes. In Ukraine, 16 out of every 1,000 children died before their fifth birthday in the year 2000. MDG #4 aims to reduce this child mortality rate. One in 4,000 pregnancies ended in the death of the mother during childbirth. MDG #5

seeks to reduce this maternal mortality rate. There are an estimated 500,000 people in Ukraine who are HIV-positive, which is greater than one percent of the total adult population in Ukraine. This figure is increasing every year. MDG #6 combats HIV/AIDS. Forty percent of the total territory of Ukraine is now eroded land and is increasing by approximately 80,000 hectares annually. Ukraine is one of the least energy-efficient countries in the world, and has the sixth highest level of CO2 emission per capita globally (United Nations, 2006). MDG #7 promotes environmental sustainability. Transcultural nurses are in a unique position to defend health as a human right, advocate for change, and bring policies alive that will achieve these MDGs.

One of the high-risk populations in the world today exists in the villages surrounding Chornobyl, Ukraine. HIV/AIDS rates are escalating due to profound psycho-social reasons, such as personal beliefs of declining health status, lack of faith in the government after years of Soviet oppression, and the ever-present fear of living in the shadows of the decaying Chornobyl nuclear power plant (Petryna, 2002). Without urgent interventions Ukraine's HIV/AIDS epidemic may become as devastating as the crisis in Sub-Saharan Africa. Ukrainian nurses are in a critical position to turn this crisis around.

This transcultural nursing practice project supports the Ukrainian nurses' ability to deal with the consequences of HIV/AIDS in their villages by increasing nurses' autonomous caring practices and enhancing their culturally appropriate public health skills. In this project, establishing caring relationships with Ukrainian nurses, collaboration and professional exchange of public health nursing

information and resources will sustain nurses' long-term commitment to the village communities. As such, the Ukrainian nurses will expectantly develop confidence and competence in their public health nursing practices.

Local implications

Approximately 40,000 Ukrainian and Russian immigrants live in Minnesota with 89-94% residing in the Minneapolis- St. Paul metropolitan area (Minnesota Department of Health, 2004). This older immigrant population suffers from chronic disease and poor compliance with health maintenance behaviors. Benosivich (2003) examined the qualitative meanings behind the behaviors of elder immigrants from the former Soviet Union (FSU). She found distrust, alienation, stress, and helplessness as the important underlying reasons for their lack of participation in health practices. These reasons highlight the importance of adapting health promotion and disease prevention interventions to the immigrant population.

To create professional caring relationships with this population, it is important to integrate their unique health beliefs and patterns of care into the relationship. Learning the specific cultural values, beliefs, and practices of Ukrainians will create deeper understanding and improve the delivery of culturally congruent care in Minnesota and the United States. Therefore, this transcultural nursing practice project will build bridges with Ukrainian and Russian immigrant clients locally and globally. In addition, it will enhance the understanding of nursing's contribution in a culturally congruent context which applies to all culturally diverse communities.

Specific aims

This transcultural nursing project strives to illuminate public health nursing practices and intends to improve the quality, capacity, efficiency, and equity of health care in the underserved villages affected by the Chornobyl nuclear disaster. As such, this transcultural nursing project is directly related to the ongoing HIV/AIDS campaign in Ukraine and globally. It attempts to avert a crisis such as the epidemic presently devastating Sub-Saharan Africa. Since nurses are concerned about the health status of their village communities, this transcultural nursing project explores their caring ways. It focuses on nurses' contribution to the well-being of the people living in villages affected by Chornobyl.

The specific objectives of this transcultural nursing practice project are to:

- Strengthen village nurse's caring practices;
- Enhance village nurse's autonomous practices.

Framework of the project

Not understanding a multicultural patient's perspective alienates patients from healthcare services and compromises standards of care. As proposed by the Culturally Competent Community Care model (Kim-Godwin, 2001), caring, cultural sensitivity, cultural knowledge, and cultural skills are dimensions of cultural competence in the community. This nursing practice model defines cultural competence as the knowledge of diverse cultures and should guide future public health interventions in Ukrainian villages and locally in the Ukrainian and Russian refugee community. It focuses on understanding and respecting a

diverse culture's beliefs and patterns of behavior. Cultural sensitivity is demonstrated by a respectful attitude, while cultural skills refer to the roles necessary to perform community-based care. This model for the delivery of healthcare also includes the core nursing concept of caring. Described by Watson (1999) as the nurse's moral ideal that transcends the act itself, the act of caring balances the fragmented health care system that fosters health disparities in immigrant populations.

Dr. Madeline Leininger's theory of Culture Care Diversity and Universality (2001) blends both anthropology and nursing science. First and foremost, the theory focuses on human care and caring in diverse cultures. It does not attempt to describe medical diseases or treatments, but on those methods of caring that mean something to the people to whom the care is given. It challenges nurses to look at culture from the person's framework (Leininger, 2001).

Application of Leininger's theory to Ukrainian village nurses' practice encourages them to identify "what caring looks like" in their practice. What do they do? How effective are their actions? Leininger's concepts of *emic*, generic folk ways, and *etic*, professional care systems, and understandings of generic and professional concepts, along with the action modalities---maintaining, negotiating, repatterning care actions, are all important to illuminate in the village nurses' practices.

Chapter 2: Literature review

Lack of health care, limited treatment options and persistent social inequalities intensify the burden of preventable chronic and infectious disease such as HIV/AIDS for populations at risk. Paul Farmer (2005) has identified these social dynamics as an example of "structural violence." Although this literature review is not focused on social justice, it looks at the interplay of biological, psychological, social, and economic factors that have created the marginalized villages in Ukraine beginning with an overview of the Chornobyl nuclear disaster.

Most Chornobyl research focuses on the biophysical effects of exposure to ionizing radiation from the 1986 nuclear disaster. Most HIV/AIDS research in Eastern Europe and Ukraine focuses on the critical issues and major challenges of diagnosis and treatment. Fewer studies examine the beliefs, values, and specific challenges of the Ukrainian people. No qualitative nursing research studies were found that explored nursing's caring behaviors and their unique contribution to healthcare in villages affected by Chornobyl.

The preferred Ukrainian spelling of Chornobyl is used throughout this paper. However, the Russian spelling of *Chernobyl* is still commonly found in the literature. Since Ukraine declared independence from the former Soviet Union August 24, 1991, Ukrainians have set about to reestablish their own language and original spellings. Since the Chornobyl nuclear power plant is located in Ukraine, the Ukrainian spelling, not the former Russian spelling, is used.

The Chornobyl disaster

On April 26, 1986 there was a major accident at the Chornobyl nuclear power plant in then Soviet Ukraine. A routine 20-second shut down of reactor four's power system seemed to be another test of the electrical equipment. But seven seconds later, a surge created a chemical explosion that released nearly 520 dangerous radionuclides into the atmosphere. About 155,000 sq. km of territories in the three countries of Ukraine, Belarus, and Russia were contaminated with radioisotopes of iodine, caesium-137, strontium-90, and plutonium. The half-lives of caesium and strontium are 30 and 28 year respectively (United Nations, 2006).

This was the largest technological disaster of the 20th century. Large amounts of radioactive materials were released into the atmosphere across Europe for over one week which amounted to 200 times more radiation than Hiroshima and Nagasaki combined (Todkill, 2001). Strong wind and rainfall during this time resulted in uneven distribution of the radionuclides with most of the contamination dumping on Belarus and Ukraine. Soviet record-keeping and disagreements as to cause and effect make the disaster's toll difficult to quantify. But based on the official reports, 8,400,000 people in Ukraine, Belarus, and Russia were exposed to the radiation (United Nations, 2006). Nearly half a million Ukrainian people were resettled but millions continue to live in an environment where continued latent exposure to ionizing radiation creates a range of adverse effects (United Nations, 2006). Half a million children still live in affected areas (Kapp, 2000).

Biophysical effects

Since 1987 there have been alarming increases in thyroid cancer rates in Ukraine and Belarus. Children are especially vulnerable to the latent effects of exposure to ionizing radiation. The British Medical Journal (2004) published results of a report citing increased rates of thyroid cancer since 1986 with up to a 12-fold increase of all ages and 30-fold increase in girls less than 14 years of age. However, the International Programme on the Health Effects of the Chernobyl Accident (IPEHCA) and the Chernobyl Sasakawa Project report thyroid cancer incidence rates 100 times greater than before the nuclear disaster (Takamura, 2001). Children living in caesium-137 contaminated areas after the Chornobyl nuclear disaster have significant shifts in lymphocyte cell populations reflecting changes in immune status (Kirylchyk, 2003) and chromosomal aberrations, where segments of chromosomes are structurally rearranged or all together missing (Savage, 2000).

The latent health effects of ionizing radiation are widespread and often too subtle to be detected by modern epidemiological methods. Long after the acute exposure of radiation, people are being exposed to low-levels of radionuclides leaking from the damaged reactor. Miscarriages, birth defects, immune related diseases, and a variety of cancers are more prevalent in the exposed population (Petryna, 2002). The long-term effects of living in an environment contaminated with caesium-137 are simply not known.

The *Chornobyl Forum* (2006) recently reported on the long-term health, environmental and economic effects of the nuclear accident. The global

community has responded to this report stridently. The report details the findings of more than 100 expert scientists with the collaboration of eight UN agencies, the World Health Organization, and the governments of Ukraine, Belarus, and Russia.

The *Chornobyl Forum Report* (2006) estimates that of the 6.8 million people most exposed to radiation, up to 9,000 people may die sooner than they otherwise would, due to radioactive releases from the accident. It is also estimated that, of the 570 million people in Europe exposed at the time of the accident, up to16,000 people will ultimately die over the next 70 years as a result of Chornobyl.

Environmental effects

Today the radioactive remnants of reactor four continue to smolder and threaten the environment. The hastily built concrete and steel shelter, called a sarcophagus, is crumbling and threatening to collapse. With financial support of the international community, an arched structure the size of a stadium will soon be built directly over the sarcophagus (Williams, 2006). While this may conceal reactor four, the contamination will remain for many more years.

Hippocrates, regarded as the father of Western medicine, did not ascribe to divine origins of disease. His work greatly influenced Western biomedicine's departure from mystical superstition. An important work from the *Hippocratic Collection* is *On Airs, Waters, and Places* (5th century BC), which proposes the weather, drinking water, and site along the paths of favorable winds can help determine the general health of citizens (Hippocrates). Hippocrates understood

the environmental influences on health long before the Chornobyl nuclear disaster.

Psychological effects

Ukrainians have recently experienced profound social change from the political collapse of the FSU, declaration of independence in 1991, and hope for socio-political and healthcare reform resulting from the peaceful 2004 Orange Revolution. Even so, compounding the impact of the Chornobyl nuclear disaster and a failed Soviet government, psychological stress manifested as depression and anxiety is common. Polyakova (2006) attributes the high rates of depression among Soviet elders to culturally specific tendencies to express distress in somatic terms (p.41). Complaints of head, heart, liver, and thyroid pain were common from patients in the village clinics while depression and anxiety was virtually always denied.

"Limited knowledge of the long-term effects of exposure to radiation and the inevitable rumors of hideous ailments and genetic mutants have induced psychological trauma and prolonged panic in the hearts and minds of millions of people" (Kapp, 2000, p. 1625). The elusive and poorly understood nature of long-term exposure to ionizing radiation has produced wide-spread radio-phobia amongst the people still living in affected villages. In addition, the Soviets harshly punished those who did not pledge allegiance to the Communist party. Organized religion was prohibited and Christians, Jews, and Muslims were severely reprised. Without a history of religion, the people are left without hope (Waters, 2002).

In Ukraine, the government's efforts to remediate the Chornobyl aftermath have actually created tensions amongst the people, described as "biological citizens" by Petryna (2002). Economic and social entitlements, both short and long-term, are distributed to victims of the Chornobyl nuclear disaster. Diagnosis as a victim or sufferer is the means to compensation. As a result, citizens have come to rely on technologic diagnostics, have medicalized knowledge of symptoms, and somatisize their anxiety and depression (Petryna, 2002).

The survivors believe they have a right to compensation based on biological damage. This belief further drives their suffering. The pervasive culture of dependency in the affected areas is considered a major barrier to the region's recovery (Rosenthal, 2005). These findings enlighten why public health nursing interventions such as HIV/AIDS prevention and smoking cessation campaigns receive less consideration and resource allocation in villages facing the latent effects of exposure to ionizing radiation from the Chornobyl nuclear disaster.

Economic effects

The economy of the Chornobyl region of Ukraine collapsed in the years after the Chornobyl nuclear disaster. With radiological contamination, agricultural production was halted in areas near the reactor. Locally grown products gained an undesirable stigma in the eyes of consumers, making it extremely difficult for local producers to sell these tainted goods on the market. Depressed economic conditions were worsened by the effects of Ukraine's economic transition to a market economy. International investments declined sharply and many jobs were eliminated with the restructuring of a Soviet-era economy (United Nations, 2006).

HIV/AIDS

Compounding Ukraine's social and economic instability, the burgeoning HIV/AIDS epidemic increasingly destabilizes village communities. Ukraine has the highest prevalence of HIV infection in Europe, estimated at 1.4% of the population. Meanwhile, no systematic approach to prevention, treatment, or care exists in Ukraine (McKee, 2005).

HIV/AIDS in Ukraine was at the outset a concentrated epidemic among young intravenous (IV) drug users, who make up 73% of all reported cases since 1986 and 59% of all newly diagnosed HIV infections in 2003 (World Health Organization, 2004). However, heterosexual transmission rates are increasing especially to female sexual partners of IV drug users and sex workers. More pregnant women are testing positive which suggests the epidemic is spreading out from high risks groups to the general population. These rates of prevalence are markedly higher than in Western Europe.

Ukrainian law passed in March 1998 made HIV testing among IV drug users voluntary which has decreased testing overall. The law also implies HIV/AIDS treatment including antiretroviral therapy should be free for all Ukrainians but limited resources have restricted this plan. The World Health Organization (2004) reports only 170 people receiving antiretroviral therapy to date with an estimated 45,000 Ukrainians needing therapy. Major challenges include: (1) discrimination of IV drug users; (2) marginalization of sex workers; (3) coordination between drug treatment centers and HIV/AIDS treatment services; (4) availability of antiretroviral therapy; (5) use of condoms.

Corruption

Formerly part of a centralized Soviet health system, Ukraine now struggles to reform its political, economic, and social system and rebuild its public health infrastructure. In addition, there exists an extreme gap between the rich and the poor (World Bank, 2005). Corruption is a global problem and plagues the developing country of Ukraine. Bribes in the health sector and the judiciary are rampant in former communist countries not in the European Union (EU). Unfortunately, bribes of gifts or money markedly increase waiting periods of several months for healthcare services (Stracansky, 2004). "At best corruption can mean hospitals and patients have to overpay for services, at worst it can mean people dying because of counterfeit drugs" (BBC News, 2006). Under communist rule, bribes were considered necessary to receive an adequate level of health care. Regrettably, this practice continues today. Tanya, a 50 year old woman living in the Zhytomyr region of northern Ukraine, described a recent hospitalization for acute back pain:

> If you do not give the nurse extra money, the nurse will not help you. It costs extra to have a hospital bed otherwise you are assigned a hammock. You have to fend for yourself and roommates take care of each other. I would be afraid if I did not have extra money to offer nurses in the hospital (personal communication, September 21, 2005).

Health status

Since Ukraine declared its independence from the FSU in 1991, the health status of its people has further deteriorated. The Centers for Disease Control (2004) reports rising infectious disease rates and decreasing rates of vaccination in Ukraine. The death rate in Ukraine exceeds the birth rate with an infant mortality rate of 19 per 1,000 live births. The healthy life expectancy is just 59 years of age (WHO, 2005). Eastern Europe is only one of two regions in the world where the life expectancy is decreasing; the other area is sub-Saharan Africa (McKee, 2005).

The complex interplay of biological, psychological, social, and economic factors intensifies the burden of disease for people living in the shadows of Chornobyl. It is important to value these dynamics while empowering village nurses to enhance their own autonomous nursing practice. Chapter 3 discusses the transcultural nursing project that seeks to strengthen the village nurses' practices.

Chapter 3: Development of transcultural nursing practice project

Setting

Ukraine is located in Eastern Europe just west of Russia, south of Belarus, and east of Poland (see Appendix A for a map of Eastern Europe). It is the second largest country in Europe after Russia. The population is nearly 48 million with a most recent decline in population. The death rate presently exceeds the birth rate (United Nations, 2006).

The Chornobyl nuclear power plant is located 110 kilometers north of the capitol city of Kyiv (see Appendix B for a map of Ukraine). Chornobyl rests on the banks of the river Pripyat which connects with the largest river Dniepro and dissects the country. In the late 1960s, Chornobyl was built as a sort of nuclear reactor theme-park to show off to the world the technological advancements of then Soviet society (Petryna, 2002).

Contaminated territories of Ukraine are classified by the government into four zones based on levels of cesium, strontium, and plutonium contamination emitted from the Chornobyl nuclear accident. Zone one, or the 30 kilometer exclusion zone, directly surrounds the Chornobyl plant and is managed by the Ukrainian government. This area is declared too contaminated for human habitation. Two military check points monitor the exclusion zone. Zone two is an area of compulsory resettlement, zone three is an area of guaranteed voluntary resettlement, and zone four is an area of heightened radiological monitoring. The zone demarcations seem arbitrary and lack signs telling you what zone you are in (Petryna, 2002). The Zhytomyr *raion*, or region, is located northwest of the

capitol city of Kyiv. The industrial city of Zhytomyr is classified zone three while the villages in which I volunteered are considered zone two.

This transcultural nursing practice project was conducted over a 2 week period while volunteering as a nurse with the non-profit organization Volunteers in Medical Missions (VIMM) to the underserved villages affected by Chornobyl in northern Ukraine. This was my second volunteer medical mission trip to the same underserved area, thus professional and lay connections were developed over 2 years. I speak, read, and write Ukrainian. All communication was in the village nurses' native Ukrainian language. Several native Ukrainian university students were hired and served as bilingual interpreters for the VIMM team. A native Ukrainian bilingual nurse worked alongside me and supplemented both verbal and written translations.

VIMM, a non-profit 501c3 organization, provided access to Ukraine's underserved people. VIMM is composed of Christian volunteers who wish to serve God by delivering healthcare to some of the world's poorest people. VIMM teams take medications, medical supplies, love, and concern to impoverished places in the world. VIMM believes we must have concern for the hurts and social needs of our fellow brothers and sisters. Goals of the organization include promoting a Christian approach to the medical treatment of persons throughout the world and disseminating public health information (VIMM, 2005). VIMM has formed a long-lasting partnership with the community of Zhytomyr. This partnership ensured access to the region's most underserved peoples and decreased barriers to delivering medical care abroad such as, language and

corruption. VIMM was the vehicle for this transcultural nursing practice project and provided access to nurses serving in villages affected by Chornobyl.

The free VIMM clinics were set up in existing village clinics, churches, and community centers throughout the Zhytomyr region of Ukraine. As many as 200 people per day came to the VIMM clinics for free medical treatment. Patients covered the lifespan from infancy to the elderly. Medical treatments and nursing care focused on the poorly managed chronic diseases suffered by the elderly but nobody was turned away. The most common treatments included screening for hypertension, diabetes, and coronary artery disease, steroidal joint injections for debilitating osteoarthritis, pain management, wound debridements and dressing of non-healing wounds, and treatment of community acquired infections. Nursing education efforts focused on the following health promotion and disease prevention topics: smoking cessation, diabetes management, hypertension management, low-sodium and low-fat diets, depression and anxiety, domestic violence, HIV/ADS, bacterial versus viral infections, non-pharmacologic treatment of pain, and dental hygiene. Some people presented with known cases of tuberculosis and HIV/AIDS. While palliative treatments were offered, referrals were made to seek acute medical care in the city and follow-up with the village nurse.

Participants

All nurses that I encountered in the villages were asked to participate in this transcultural nursing practice project. Including all nurses provided a more diverse representation of the target population. Ten nurses participated as

primary informants in this transcultural nursing practice project. The names of nurses have been changed to protect their identity. Throughout the busy VIMM clinic days, village nurses worked alongside me.

Concepts and model

This transcultural nursing practice project demonstrates the American Association of Colleges of Nursing scholarship of application. It is the application of a theory-based model to nursing practice (AACN, 2006). Examples of the scholarship of application conducted include; implementing professional nursing interventions, evaluating quality of life indicators, and critically reflecting on current community nursing practices in the villages.

This transcultural nursing practice project uses Leininger's theory of Culture Care Diversity and Universality. Leininger discusses culturally based care as the most comprehensive way of understanding nursing care practices and behaviors. She believes culturally based care is essential to curing. There can be no curing without caring but caring can exist without curing (Leininger, 2002). Applying Leininger's Culture Care Theory is important because it helps nurses locally and globally understand the social, political, environmental, and spiritual factors that influence nursing's care delivery.

Leininger's Sunrise Enabler, a qualitative conceptual guide or map, helps nurses apply the culture care theory to their nursing practice (see Appendix D). It outlines the cultural dimensions of care. The Sunrise Enabler highlights the influences on an individual or community such as; technological factors, religious and philosophical factors, kinships and social factors, cultural values, beliefs and

lifeways, political and legal factors, economic factors, and educational factors. The nurse uses the Sunrise Enabler in formulating questions that are influenced by these factors.

As a novice to the theory, the Sunrise Enabler was primarily applied with nurses that serve villages affected by Chornobyl. I began the process of discovery in the uppermost section of the Sunrise Enabler. As a result, I was able to discover worldview, cultural, and social dimensions that reflect the lifeworld of Ukrainian nurses. All dimensions of the Sunrise Enabler influencing care expressions, patterns, and practices were considered such as; technological factors, religious factors, kinship and social factors, cultural values, beliefs and lifeways, political factors, economic factors, and educational factors.

Leininger's Culture Care Theory also discusses the concepts of *emic*, generic or folk practices, and *etic*, professional care practices. Leininger discusses generic care to mean the oldest or traditional cultural ways of supporting the health and healing of people (Leininger, 2002). Generic care is the product of generations of survival without formal healthcare study. In contrast, professional care tends to be based on presently held scientific knowledge within the current dialogue of the profession. Professional care is rigidly learned and practiced within the guidelines of licensure. For example, in this transcultural nursing practice project, asking questions about the village community's generic folk care practices and discussing professional care-cure practices aims to bridge health care practices of the Ukrainian people and the village nurses. The goal is to prevent non-therapeutic care practices from occurring all together (Leininger,

2005). Building relationships with village nurses and practicing alongside them is at the heart of this transcultural nursing practice project.

Continuing along with the Sunrise Enabler, together the village nurses and I explored the three theoretical modes of culture care actions: 1) culture care preservation or maintenance; 2) culture care accommodation or negotiation; and 3) culture care repatterning or restructuring. My focus was to facilitate the three culture care actions within a culturally congruent context. With the village nurses beside me, I modeled care actions that fit within their lifeways while suggesting professional nursing interventions that would benefit the people they served. Using practice knowledge in this way to improve nursing practice is an example of praxis. The village nurses were actively involved as coparticipants in this phase of the project. They included feedback regarding their caring actions and professional nursing interventions.

Methodology

The following qualitative ethnographic methods were used: participant observation, formal and informal dialogue, and examination of existing peer-reviewed literature. This is an inductive approach to praxis. While there are specific questions to be answered, no outcomes are assumed. Both formal and informal conversational approaches were employed. Questionnaires were distributed to all nurse participants and small group discussions enhanced my understanding. Responses from conversation were recorded in a small field journal.

Ethnographic participant observation is the "interweaving of looking, listening, and asking" (Roper, 2000) to understand a diverse culture's behaviors and patterns. The purpose is to observe and value the nurses' ways of knowing. By watching the village nurses interact with the people in the VIMM clinic, I was able to notice the interplay of *emic* and *etic* perspectives. Building rapport and trust as professional colleagues enabled me to ask the village nurses questions about their caring practices. For example, Ukrainians use many folk care practices in their daily lives to treat common ailments and maintain their well-being. They also somatisize their psychological distress as heart pain. The village nurse explained this is a culturally accepted way of describing pain as it is exactly how it feels to that person.

Initial contact with the nurse participants was verbal. I used the following script for recruitment:

> I am an American nurse with Volunteers in Medical Missions and a graduate transcultural nursing student at Augsburg College in Minneapolis, Minnesota, USA.
>
> I am interested in understanding the unique contributions of nursing practice on people's health and well-being. You are invited to be a part of my transcultural nursing project about the role of nurses in the villages affected by Chornobyl in Ukraine. You were selected because you are a nurse. Would you like to work alongside me today and share professional nursing knowledge? I will model several public health nursing interventions throughout the day. Please read this form and ask any

questions you may have before agreeing to participate. I am conducting this field project independently.

Prior approval to implement this transcultural nursing practice project was obtained from VIMM and the Augsburg College Internal Review Board. The consent form and nursing questionnaire (see Appendix C) was provided to the village nurses in their native Ukrainian language.

This transcultural nursing practice project applies concepts from Leininger's Culture Care Theory and Sunrise Enabler to nursing practice in villages affected by Chornobyl. It seeks to build relationships with the village nurses while practicing alongside them. Chapter 4 discusses outcomes of the transcultural nursing practice project.

Chapter 4: Evaluation

Despite the vast socio-economic challenges, nurses working in villages affected by Chornobyl are enthusiastic about the nursing care they provide. Analysis of my project field notes and nursing questionnaires revealed two persistent themes: caring and hopefulness. The themes blend professional nursing care practices with existing folk care practices and describe the unique contributions of nurses serving rural villages affected by Chornobyl.

Caring

The first theme, caring, was a primary motive for nurses' work and was expressed in several ways. For example, Anya works alone in the small village health clinic that serves 700 people, mostly elderly. Her husband is an alcoholic and does not work consistently; her elderly mother maintains a large vegetable garden to feed the family and cares for the children while Anya works in the village health clinic. Anya explained that her monthly pay of $35 USD is not enough to support her family but she is committed to the village clinic. Anya worries nobody would replace her. "I care for the elderly people here. Even though I am poor, it is okay because I love my work" (personal communication, September 30, 2005). Other village nurses supported this sentiment and attitude of caring:

> Natalia: God has blessed me with good health. I express my gratitude by caring for His sick people.

Vera: I was sick after Chornobyl but am one of the lucky ones. I received good medical care, had an operation in Kyiv, and am now healthy. I care about the ones that are not so lucky.

Luba: American and Ukrainian nurses are really similar. We all care. We all want to provide comfort and relieve suffering.

Hopefulness

The second prevalent theme, hopefulness, was expressed in many ways. Village nurses are enthusiastic about their professional roles and hopeful improvements in their independent nursing practice will soon amend health outcomes for people living in the villages affected by Chornobyl. However, they acknowledge their dependency on inaccessible physicians to give them direction and orders.

For example, Olga had many stories about the relationship between village nurses and regional medical directors. “I have been running this small village clinic single-handedly for 7 years now and today is the first day I have met the regional medical director [who apparently arrived after hearing of the free VIMM clinic]” (personal communication, September 22, 2005). Olga hopes the regional medical director will soon give the direction to monitor HIV/AIDS in the village. Meanwhile, she distributes HIV/AIDS prevention pamphlets to all young people who seek health care in the clinic. Case management approaches to public health nursing were introduced and greeted with interest. Other village nurses supported this attitude of hopefulness.

Svetlana: The more nurses learn, the better we can help our poor people.

Elena: Nursing in Ukraine will change soon. To be a good nurse, you must always look for ways to make things better.

Ludmilla: Faith and hope are closely related. I have both. Nurses can make a difference here.

Transcultural care actions

Leininger's three action strategies are based on cultural knowledge of the people living in the villages affected by Chornobyl and developed in partnership with the nurses that serve them. This knowledge is grounded in both *emic* and *etic* perspectives. The following model (Figure A, p. 30) illustrates the interplay of professional and generic folk care practices developed by *emic* and *etic* perspectives. The emerging transcultural nursing practices make possible Leininger's three action strategies: culture care preservation, negotiation, and repatterning.

According to Leininger (2001), culture care preservation or maintenance encourages nurses to retain or preserve existing care practices. Nurses in turn are a constant presence in the village, support people as they recover from illness and injury, and die peacefully. For example, Vera made daily house calls to a young woman suffering of what appeared to be end-stage liver disease. The woman was severely jaundiced and suffered from dehydration with nearly constant vomiting and diarrhea. Vera prepared a simple rehydrating solution of water, salt, baking soda, and honey. Vera helped the grandmother bathe the young woman and offered palliative medications that VIMM provided. These essential nursing care practices must be preserved.

Culture care accommodation or negotiation assists nurses adapt to the newly introduced public health nursing interventions. For example, Tanya organized a resource table in the entry of the clinic with HIV/AIDS pamphlets and resources provided by VIMM. She distributed the pamphlets to all young people who come to the clinic. Tanya continued on with the VIMM team to a neighboring village the next day to collaborate with that village's nurse. Together they shared clinic resources and organized an HIV/AIDS presentation for the local school. Their enthusiasm was palpable. These practice modalities were new to village nurses. In the past Tanya would have waited for the medical director's direction. Now she is reorganizing her interventions and accommodating her scope of practice to further enhance her nursing practice.

Culture care repatterning or restructuring facilitates change that help nurses reorder or modify their practices to provide healthier or more beneficial outcomes for people. For example, Luba explained why she reuses the needles in her village health clinic. Luba stated:

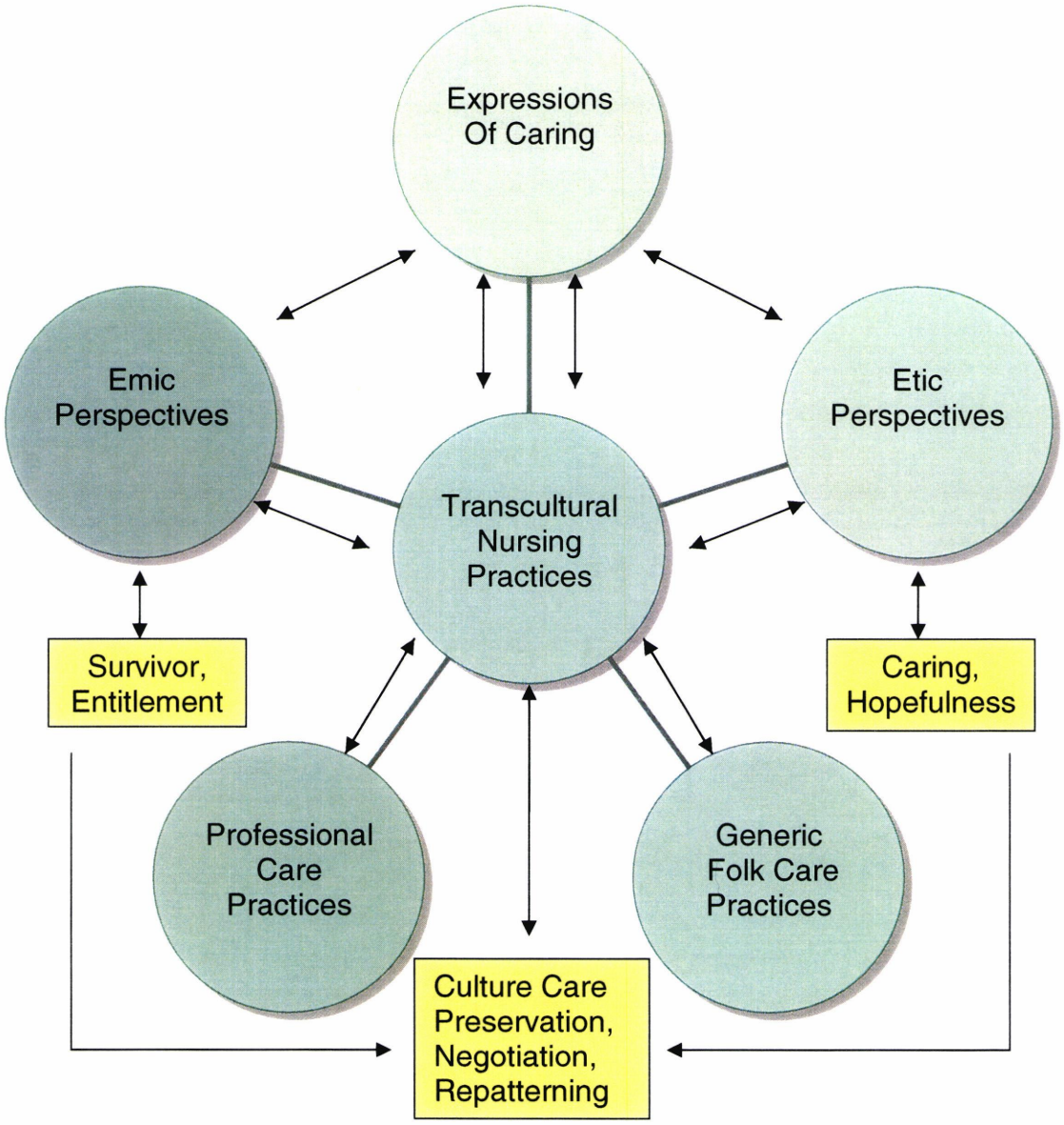
> Needles are scarce and expensive. I cannot afford to replace the needles you have donated. What kind of nurse does not have needles in her clinic? Sure, I know HIV can be passed along through needles but I need to give shots too. This is what the people expect of me (personal communication, September 27, 2005).

As a result of these circumstances, VIMM consciously chooses to distribute oral medications if possible and destroys all injected materials after use. Sealed sharps containers for the disposal of used needles were left in each

village health clinic and a means to dispose of the sharps container established. These changes repattern nursing practices in villages affected by Chornobyl.

The outcomes of this transcultural nursing practice project are applicable to other marginalized settings globally. Building relationships with nurses through praxis develops unique understanding of their caring practices and challenges. Through sustained dialogue and exchange of resources, nurses may develop transglobal partnerships to further enhance autonomous nursing practice in underserved settings. As a result, these transcultural relationships will improve health outcomes for marginalized people, improve nursing satisfaction, and advance nursing practice in our global community.

Figure A. Model illustrating transcultural nursing caring practices in Ukrainian villages affected by Chornobyl:



Chapter 5: Reflections and recommendations

Reflections

Outcomes from this transcultural nursing practice project suggest nurses serving the villages affected by Chornobyl are not well supported or equipped to care for the complex physical and psychological problems facing their people. Basic medical supplies, medications, and functioning equipment must be available in all village health clinics. Up to date health promotion and disease prevention education materials must be on hand for distribution. Public health infrastructure must be improved with immediate priority given to childhood immunizations, smoking cessation, chronic disease management, HIV/AIDS prevention, diagnosis, and treatment. An integral part of public health practice, nursing interventions that are focused on the individual, community, and systems level must be built upon.

Ukrainian nurses demonstrated caring commitments to people living in the shadows of Chornobyl and hopefulness to enhance nursing practice in Ukraine. On one hand, the optimism of Ukrainian nurses invites continued transcultural nursing relationships. On the other hand, Ukrainian nurses need global partnerships to expand their autonomous nursing practice and ultimately improve health outcomes. Therefore, sustaining professional relationships with Ukrainian nurses and integrating transcultural nursing content into existing nursing education curriculum will be important.

Recommendations for future work

The Ukrainian nurses who participated in the transcultural nursing practice project were unique. They adapted their professional caring practices while living in the shadows of Chornobyl. Similar nursing practice projects in other regions of Ukraine, Belarus, and Russia that are deeply affected by the Chornobyl nuclear disaster should be conducted. Transcultural nurses could research whether other Eastern European nurses have similar professional caring practices as the nurses in the Zhytomyr region of Ukraine.

A transcultural nursing theory-based practice model was newly introduced to Ukrainian nurses that participated in the project. All village nurses admitted dialogue regarding nursing theory was new to them and had not been integral in their nursing education. They were inquisitive and eager to discuss nursing science and knowledge development as a unique contribution separate from the science of biomedicine. Future nursing practice projects should further emphasize the science of transcultural nursing theory and practice to Ukrainian nurses.

These findings support the individual-focused nursing functions of promoting the health and healing of people and the community-focused functions of changing village attitudes and awareness. Advanced practice nurses in the U.S. would be wise to support Ukrainian nurses' caring commitment and hopefulness. Together Ukrainian and American nurses could develop community-focused models of culturally congruent care and independent nursing education in Ukraine.

Further questions

Further questions come to mind that may drive future transcultural nursing practice projects and research in Ukraine. Should the Ukrainian government permit people to live in Zone 2 villages? Does this essentially encourage, at least not discourage, increased exposure to ionizing radiation? Should compensation continue for people living in heavily contaminated areas while resources for HIV/AIDS, tobacco abuse, and tuberculosis are grossly lacking? Is this a post-Soviet chapter of continued suffering and dependency? Is this an example of culturally appropriating suffering? What similarities and differences exist between the Chornobyl survivors and the Hiroshima and Nagasaki survivors?

Perspectives on making change

Bolman and Deal (1997) discuss four frames or perspectives in organizational culture that describe the dynamic process of social change. These perspectives are especially relevant when applied to the poorly functioning community healthcare system in villages affected by Chornobyl. First, the human resource frame focuses on the relationship between people living in the village, nurses that serve them, and the change agent. In this context, the change agent may be the Ukrainian federal or local government; non-profit organizations like VIMM, or the transcultural nurse who seeks to understand and enhance nursing practice in these marginalized villages. Analogous to a family system, the village healthcare system exists to serve human needs. Second, the political frame describes the interplay of power structures and politics. Bolman and Deal describe the political frame as a jungle. The healthcare system is a coalition of

individuals with varied interests, differing values, and perceptions of reality. Third, the structural frame focuses on the Ukrainian government's laws and nursing practice protocols. The healthcare system exists primarily to accomplish goals like a factory or machine. Fourth, the symbolic frame emphasizes cultural norms and behaviors. It's not what happened but what this means to the people. Bolman and Deal describe this perspective as a cathedral or temple.

To illustrate how Bolman and Deal's (1997) four frames or perspectives may be used to create different outcomes in the villages affected by Chornobyl, consider the following recommendations. Change agents in the human resource frame would seek to empower village nurses and enhance their autonomous caring practices further. This transcultural nursing practice project most closely reflects the human resource frame. Change agents in the political frame will approach this differently. They will identify key power players in the village, regional government and beyond. They will partner with international non-governmental organizations like VIMM to increase the supply of donated resources and augment nursing education.

Change agents in the structural frame will support public policies and procedures that decrease health inequities. They will provide nurses ongoing HIV/AIDS education and provide free, accessible HIV/AIDS diagnosis and treatment. These interventions support the global initiatives of the Millennium Development Goals. Change agents in the symbolic frame will use ceremony to facilitate change. They will include prayer and culture-bound rituals that are meaningful to people living in villages affected by Chornobyl. This presents an

opportunity to partner with spiritual leaders and integrate health improvement initiatives within the church.

All four of Bolman and Deal's (1997) frames or perspectives offer opportunities to create change but none should be used in isolation. A combination of these perspectives is recommended to achieve improved health status outcomes in villages affected by Chornobyl.

Conclusion

HIV/AIDS is upsetting the already marginalized villages affected by the Chornobyl nuclear accident. This transcultural nursing practice project highlights the need for renewed public health nursing efforts. Nurses must discover ways to deliver the basic human right of healthcare in spite of political, social, and economic upheaval. With the Sunrise Enabler to guide practice and praxis to uncover deeper meanings of care constructs, nurses can identify health disparities in the villages, implement collaborative approaches to care delivery, and assure the health status of the community-at-risk is never forgotten. Leininger (2001) reminds nurses to recognize in themselves and those in their care the diversity and universality amongst us.

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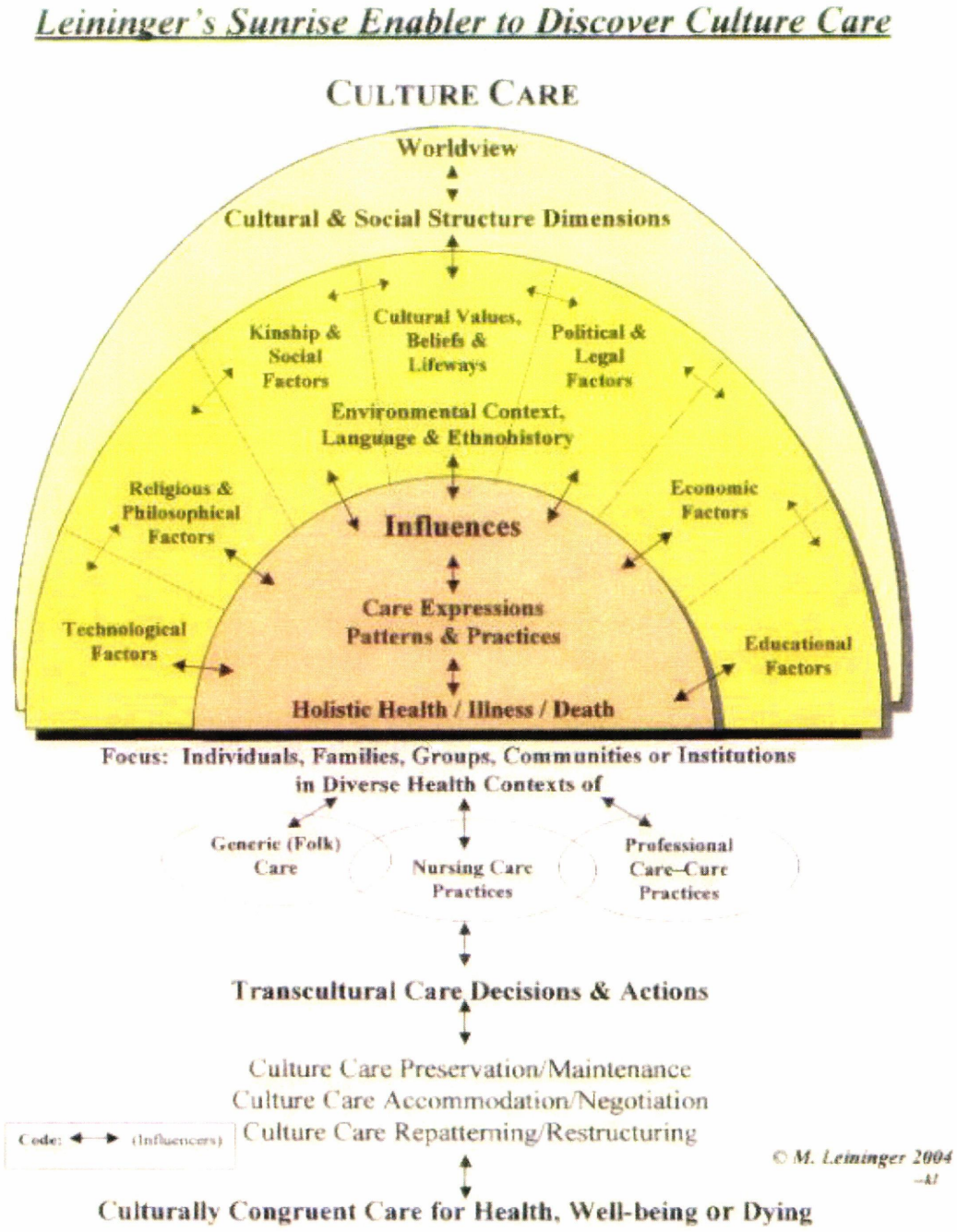
Appendix A: Map of Eastern Europe

Appendix B: Map of Ukraine

Appendix C: Leininger's Sunrise Enabler



Appendix D: Letter of Consent

Lisa Prytula
1377 S. Smith Ave.
W. St. Paul, MN 55118

April 11, 2006

Dr. Madeline Leininger
Transcultural nursing consultant
923 S. 173rd Plaza
Omaha, NE 68118

Dear Dr. Madeline Leininger:

Hope this note finds you well!

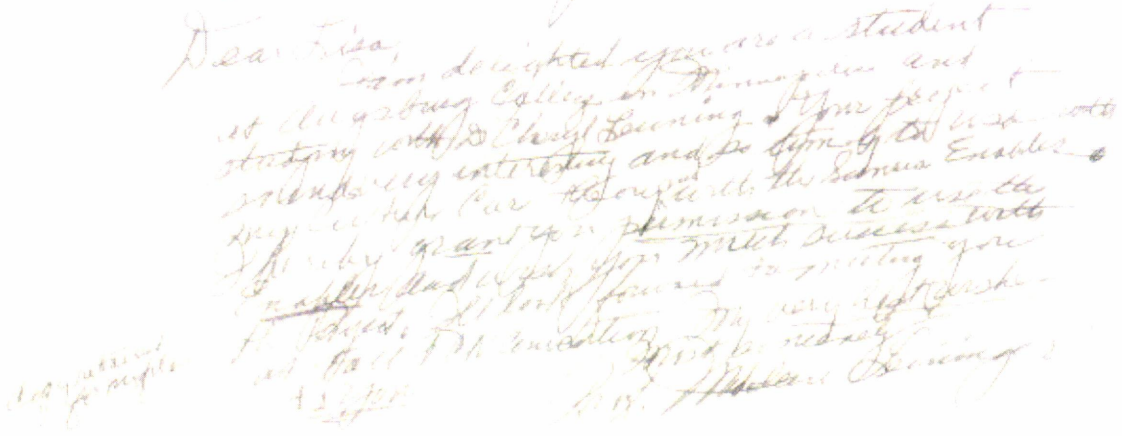
I am a graduate-level transcultural nursing student at Augsburg College in Minneapolis. I am writing to ask you for permission to include the Sunrise Enabler in my published thesis document.

With Dr. Cheryl Leuning's guidance, I implemented a nursing practice project in underserved villages affected by Chornobyl in Ukraine. My practice project is based on your theory of Culture Care Diversity & Universality. The Sunrise Enabler guides my project.

Despite the biological, psychological, social, and economic challenges of living in the shadows of Chornobyl, nurses in Ukraine are enthusiastic. I introduced them to the Culture Care Theory and hope to continue my work there soon.

I look forward to seeing you again and discussing my project at the Transcultural Nursing Society Conference this fall. Thank you in advance for your consideration.

Respectfully,
Lisa Prytula, RN



Appendix E: Consent form and nursing questionnaire (English and Ukrainian)

Consent form:

You are invited to be in a transcultural nursing practice project about the role of nurses in the villages affected by Chornobyl in Ukraine. You were selected as a possible participant because you are a nurse. I ask that you read this form and ask any questions you may have before agreeing to be in this project.

This project is being conducted by me as part of my Master's practice project in Nursing at Augsburg College, Minneapolis, Minnesota, USA.

Background information:

The purpose of this transcultural nursing practice project is

- to make explicit your nursing practices that affect the health of the people living in the villages affected by Chornobyl
- to identify the caring behaviors of nurses

Procedures:

If you agree to be in this project, I would ask you to do the following things:

- answer questionnaire about your nursing practice
- participate in small group discussion
- attend the all nurses dinner and dialogue

Risks and benefits of being in this transcultural nursing practice project:

The project has no identifiable risks.

The direct benefits to participation are: a dinner meal, gifts of a stethoscope, blood pressure cuff, pen light, and public health nursing book.

Indirect benefits to participation are improved public health nursing knowledge.

Confidentiality:

The records of this project will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify you. Complete anonymity cannot be guaranteed because of the small participant group size; however every effort will be made to maintain confidentiality. Project records will be kept in a locked file; only I will have access to the records. All my field notes will be kept but all identifying information removed by October 10, 2005.

Voluntary nature of the transcultural nursing practice project:

Your decision to participate will not affect your current or future relations with Augsburg College or Volunteers in Medical Missions. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts and questions:

The nurse conducting this project is Lisa Prytula. You may ask any questions you have now. If you have questions you may contact me later via telephone at #651.451.9624 or my adviser, Dr. Cheryl Leuning, #612.330.1046.

You will be given a copy of this form to keep for your records.

Statement of consent:

I have read the above information or you have read it to me. I have received the answers to questions I have asked. I consent to participate in this transcultural nursing practice project.

Signature: _____ **Date:**_____

Signature of project coordinator: _____ **Date:**_____

I consent to allow use of my direct quotations in the published thesis document.

Signature: _____ **Date:**_____

Форма Консент:

Ви запрошуєтесь щоб бути в проект практики про роль медсестри у селах вплинутих на Чорнобилем в Україні. Ви були вибрані як можливий учасник тому що ви є медсестра. Я запитую що ви читаєте оцю форму та запитуєте будь-які питання ви можете мати перед тим як погоджуватися бути у цьому проекті.

Цей проект ведеться тому що частина мого Майстра проект практики у Коледжі Аугсбургу, Міннеаполис, Міннесота, США.

Тло інформація:

Мета проект практики:

- Щоб примусити експліцитні ваші вправи що впливають на здоровя' людей життя в селах вплинутих на Чорнобилем.
- Щоб ототожнити дбайливі поведінку медсестри.

Процедури:

Якби ви погоджуєтеся бути у цьому проекті, я би попросив вас зробити слідуючі речі:

- Відповідати анкету про вашу практику.
- Візьміть участь в дискусії групи.
- Відвідайте обід медсестри та діалог.

Ризики та вигоди будучи у проект практики:

Проект не має наявних ризиків.

Безпосередні вигоди до участі: страва обіду, дарунки, та книга суспільне здоровя' .

Посередні вигоди до участі покращуються знання суспільне здоровя'.

Довіра:

Записи цього проекту будуть держатися приватні. У будь-якому сорті звітного я можу надрукувати, я не включу будь-яку інформацію що встигну можливий ототожнити вас. Проектувати записи буде держатися у замкненому файлі; тільки я буду мати доступ до записів.

Всі записки будуть держатися але весь ототожнюючі інформаційний усували жовтнем 10, 2005.

Добровільна природа проект практики:

Ваше рішення взяти участь не вплине на вашу течію або майбутні відношення з Коледжем Аугсбургу або Добровольцями в Медичних Відрядженнях. Якби ви вирішите взяти участь, ви є вільні вилучити в будь-який час без того, щоб впливати на ці співвідношення.

Контакти та питання:

Медсестра ведучий цей проект Ліса Притула. Ви можете попросити будь-які питання. Ви можете контактувати мене пізніше через телефон #651.451.9624 або мого консультанта, Др. Черил Леунинг, #612.330.1046.

Вам будете даватися копію цієї форми утримати для ваших записів.

Твердження згоди:

Я прочитав вищезгадану інформацію або ви прочитали мені. Я отримав відповідь я запитав. І згода взяти участь у проект практики.

Підпис: _____: _____

Підпис координатора проекту: _____: _____

І згода дозволити користуванню моїми цитатами у надрукованому документі дисертації.

Підпис: _____: _____

Nursing Questionnaire:

- How do you define nursing?
- How do you describe health?
- How do you describe illness?
- What is your theory of nursing?
- What does it mean to be a nurse?
- Describe your role as a nurse.
- Describe your education and training to become a nurse.
- How did you choose the vocation of nursing?
- Describe the demographics of the people residing in your village.
- What are your greatest challenges as a nurse in this village?
- What nursing practices have you adapted to living in the shadows of Chornobyl?

- What are the greatest concerns of the people residing in this village?

Would you like to continue this dialogue and participate in a professional exchange of transcultural nursing information?

If you would like to correspond with me, please write your name and address.

Медсестра Анкета:

- Визначте медсестра.
- Визначте здоровя'.
- Визначте хворобу.
- Що ваша теорія?
- Що це означає бути медсестра?
- Опишіть вашу роль як медсестра.
- Опишіть вашу освіту та навчання стати медсестрою.
- Чому ви стали медсестрою?
- Опишіть демографію людей проживаючих у вашому селі?
- Що ваші найбільші виклики як медсестра у селі?
- Що ваше майно?

- Що найбільші турботи людей проживаючих у вашому селі?

Якби ви бажаєте взяти участь у професійному обміні інформації та листуєтеся зі мною, будь ласка напишіть вашу назву та адресу. Це не є частина дослідження.