

**MEDICAL READINESS IN HUMANITARIAN AND CIVIC ASSISTANCE
MISSIONS: SIGNIFICANCE OF CULTURAL TRAINING FOR NURSES**

by

JULIE M. STOLA

BSN, Moorhead State University, Moorhead, Minnesota 1986

A proposal submitted to the
Faculty of the Graduate School of the
University of Colorado in partial fulfillment
of the requirements for the degree of

Master of Science

School of Nursing

1997

DISTRIBUTION STATEMENT A

Approved for public release
Distribution Unlimited

19971031 017

REPORT DOCUMENTATION PAGE			Form Approved OMB No. 0704-0188	
Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0188), Washington, DC 20503.				
1. AGENCY USE ONLY (Leave blank)		2. REPORT DATE 27 Oct 97	3. REPORT TYPE AND DATES COVERED	
4. TITLE AND SUBTITLE MEDICAL READINESS IN HUMANITARIAN AND CIVIC ASSISTANCE MISSIONS: SIGNIFICANCE OF CULTURAL TRAINING FOR NURSES			5. FUNDING NUMBERS	
6. AUTHOR(S) Julie M. Stola				
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) University of Colorado			8. PERFORMING ORGANIZATION REPORT NUMBER 97-138	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES) THE DEPARTMENT OF THE AIR FORCE AFIT/CIA, BLDG 125 2950 P STREET WPAFB OH 45433			10. SPONSORING/MONITORING AGENCY REPORT NUMBER	
11. SUPPLEMENTARY NOTES				
12a. DISTRIBUTION AVAILABILITY STATEMENT <div style="border: 1px solid black; padding: 5px; text-align: center;"> DISTRIBUTION STATEMENT B Approved for public release Distribution Unlimited </div>			12b. DISTRIBUTION CODE	
13. ABSTRACT (Maximum 200 words)				
14. SUBJECT TERMS			15. NUMBER OF PAGES 100	
			16. PRICE CODE	
17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT	

DTIC QUALITY INSPECTED 3

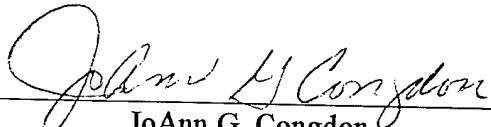
This thesis for the Master of Science degree by

Julie M. Stola

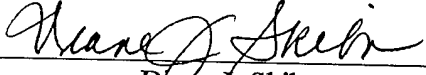
has been approved for the

School of Nursing

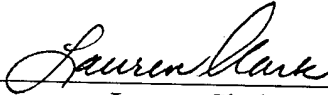
by



JoAnn G. Congdon



Diane J. Skiba



Lauren Clark

Date: 09 APR 97

Stola, Julie M. (M.S., Nursing)

Medical Readiness in Humanitarian and Civic Assistance Missions: Significance of Cultural Training for Nurses

Thesis directed by Associate Professor JoAnn G. Congdon

American military members have participated on humanitarian missions in increasing numbers since the end of the Cold War. One type is the Humanitarian and Civic Assistance (HCA) mission in which United States Air Force personnel travel to a poor, medically underserved country, establish a temporary clinic and care for patients.

HCA missions provide benefits to military members by allowing participation in "real world" situations, practical training experiences, and contribution to nation building. To provide culturally congruent care to persons in the host nation, nurses need cultural training in preparation for HCA missions. However, the amount, significance, and usefulness of cultural training prior to and during the mission is unknown.

The purpose of this study was to: 1) Describe military nurses' perceptions of cultural training provided to them prior to and during HCA missions. 2) Describe military nurses' perceptions of the HCA mission's effect on daily nursing practice.

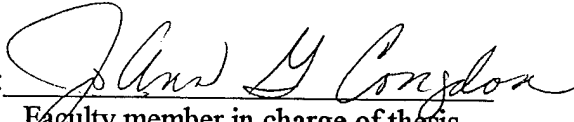
A descriptive survey design, guided by Leininger's Sunrise Model was utilized. The survey instrument was developed by the researcher after a literature search of concepts identified as important for success of HCA missions. The instrument was pilot tested by ten nurses who had recently participated on HCA missions for content validity and clarity of questions. The mailed survey tool, Training for Humanitarian and Civic Assistance Missions Survey, provided data on demographics and type of training nurses

received prior to and during a mission. Five open-ended questions asked for a written, opinion response regarding the mission. Data collection occurred during four weeks in January-February, 1997. Descriptive statistics were used to analyze results of the survey.

Ninety-three surveys were distributed with a return rate of 54.8%. Fifty-eight percent of the nurses stated cultural training occurred prior to the mission and 72% participated in cultural training during the mission. Seventy-six percent of the nurses stated HCA missions provided experiences they can utilize in daily work including cultural training, teamwork skills, and the importance of flexibility and adaptability.

The results of the study supported the need for additional cultural training for nurses who participate on HCA Missions. Recommendations for education and implementation include guidelines for training and cultural assessment.

The form and content of this abstract are approved.

Signed: 
Faculty member in charge of thesis

This thesis is dedicated to my husband for his constant support and understanding and to all military nurses who have the privilege to care for people from cultures around the world.

ACKNOWLEDGMENTS

I would like to thank Dr. JoAnn Congdon, my thesis chairperson, for her support throughout the entire research process. Her scholarly approach and thorough understanding of the process have made graduate school a truly rewarding experience and brought research to life for me.

To Dr. Diane Skiba I say thank you for helping me to realize that the research and the evaluation process can bring meaning into nurses practice in many ways. You are a true nurse advocate.

To Dr. Lauren Clark I say thank you for sharing your passion about cultural diversity and the development of cultural understanding. Nurses cannot truly care for patients until we understand them in a holistic sense.

To my mentor during the past eleven years, thank you for encouraging me to continue with the education process. My dreams are becoming reality.

To Col. Nina Rhoton and Lt. Col. Margaret Williams who have been nursing mentors not only for me but for many other military nurses, I say thank you. I would also like to thank the United States Air Force for allowing me the opportunity to attend graduate school. I take pride in the honor of serving my country with such a prestigious and professional organization.

To each of you I say: *Todo la tierra es mi lugar de nacimiento y todos los humanos son mis hermanos. Gracias hermanas/hermanos por toda su asistencia.* (All the earth is my place of birth and all human beings are my brothers. Thank you sisters/brothers for all of your support.)

CONTENTS

CHAPTER		
I.	INTRODUCTION	1
	Problem Statement	3
	Purpose and Aims	3
	Historical Background	4
	Definition of Terms	7
	Significance to Nursing and to Air Force Medical Readiness Planning	8
	Chapter Summary	10
II.	THEORETICAL FRAMEWORK AND REVIEW OF THE LITERATURE	12
	Culture Care Theory	12
	Conceptualization of the Theoretical Framework	19
	Selected Review of Literature	21
	Air Force Nurse Demographics	21
	Nursing Care Provided on HCAs	22
	Impact of Cultural Knowledge on Health Care Providers	25
	Chapter Summary	27
III.	METHODOLOGY	28
	Overview	28
	Research Design	28
	Population	31

Sample Selection	31
Sampling Technique	31
Protection of Human Subjects	33
Instruments	33
Data Collection	34
Data Analysis	35
Chapter Summary	36
IV. RESULTS	37
Introduction to Organization of Data	37
Return Rate	38
Description of the Respondents	38
Findings	41
Narrative Response Analysis	47
Chapter Summary	54
V. CONCLUSIONS	55
Review of Study	55
Discussion of Major Findings	55
Implications for Nursing Practice	66
Implications for Nursing Education	71
Recommendations	71
Future Research	71
Instrument Refinement	73

Limitations of the Study	. . . . .	74
Return Rate	. . . . .	74
Instrumentation	. . . . .	75
Summary of Study	. . . . .	76
BIBLIOGRAPHY	. . . . .	78
APPENDIX	. . . . .	85
A. University of Colorado Multiple Institutional Review Board (COMIRB) Letter of Approval	. . . . .	84
B. Survey Approval and Assignment of USAF Survey Control Number	. . . . .	86
C. Cover Letter to Subjects	. . . . .	88
D. Letter for Chief Nurse Executives	. . . . .	90
E. Follow-up Letter for Chief Nurse Executives	. . . . .	92
F. Survey Instrument	. . . . .	94

LIST OF TABLES

Table

1. Demographics	40
2. Training Categories and Percent of Nurses who Received Training Prior to and During the Mission	41
3. Hours Spent in Cultural Training Prior to and During the Mission	42
4. Cultural Training Methods Prior to and During the Mission	42
5. Cultural Factors Included in the Training Prior to During the Mission	43

LIST OF FIGURES**Figure**

1. Leininger's Sunrise Model	14
2. Conceptualization of the Theoretical Framework	20
3. Cultural Training Made a Difference to Nursing Care Provided	44
4. Degree of Difference Cultural Training Made on Nursing	45
5. Overall Value of HCA Mission	45
6. HCA Mission's Value in Daily Military Work Environment	46

CHAPTER I

INTRODUCTION

Medical Readiness is of particular interest to the United States military since Congress reviewed the readiness of the medical forces after the Gulf War. Many different types of training must occur for our military forces to prepare for any type of deployment, ranging from specific technical skills to security briefings and sanitation practices at the units final base of deployment. The United States Air Force has seen an increased tasking in the area of Humanitarian and Civic Assistance (HCA) Missions so Medical Readiness personnel must consider how to continue training U.S. military forces for HCA missions.

The HCA mission provides many benefits to those military members who are deployed. Military members are participating in a "real world" situation (medical personnel are actually providing health care to people who need it), contributing practical training, and HCAs furnish a means of increasing indigenous populations' exposure to the United States military in a non-combat situation. Not only are military members working to improve technical skills, but they are working at nation building with the countries where they are deployed.

If U.S. forces are going to continue to participate in HCA missions, Medical Readiness Planning must reexamine how to provide the best health care possible in what is sometimes a difficult situation. There is much research to support the idea that if one is providing health care to groups of a culture different from the one encountered most frequently, the health care provider must become familiar with the new culture and any

health care practices (Anderson, J., 1990; Andrews & Boyle, 1995; Lipson, Dibble, & Minarik, 1996). Familiarity with the culture the health care provider is working with allows the health care provider to provide culturally congruent health care which does not interfere with his or her own cultural practices and belief system.

Training for an Humanitarian deployment must also have value for the unit if the unit were to deploy for a war time situation. Cultural training must be specific to the area being deployed to, therefore, it may seem as though it will not have value for a war time situation. The value of the training for the real world situation is that concepts related to culture introduced during the training can be transferred to the real world situation.

Without the exposure during the HCA, military personnel do not have a great deal of experience working with differing cultures. Reviewing the locations where the United States Air Forces are deployed for various types of missions (Peace Keeping Missions, Overseas Deployments, Overseas Assignments and Humanitarian Missions), it is evident that the military member will come into contact with a wide variety of differing cultures. The training provided should minimally provide a basis for the team's consideration of cultural implications when providing health care to groups of people from different ethnic and cultural backgrounds.

Weisser (1993) made a very strong argument for cultural training:

If Medical Readiness Training Exercises are to prosper in these times of austerity, they must provide measurable benefits to host nations, as well as to American soldiers, to justify their continuation. The tenets of preventive medicine are the foundations on which such a program can be built. It is time to capitalize on the early successes and move into higher levels of medical assistance, (p. 575).

In order to accomplish cultural training, military nurses must be aware of the cultural variances within the host nation's current health care practices. Hand, Wiener & Sanford (1989), noted the importance of cultural impact on health care by saying, "anecdotal experiences demonstrated the importance of the local environment and social customs in the genesis of certain illnesses and symptoms," (p. 417).

HCA's have taken place in countries around the globe, particularly in Central and South America, but also in numerous deployments to various countries in Africa and Eastern Europe. Military Nurses are being asked to provide primary health care to groups of people with backgrounds which differ from their own. Training must be provided to assist them in providing appropriate health care to these varied groups of people.

Problem Statement

The problem was military medical personnel may not be receiving adequate cultural training prior to deployment to a foreign country. Appropriate health care delivery to any population should be culturally congruent. Without cultural training, military medical personnel may not deliver appropriate care.

Purpose and Aims

The purpose of this study was to describe the cultural training provided to Air Force nurses prior to and during an HCA mission. The specific aims of this study were to:

- 1) Describe military nurses' perceptions of cultural training that was provided to them prior to the HCA mission.
- 2) Describe the military nurses' perceptions of cultural training that was provided to them during the mission.
- 3) Describe military nurses' perceptions regarding the extent to which cultural training would impact their practice in military work

after completion of the mission. Selected personal characteristics of military nurses who have participated on an HCA are also described

Historical Background

There are a number of different types of Military Civic Action (MCA) projects in which the various military services participate. The missions range from Medical Readiness Training Missions, Peace Keeping Missions, Humanitarian and Civic Assistance (HCA) Missions, and Medical Civic Action Programs (MEDCAPs). This study was designed to describe a specific type of military mission where a group of medical personnel travel to a poor, medically underserved area, set up a temporary clinic and provide care to any number of patients over the course of one to several days. The United States Air Force classifies this type of mission as an HCA.

The United States Military has, in the last ten years, changed from medical readiness training primarily for wartime situations to the addition of readiness training for Peace Keeping Missions and Humanitarian and Civic Assistance Missions. The Southern Command (SC) Regulation 40-6 (15 JAN 95) governs the process for the "Administration of Medical Deployments for Training." This regulation states that, "By law, (U.S.C. Title 10, Section 401), HCA funds and/or supplies will be used for the development of specific operational readiness skills of U.S. Armed Forces personnel who participate in the activities. The benefits to the host country are incidental to the training of the U.S. Forces." Therefore, the emphasis of these missions continues to be military training. One of the reasons this type of training is so valuable was well stated by Deckert, Dempsey, & Shaffer (1995). They stated:

Conventional military medical field training does a good job in training military personnel how to survive in primitive surroundings but a poor job of training patient care techniques under those circumstances. A volunteer 'patient', pretending to have an injury or condition just doesn't compare to the genuine article (p. 212).

Various types of humanitarian missions have been in existence since the Korean Conflict and have gone through numerous changes in mission goals. Since the end of the Cold War, it has become more apparent that military civic actions are "reemerging as a way to assist the military establishments of newly emerging democracies to transition into new roles within their nations" (Luz, DePauw, Gaydos, Hooper & Legters, 1993, p.362). More immediate benefits provided are training and gathering of medical knowledge that may be used to promote the health of indigenous people and to protect the health of the U.S. public from newly discovered pathogens in emerging nations. Perhaps it could be even more general as U.S. forces are able to observe and gather information on the cultural differences of the people the military is providing care. Participation in military civic actions lead to continued nation building by promoting a better understanding of the indigenous people as well as promoting a more realistic view of North American culture to the host nation.

Enthusiasm about Military Civic Action (MCA) reached a high point under President Kennedy, who declared, "The new generation of military leaders has shown an increasing awareness that armies cannot only defend their countries - they can help to build them" (Luz et al., 1993, p. 363). The rationales for continuing to use MCAs for training missions include: helping to further U.S. policy, providing realistic field readiness

training, and offering a professionally rewarding experience to the military member, (Deckert et al., 1995).

There are arguments against HCA deployments as well. Crutcher, Beecham, & Laxer, (1995), stated that although HCAs may provide an excellent training experience, many factors make it difficult for these missions to have any meaningful impact on the health of the local population. One must consider the potential for doing harm by giving false hope to persons who need more care than can be provided and by giving out medications without being able to handle complications. Crutcher et al. (1995), offered guidance as to how HCA missions might better address the health care needs of the population being offered assistance by proposing utilization of the World Health Organization's (WHO) 1978 recommendations: 1) childhood immunizations, 2) oral rehydration therapy for diarrheal diseases, 3) promotion of breast feeding, and 4) the use of anti-malarial drugs. In addition, HCAs would include programs for helminths, Vitamin A supplementation, treatment of "selected" infectious processes and the focus should be on children and women of childbearing age.

Argument can be made against utilization of the recommendations mentioned above in that health promotion activities may offer little training value the military member will be able to transfer to a "real world" (wartime) situation. Others may question if health promotion activities are the type of mission in which our military personnel should be involved. If the missions changed and focused on health promotion, the training experience would not prove to be of significant value if an adequate cultural assessment was not accomplished prior to the mission and cultural training was not provided for those

participating in the exercise. Reasons for this are that differing cultural groups look at health promotion and preventive medicine in ways that are different from that of western medicine. If the military were to impose its beliefs on other cultures, they could face opposition or indifference to the concepts proposed. Imposition of western health beliefs is less likely to occur if the military unit has information on the health care practices of the cultural group being provided assistance.

Definition of Terms

1. **Humanitarian Assistance** - activities undertaken to advance the general welfare of populations or individuals independent from disasters, politics, race or religion.
2. **Humanitarian and Civic Assistance (HCA) Missions** - the development of specific operational readiness skills of U.S. Armed Forces personnel who participate in the HCA activities. The mission must be completed in less than 180 days. The benefits to the host country are incidental to the training of U.S. Forces. .
3. **Medical and Civic Action Programs (MEDCAPs)** - military missions where emphasis is on providing medical care to local populations, training and education value is a secondary gain. This type of mission was primarily used prior to 1985.
4. **Host nation** - the country in which U.S. military forces are providing health care.
5. **Indigenous** - the people who are residents of the host nation.
6. **Medical Readiness Education and Training Exercises (MEDRETEs)** - a mission where a medical team goes to a rural village and conducts a sick-call or walk-in clinic for the local inhabitants. The primary purpose is to improve the operational efficiency of medical units. Secondly there are the gains of increased goodwill of the indigenous

population toward U.S. Forces and the training of indigenous medical personnel. It is important to note that since 1985, the use of Department of Defense Funds on humanitarian assistance is not authorized under Title 10 of the United States Code. Hence, the emphasis is on training and education in the current MEDRETEs & HCA programs.

Significance of the Study to Nursing and to Air Force

Medial Readiness Planning

Determining the cultural knowledge of medical personnel deployed in an HCA is important for many reasons. The HCA missions as nation building mechanisms go beyond training as their primary goal and have as an inherent secondary goal provision of valuable medical benefits to the host nation. Therefore, nursing personnel must first, do no harm by importing their own beliefs on the culture which the military mission is providing medical assistance. To provide the culturally congruent care required, the nurse corps must use a culturally sensitive approach to meet the needs of the host nation patient. The lack of cultural knowledge has been addressed as an area which has significant impact on the effectiveness of military missions, (Luz et al., 1993, Weisser, 1993, Crutcher et al., 1995) and on nursing care provided to groups of people of a different cultural background (no studies have looked at this aspect of training or its importance). In the present times of military cutbacks and drawdown, it is imperative that the United States Air Force ensures that these missions, which cost thousands of dollars, are providing the most effective nursing care possible.

Crutcher et al., (1995), noted that although HCAs may provide an excellent training experience, many factors make it difficult for these missions to have any meaningful impact on the health of the local population. These factors include the short amount of time the medical support team is on location, lack of follow-up care, large number of patients, lack of support services, limited medications, language barriers, and being unfamiliar with the local culture, endemic diseases, health-care system, and standards of care. If these missions are to continue, training of the medical support team prior to the mission must address these problem areas including specific information regarding cultural practices as they relate to health care.

Lux et al., (1993), listed twelve requirements for the Medical and Civic Action Missions (MCA's), one of which stated:

Interpreters and translators for the U.S. Forces must be extremely knowledgeable about the native customs, competent in the language (including the pertinent technical vocabulary), and interested in continually advising and teaching other U.S. team members; U.S. personnel must be knowledgeable about indigenous customs and traditions and must show respect for these at all times (p. 365).

Without paying attention to the countries mores, traditions and taboos, these missions will be set up for failure and perhaps jeopardize any future missions which might take place.

Nurses have an obligation to all patients to treat them in a culturally congruent manner which is required to provide professional nursing care to any population. If military nurses attempt to provide nursing care or to intervene without understanding the effects of culture on patients and ourselves, the results will be, "futile, sometimes dangerous, and always limiting" (Ferris, 1990, p. 46).

The military nurse must provide sensitive care to individuals from diverse groups whether it is during work in a military hospital, on a military deployment or in a wartime situation. To provide sensitive care to individuals from diverse groups, Flemming (1989) stated, "it requires the health care worker to examine and try to understand the meaning of human actions and values that determine choices made in health and illness. Learning the culture is essential if a relationship is to be effective" (p. 566).

Leininger's Culture Care Model assists the nurse in delineating the various areas where culture is displayed and should be considered when delivering health care. The list includes technological, religious and philosophical, kinship, political and legal, economic, and educational factors as well as cultural values and lifeways. The nurse must also consider care expressions, patterns and practices within a culture which assist in determining the level of acceptance of the U.S. military's approach to provision of health care.

In order for the relationship to be beneficial to the patient, the military nurse must realize that he or she does not only deal with the individual, but with the family, groups, communities and institutions when providing health care. The concept of community health is of particular importance because the deployment is made to a specific community to accomplish training and provide health care during that training within the designated community.

Chapter Summary

This chapter provided an introduction to the problem that military medical personnel may not be receiving adequate cultural training prior to deployment to a foreign

country. There has been a change of military missions from wartime scenarios to HCAs, MEDRETEs and Peace Keeping Missions and military nurses have seen a change in the patient population. This change in the population has led to a need for altering the type of training accomplished prior to and during HCA missions. The purpose of the study, specific aims, significance and definition of terms were presented.

In Chapter II, the theoretical framework for the study and a review of the literature is presented. Leininger's Conceptual Model of human care diversalities and universalities is used as the guiding framework for this study. The review of the literature addresses the significance of cultural knowledge of medical personnel in previous missions as well as the impact of cultural knowledge on health care providers.

CHAPTER II

THEORETICAL FRAMEWORK AND REVIEW OF THE LITERATURE

Chapter two contains 1) an overview of Leininger's Culture Care Theory and how it can be utilized as the basis for cultural training for deployed military units, and 2) an overview of the literature and research findings related to cultural training in military missions and cultural training and education as it relates to non-military nurses.

Culture Care Theory

Culture care theory guides the provision of culturally congruent care that fits with the cultural beliefs and lifeways of the people and will be beneficial and meaningful to the client, family or cultural group. The purpose of the culture care theory is to discover human care diversalities and universalities in relation to world view, social structure, ethnohistory, sociocultural institutions, environmental context and language uses, of people of different or similar cultures (Leininger, 1991a). Leininger summed up her theory by stating that the purpose is to describe, account for, interpret and predict cultural congruent care as well as to provide quality care to clients of diverse cultures that is congruent, satisfying and beneficial to the client, family or cultural group (Leininger, 1988). Leininger's theory is based on the premise that "Care is the essence of nursing and the distinct, dominant, central and unifying focus of nursing" (Leininger, 1991b, p.56).

The field of transcultural nursing, which looks at the impact of culture on health care practices, was conceived in the mid-1950's and developed in the 1960's by Madeleine Leininger. It was not until the early 1970's that transcultural nursing began to take hold

and its theoretical framework began to be utilized to a greater degree by nurses as they began to provide health care to increasing numbers of clients from a broadening number of cultures.

Leininger theorized that care was culturally constituted in every culture. She stated that transcultural nursing offers nurses the opportunity to appreciate individual clients and their culture and to develop ways of working cooperatively with clients. If this is true of the individual, nurses will also find that to provide care to a community, nurses must be afforded the opportunity to appreciate the cultural needs of the community.

Leininger went on to say that in the community health setting, the culture of the community is the determining factor for what nursing activities will be allowed and therefore, nursing can only be effective if it takes place in a culturally acceptable context (Leininger, 1991b).

Leininger's Sunrise Model (1991a, Figure 1) illustrates a visualization of the different dimensions of the culture care theory with directional influences on cultural care expressions and patterns, and includes a focus on the three predicted modes of nursing action. Elaboration of the model begins from the superior dimension which elucidates a broad theoretical framework for understanding the cultural and social dimensions of individuals, families, and groups that influence health care values, beliefs, patterns, and practices. Values and beliefs are embedded in the social structure and world view of a culture. Environmental context and language are regarded as essential for understanding the influencing factors of the social structure and world view of a culture. The model depicts a gestalt of the religious, educational, political, technological and economic

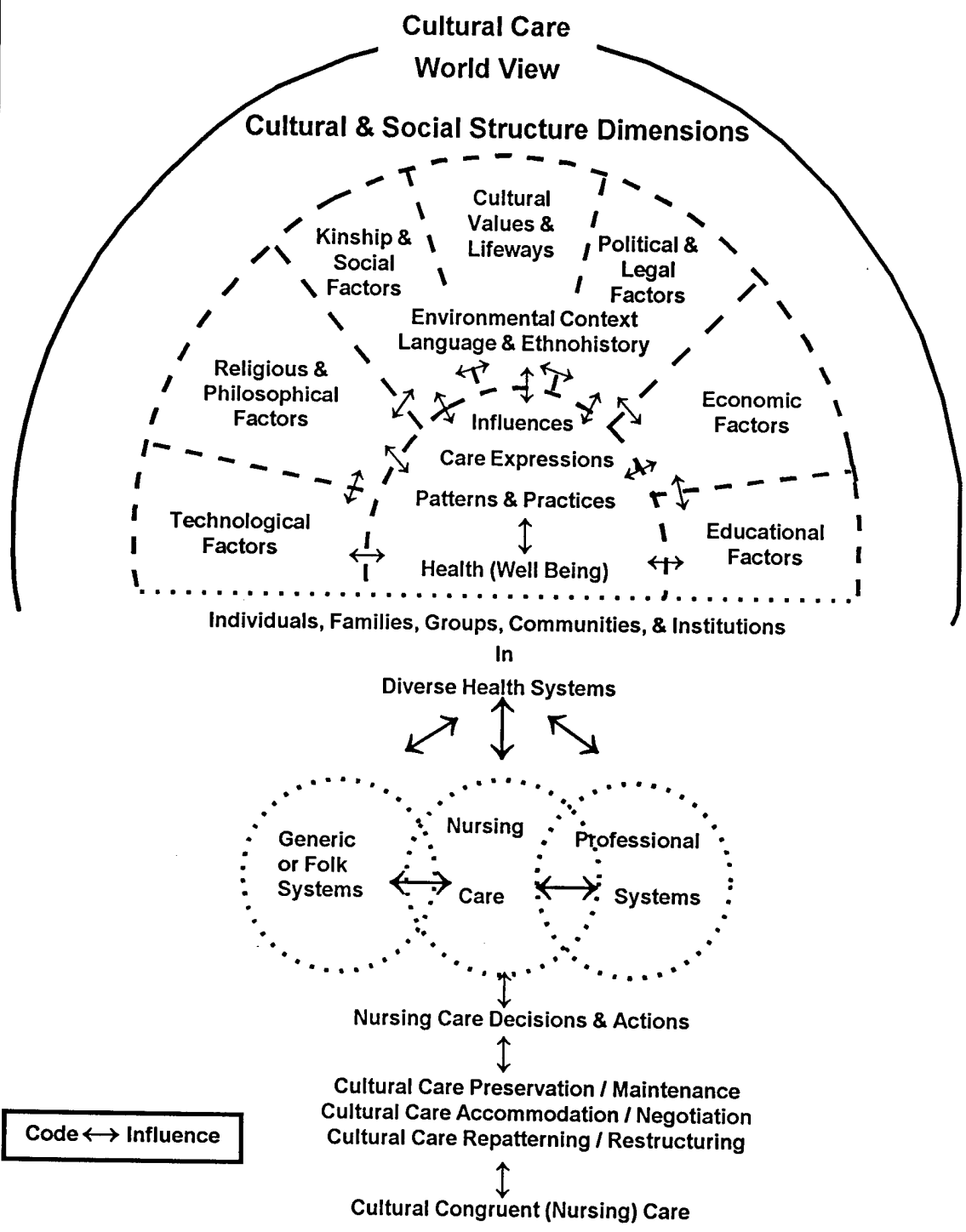


Figure 1 - Leininger's Sunrise Model (Note: In M. Leininger (1991). Cultural Care Diversity and Universality: A theory of Nursing, New York: National League of Nursing, pg. 34.)

factors, as well as the cultural and kinship values that must be considered to appreciate the emic view. These dimensions provide a look at the “totality of cultural lifeways” (Leininger, 1993, p. 106) and serve to keep the researcher aware of the numerous influences on cultural caring practices.

The inferior dimension of the model correlates to the influences of the folk health care system (the emic) or people perspective of health care and the professional (the etic) perspective of health care. These perspectives are in an ongoing dynamic interrelationship influencing the planning and provision of nursing care. The nursing care decisions and actions may involve one or more of the major modalities of planning and providing culture congruent care. Culturally congruent care is a combination of culture care and cognitively based professional care.

Leininger’s theory contains three major modalities to guide nursing judgements in providing culturally congruent care; cultural care preservation or maintenance, cultural care accommodation or negotiation, and cultural care repatterning or restructuring (Leininger, 1991a). Findings from the world view, social structure, cultural values, and environmental context have direct implications for the modes of decision making and culture care. Culture care preservation and maintenance of those generic care practices which contribute to health and well being should be encouraged. Culture care accommodation and negotiation may be necessary to provide culturally congruent care and for those situations where repatterning is needed. The nurse should be particularly cautious as a truly creative approach will be necessary to propose nursing care when repatterning is being undertaken. All care modalities require co-participation of nurse and

client to plan culturally congruent care that is beneficial, meaningful, and satisfying to the client.

Cultural care theory has the potential to discover the interrelationships of culture care and professional care. It provides nurses a comparative view of differences and similarities as they work with people in different contexts as well as providing a perspective to reduce ethnocentrism through an appreciation of the world view of others. Cultural care theory can become the basis of the training provided to military nurses prior to and during the HCA. The Sunrise Model provides the military nurse with training focus areas as they prepare to provide care in a different culture.

Leininger addressed some of the consequences of not providing culturally congruent care. She stated:

Nurses are realizing that their clinical efforts will be ineffective and can lead to frustrations and unfavorable consequences unless nurses know how to care for clients of different lifeways and values in the hospitals, homes, schools or wherever people live or work (Leininger 1994, p.254).

The ideal HCA mission in which the nurse has completed an analysis of the impact of culture prior to the mission may seem particularly overwhelming since the team is only in the community for a brief period of time. However, Tripp-Reimer, Brink, and Saunders, (1984), noted that it is unnecessary to complete a total cultural assessment for every patient. Instead, nurses collect enough basic cultural data to identify patterns of behavior which may either facilitate or interfere with a nursing strategy or treatment plan. Dobson, (1988) commented that there are problems when you rely on such assessment guides as "cognitive guides" in nursing practice. Caution should be used then when

utilizing pre-written assessment plans since there will be variances within any specific culture.

Nurses learn how to adapt what is provided in the cultural guidelines to the situation at hand the same as they do for any tool provided to them which does not meet their specific needs. If a nurse has never worked with groups of people from another culture, any guidance at all is better than only using the nurse's individual culture as a reference for providing health care.

Lipson et al., (1996) further stated that, "the cultural perspective in nursing care includes three interactive view points - objective, subjective, and the context of the cross-cultural encounter" (p. 1). The objective component, from the nurse's perspective, focuses on the patient, family, and community's cultural and social characteristics. The subjective perspective emphasizes the nurse's personal and cultural characteristics. If military nurses are working in "nation building" as well as providing health care, they will not be able to provide culturally competent care unless nurses acknowledge their own values, beliefs, and communication style. The context includes the broader cultural, socioeconomic and political influences on the health care system and is an area of particular interest to those in a deployment situation because an HCA mission is usually in an economically suppressed area and the presence of the U. S. Military in any setting has political connotations.

Mulholland (1995) criticized transcultural nursing models by stating a fundamental limitation of the models is the "inadequate theorization of power, a limitation that has its origins in its humanist foundation." He further stated,

transcultural nursing models, rather than discrediting and challenging the essentialisms of both traditional assimilationist approaches and those of the New Right, have inadvertently reproduced them. The adoption of multicultural frameworks and strategies by nursing may reflect that multicultural education is simply the latest and most liberal variant of the assimilationist perspective (p. 446).

The Cultural Bridge Model, proposed as an alternative to Culture Care Theory was described by West (1993), as making it possible to “bridge,” but not change, and to build, but not obliterate the cultural uniqueness of two interacting groups of people. Accomplishment of building the bridge is through the utilization of the cultural bridge building model, based on the concept of mutual respect. West provided case studies of how the Cultural Bridge Model was put into practice and included an assessment tool which focuses on cultural data. West criticized past models of transcultural nursing as having emphasized modification of the cultural traits of patients that do not fit into existing plans of care or as modifying existing plans of care to address the needs of patients.

A frequent criticism of transcultural nursing is that it is saturated with confusions and ambiguities over terminology. Solomos & Back (1994) appealed for greater theoretical clarity on key concepts since such ambiguities constitute an ongoing handicap. George (1995) stated that Leininger’s theory and model are not simple in terms of being easily understood upon first contact and it is only after careful study of a list of definitions that interrelationships can be grasped.

With all of the critiques, the Leininger Model is useful for the purpose of delineating the various aspects which should be addressed during the assessment phase. Once the personnel begin to utilize the Model, the definitions begin to make sense since

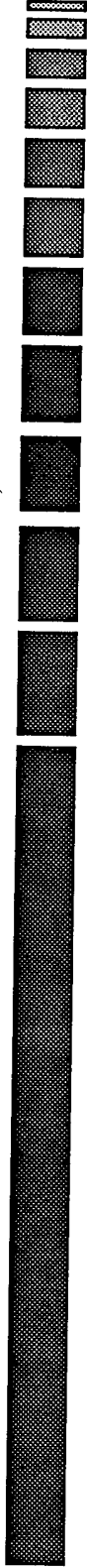
they actually have a patient to evaluate and the variety of responses which are elicited bring out aspects of the patient which they otherwise would not have know but are important for providing adequate care.

Conceptualization of the Theoretical Framework

The researcher's conceptualization of the relationship between military training of cultural concepts (specific to the group of people in the area where the HCA is taking place) and provision of health care is presented. Figure 2 illustrates how military training is the key to unlocking the culture care theory and that if the culture care theory is utilized the result will be that nurses may be better able to provide health care appropriate for the culture for whom they are providing care. As training is accomplished regarding cultural issues, nurses will sense that the care which they provide is beneficial to the host nation and meets the patient's specific culturally determined health care needs. The skills learned during the training opportunity will be transferred to use in the nurse's day-to-day health care setting as well as to other military deployments (i.e., Peace Keeping Missions, Overseas Assignments and Wartime Scenarios).

The United States Military utilizes training as the key to success in deployments of all categories, for all military personnel, regardless of your duty title. The intent of the study was to identify which types of training (i.e., security, safety and language) were accomplished prior to and during an HCA with an emphasis on cultural training. Data generated from this investigation will provide a better understanding of the training for an HCA as it relates to providing nursing care to groups of people with differing cultural backgrounds.

CONCEPTUAL MODEL



- Training is the Key to:

- Unlocking the Theory

Madeleine Leininger, Sunrise Model

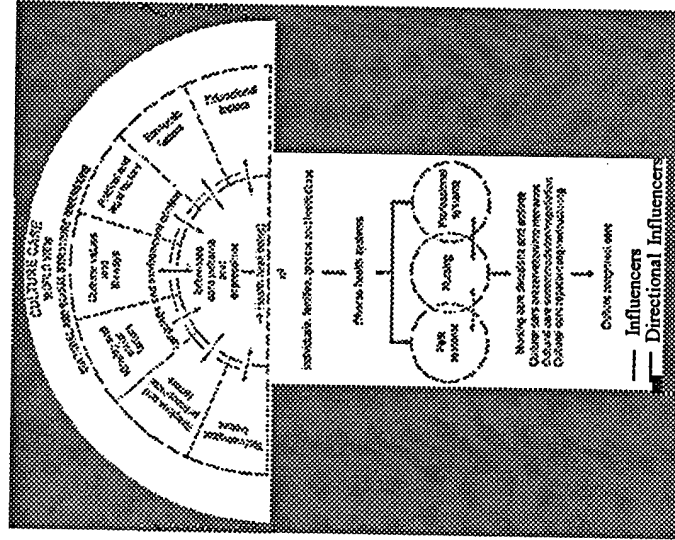
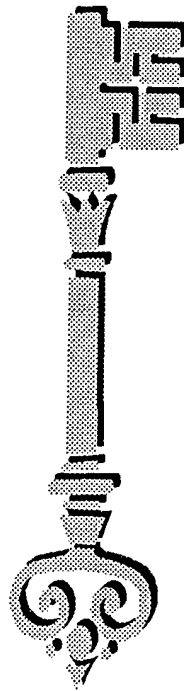


Figure 2 - Conceptual Model (Note: In M. Leininger (1991). Cultural Care Diversity and Universality: A theory of Nursing, New York: National League of Nursing, pg. 34.)

Selected Review of the Literature

A review of articles about military missions which contained information specific to humanitarian missions was accomplished. Few if any studies have been conducted on the specific type of care that is provided to clients during an HCA. The lack of studies found during the literature review may be in part due to the fact that the HCA is a relatively recent development for missions in which military forces participate. It may also be due to the fact that "care rendered is incidental" as directed by the regulation, decreases the significance and therefore doesn't warrant being studied. Although providing care may be deemed insignificant (as stated in the regulation), the means in which the military medical team prepares/trains for the mission and inevitably for work with "real world" clients, continues to be an important area of study.

Air Force Nurse Demographics

The Air Force Nurse Corps consists of 4763 nurses. Twenty-five percent are male nurses. Rank structure is as follows: 2Lt.- 9%, 1Lt.- 19%, Capt. - 45%, Maj.- 19%, Lt.Col.- 7%, and Col.- 1%. Ethnicity is broken down by gender as follows for male nurse: Asian - 2%, African American - 4%, Hispanic - 2%, White, non-Hispanic - 82%, and Other - 2%. For female nurses, ethnicity is the same except for an increase by one percent for Asian nurses and an increase to 11% for African American nurses. Educational level for Air Force nurses described as follows: <1% have less than a BS/BSN, BS/BSN - 71%, MS/MSN - 27%, and Doctorate - <1%. These statistics were received from the Air Force Personnel Center, March 1997.

Nursing Care Provided on HCAs

Cultural training is essential when United States military personnel participate in United Nation sanctioned Peace Keeping Missions or during Wartime Missions. Johnson (1992) discussed the importance of noting differences in cultural practices while working in Dubai, United Arab Emirates, during Operation Desert Storm. He discussed training which occurred while in Dubai regarding cultural sensitivity and the importance this training played in allowing the multinational team to work together as a cohesive unit.

Luz et al., (1993) condensed reports of cultural problem areas which had been noted in previous missions. After a mission to Botswana, it was noted that "lists of country mores, military structure, traditions, and taboos were considered essential" for the pre-mission briefing (p. 365). A report from a mission in Mauritania highlighted the importance of a briefing on the Muslim religion and customs. A project in Thailand was affected by the Buddhist spirituality. Animals as well as people had special rights which needed to be considered before acting to control a rabies outbreak. The conclusion of the officers in charge of the missions was that personnel must be knowledgeable about indigenous customs and traditions and must show respect for these at all times in order for the mission to be successful.

Smith & Smith (1993) reported on a United Nations Humanitarian Mission near Zagreb, Croatia in 1993. They expected cultural diversity to present challenges to their work. Certain anesthetic procedures were resisted or refused by the patients of differing cultural backgrounds because of preconceived ideas regarding the effectiveness of the

treatment. With proper cultural training, the staff might have been alerted to cultural differences and offered a culturally acceptable approach to anesthesia.

Lillibridge, Burkle, & Noji (1994) looked at both disaster mitigation and humanitarian assistance training for military personnel. They emphasized the changing mission requirements for uniformed service medical personnel and therefore the changes in training which will be required. A general framework for working through disaster mitigation and HCA missions was proposed as well as a curriculum proposal. Their recommendations to improve the readiness of the medical personnel to perform the increasingly common disaster mitigation and humanitarian assistance mission were as follows: 1) development of a comprehensive program which draws on the strength of all branches of the uniformed services, as well as other disaster-related Federal agencies and intergovernmental relief organizations; 2) creation of a skill designator or career path for the health officers who wish to continue in this area; 3) invest more in long-term postgraduate public health training in order to enhance intra service capacity for dealing with these disasters; 4) provide increasing opportunities for the uniformed service medical personnel to be assigned to these missions so that experience and leadership is gained; 5) initiate such training at the medical or graduate student level and continue the education throughout the officer's career.

The primary reason the above recommendations for readiness were proposed was that, "one of the most pressing initial issues to resolve will be establishing an appropriate standard of care that can be delivered to disaster-affected communities" (p.402). That

standard of care will certainly take into consideration the effects which culture has on the health care system within the country being provided assistance.

The HCA mission is used as training for rapid host nation medical deployment.

Ludwig, Horak, Wallace, & Deafenbaugh (1992) reviewed some of the problems of deployment in Operation Desert Shield/Storm. They noted that standards of care differed between the host nation and the United States standard. One of the greatest threats to the combination of United States military and host nation medical personnel was, "hostility between the hosts and the military medical team, arising from professional or cultural differences" (p. 599). Recommendations resulting from the experience included:

- 1) experienced medical, nursing, and ancillary personnel are highly recommended;
- 2) medical officers must remember that different acceptable methods of treatment may exist;
- 3) all personnel must remember that the host nation detachment has been invited to facilitate care, not overturn existing standards;
- 4) pre-arrival briefings should be as complete as possible, providing information on local habits, customs, and cultural considerations;
- 5) once in country, daily meetings of the whole group, both officers and enlisted, to discuss common problems, cultural considerations, and new ideas are helpful;
- 6) respect for the host nationals is critical. In the summary of the mission it was clearly stated that "the cornerstone of the success of this unique mission was the willingness of the team members to work in the host nation hospital milieu, respect the culture, and accept the nuances of the local system." (p.601)

Hand et al., (1989) mentioned cultural practices by saying that,

MEDRETEs (Medical Readiness Education and Training Exercises) also generate goodwill toward U.S. Forces and toward local government military forces, especially if practiced with due regard to local custom and protocol. Giving full regard to local tribal customs was important for the success of the mission (p.421).

Impact of Cultural Knowledge on Health Care Providers

Goodman (1994) practiced transcultural nursing in an overseas environment and wrote about the challenges of working in underprivileged areas where the patients speak little or no English. The challenges included personal and professional challenges which were met by becoming aware of the differences within the culture and recognizing one's basic values and beliefs. Teamwork skills were noted as important in the development of a cohesive and productive unit. Appropriate utilization of resources was vital, the greatest resource being personnel who could speak the local language. Goodman noted that it was of significant importance that the local community provided interpreters since not only do they know the language, but they also understand the local customs and are able to explain difficult concepts to patients as well as interpret the patient's questions and concerns to the team members.

Eliason (1993) reviewed some of the recent literature which combined nursing ethics and transcultural nursing. She stated, "nursing practice cannot be ethical unless the culture and beliefs of the client are taken into consideration" (p.225). There is a difference between treating every patient equally and basing care on individual needs which must recognize culturally different needs and addressing them effectively. In addition, Eliason provided five case studies which compared ethnocentric solutions to ethnorelative

solutions showing how nurses label patients as “noncompliant” due to the nurses own prejudices. She supplied guidelines for providing culturally sensitive and ethical nursing practice. A list of eight suggestions can be utilized in practice settings within the United States as well as abroad.

Burk, Wieser, and Keegan (1995) examined implications for primary care nursing practice based on cultural beliefs and health behaviors of pregnant Mexican-American women. They utilized Giger and Davidhizar’s transcultural assessment model to evaluate the cultural beliefs and health behaviors of the women in the study. The transcultural assessment model used includes six cultural phenomena which are evidenced among all cultural groups: 1) communication, 2) space, 3) social organization, 4) time, 5) environmental control, and 6) biological variations. This researcher noticed similarities between these six items and Leininger’s Culture Care Model. Implications for primary care in diverse cultural settings were made regardless of the culture being served or the setting in which health care is provided. Burk et al., strongly concluded:

It is as important for the health care provider to be aware of the client’s culturally based health beliefs and behaviors as it is to know the client’s family history, medical history, current symptoms, and physiologic status. Understanding and respecting diverse cultural beliefs, attitudes, and life styles, while at the same time appreciating individual variances within each culture, form the basis for holistic care that is acceptable and effective.

Jackson (1993) compared biomedicine (sometimes called Western medicine) and its belief practices to those of naturalistic systems and personalistic systems. By discussing the differences in cultural practices, Jackson analyzed the negotiation process of providing treatment, beginning with the preservation of helpful beliefs or practices to accommodation of neutral beliefs and practices, and when necessary, to the repatterning of

harmful practices. The process is important in the determination of nursing care decisions and actions as depicted in Leininger's Sunrise Model.

Chapter Summary

Leininger's Model of Culture Care theory has been described. The objectives of culture care were presented along with a brief discussion of the model. The various components of the culture care theory were defined. Fig. 1, Leininger's Sunrise Model, is an example of the model. Relevance of the model to this study was also addressed.

A selected review of the literature addressing previously noted problems on missions where cultural knowledge was identified was evaluated. The review clearly illustrated a lack of information regarding care provided on the missions as well as clearly stated needs for cultural knowledge training for the HCA mission.

In Chapter III, the methodology of this study is presented. Research design, population, sample, and the protection of human subjects is discussed. Instrument development, data collection and analysis are explained.

CHAPTER III

METHODOLOGY

Overview

A descriptive survey design and convenience sample were used for this study.

Approval for conducting this study was received from the Colorado Multiple Institutional Review Board (COMIRB) at the University of Colorado Health Sciences Center and from the U.S. Air Force Survey Approval Board. Consent of the participant was given by the respondents by completion of the questionnaire.

Data on training experiences prior to and during HCA missions were obtained via use of a researcher developed survey questionnaire. Descriptive statistics were used to analyze the data.

Research Design

A descriptive survey design was used in this study. Watz and Bausell (1981) stated that a descriptive design may be used for the purpose of developing theory, identifying problems with current practice, justifying practice, making judgements, or determining what others in similar situations are doing. Burns and Grove (1995) explained descriptive research as a means in which researchers, “discover new meaning, describe what exists, determine the frequency with which something occurs, and categorize information” (p. 38). Polit and Hungler (1987) stated that “research studies that have as their main objective the accurate portrayal of the characteristics of persons,

situations, or groups, and the frequency with which certain phenomena occur” are descriptive in nature. (p. 528)

Notter and Hott (1994) stated:

descriptive research describes what is and analyzes the findings in relation to their significance. Most nursing research is of this type. It is often done for the important purpose of generating hypotheses for future experimental studies; or it may simply be a way of finding out what the facts are (for example, by means of a survey) (p.32).

Many different data collection techniques are used in this type of research, including interviewing, preparing case studies, and making surveys and observations.

A descriptive survey design was used to gather the data. The purpose of the survey design is to, “obtain information regarding prevalence, distribution and interrelationships of variables within a population.” In a survey, there is no experimental intervention, surveys are inherently nonexperimental. Surveys obtain information from a sample of people by means of self-report; that is, the people in the sample respond to a series of questions posed by the investigator. Surveys collect information on people’s actions, knowledge, intentions, opinions, attitudes and values (Polit & Hungler, 1993, p.148).

One type of survey is the questionnaire. Questionnaires differ from interviews primarily in that they are self-administered. That is, the respondent reads the question on the schedule and gives the answer in writing. A person associated with the survey may or may not be present at the time the questionnaire is completed to answer questions that arise. Because of this fact, and because respondents differ considerably in their reading levels and in their ability to communicate in writing, questionnaires are not merely a

printed form of an interview schedule. The most common way of distributing questionnaires is through the mail (Polit & Hungler, 1991, p.193).

The greatest advantage of survey research is its flexibility and broadness of scope. It can be applied to many populations, it can focus on a wide range of topics, and its information can be used for many purposes. Good surveys can be much more costly than experiments, but when one considers the amount of information obtained in the course of normal surveys, they are economical (Polit & Hungler, 1991, p.193). There are a number of limitations of survey research which should be considered. First, the information obtained in most surveys tends to be relatively superficial. Survey research is better suited to extensive rather than intensive analysis. Second, survey data do not permit the researcher to have much confidence in inferring cause-and-effect relationships (Polit & Hungler, 1991, p. 193), which is not necessary in a descriptive study.

In this study, survey design was selected to describe the cultural training provided to nurses prior to and during an HCA mission. The specific aims of this study were to:

- 1) Describe military nurses' perceptions of cultural training that was provided to them prior to the HCA mission.
- 2) Describe the military nurses' perception of cultural training that was provided to them during the mission.
- 3) Describe military nurses' perception regarding the extent to which cultural training would impact their practice in military work after completion of the mission.

Population

The target population consisted of Air Force nurses who have recently (no more than five years ago) participated in an HCA mission. This researcher was able to contact the nurses identified through Chief Nurses at Air Force bases. The Chief Nurses were requested to identify the number of nurses who had participated on an HCA in the past five years and the researcher sent the Chief Nurse (or Point of Contact) a packet with a questionnaire for each of the identified nurses.

Sample Selection

Swanson-Kaufman (1988) stated that in descriptive studies the empirical phase begins with identification of the population from which subjects will be selected. The sample is selected for its members' experiences with the phenomenon or condition of interest. Parse stated that the sample for a descriptive study consists of a social unit (Parse, Coyne & Smith, 1985). The social units studied by the researcher will be nurses who had participated in an HCA in the past five years.

A purposeful sample was utilized in this study in order to select only military nurses who have participated in the specific type of mission being studied. Those who have participated in HCA missions and MEDRETEs were sent the questionnaire via their Chief Nurse.

Sample Technique

A list of Air Force Nurses who have participated in HCAs was requested but this did not prove useful since the Medical Readiness office did not have up-to-date duty assignments or local addresses. The researcher contacted a Nursing Education Officer

who had recently participated in a similar study of nurses who had been deployed. She suggested the Chief Nurse of military bases be the contact person for questionnaire distribution. The selection of bases where the questionnaires were sent was done by a review of all Air Force Bases where nurses are assigned. The researcher and a fellow Air Force nurse reviewed the list to determine which bases were likely to have deployed nurses in the past five years and have more than five nurses currently assigned to the base. After sending a letter of inquiry via E-mail, the researcher received positive responses from 18 bases. This process resulted in a purposeful sample selected from the target population. The Chief Nurses agreed to have nurses assigned to that base participate if the nurses met the research criteria. The Chief Nurse or a designated Point of Contact (POC), designated by the Chief Nurse, was then asked to determine how many nurses met the study criterion of having participated on an HCA in the past 5 years. The Chief Nurse or POC was requested to send the researcher the number of nurses who had participated on an HCA in the past five years (Appendix D).

All surveys remained anonymous. The researcher had coded the return envelopes specific to each base by using different first class postage stamps for each base. This allowed the researcher to determine percentages of returned surveys from each of the bases and assisted the researcher in checking to be sure that the surveys had been distributed. At the two week point, the Chief Nurse or POC was asked to remind the recipients to return the questionnaires (Appendix E). The Chief Nurses were also asked specifically how many questionnaires they had distributed to assist the researcher in keeping an accurate count of distributed questionnaires.

Protection of Human Subjects

Approval for this study was received from the Colorado Multiple Institutional Review Board (COMIRB) at the University of Colorado Health Sciences Center (Appendix A) and from Headquarters, Air Force Military Personnel Center as required in Air Force Instruction 36-2601, Air Force Personnel Survey Program (Appendix B). In addition, the cover letter (Appendix C) attached to each questionnaire included: name, address and phone number of the researcher, purpose of the study, and any risks and benefits to the respondent. Completion and return of the questionnaire constituted informed consent by the respondent.

Instrument

The instrument (Appendix F) used for the study was developed by the researcher. A search of the literature found no instrument that addressed the variables of interest in this research. To develop the instrument, a search of HCA missions literature was completed. The researcher compiled a list of concepts identified as important for the success of an HCA mission.

A pilot test was conducted to determine whether the instrument had content validity and if the questions and directions were clear. Burns and Grove (1993) stated that a pilot test should be done to “determine the clarity of questions, effectiveness of instructions, completeness of response sets, time required to complete the questionnaire, and success of the data collection techniques” (p. 373). The pilot test was conducted by sending the instrument to ten nurses who had participated in an HCA within the past five years. The return rate was 100% of the surveys. All nurses were currently on Active

Duty status. Content validity of the survey questionnaire was established by having the questionnaire reviewed by at least two expert nurses who have had experience on HCAs and are currently Active Duty Air Force Nurses. The expert nurses were asked to examine the clarity and order of the questionnaire and to determine if the questions addressed nurses' opinions of training which was accomplished prior to and during and HCA, specifically as it related to cultural training. The expert nurses concluded that there was clarity and order of the questions. The nurse experts suggested that the questions on cultural training from the pilot study be expanded to delineate the specific type of cultural training which might occur as it is addressed in Leininger's Sunrise Model.

Data Collection

Data were collected over approximately four weeks. It was estimated that between fifty and seventy surveys would be mailed to Air Force nurses identified by Air Force Chief Nurses as having participated on an HCA. The final number was 93 nurses identified by the Chief Nurses or Point of Contact. Each questionnaire had a cover letter and stamped, self-addressed envelope stapled to it. The questionnaires were sent to the Chief Nurses or a Point of Contact and distributed to the identified nurses. By not sending the surveys directly to the respondents the anonymity of the questionnaires was maintained. Respondents were asked to return the completed questionnaires within two weeks of the date the questionnaire was received. A follow-up E-mail request was sent to the Chief Nurses or Point of Contact asking them to remind the nurses who had received the questionnaire to send them to the researcher. The researcher used different first-class postage stamps to allow tracking of the origin of the questionnaires. Tracking of the

origin of the returned questionnaires was useful to ensure the questionnaires had been distributed and determined the return rate from each of the bases. The cover letter (Appendix C) indicated the researcher's affiliation, reason for the study, and that response was voluntary and without risk to the respondent. The time frame for data collection was a two-week interval from the mailing to the requested return. The questionnaires were sent Priority Mail to decrease time for mailing from the researcher to the Chief Nurse or POC.

Data Analysis

Descriptive statistics were used to analyze the data. "Descriptive statistics allow the researcher to organize data in ways that give meaning and facilitate insight, to examine a phenomenon from a variety of angles in order to understand more clearly what is being seen" (Burns & Grove, 1993, p. 156). Descriptive statistics incorporate measures of central tendency (mode, median, mean), measures of variability (modal percentage, range and standard deviation) and correlational techniques (scatter plots) (LoBiondo-Wood and Haber, 1994).

Data were analyzed with the use of the Statistical Package for the Social Sciences (SPSS) software program. Data cleaning was done by the researcher prior to the onset of analysis looking for transcription errors, transposition of number errors and coding decision errors. All data were entered by the researcher and checked for accuracy on two different occasions. The error rate was 3% on the first review and no errors were found on the second review where 100% of the data was checked.

The Pearson chi-square statistic (comparable to maximum likelihood-ratio chi-square) was used due to its goodness-of-fit with the study. So as not to violate the assumptions of the Pearson chi-square (not to be confused with Pearson's r), the information was re-coded by the researcher so that there were no cells which had "no" responses and the "other" was eliminated on the comparison of the HCA benefits and level of education.

Data obtained from open-ended questions addressing opinions were analyzed for content, categorized, grouped and summarized.

Chapter Summary

This chapter described the methodology. The research design and sampling techniques were discussed. The sampling criteria and plan were outlined in detail and measures for the protection of human subjects explained. Instruments utilized were described and issues of instrument development and validity were addressed. The process for data collection and analysis was presented. Results of the study are reported in Chapter IV.

CHAPTER IV

RESULTS

Introduction to Organization of Data

Descriptive statistics (ranges, modes, frequencies, percents, means, and standard deviations) were used to analyze survey data. Values were assigned to each response set and all data were entered by the researcher into the Statistical Package for the Social Sciences (SPSS) computer program. Results were computed using the SPSS program.

Statistics for the survey data were calculated for the total sample. Results were analyzed with descriptive statistics for range, mode, frequencies, and percents. The results were reported in percentages to communicate the numeric information.

A chi-square analysis was done in addition to the descriptive statistics to assess the significance of correlations between variables within the study such as did the ethnicity of the respondent correlate to the value that cultural training had for the respondent? The more sophisticated analysis was done to determine if there was additional significance within the study which could provide insight regarding how the variables were related. The chi-square analysis was utilized since it allowed a visual comparison of summary data output related to two categorical variables within the sample. Chi-square analysis was utilized doing cross-tabulation analysis of the results. The Pearson chi-square statistic was used to report the data and the level of significance.

Data for open-ended questions were grouped for agreement or disagreement. The narratives were analyzed for similarities and grouped by the researcher. Once the

responses were grouped, each answer was read for meaning. Each time a new topic was introduced, the topic was noted on a 3 x 5 card. When a response was similar to one previously identified, the ideas were compared for fit. If the responses were similar and comparable, for example “stress need for flexibility and adaptability” and “adaptability, flexibility, use of resources”, the comments were considered appropriate to be placed in the same group. If the responses were not similar, such as “Never take the little things of life for granted; Be more compassionate” did not describe “adaptability and flexibility”, a new 3 x 5 card and group was started.

Return Rate

Of the 93 mailed surveys, 37 (39.7%) instruments were returned by the 2 week deadline date specified on the survey cover sheet. A reminder E-mail note was sent to the Chief Nurses or Point of Contact at the end of the two weeks asking them to remind nurses who had received questionnaires to return them. A final return of 51 (54.8%) instruments were returned 2 weeks after the reminder.

Description of the Respondents

Demographic information focused on rank, time in service, age, highest educational degree, ethnicity, gender, and segment of the Air Force. The demographic data were presented in Table 1. The majority of the respondents were Captains (51%) followed by Majors (33.3%). None of the respondents were 2nd Lieutenants (junior/new officers) or Colonels (more senior officer).

Fifty-eight point eight percent of the respondents had a BS or BSN and 39.2% had an MS or MSN. The “other” person had an AD but is a CRNA (Certified Registered

Nurse Anesthetist). The respondents were primarily white, non Hispanics (84.3%). The remainder of the respondents were: African American (5.9%), Hispanics (3.9%), and American Indian (2.0%), and "other" (3.9%).

Two-thirds of the respondents were female. One-third of the respondents had 6-10 years of military service. The second largest group (27.5 %), had 16-20 years of service, 23.5% had 11-15 years of service, 13.7% had 0-5 years and 5.9% had >20 years of service. All but one of the respondents were currently serving on Active Duty.

Nearly two-thirds (64.4%), stated that the HCA they most recently participated on was their first HCA mission. Just over one-third (35.6%) had participated on a mission in 1996, 31% in 1995 and 20% in 1994. Two people were on a mission in 1991, one person was on a mission in 1992, two people were on a mission in 1993, and one person was on a mission in 1997. Twenty percent of the missions started in June and another 20% were on missions starting in December, the remainder were spread throughout the calendar year. Thirty-seven point eight percent (37.8%) were on missions lasting one month or less, 13.3% were on missions lasting 2 months and the remainder varied from three months to a reported 24 months (24 months is not within the definition of an HCA).

Nurses were asked to state their current duty title. Thirty-seven percent of the nurses described their duty title as Nurse Manager positions, 21.6% were Chief Nurses or in Command Nurse positions, 15.7% were Staff Nurses, 11.7% were Flight Nurses and the remaining 11.7% varied in their duty title ie., Dedicated Nurse Transition Preceptor, Pediatric Nurse Practitioner, and Group Patient Education Coordinator. A typical profile was a white, non Hispanic, Active Duty, female Captain who had spent 6-10 years in the

Air Force, had a BS/BSN, completed her first HCA in 1996, and duty title was "Nurse Manager".

Table 1 - Demographics

Demographic	Variable	N	%
Rank	1 Lieutenant	3	5.9
	Captain	26	51.0
	Major	17	33.3
	Lieutenant Colonel	5	9.8
Educational Level	BS/BSN	30	58.8
	MS/MSN	20	39.2
	Other *	1	2.0
Ethnicity	African American	3	5.9
	Hispanic	2	3.9
	American Indian	1	2.0
	White, non Hispanic	43	84.3
	Other	2	3.9
Gender	Female	34	66.7
	Male	17	33.3
Years of Military Service	0-5	7	13.7
	6-10	15	29.4
	11-15	12	23.5
	16-20	14	27.5
	>20	3	5.9
Segment Air Force	Active Duty	50	98.0
	Reserve	1	2.0
*Certified Registered Nurse Anesthetist			

Findings

Findings from specific survey questions were presented using tables, figures, and narrative analysis. The survey questions addressed the specific aims of the study which were: 1) describe military nurses' perceptions of cultural training that was provided to them prior to the HCA mission, 2) describe the military nurses' perceptions of cultural training that was provided to them during the mission, and 3) describe military nurses' perceptions regarding the extent to which cultural training would impact their practice in military work after completion of the mission.

Training was categorized into 6 types: Security, Personal Health, Cultural, Safety Issues, Weapons, & Other. Table 2 shows the categories of training and the percent of nurses who received training both prior to the mission and during the mission. Cultural training was provided to 58.8% of the nurses prior to the mission and 72.5% during the mission.

Table 2 - Training Categories and Percent of Nurses who Received
Training Prior to and During the Mission

Category of Training	Prior to the Mission	During the Mission
Security	62.7%	70.6%
Personal Health	84.3%	68.6%
Cultural	58.8%	72.5%
Safety Issues	68.6%	74.5%
Weapons	39.2%	9.8%
Other	19.6%	7.8%

Table 3 illustrates the time spent by nurses in cultural training prior to the mission and the time spent in cultural training during the mission.

Table 3 - Hours Spent in Cultural Training Prior to and During the Mission

Approximate Hours	Prior to the Mission	During the Mission
<1 Hour	41%	43%
1-3 Hours	48%	43%
> 3 Hours	11%	14%

Table 4 depicts the types of training methods used to instruct nurses on cultural training topics. The number of nurses who responded they had received training by the specified method are reported in percentages for prior to and during the mission.

Table 4 - Cultural Training Methods Prior to and During the Mission

Method of Presentation	Prior to the Mission	During the Mission
Classroom Instruction	30%	12%
Handouts	65%	18%
Briefings	69%	81%
Combination	19%	9%

Table 5 delineates the cultural factors (as depicted in Leininger's Sunrise Model) presented to the nurses prior to the mission and during the mission.

Table 5 - Cultural Factors Included in the Training Prior to and During the Mission

Section of Sunrise Model	Prior to the Mission	During the Mission
Local Use of Technology	15.7%	15.7%
Religious Influences	43.1%	37.3%
Cultural Values	43.1%	52.9%
Political Influences	43.1%	43.1%
Economic Situation	39.2%	54.9%
Educational Level	17.6%	29.4%
Health Care System in Country	33.3%	43.1%
Folk System of Health Care	3.9%	19.6%
Importance of Family and Social Ties	7.8%	23.5%
Holistic Health Concepts	3.9%	9.8%
Other	2.0%	2.0%

Respondents listed the Cultural Training in hours during the mission: 1 hour - 11.1%, 2 hours - 22.2%, 3 hours - 11.1%, and 4 or more hours - 6.7%. The time range of training extended from no cultural training to one person who had 100+ hours of cultural training. The person who had 100+ hours of cultural training reported having two-hour classes on a weekly basis during the entire mission.

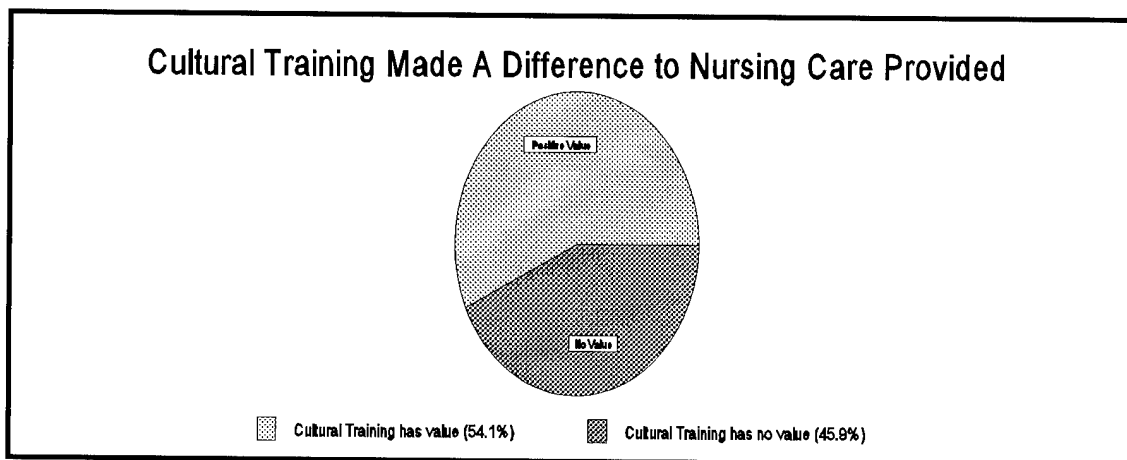


Figure 3 - Cultural Training Made a Difference to Nursing Care Provided

Figure 3 depicts the results of the question, “Did you encounter specific instances where cultural training made a difference in the quality of nursing care you provided?”, 54.1% said that it did, 45.9% said that it did not (See figure 3 above).

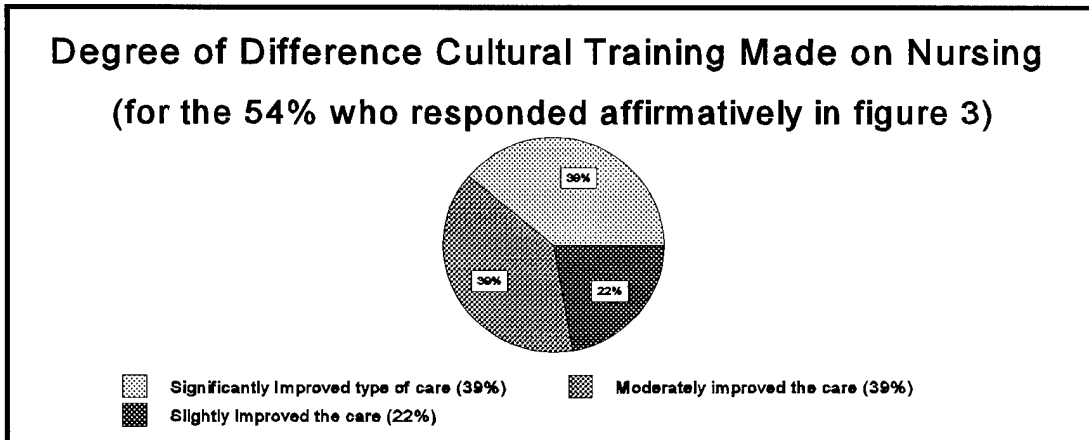


Figure 4 - Degree of Difference Cultural Training Made on Nursing

Of the 54.1% who said cultural training did make a difference, 39% said it significantly improved the quality of care they provided, 39% said cultural training moderately improved the quality of care, and 22% said cultural training slightly improved the quality of care they provided. None of the respondents stated that cultural training worsened the quality of care provided (see figure 4 above).

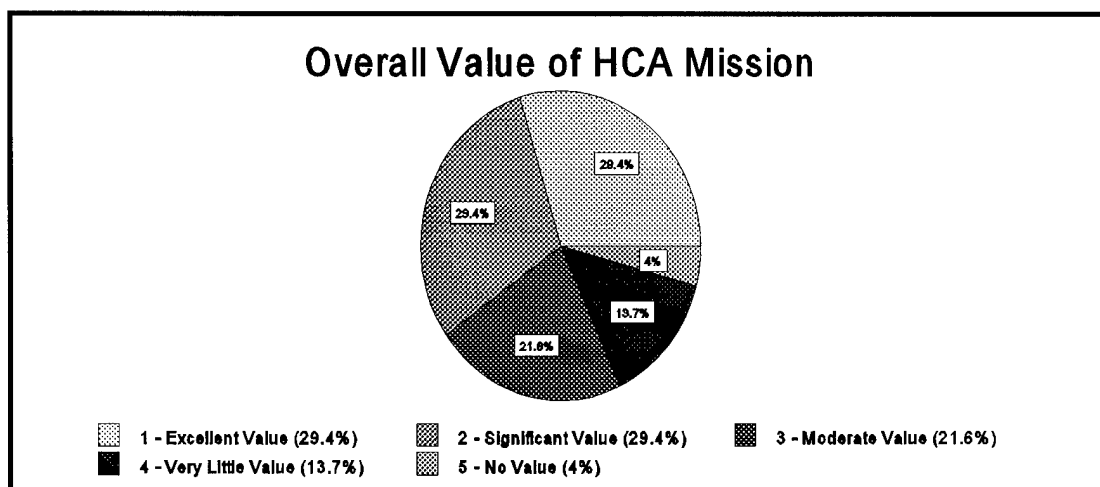
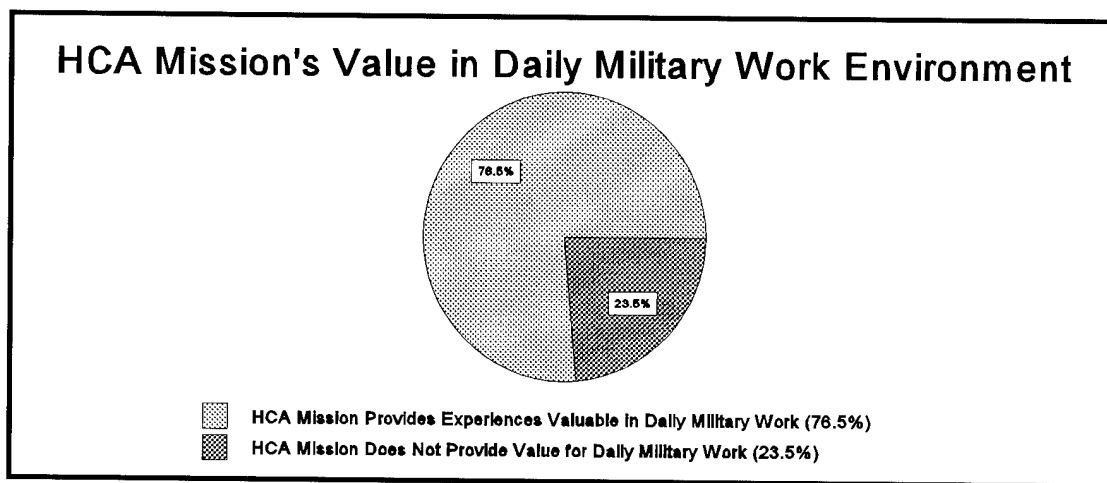


Figure 5 - Overall Value of HCA Mission (HCA - Humanitarian and Civic Assistance)

When rating the overall value of the HCA, 29.4% responded that the mission had excellent value, 29.4% stated it had significant value, 21.6% stated it had moderate value, 13.7% stated the mission had very little value and 4.0% stated the HCA had no value. (See figure 5 on previous page). When asked if the nurses' opinion would change if cultural training was added prior to the mission, 39.2% stated that their opinion would change. The remainder stated that their opinion would not change if cultural training was added prior to the mission.



**Figure 6 - HCA Mission's Value in Daily Military Work Environment
(HCA - Humanitarian and Civic Assistance)**

Figure 6 depicts the results of the survey question, "Did the HCA provide experiences which will benefit you in your day-to-day, military work environment?" When asked if the HCA benefits their daily work, 76.5% said that it did. (See figure 6 above.)

The Chi-square results showed significance in two areas: 1) comparing educational level and the benefit the HCA provided and 2) comparing ethnicity to the benefit the HCA provided. When comparing educational level and benefit the HCA provided, the Pearson

value of 10.98 with 4 degrees of freedom led to a significance at the .02 level. Those with more education (MS or MSN) noted more benefits to their daily work because of the HCA than did those who had a BS or BSN.

Narrative Response Analysis

Responses to specific survey questions

Responses to the question which asked the degree HCA missions provide valuable training for military readiness is displayed in figure 5. Part b asked: *would this opinion change if there was specific cultural training added prior to the mission? Please explain why your response was yes or no.* Of the respondents, 39.2% stated that their opinion of the value of the HCA would change if cultural training was provided. The responses were analyzed for patterns and similarities. The following statement by one nurse characterized the pattern of several respondents:

the mission would be more successful if we understood the people we were providing a service to. All cultures do not have the same beliefs we do. If we are going to have a positive effect on the standard of health care, we must respect their culture, values and beliefs.

The second most common pattern related to being prepared for the mission.

'Readiness', by definition means being prepared for the mission, which I was not. I have had more than adequate training in war 'readiness' but not for humanitarian missions. I am thankful that the people I worked with were so wonderful about sharing of themselves.

The responses of respondents who stated that cultural training would not make a difference (60.8%), were similar to the following: "it does not matter what the culture of the deployment (is), the mission stays pretty much the same" and "Regardless of where the mission is, as military members we have to adapt. Look, listen and learn, quickly."

Another common response was that although in a foreign country, the nurses were only expected to provide health care to UN Troops: "We served in one area (Bosnia) but our mission was to care for UN troops from many countries, not the locals."

Part c of the same question asked: *would this opinion change if language training was added to the mission?* Forty-six percent stated that their opinion would change, 54% said that it would not. Of the 46% who said that it would change, a frequent response was that communication was a key/essential part of being able to effectively provide health care. One person stated, "Unable to communicate except with interpreters. The actual translation and then the interpretation may not be clear." Some respondents wrote that being able to speak the language was essential:

The particular mission I was involved with was not planned out very well. The information given to us prior to leaving was inaccurate. We were told that many of our patients spoke English when in fact they did not. We had no interpreters initially and it was at least a month before we had an adequate number of interpreters.

For the majority of nurses who stated that language training would not make a difference, the most common comment was that there were too many languages and some were too difficult to learn for short missions. Related to the use of interpreters or linguists: "It would have been nice, but not necessary as linguists were provided" and "interpreters were provided."

Responses to the question: *Did the HCA have a post-mission debriefing?* Only 35.5% stated that there was a debrief. The second part of the question asked: *If yes (there was a debrief), please describe how it benefited you, if no, give your opinion on whether this has affected you or not.* Thirty nurses responded with written answers. Half of the

responses were positive and half of the responses were negative. Of those who responded that there was a debrief, three patterns emerged. The first was that the debrief summed up the experience:

It essentially summed up what our team managed to achieve during the mission and was provided by the commander of the mission, the Sri Lankan Minister of Health, and the U.S. Ambassador to Sri Lanka. It instilled a sense of pride and accomplishment in our team. It also reiterated how important this humanitarian mission was for diplomatic ties between the two countries as well (as) how the Sri Lankan people would benefit in their medical care.

The second pattern was that of closure: "Allowed closure, also presented a full picture of mission accomplishments. Our hospital-based medicine is fixated on curing not making it better. Most of the time in the field all you can do is make it a little bit better." The third pattern was that the debrief provided participants a way to look at strengths and weaknesses: "It provided the opportunity to discuss strengths/weaknesses, ways to improve future trips."

For those who did not have a post-mission debrief, 33% said that it did not affect them. Those who felt it did affect them stated they felt "neglected" and that it was a "big deficit" or that it "would have been nice". One person stated, "due to the situation at our home base those returning from the deployment were treated with hostility. A good percentage (33%) of the deployed unit did eventually seek some help from mental health for feelings of anxiety, sleeplessness, etc."

Responses to the question: *Did the HCA provide experiences which will benefit you in your day-to-day military work environment?* A majority, 76.5% replied that the HCA experience did benefit their day-to-day work environment. There were six basic

patterns which the respondents stated they could relate the HCA experience to their work environment upon return:

- 1) The need for flexibility and adaptability: "Learning to work under adverse conditions. Short staff, being able to express concerns clearly, and making a difference."
- 2) Culture: "HCA has benefited my nursing practice at my present base. I work with many Hispanics & Cubans (dependents & retirees) & I feel I have gained a broader knowledge base of the Cuban/Hispanic culture."
- 3) General experiences: "No matter what hardships I suffered, they pale in the overall picture. The experiences were invaluable and I will always remember the great folks I met because of it."
- 4) Mission readiness: "My opinion of serving in the military, better understanding of mission (readiness)."
- 5) Tri-Service work: "It broadened my knowledge and experience of working on a Tri-Service team as well as working within a foreign country where we do not have bases located. It gave me a better working knowledge of my sister services ie. USA, USN. Besides it's things like this mission that brought me into the Air Force. If I wanted to be an ordinary R.N., I would have stayed in the civilian world but I wanted more and I also wanted to serve my country. I feel this did just that."

6) Clinical skills: "It helped in increasing the everyday knowledge on how to handle mass casualties and the trauma injuries" and "the clinical skill of assessment is something I used everyday."

For the nurses who did not find any value for the HCA which they could bring back to their day-to-day military work environment, there were two patterns:

- 1) The HCA was different from their daily work: "completely different and unique operation than day to day operation."
- 2) The HCA was no different than their daily work, "I did the same thing on the deployment that I do day-to-day. No big difference."

Responses to the question: *What are your thoughts on the overall value of HCAs.*

Forty-eight nurses provided written responses. Five patterns emerged from the responses:

- 1) The mission provided an invaluable experience. Responses from two of the senior nurses were: "Superb - it was one of the highlights of my career (I was Chief Nurse of the...) Learned a great deal about leadership, training, joint service operations", and "I thought our deployment was a learning experience, one of the best I've had. To actually work in an ATH, we could see where improvement was needed and gained confidence in the areas that were no problem at all. As my first deployment experience - I'm glad it was an HCA."
- 2) The training was beneficial: "Win/Win situation! Great training for us and benefit for others" and "very beneficial - closer to actual conditions during disasters." Another person said, "more useful to readiness issues is the chance to work (actually provide care not just simulate) outside your normal environment

and make do with what is available and still provide top-notch care!”

3) Teamwork was prevalent: “I think they are more valuable in training personnel in working together as team players with a mission.”

4) Clinical practice was enhanced: “Great to provide care for those who could not afford the care. Great experience to practice nursing with adjustments to the environment.” Some respondents wrote that the clinical skills could be used to benefit people right here in the United States. “Good experiences, opportunity to treat illnesses rarely seen in US (could be used in) areas in US could benefit from HCA’s.”

5) Humanitarian, diplomatic or political mission: “It’s a great experience that I loved and wouldn’t have missed for the world. This one promoted diplomatic relationships with the other country as I’m sure most HCA’s do. They provide a valuable avenue for interactions between the countries and the people which couldn’t be achieved any other way. This in turn can only benefit the two governments and the countries involved.” A contrary opinion was also expressed: “the USA can’t continue to help everyone in the world all the time. In some (majority) cases our help only delays the problems and it starts back as soon as we leave,” and “Very valuable but question long-term effects. How do countries we support maintain the level of health care we have shared with them? Appear to be more of a public relations program than humanitarian.”

Responses to the question: *What would you recommend to make the HCA mission more valuable?* The replies were grouped into 6 patterns:

- 1) Make the training mission specific: "Better training/briefing before deployment. Better indoctrination that HCA's are important - maybe more important than caring for non-active duty" and "briefings on why we're going, what we'd be doing, cultural/language classes."
- 2) Increase the ability for more people to participate on this type of mission: "Require reservists/guard to complete one HCA mission every 3 years and active duty every other year. (Tour to range from 2-12 weeks.) This was the best annual tour in my 27 years. I feel I am much better/ready for mobilization and war time mission."
- 3) Language and cultural training: "More language prep time." "Cultural training prior to deployment."
- 4) Supplies which the unit brings: "Before shipping surplus equipment/supplies, do a site visit to see what can be used. A lot of supplies went on my HCA were inappropriate (too sophisticated) for local use." "Have our supplies configured for a humanitarian contingency instead of a wartime contingency."
- 5) General planning: "preplanning might help." Some of the respondents wrote that the Air Force should develop specifically trained forces to handle nothing but HCAs. "Development of a specifically trained force to handle nothing but HCAs in the future. This would be a Tri-Service force."
- 6) Support: "Better support for those deployed by home base."

Chapter Summary

Chapter IV presented the analysis of survey data. Return rates were discussed along with the method employed to increase response rate. Demographic data were reported with a picture of the typical respondent. Percentages were used to display the data. Descriptive data were organized into tables and figures for ease of presentation and described in narrative text.

Respondent's answers to cultural training provided prior to and during the mission were depicted using percentages. The cultural factors included in the training were depicted for prior to and during the mission. Leininger's Sunrise Model was used as the guide for the factors which were covered in the training. Chi-square analysis was discussed and presented using the Pearson value and the level of significance.

The narrative response questions were discussed individually. They were grouped by categories of agreement and disagreement and the major patterns were discussed by the researcher. The discussion of major findings and how these findings relate to other studies, limitations, and implications for practice, and recommendations for future research are presented in Chapter V.

CHAPTER V

CONCLUSIONS

Review of Study

This study was designed to describe the cultural training provided to Air Force nurses prior to and during a Humanitarian and Civic Assistance mission. The specific aims of the study were to: 1) Describe military nurses' perceptions of cultural training that was provided to them prior to the HCA mission. 2) Describe the military nurses' perceptions of cultural training that was provided to them during the mission. 3) Describe military nurses' perceptions regarding the extent to which cultural training would impact their practice in military work after completion of the mission. Selected personal characteristics of military nurses who have participated on an HCA were also described. A survey instrument developed by the researcher was used to elicit the Air Force nurses' description of training that took place prior to and during their HCA and the specific areas of training that were addressed during the mission. Six open-ended questions were included in the questionnaire which asked for a written, opinion response. Descriptive statistics were used to analyze the data. Data from open-ended questions were analyzed for content and grouped into patterns.

Discussion of Major Findings

Major findings in the study will be compared to the articles from the literature related to HCA missions. There were eight main points identified which included: training, education of nurses, benefits of mission to daily work, comparison of mission

types, recommendations for future missions, teams for HCA training, quality and effectiveness, and teamwork skills.

Training

Prior to the mission, 58.8% of the respondents stated they had received cultural training. That number of nurses increased to 72.5% receiving cultural training during the mission. Cultural training was only surpassed by training on safety issues during the mission. The increase in cultural training during the mission may be related to the following: 1) cultural training becomes more important once at the deployment site since cultural differences are more obvious when a nurse attempts to provide care to someone he or she can't communicate with and the health care practices of the patient vary from what the nurse works with on a day-to-day basis; 2) unit Commanders in charge of the mission may be unable to understand the specific cultural issues that will impact the care provided until the unit is in the country of deployment; and 3) cultural training can be more specific once in the country where instruction on cultural topics can be enhanced by having local authorities participate in the training.

Most nurses had 1-3 hours of cultural training prior to the HCA mission. During the mission, there was a slight increase in those who had >3 hours of training. The mean number of hours of cultural training during the mission may have been inflated by the respondents who stated that they had 1-2 hours of cultural training on a weekly basis throughout the mission.

An examination of the method of presentation for the cultural information both prior to and during the mission showed some differences. Classroom instruction is much

more prevalent prior to the mission as well as the use of handouts. Once arriving in the country of deployment, briefings were the primary means of providing cultural training. Using a briefing as the method of presentation may be due to convenience. The availability to utilize other types of technology besides briefings for classroom instruction is significantly restricted due to the remote sites and the time available each day to present cultural information is limited. The military generally utilizes the format of briefings to quickly provide information which is pertinent for the troops on a daily basis.

By grouping the areas of cultural training according to Leininger's Sunrise model, this researcher was attempting to uncover patterns used to present cultural information. For those who had cultural training prior to and during the mission, there was only one respondent who listed an additional topic. The respondent categorized the "other" cultural training as "historical information on the culture."

Overall, the respondents who had cultural training stated that training, whether it was cultural or technical, was the "key to success of the mission". Communication, whether it was language specific or cultural specific, also contributed to the success of the mission. The nurses who responded that cultural training was important to the success of the mission represented 54.1% of the nurses in the study.

Education of Nurses

The majority of the nurses were BS or BSN educated, but a significant number had a MS or MSN degree (39.2%). Compared to the civilian sector, a larger portion of the military nurses had postgraduate education. The respondents in the study represented a

larger percentage of nurses with advanced degrees than the number of United States Air Force Nurse Corps which has 27% with a MS or MSN.

Benefits of Mission to Daily Work

When asked if the HCA benefits their daily work, 76.5% of the nurses stated that the mission did provide benefits to their daily work. Being aware of the importance of flexibility and adaptability was the most frequent pattern of responses for how the mission affected their daily work. The second most frequent pattern was culture, gaining a broader knowledge base of a specific cultural group.

Using the Chi-square statistics allowed this researcher to determine if there were any significant correlations between variables within the study. It should not be surprising that the nurses with more education could extrapolate from the HCA the cultural training and apply it to their daily work. Masters level education, particularly advanced practice nursing, encourages the integration of education, research, management, leadership and consultation into the nurses' clinical roles. The advanced practice nurses integrated the cultural training (education) from the mission into the day-to-day military work (the clinical role).

Comparison of Mission Types

The respondents in the study who stated the HCA mission provided care to UN Troops, estimated at 5%, could be compared to the nurses in the Smith-Smith (1995) article in which nurses provided care for patients from the following list of countries: U.S., France, England, Poland, Canada, Argentina, Jordan, Russia, Ukraine, Belgium, Denmark, Norway, Finland, Slovakia, Kenya, Nigeria, Bangladesh, Spain, and Sweden.

This researcher believes that taking care of UN troops would require even a greater degree of cultural knowledge due to the wide variety of locations/cultures that are/could be represented.

The summary of the overall mission in Smith-Smith (1995) article was similar to what respondents in this study suggested:

Our experience in Croatia enhanced our perioperative skills, overall nursing knowledge, and ability to interact positively with soldiers and civilians from many different countries. We learned much about flexibility and problem solving, and we were reminded of the importance of cooperation (p.883).

Missions which provide care for UN Troops of diverse backgrounds such as those listed in the Smith article reinforce the need to train nurses regarding cultural diversity regardless of the type of HCA mission.

What is interesting is that cultural diversity training could be addressed by nurses who have been trained in the Leininger Sunrise Model and then are able to adapt the model to whatever cultural group they are providing care. Training is not only important for the specific information regarding culture, but for the utility of using the model as a guide for future reference. Nurses who are not provided specific training for a future deployment should be able to utilize Leininger's model to guide them in their own assessment of the specific cultural needs of the patient. Nurses in the study who stated that they did not provide care for the local community but did provide care for UN Troops did not state that there was a need for cultural knowledge about the UN Troops. If the nurses had been trained to use the Sunrise Model, their assessment would have included a cultural assessment and cultural knowledge regarding UN Troops.

Recommendations for Future Missions

Recommendations for future missions matched the following points made by Luz:

If MCA (HCA) projects are to be successful and if successes and failures are to be used effectively in training military medical people, thoughtful and deliberate mission planning, execution and evaluation must occur using meaningful criteria (Luz 1993, p.366).

Adequate training regarding the culture and language of the host country and also what the purpose of the mission was noted as a recommendation for future missions by nurses who participated in this study. Nurses in this study wrote they wanted to know if the mission was for diplomacy and nation building and should be told from the beginning that providing health care and an opportunity to train for medical readiness was not the only reason for the mission. Without knowing the reason for the mission the nurse could not fully execute the plans for the mission and could not fully evaluate the success of the mission.

Responses by the nurses in this study were similar to statements by Deckert et al, who noted the value of actual, as opposed to simulated, learning opportunities. Deckert stated:

A volunteer 'patient,' pretending to have an injury or condition just doesn't compare to the genuine article. A real patient removes all simulation; the trainee doctors and technicians must somehow properly resolve the problem with on-hand supplies and instruments, (Deckert et al., 1995, p.212).

Nurses in this study stated they had to use their basic assessment skills which are not necessary in a "make-believe" scenario. The nurses in this study also stated that "real" patients provide for more realistic training.

This study also strengthens statements by Deckert et al. (1995):

The rationales for continuing to use MCAs (Military Civic Assistance) for training missions include: helping to further U.S. Policy, providing realistic field readiness training and offering a professionally rewarding experience to the military member.

Helping to further U.S. policy was an aim of the mission apparent to nurses in this study.

However, some nurses responded that they should have been told what was the U.S. policy. One nurse questioned whether the mission was public relations or humanitarian. Other nurses stated the mission promoted diplomatic relations, as most HCA's do. The nurses in this study commented that the HCA had connections to U.S. policy, but no nurses stated they knew the U.S. policy. When possible, the nurses should be told what the specific U.S. policy is and how it relates to the stated mission.

Realistic field training was discussed as a valuable portion of the training with both professional and personal benefit. Providing care to patients is only part of the training. Setting up a clinic, working out the logistic problems of transportation, and working in cooperation with the host nation are also invaluable to readiness training. Offering a professionally rewarding experience was emphasized by some of the senior nurses in the study. The senior nurses recommended that HCA participation become mandatory for military personnel because of the value of the experiences. Comments from nurses regarding personal gains were frequent. Helping the "less fortunate", "making a difference", and "realizing how much we take for granted" were frequent altruistic responses stated by the nurses. Although the nurses did not state specific professional gains, the experience of working in a difficult environment and becoming aware of the

adversities other people face on a daily basis strengthens the military member on a personal level which enhances their professional work.

Crutcher et al., (1995) recommended there should be a change from health care to health promotion for HCAs. There was no clear evidence in this study that nurses support that type of change. This researcher believes that military nurses are generally trained to provide health care to patients during wartime missions and to transition to health promotion for the HCA mission may not be realistic at this time. With military cutbacks, the nurses may believe health promotion should be left to development organizations which spend more time at the location than the military allows during an HCA. As stated by Crutcher et al., (1995) there is little "training value" for the military member while providing health promotion activities. If the mission intent is training for wartime readiness, health promotion activities will not be beneficial. However, if the mission intent is nation building or promoting diplomacy, health promotion activities may be appropriate. This researcher believes that the military does not have the training nor is it part of the military mission to provide preventive medicine in foreign countries as part of an HCA.

Teams for HCA Training

Nurses in this study recommended that teams be trained for the specific duty of organizing HCA missions and participating as core members of units which are deployed. That team could ideally consist of personnel trained in areas including but not limited to the following:

- 1) how to set up a deployed unit
- 2) what type of supplies need to be brought for HCA missions

- 3) how to accomplish the pre-site inspection
- 4) how to complete an assessment of the health care needs based on a cultural assessment of the specific area
- 5) how to provide training for the unit being deployed (training both prior to and during the mission)
- 6) how to include the host nation in the accomplishment of mission goals
- 7) cultural assessment models and techniques for using the models
- 8) importance of cultural assessment to the care delivery

In order to accomplish the training of specific HCA teams, a military course or courses addressing the unique aspects of an HCA would have to be created.

The curriculum proposal by Lillibridge et al., (1994) was supported in part by nurses who feel special training is important for the primary members of the team.

Lillibridge et al., recommended the following:

- 1) Develop a comprehensive disaster mitigation and humanitarian assistance curriculum for military members which is representative of all branches of the uniformed services, Federal agencies and intergovernmental relief organizations.
- 2) Create an appropriate career path for health officers who work in humanitarian assistance and disaster mitigation.
- 3) Long-term postgraduate public health training should be used to enhance intra service ability in dealing with domestic and international disasters.

4) Provide increased opportunities for military personnel to be assigned to humanitarian relief organizations/missions so that they can gain important experiences

5) Initiate training at the graduate level for humanitarian/disaster relief work and continue the education throughout the officer's career.

In regard to the Lillibridge's first recommendation, there was support for this type of team by the nurses in the study. The nurses in this study recommended the development of Tri-Service teams to enhance the HCA mission's value. Special skills for organizing and successfully completing the mission would be brought to the mission by the team.

Recommendations 2 & 3 by Lillibridge were not supported by any of this study's participants. Lillibridge's fourth recommendation was supported in this study. The senior nurses, in particular, suggested specific requirements for participation in HCA missions by active duty and reserve nurses. Other nurses in the study stated that specific teams who work mainly on HCAs should be utilized to provide an experience based team which can enhance the continued training on cultural issues during the mission. Lillibridge's fifth suggestion was not supported; none of the nurses suggested that the Air Force should initiate training at the graduate level for humanitarian/disaster relief work and continue the education throughout the officer's career.

Quality and Effectiveness

Nurses in the study made recommendations on how the military could improve the quality and effectiveness of the HCA missions. Ludwig et al., (1992) also recommended areas which could be improved to increase the effectiveness of medical deployment

missions. Two of Ludwig's recommendations were supported in this study. Sending experienced personnel on the mission was recommended by Ludwig et al. The nurses in the study had an average of 6-10 years of military service. There were no Second Lieutenants and only 3 First Lieutenants indicating that nurses at these levels do not have the military experience necessary to participate on an HCA mission. Ludwig et al., also suggested that pre-arrival briefings should be as complete as possible, providing information on local habits, customs, and cultural considerations. Nurses in the study stated that many times they left for the mission with short-notice and they were at a disadvantage by not receiving adequate pre-mission training. The nurses in the study suggested training prior to the mission include specific cultural and language information as well as the purpose of the mission.

Teamwork Skills

Goodman (1994) stated that teamwork skills were important in the development of a cohesive and productive unit. The nurses in this study supported this by stating that teamwork was an important aspect in the overall value of the HCA. The nurses in this study learned during the mission that teamwork was essential and they are able to transfer the teamwork skills and knowledge to future missions as well as their daily work.

Goodman also noted that having local interpreters was important. The nurses in this study felt that two types of interpreter's skills were important: 1) linguistic translation and 2) cultural meaning (the ability to convey to the nurses information on the local culture and health care beliefs). Missions which began without interpreters left nurses in the study feeling frustrated that they could not provide health care to the local people because they

could not communicate with them. This frustration has significant implications for the success or failure of the mission. A mission without interpreters may be suggesting that language is not important since interpreters are not always provided or that safe care can be provided without talking with patients. This may be an instance of inappropriate training with implications (negative) for care delivery in other settings such as nurses' daily military work. The patient is always part of, in fact the most crucial member of the health care team regardless of the situation. Effective health care cannot be delivered without communicating with the patient and nurses should not be misled to think otherwise. The enhancement of teamwork skills must not be limited to the military members but must include the patient as an active participant on the team.

Implications for Nursing Practice

The implications for nursing practice will be broken down into five areas: cultural training, systematicity of training, model or framework, training, and the debriefing.

Cultural Training

The findings of this study indicate the majority of Air Force nurses are receiving some cultural training prior to and during an HCA mission. However, cultural training ranks behind training on the categories of security, safety issues and personal health. Cultural training ranks ahead of only weapons and "other" categories of training. Fifty-four percent of the nurses reported that cultural training made a difference in the level of care they provided, but those nurses had only an average of 1.5 hours of cultural training. The respondents in the study did support that cultural training made a difference in the care provided, but could have been increased if the nurses had received more training

specific to the cultural issues they faced on the mission. With more training and more appropriate training experiences (e.g., interpretation for languages in clinical encounters), the nurses will realize that the care they provide is appropriate to the population and the care they provide can make an impact on the patient.

Systematicity of Training

There is no apparent systematic way in which the cultural training takes place. Sometimes the training is more of an impromptu presentation by one of the local nationals to a group of interested nurses rather than an organized class covering specific topics. If the recommendations by the nurses in the study are considered for future missions, personnel in charge of the mission will have special training on cultural issues and will increase the amount of cultural training for nurses both prior to and during the mission.

Model or Framework

Leininger's Sunrise Model could be utilized in two general ways. The Sunrise Model could be used for organizing the data presented during cultural training to Air Force nurses on HCA missions both prior to and throughout the missions. Nurses who work in Medical Readiness could utilize the guide in preparing written information specific to the local culture which could then be distributed to the deployed nursing personnel. The guide could also be used at the mission site to present additional classes, either by someone from the local community or by someone from within the Air Force group who has knowledge of the culture.

A second use for the model is as a guide to individual assessment for patients and the tailoring of care specific to the patient. If one takes the Sunrise Model and divides the

areas which can be assessed, the tool has been transformed from training tool to assessment guide. This researcher envisions the following broad categories which should be addressed by this training/assessment tool:

Culture and Social Structure Training/Assessment Tool

1. Technological Factors
2. Religious & Philosophical Factors
3. Kinship & Social Factors
4. Cultural Values & Lifeways
5. Political and Legal Factors
6. Economic Factors
7. Educational Factors
8. Language
9. Folk Systems of Health Care
10. Professional Health Care Systems

Training

Suggestions by nurses in the study for improving the missions included an overwhelming recommendation that the training for the mission be specific to the designated HCA mission dealing with a specific culture. There are inherent strengths and weaknesses in training nurses about a specific culture. Strengths include that the information can be gathered in advance from a pool of government agencies who already have the information and handouts or classes can be easily prepared. One of the main weaknesses is that within any culture there are unique nuances which may vary

significantly from one area in the country to another which may not be noted in the general assessment. Without an assessment done on the specific community where care is being provided, nurses risk the chance of providing care which is not culturally congruent.

An additional important suggestion which was made not only in this study, but in the literature as well, was that the military set up special units trained to do only HCA missions. If nurses are to participate in HCA missions, they must participate from the very beginning in planning the training which takes place prior to and during the mission. This researcher would recommend increasing the number of hours spent on cultural training. This study did not ask the nurses to describe how many hours were spent on other issues, but an average of 1.5 hours of cultural training is not reflective of its importance. The researcher would suggest a minimum of one full day of training on cultural issues prior to an HCA mission with additional weekly classes while on the mission. The previously described format for training can be used throughout the training. Difficulties will arise once at the deployment site and nurses must have an organized means in which questions, concerns, and insights about the culture can be addressed. As one researcher suggested, "it is what you don't know that causes the anguish" (Stern, 1986, p.142). The nurses must be given the opportunity to explore areas within the culture they are not familiar with so the amount of information they don't know is decreased which will also decrease their level of frustration.

Military nurses stated that the most valuable aspect of the HCA was what they learned about flexibility and adaptability. Nurses can take that a step further and realize that by adapting the cultural specific training to differing environments, they will be able to

provide more appropriate care for their patients, whether they are the local nationals, UN Troops, or our own troops who come from a variety of cultural backgrounds. Only a few of the nurses mentioned that the cultural training and work during the mission helped improve their daily nursing practice. These nurses reported that culture training helped them understand their patients. This researcher believes that the benefit of better understanding your patients should be an aim of all nurses whether the patient is someone being cared for because of an HCA mission, UN Troops, or in the nurses' clinical practice setting.

Debriefing Process

Nurses in the study who received a debriefing reinforced its value in the following three ways: the debrief summed up the experience, it provided closure, and the debrief provided a means of looking at strengths and weaknesses. For nurses who did not have a debrief, some felt it made no difference but others felt it was a big deficit. With these results and the fact that a debriefing is a requirement, it must be stressed to those in command the value of the debrief. This researcher feels that each member who participates on the mission should be provided with a written copy of what was discussed in the debrief to help reinforce the positive aspects of the mission, discuss areas which can be improved on in future missions, and makes the information available to anyone who was not physically present. This would allow personnel who participated on the mission to continue with the closure process which is important to those who participate on humanitarian missions.

Implications for Nursing Education

Implications for nursing education are more generalized than those for practice.

Implications for education include: 1) all nurses need to continue to explore theories and models of providing culturally acceptable nursing care; 2) practical application and utilization of these nursing theories and concepts should be considered when preparing for HCA missions; 3) development of a computer-based simulation for interacting with patients of a different culture; and 4) cultural training must be included in education provided to nurses both prior to and during the mission not only for the local nationals, but for other cultures the nurse may provide care who are represented within the UN Troops and US Troops.

Recommendations

Future Research

Repetition of this study with a larger sample which includes guard and reserve units would be beneficial. Additionally, by including other aspects of the military (guard and reserve), there could be implications for the generalizability of this study's findings beyond the present sample to the target population of all military nurses who are deployed on an HCA mission.

A step further would be to conduct this study with all medical personnel who are deployed on HCAs such as medical technicians, dentist, and physicians. The study based on this researcher's survey would look further at the military's perception of the value of cultural training and it's significance for the real world mission. It would be interesting to conduct the study immediately after the HCA mission and repeat it one year after the

mission to reevaluate if the participants are using what they learned during their real world mission. Medical Readiness could conduct the study for all missions over a six-month time frame by including it in the debriefing. A larger study would provide information on the interdisciplinary health care team and how the military members integrate cultural training into their practice.

This researcher also recommends an additional survey of the personnel who prepare the nurses/military members for HCA missions which might provide insight on the knowledge they have and the value they place on cultural issues in training. The trainers or those in command may not have clear guidelines as to what cultural topics should be covered prior to and/or during the missions (see previously mentioned list of suggested topics which can be covered) or they may not see it as a training topic of importance.

Since some of the missions have been Tri-Service, the study could also be done to acquire information on how the other services (United States Army, United States Navy, United States Marine Corps) prepare nurses for HCA deployments and if they include cultural training as a topic for training or if cultural training is only mentioned as a point of interest in the training.

The following questions were raised as a result of this study and are recommended areas for investigation in future research studies.

1. Do military nurses consider cultural issues important when providing daily health care to their patients?

2. Is cultural training provided to nurses on deployments where they are required to care for UN Troops from a wide variety of countries/cultures?
3. Do military nurses believe cultural training is not congruent with the “war-time mission” and therefore is not an area which needs to be addressed for deployments?

Instrument Refinement

The researcher developed tool has several limitations. Some of the questions need clearer directions. The questions which required a written response did not always receive an answer. Either the respondent did not feel they had anything to comment on, or they did not fully understand the question. An example, question 19 had two parts and asks the respondent to explain his or her answer after answering the second question. One person specifically wrote that she wasn't sure she understood the question. More space is needed for the narrative. By not leaving a lot of space, the respondents may have felt that the researcher was not truly interested in their response.

Question 21, should have been more clearly written to elicit a response regarding the cultural experiences/training of the HCA and how the nurse will utilize the cultural training to benefit his or her day-to-day military work. The question as written elicited information about the general HCA experience which included the value of cultural training but it was difficult for the researcher to fully assess the specific cultural training value as it relates to the nurse's daily work.

Limitations of the Study

Return Rate

The generalizability of the study is limited by the small, convenience sample size (n=51). The sample consisted of 98% Active Duty nurses and can only be used to compare to a similar group. Reserve/Guard Units were not excluded in the study but due to the timing of the study during the holiday season the researcher did not have adequate time to distribute the survey to Reserve/Guard members. With only one month used to collect data and a two-week window once the questionnaires were handed out by the contact person, there was a high likelihood that Guard/Reserve units would not meet during the two week time period and distribution of the questionnaires would be limited or significantly decreased.

The return rate of 54% may be partly interpreted by an inadequate explanation of what type of HCA was being studied. Renaming of mission types has occurred in the past few years and some nurses consider all non war-related missions to be an HCA mission. An example would include deployments to Bosnia where the units provide care for UN Troops and are not in Bosnia specifically to provide care for the local national population. It is obvious to this researcher that some of the missions which nurses in the study had participated on were not the type of HCA mission this researcher intended study. Some of the respondents stated that the mission they participated on was only to provide care to UN troops and care was not provided to the local population, this researcher would not have included nurses on a mission only providing care to UN Troops in the study. Other nurses, who had been handed the questionnaire, upon reading it, may have decided they

did not meet the criteria and simply did not complete the questionnaire thus decreasing the return rate. A future suggestion would be to ask the participant to return the unanswered questionnaire with a note, "not applicable to the mission I participated on" if that is the case. A second suggestion would be to be more specific in what is meant by an HCA mission when describing the study to those who are distributing it. Being more specific could increase the return rate as well as increase the likelihood that the appropriate type of mission is being studied.

Instrumentation

Using Leininger's Sunrise Model as the means of determining what type of cultural training was accomplished prior to and during the mission may have misled nurses into thinking that the Sunrise Model is the format presently used to conduct the cultural training by the military. Each base and each mission utilized their own guidelines for covering what was important regarding cultural information. What is interesting is that there was only one other area described by participants under cultural training and that was historical background of the culture (described by one respondent). It was evident that not all areas of the model were discussed prior to or during the missions, but there were no areas discussed which are not covered in Leininger's Sunrise Model. This leads the researcher to believe that Leininger's Sunrise Model could be used as a guide by the United States Air Force in presenting cultural information to nurses who will be participating on an HCA.

Summary of Study

The purpose of this study was to describe the cultural training provided to Air Force nurses prior to and during an HCA mission. This study addressed the following specific aims: 1) describe military nurses' perceptions of cultural training that was provided to them prior to the HCA mission. 2) describe the military nurses' perceptions of cultural training that was provided to them during the mission. 3) describe the military nurses' perceptions regarding the extent to which cultural training would impact their practice in military work after completion of the mission. Selected personal characteristics of military nurses who participated on an HCA were also described. A review of the literature revealed no specific studies which addressed cultural training of nurses who participated on an HCA. Anecdotal comments were made in some of the literature regarding the importance of cultural training, but no studies were conducted specifically that addressed the target population. Leininger's Sunrise Model was used as the guiding framework for this study.

A descriptive survey design was used for the study utilizing a researcher developed questionnaire. The final convenience sample size gave a return rate of 54% (n=51) Air Force Nurses. Notable findings included a description of the cultural training prior to and during missions and the topics covered during the training. Overall use of the HCA mission as it applies to the nurses daily work was very high although it is not specific to the cultural training that was provided prior to and during the mission. A surprising finding which was unrelated to the specific aims of the study was a lack of a post-mission debriefing. Military personnel who plan future missions must consider how the debriefing

is included upon completion of the mission because it is an HCA mission requirement.

The debriefing must be incorporated into the schedule like all other aspects of the mission, especially since the majority of the nurses in the study found the debriefing very beneficial for closure and those who do not receive a debriefing found lack of a debriefing to be detrimental to their readjustment back to daily work.

Training is the key to the success of a mission and cultural training can have an impact on the overall success of the mission. The military nurse does not work in a cultureless society during an HCA or even during their daily work in the United States. Military nurses should strive to understand their patients in a holistic sense which includes cultural aspects. If training is not being presented which is appropriate and thorough, the military nurse must request that training be improved to more adequately address cultural issues.

This researcher believes that further studies of this type will only help to improve the efficacy of these missions. HCAs already offer an invaluable opportunity for clinical/cultural training and adequate training will only serve to strengthen the value the missions have for nurses daily work.

BIBLIOGRAPHY

- Anderson, G. (1990). A decade of great progress in medical readiness. Military Medicine, 155, 535-538.
- Anderson, J. (1990). Health care across cultures. Nursing Outlook, 38(3), 136-139.
- Andrews, M., & Boyle, J. (1995). Transcultural concepts in nursing care (2nd ed.). Philadelphia: J. B. Lippincott Company.
- Aune, R. (1995). Reflections on a humanitarian mission 20 years later: Operation babylift. Military Medicine, 160, 584-587.
- Barger, J. (1991). Preparing for war: Lessons learned from U.S. Army flight nurses of world war II. Aviation, Space, and Environmental Medicine, 62, 772-775.
- Bartz, B., Bowles, M., & Underwood, J. (1993). Student experiences in transcultural nursing. Journal of Nursing Education, 32(5), 233-234.
- Billingsley, M. (1990). The Saudi experience. Nursing Connections, 3(4), 15-19.
- Brink, P.J., & Wood, M.J. (1988). Basic steps in planning nursing research: From question to proposal (3rd ed.). Boston: Jones and Bartlett Publishers.
- Brink, P.J. & Wood, M.J. (Eds.). (1989). Advanced designs in nursing research. Newbury Park: Sage Publications.
- Burk, M., Wieser, P., & Keegan, L. (1995). Cultural beliefs and health behaviors of pregnant Mexican-American women: Implications for primary care. Advanced Nursing Science, 17(4), 37-52.
- Burns, N., & Grove, N. (1993). The practice of nursing research: Conduct, critique, & utilization (2nd ed.). Philadelphia: W.B. Saunders Company.
- Burns, N., & Grove, N. (1995). The practice of nursing research: Conduct, critique, & utilization (3rd ed.). Philadelphia: W.B. Saunders Company.
- Calderwood, B., & Nathan, L. (1985). Participative educational experience: Providing an alternative to medical readiness. Military Medicine, 150, 272-274.
- Cardinal, P. (1992). Health service support in operations desert shield and desert storm. Military Medicine, 157, 175-179.

- Crutcher, J., Beecham, J., & Laxer, M. (1995). Short-term medical field missions in developing countries: A practical approach. Military Medicine, 160, 339-343.
- Davis, R., Bachman, L., Normile, J., & Skinner, R. (1990). Joint service training for medical readiness. Military Medicine, 155, 80-83.
- Deckert, B., Dempsey, W., & Shaffer, S. (1995). Maintaining wartime medical readiness in the peacetime Air Force. Journal of the American Optometric Association, 66(4), 208-212.
- Dobson, D.M. (1988). Transcultural health visiting and caring in a multi-cultural society. In Morse, J.M. (Ed.), Issues in cross-cultural nursing, recent advances in nursing, (pp. 61-78). Edinburgh: Churchill-Livingston.
- Eliason, M. (1993). Ethics and transcultural nursing care. Nursing Outlook, 41(5), 225-228.
- Ferris, M (1990). Redirecting transcultural nursing research: For the future . . . for our patients. In Wang, J., Simoni, P., & Nath, C. (Eds.), Proceedings of the 1990 WVNA research symposium: Vision of excellence. The decade of the nineties, (pp. 45-48). Charleston: West Virginia Nurses Association Research Conference Group.
- Fieg, E., Baker, T., & Bishop, E. (1987). Army expert field medical badge (EFMB) enhances Air Force medical readiness. Military Medicine, 152, 351-354.
- Finfgeld, D. (1991). What does a military nursing shortage mean to us? Nursing Economics, 9(1), 44-47.
- Fleming, J. (1989). Meeting the challenge of culturally diverse populations. Pediatric Nursing, 15(6), 566 & 634.
- Fowler, F. J. (1988). Survey Research Methods (rev. ed.). Newbury Park: SAGE Publications.
- George, J. (1995). Madeleine M. Leininger. In J. George (Ed.), Nursing theories: the base for professional nursing practice, (pp. 373-389). Norwalk: Appleton & Lange.
- Gigar, J., & Davidhizar, R. (1991). Transcultural nursing: Assessment and intervention. St. Louis: Mosby Year Book.
- Goodman, T. (1994). Transcultural nursing: A personal and professional challenge. Nursing Clinics of North America, 29(4), 809-815.

- Gordon, C., & Bisgard, J. (1983). Medical readiness planning: Identifying critical elements and aggregate requirements. Military Medicine, 148, 103-107.
- Hand, R., Wiener, S., & Sanford, J. (1989). Medical readiness education and training exercises by United States Army medical personnel in Kenya. Military Medicine, 154, 417-421.
- Jackson, L. (1993). Understanding, eliciting and negotiating clients' multicultural health beliefs. Nurse Practitioner, 18(4), 30-43.
- Johnson, H. (1992). Psychiatric mental health consultation and nursing in the United Arab Emirates. Journal of Psychosocial Nursing, 30(5), 25-28.
- Lea, A. (1994). Nursing in today's multicultural society: A transcultural perspective. Journal of Advanced Nursing, 20, 307-313.
- Leininger, M. (1973). An open health care system model. Nursing Outlook, 21(3), 171-175.
- Leininger, M. (1977). Cultural diversities of health and nursing care. Nursing Clinics of North America, 12(1), 5-18.
- Leininger, M. (1984). Transcultural nursing: An overview. Nursing Outlook, 32(2), 72-73.
- Leininger, M. (1986). Care facilitation and resistance factors in the culture of nursing. Topics in Clinical Nursing, 8(2), 1-12.
- Leininger, M. (1986). Introduction: The nature of science in nursing. In Nicoll, L.H. (Ed.), Perspectives on Nursing Theory, (pp. 192-193). Boston: Little, Brown & Company.
- Leininger, M. (1986). Introductory comments. In Nicoll, L. H. (Ed.), Perspectives on nursing theory, (pp. 150-155). Boston: Little, Brown, & Company.
- Leininger, M. (1988). Leininger's theory of nursing: Cultural care diversity and universality. Nursing Science Quarterly, 2, 152-159.
- Leininger, M. (1991a). Cultural care diversity and universality: A theory of nursing. New York: National League for Nursing Press.
- Leininger, M. (1991b). Transcultural nursing: The study and practice field. Imprint, 38, 55-66.

- Leininger, M. (1993). Culture care theory: The relevant theory to guide nurses functioning in a multicultural world. In Parker, M. (Ed.), Patterns of nursing theories in practice, (pp. 105-121). New York: National League for Nursing Press.
- Leininger, M. (1994). Quality of life from a transcultural nursing perspective. Nursing Science Quarterly, 7(1), 22-28.
- Leininger, M. (1994). Transcultural nursing education: A worldwide imperative. Nursing & Health Care, 15(5), 254-257.
- Lesho, E. (1994). Supply consumption and disease surveillance during an overseas training exercise in Southeast Asia. Military Medicine, 159, 53-55.
- Lillibridge, S., Brukle, F., & Noji, E. (1994). Disaster mitigation and humanitarian assistance training for uniformed service medical personnel. Military Medicine, 159, 397-403.
- Lipson, J., Dibble, S., & Minarik, P. (Eds.). (1996). Culture & nursing care: A pocket guide. San Francisco: UCSF Nursing Press.
- LoBiondo-Wood, G., & Haber, J. (1990). Nursing research: Methods, critical appraisal, and utilization (2nd ed.). St. Louis: C.V. Mosby Company.
- LoBiondo-Wood, G., & Haber, J. (1994). Nursing research: Methods, critical appraisal and utilization (3rd ed.). St. Louis: Mosby Yearbook, Inc..
- Ludwig, F., Horak, B., Wallace, M., & Deafenbaugh, M. (1992). Rapid host nation medical deployment. Military Medicine, 157, 598-601.
- Luz, G., DePauw, J., Gaydos, J., Hooper, R., & Legters, L. (1993). The role of military medicine in military civic action. Military Medicine, 158, 362-366.
- Meleis, A. (Ed.). (1995). Diversity, marginalization, and culturally competent health care issues in knowledge development. Washington: American Academy of Nursing.
- Moloff, A., & Bettencourt, B. (1992). The special forces medic: Unique training for a unique mission. Military Medicine, 157, 74-76.
- Mulholland, J. (1995). Nursing, humanism and transcultural theory: the 'bracketing-out' of reality. Journal of Advanced Nursing, 22, 442-449.
- Nolan, D. (1988). A perspective on operational medical readiness. Military Medicine, 153, 526-529.

- Notter, L. E., & Hott, J.R. (1994). Essentials of nursing research (5th ed.). New York: Springer Publishing Company.
- Parisi, R. (1990). Medical readiness training. Military Medicine, 155, 214-215.
- Parse, R., Coyne, A., & Smith, M. (1985). Nursing research: Qualitative methods. Bowie: Brady Communications Company.
- Polit, D.E., & Hungler, D.P. (1987). Nursing research: Principles and methods (3rd ed.). Philadelphia: J. B. Lippincott Co..
- Polit, D.E., & Hungler, B.P. (1991). Nursing research: Principles and methods (4th ed.). Philadelphia: J.B. Lippincott.
- Polit, D.E., & Hungler, B.P. (1993). Essentials of nursing research: Methods, appraisal, and utilization (3rd ed.). Philadelphia: J.B. Lippincott Company.
- Smith, S., & Smith, K. (1995). Perioperative perspective of a United Nations humanitarian mission. AORN Journal, 62(6), 875-883.
- Solomos, J., & Back, L. (1994). Conceptualizing racisms: social theory, politics and research. Sociology, 28(1), 143-161.
- Stern, P., & Cousins, M. (1986). Culture shock and the working woman: Surviving west coast to Northern Louisiana relocation. In P. Stern (Ed.), Women, health and culture (pp.135-150). New York: Hemisphere.
- Tripp-Reimer, T., Brink, P.J., & Saunders, J.M. (1984). Cultural assessment: Content and process. Nursing Outlook, 32(7), 78-82.
- Weisser, R. (1993). The maturing of MEDRETEs. Military Medicine, 158, 573-575.
- West, E. (1993). The cultural bridge model. Nursing Outlook, 41(5), 229-234.
- White, G., Hartwig, L., Thiese, S., Murdock, R., & Pedersen, D. (1991). Essential health education for deployment in underdeveloped countries. Military Medicine, 156, 169-171.
- Withers, B., Erickson, R., Petruccelli, B., Hanson, R., & Kadlec, R. (1994). Preventing disease and non-battle injury in deployed units. Military Medicine, 159, 39-43.

Wittich, A. (1989). The medical care system and medical readiness training exercises (MEDRETEs) in Honduras. Military Medicine, 154, 19-23.

Yarington, C. (1985). Medical readiness. Military Medicine, 150, 119-122.

APPENDIX A
UNIVERSITY OF COLORADO MULTIPLE INSTITUTIONAL REVIEW
BOARD(COMIRB) LETTER OF APPROVAL

COLORADO MULTIPLE INSTITUTIONAL REVIEW BOARD

Office of the COMIRB

Assurance # M-1494-01

Participating Institutions

Room 1810C
 Campus Box C-290
 4200 East Ninth Avenue
 Denver, Colorado 80262
 (303)315-8081
 FAX (303) 315-8540

The Children's Hospital
 Colorado Prevention Center
 Denver Health & Hospitals
 University of Colorado Health Sciences Center
 Department of Veterans Affairs Medical Center, Denver
 University Hospital

TO: JULIA STOLA BOX: C288 DATE: 11/18/96

FROM: COLORADO MULTIPLE INSTITUTIONAL REVIEW BOARD

YOUR APPLICATION ENTITLED: MEDICAL READINESS IN HUMANITARIAN AND CIVIC ASSISTANCE
 MISSIONS: SIGNIFICANCE OF CULTURAL TRAINING FOR NURSES

COMIRB PROTOCOL NUMBER -: 96-666

Has been unanimously approved by the COMIRB 11/18/96 which includes your protocol and consent form/revised consent form. The COMIRB will require a follow up on the status of this project within a 12 month period from the date of approval unless a restricted approval applies. If you have a restricted or high risk protocol, specific details will be spelled out with a special set of instructions. We shall send you a form to be completed to define the status of your project.

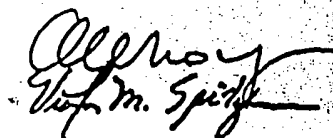
The investigator bears the responsibility for obtaining from all patients and subjects "Informed Consent" as approved by the COMIRB.

It is also your responsibility to inform the COMIRB immediately of any deaths, serious complications or other untoward effects of this research.

Please notify the COMIRB if you intend to change the experimental design in any way.

As of July 1, 1983, the COMIRB REQUIRES that the subject be given a copy of the consent form which includes the name and telephone number of the investigator.

Any questions about the COMIRB's action on this project should be referred to the Secretary Vicky Starbuck (315-8081 or UCHSC BOX C-290).



Allan V. Prochazka, M.D., M.Sc.
 Victor M. Spitzer, Ph.D.
 Co-Chairs
 Colorado Multiple Institutional Review Board

APPENDIX B
SURVEY APPROVAL AND ASSIGNMENT OF USAF
SURVEY CONTROL NUMBER



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR FORCE PERSONNEL CENTER
RANDOLPH AIR FORCE BASE TEXAS

23 December 1996

MEMORANDUM FOR CAPTAIN JULIE M. STOLA, AFIT CIMI STUDENT

FROM: HQ AFPC/DPSAS
550 C Street West, Suite 35
Randolph AFB TX 78150-4393

SUBJECT: Survey Approval and Assignment of USAF Survey Control Number

Your proposed "Humanitarian and Civic Assistance Missions Survey" is approved for use with Air Force personnel. A Survey Control Number (SCN) of USAF SCN 96-84 is assigned to your survey. This number and authorization will expire on 31 December 1997.

With regard to the survey and its associated results, it is important to draw your attention to the provisions of the Freedom of Information Act (FOIA). Under the FOIA, the results of your survey can be requested by the public. Finally, the USAF SCN needs to appear either in the cover letter or on the face of the survey itself.

Any further questions or concerns can be directed to me at (210) 652-5680 or via e-mail (bensojm@hq.afpc.af.mil). Thank you and good luck with your data collection efforts.

A handwritten signature in black ink, appearing to read "Michael J. Benson", is written over a horizontal line.

MICHAEL J. BENSON, Lieutenant, USAF
Personnel Survey Analyst

APPENDIX C
COVER LETTER TO SUBJECTS

01 JAN 97

Dear Air Force Nurse:

I am a fellow Air Force nurse currently completing an AFIT sponsored graduate nursing degree at the University of Colorado Health Sciences Center. I am conducting a survey on the perceptions of nurses regarding training prior to and during an HCA (Humanitarian and Civic Assistance) mission with special emphasis on cultural training. The results of this research will be used in my master's thesis.

I would like to invite you to answer the enclosed questionnaire. It will take approximately 10 minutes of your time to complete. There are no risks or benefits to you in completing this survey and your participation is completely voluntary.

Your answers will remain confidential and your name or identification is not requested or obtained by other means. A code number will be assigned to your questionnaire to expedite the analysis process and the researcher will only know your geographical area. The results of this research will be shared with other health care providers in a scholarly manner. As required by AFIT, a copy of the completed thesis will be sent to HQ AU/SGN. If you want information about the results of the completed study, please enclose with the questionnaire but on a separate sheet of paper, your name and address. The results will be sent to you in May 1997.

Attached to the survey is a self addressed, stamped envelope for you to return the survey. Please return the completed survey by January 14, 1997.

Please feel free to contact me if you have any questions about the survey or would like to comment on my research. Thank you very much for your time and effort in helping me to complete this study in which I have a great deal of interest.

Sincerely,

Julie M. Stola
Capt, USAF, NC
University of Colorado Health Sciences Center
School of Nursing
4200 East Ninth Avenue C-288
Denver, CO 80262
E-mail: julie.stola@UCHSC.edu

Please return completed questionnaires to:

Julie M. Stola
1215 Dahlia St.
Denver CO 80220
(303) 377-7703

APPENDIX D
LETTER FOR CHIEF NURSE EXECUTIVES

MEMORANDUM FOR: CHIEF NURSE EXECUTIVES

FROM: CAPT. JULIE M. STOLA, AFIT STUDENT

RE: SURVEY DISTRIBUTION

1. This letter is a request for your assistance in distribution of a survey I have prepared for research being accomplished to complete my thesis work in the Masters program at the University of Colorado Health Sciences Center. The survey is 23 questions, can be completed in ten minutes and is specifically for nurses who have participated on a Humanitarian and Civic Assistance (HCA) mission in the past five years. The research examines training provided for the nurses prior to and during these missions. The military has made training a priority and gathering this information will be beneficial to those who provide training for these missions in the future.
2. If you would like to have the nurses you supervise participate in the survey, I am willing to work with you or the professional development officer at your base to get approximate numbers of nurses who meet the criteria and have a packet with the appropriate number of questionnaires sent to whomever you designate to distribute them. A postage paid envelope will be included with the questionnaire so there will be no expense to those who complete the questionnaire.
3. If you respond to this request in the affirmative, could you please send me the E-mail address of the person I will be working with to distribute the questionnaires. It would be greatly appreciated if your response was received by 30 December so that I can send out the questionnaires the first week of January.
4. The survey control number is listed on the questionnaire, all approval for completing the study has been achieved.
5. Results of the study will be ready in May 1997 which I would be willing to share with anyone interested. Include the request for results with the initial response.
6. If you have further questions, I can be reached at (303) 377-7703 or my E-mail account is: julie.stola@UCHSC.edu

Julie M. Stola, Capt, USAF, NC
AFIT/CIMI Student

APPENDIX E
FOLLOW-UP LETTER FOR CHIEF NURSE EXECUTIVES

MEMORANDUM FOR: CHIEF NURSE EXECUTIVES

FROM: CAPT. JULIE M. STOLA, AFIT STUDENT

RE: REMINDER LETTER FOR SURVEY DISTRIBUTION

1. The two week time frame for survey distribution at your base is complete. Approximately 100 questionnaires were sent out and I have, to date, received 35.
2. I know there are some still in the mail, but it would be appreciated if you could remind those nurses who received a questionnaire that, if they haven't already completed it and returned it, to please do so.

Thank you for all of your assistance!

Julie M. Stola, Capt, USAF, NC
AFIT/CIMI Student

APPENDIX F
SURVEY INSTRUMENT

TRAINING FOR HUMANITARIAN AND CIVIC ASSISTANCE
MISSIONS SURVEY

Please indicate your answers to the following questions by circling the appropriate response. Some answers may require a short written response or a check mark where indicated. If your response doesn't fit in the space provided, please use an additional paper to complete your response. Completion of the questionnaire will take approximately ten minutes.

1. What is your current rank?

1. 2Lt	4. Major
2. 1Lt	5. LtCol
3. Capt	6. Col

2. What is your highest level of Nursing education?

1. AD	4. PhD, DNSc
2. BS or BSN	5. Other (describe)
3. MS or MSN	_____

3. What is your current job title?

4. What was your age on your last birthday? _____

5. Ethnicity:

1. African American	4. American Indian
2. Asian American	5. White, non Hispanic
3. Hispanic, Non white	6. Other _____

6. Gender: 1. Female 2. Male

7. How many years have you served in the military?

1. 0-5 yrs	4. 16-20 yrs
2. 6-10 yrs	5. >20 yrs
3. 11-15 yrs	

8. Which segment of the Air Force do you represent?

- | | |
|----------------|------------------|
| 1. Active Duty | 4. Ready Reserve |
| 2. Guard | 5. IMA |
| 3. Reserve | 6. Other |

9. Was your most recent Humanitarian and Civic Assistance Mission (HCA) your first HCA?

1. Yes 2. No

a. If No, how many previous missions have you participated in? _____

10. When did you participate in the most recent HCA?

- a. From (month, year) _____
 To (month, year) _____

11. What type of training did you have prior to the mission?

(Please circle all which apply.)

- | | |
|--------------------|---------------------|
| 1. Security | 4. Safety Issues |
| 2. Personal Health | 5. Weapons Training |
| 3. Cultural Issues | 6. Other (Describe) |
-

12. Approximately how many hours were spent prior to the mission in training per category? (Please check the appropriate response.)

	1. None	2. <1hr	3. 1-3 hrs	4. >3 hrs
a. Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Personal Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cultural Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Safety Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Weapons Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other (Please describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

USAF SCN 96-84

13. Approximately how many hours were spent **during** the mission in training per category? (Please check the appropriate response.)

	1. None	2. <1hr	3. 1-3hrs	4. >3 hrs
a. Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Personal Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cultural Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Safety Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Weapons Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other (Please describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Rate your level of language proficiency for the language spoken by the country in which you most recently provided health care on an HCA.

(Please check the appropriate responses.)

	a. Prior to HCA	b. After HCA
1) None	<input type="checkbox"/>	<input type="checkbox"/>
2) Phrases only	<input type="checkbox"/>	<input type="checkbox"/>
3) Conversational	<input type="checkbox"/>	<input type="checkbox"/>
4) Proficient	<input type="checkbox"/>	<input type="checkbox"/>

15. a. Were you provided any language training by the military **prior** to the mission?

1. Yes 2. No

b. If yes, what type, if no, go to 16 (Please circle all which apply.)

- | | |
|--------------------------|---------------------|
| 1) Classroom instruction | 4) Combination |
| 2) Handouts | 5) Other (describe) |
| 3) Cassettes | |
-

c. Approximate number of hours of language training? _____

16. a. Were you provided any cultural training by the military **prior** to and for this mission?

1. Yes 2. No

b. If yes, what type, if no, go to 17. (Please circle all that apply.)

- | | |
|--------------------------|---------------------|
| 1) Classroom instruction | 4) Combination |
| 2) Handouts | 5) Other (describe) |
| 3) Briefings | |
-

c. Which of the following cultural factors regarding the host nation were discussed in the training **prior** to the mission. (Please circle all which apply.)

- | | |
|----------------------------|--|
| 1) Local use of Technology | 7) Health care system within the country |
| 2) Religious influences | 8) Folk system of health care |
| 3) Cultural values | 9) Importance of family/social ties |
| 4) Political influences | 10) Holistic health concepts |
| 5) Economic situation | 11) Other (describe) |
| 6) Educational level | |
-

d. Approximate number of hours spent on cultural training **prior** to the mission? _____

17. a. Was there any cultural training provided **during** the mission?

1. Yes 2.No

b. If yes, what type of training, if no, go to 19. (Please circle all which apply.)

- | | |
|--------------------------|---------------------|
| 1) Classroom instruction | 4) Combination |
| 2) Handouts | 5) Other (describe) |
| 3) Briefings | |
-

USAF SCN 96-84

c. Which of the following cultural factors regarding the host nation were discussed in the training **during** the mission (Please circle all which apply.)

- | | |
|----------------------------|--|
| 1) Local use of Technology | 7) Health care system within the country |
| 2) Religious influences | 8) Folk system of health care |
| 3) Cultural values | 9) Importance of family/social ties |
| 4) Political influences | 10) Holistic health concepts |
| 5) Economic situation | 11) Other (describe) |
| 6) Educational level | |

d. Approximate number of hours spent on cultural training **during** the mission? _____

18. a. Did you encounter specific instances where cultural training made a difference in the quality of nursing care you provided? 1. Yes 2. No

b. If yes, rate the degree, if no, go to 18. (Please circle one response.)

- 1) significantly improved the quality of care
- 2) moderately improved the quality of care
- 3) slightly improved the quality of care
- 4) slightly worsened the quality of care
- 5) moderately worsened the quality of care
- 6) significantly worsened the quality of care

19. a. Please rate the degree HCA missions provide valuable training for military readiness: (Please circle one response.)

- | | |
|----------------------|----------------------|
| 1) No value | 4) Significant value |
| 2) Very little value | 5) Excellent value |
| 3) Moderate value | |

b. Would this opinion change if there was specific cultural training added **prior** to the mission? 1. Yes 2. No
(Please explain why your response was yes or no.)

USAF SCN 96-84

- c. Would this opinion change if there was adequate language training added **prior** to the mission? 1. Yes 2. No
(Please explain why your response was yes or no.)

20. Did the HCA have a post-mission briefing? 1. Yes 2. No
a. If yes, please describe how it benefited you, if no, give your opinion on whether this has affected you or not.
21. a. Did the HCA provide experiences which will benefit you in your day-to-day, military work environment? 1. Yes 2. No
b. If yes, please describe how the HCA will benefit you, if no, give your opinion on why it will not benefit you.

**FOR THE FINAL QUESTIONS, PLEASE PROVIDE YOUR
OPINION BASED ON YOUR EXPERIENCE WITH AN HCA
DEPLOYMENT**

22. What are your thoughts on the overall value of HCAs?
23. What would you recommend to make the HCA mission more valuable?

Thank you for your valuable input!

If you would like a report of the findings, please enclose your name and address on a **separate sheet of paper**. I will be sending out the report in May 1997.