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Cultural Safety and the Provision of Humanitarian Nursing in Haiti

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CULTURAL SAFETY AND THE PROVISION OF HUMANITARIAN NURSING IN HAITI

by

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ABSTRACT

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Nurses comprise the largest segment of the global health workforce including in humanitarian settings. Guided by strict ethical to address issues of global health inequities, nurses are currently limited in their ability to address root causes of inequities as the most commonly used nursing concepts and theories are informed by racist and colonist ideologies. To address this gap, this study was guided by critical race theory and cultural safety to explore how nurses' worldviews, with explicit attention to race, influence care in the humanitarian setting. The study focused on care delivered in Haiti taking into account its history with the United States (U.S.) and number of U.S. volunteers working there at any given time. The qualitative inquiry included in-depth one-on-one interviews with U.S. nurses and analysis of blog posts. The findings of this study add to decolonizing discourse with which to inform nursing education in cultural theorizing and subsequently nursing practice in the humanitarian setting.

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Chapter I: Introduction

Statement of Problem

The legacy of colonialism and the ways in which it has informed nursing practice in the United States (U.S.) remains a specter threatening to undermine efforts to genuinely engage with marginalized populations (Anderson, Rodney, Reimer-Kirkham, Browne, Khan, & Lynam, 2009). Decolonizing discourses and explicit attention to the impact of racism on health remain largely absent from nursing education, research and practice in the U.S. (Blanchet Garneau, Browne & Varcoe, 2018; Hilario, Browne, & McFadden, 2017; McGibbon, Mulaudzi, Didham, Barton & Sochan, 2014). With a few notable exceptions, nursing text books homogenize group membership largely by race and ethnicity, for example, Purnell's Guide to Culturally Competent Health Care. Purnell is a highly credentialed nurse with several published text books. His guide claims that "Race is genetic and includes physical characteristics that are similar among members of the same group" (Purnell, 2014, p. 3). The table of contents organizes the book chapters as "People from (insert race or ethnic) heritage" (p. xi). This cookbook approach to teaching about culture is more the rule than the exception in nursing education (Gustafson, 2005). This is an example of how principles of colonial ideologies reifying social constructions (primarily race and ethnicity) continue to inform U.S. nursing practice and education (Duffy, 2014).

Nursing as a science was historically constructed from a positivist and Eurocentric framework that served to sustain the domination of "whiteness as a form of disciplinary power" (Puzan, 2003, p. 196). Lough and Carter-Black use this same language, "whiteness as power" (p. 210), to describe the structures of humanitarian organizations in the United States. Nurses comprise the largest segment of the humanitarian workforce (Dawson, Elliott, & Jackson, 2017)

Left unexamined, the same oppressive ideologies that continue to influence the delivery of nursing care will carry over into the humanitarian setting and unintentionally perpetuate inequities (McGibbon, Mulaudzi, Didham, Barton & Sochan, 2014). In fact, the literature is replete with evidence that volunteer organizations, including university-sponsored service-learning courses, are reverting to the ideologies of colonialism at the expense of contemporary understandings of human rights and equity (Bauer, 2017). One concept widely touted in nursing that requires critiquing is cultural competence.

Cultural competence remains the primary concept used to guide the nursing profession in addressing the needs of diverse populations locally and globally (Rajaram & Bockrath, 2014). The principles of cultural competence are heavily influenced by the social and political history of the United States (Kirmayer, 2012). Practicing with cultural competence is tainted with the effects of racial bias as this concept fails to recognize how perceived "cultural differences" are code for modern-day racist ideologies (Hester, 2012). What is believed to be cultural knowledge is rooted in white, European worldviews and codified into healthcare practices based on faulty interpretations and observations of the "Other." It is fundamentally impossible for nurses to provide culturally competent care under this model. Thus, new frameworks must underpin the delivery of nursing care to meet the needs of diverse populations.

Despite operating in the aid of others, humanitarian efforts are increasingly facing criticism. Critiques of humanitarian approaches include claims of paternalism and imposition of western values (Bandyopadhyay & Patil, 2017; Bauer, 2017; Lough & Carter-Black, 2015). Bauer (2017) identifies two additional failings of humanitarianism: the needs of volunteers taking precedence over the needs of recipients and the goal being to fill in gaps in services as opposed to supporting and building on local capacity. Other critics go as far as to call volunteer

humanitarian organizations modern day colonizers (Bandyopadhyay & Patil, 2017). There are a number of reasons for the reference to colonialism. First, colonial depictions of white people of European descent as "superior" and non-white people as "inferior" continue to be played out in contemporary humanitarian settings (Lough & Carter-Black, 2015). Also, the rhetoric used in humanitarian discourses (e.g. "missions," "changing the world" etc.) are metaphors for white superiority (Henry, 2018; Lough & Carter-Black, 2015). White college graduates who are employed and earning a higher than average income comprise one of largest segments of international volunteers (Bandyopadhyay & Patil, 2017; Lough, 2013; Lough & Carter-Black, 2015). An overrepresentation of whites in these spaces points to the clandestine nature of structural racism (Henry, 2018).

Haiti has earned the dubious distinction of the "republic of non-governmental organizations (Schuller, 2012). It proximity to the United States along with ubiquitous images of poor, desperate Haitians in need of saving make Haiti a frequent destination for humanitarian groups. As the 10th anniversary of the devastating earthquake came and went, questions such as: "why have conditions not improved?" and where did all of the money go?" were asked. This renewed attention will provide an opportunity for the humanitarian sectors to ask ourselves tougher, more self-incriminating questions.

Purpose and Specific Aims

The purpose of this study was to explore how nurses' world views influence their professional role in addressing health inequities through service abroad or international service activities. Specific aims included:

1. An exploration of how my worldviews have evolved since the beginning of my work in Haiti and the affect this has had on my nursing practice.

2. An exploration of the motivations, implicit and explicit, that informed nurses' desire to work in a low income country, specifically Haiti.

3. An analysis of nurses' understanding of health equity in the delivery of care in Haiti.

4. An exploration of nurses' values, beliefs and attitudes toward patients of different racial and ethnic backgrounds.

Significance

This study utilized a concept and theory that heretofore have not been used together to explore humanitarian nursing. Cultural safety (CS) and critical race theory (CRT) with an attention to the structural nature of inequities offers a framework to explore and address global health inequities that are at best ignored, at worst exacerbated (Kirmayer, 2012). In general, the application of critical race theory has been limited to domestic (U.S.) borders but is well-poised to explore the permeability of racism across borders (Henry, 2018).

Harrowing, Mill, Spiers, Kulig and Kipp (2010) note that researchers have yet to apply critical theories, like critical race, in the context of the global south. A review of literature using the key words “critical race theory” and “nursing” yielded 24 results. A review of abstracts revealed that only two of the 24 articles actually used CRT as the theoretical framework. This is congruent with the claim that antiracist theories are limited in the nursing literature.

Since its inception in the 1980s, cultural safety has been applied to nursing practice in Canada and Australia but remains largely absent from research generated in the United States. conducting a concept analysis on the cultural safety, the databases CINAHL, Academic Search Complete, PubMed, and Anthropological Literature for the years 2006-2017 were searched using various combinations of the key terms, “cultural safety,” “culture,” “medicine,” and “health.” Additional inclusion criteria included: published in the English language and in a peer-reviewed

journal and the availability of a full-text article. A total of 63 articles met inclusion and criteria and six of these were from United States based scholars. My goals as a nurse scholar examining the concept of cultural safety were two-fold. I aimed to contribute to the gap in the literature regarding the application of cultural safety in US nursing practice. This required a problematization of our own, Western, bias' that has largely been ignored. As stated by the Nursing Council of New Zealand (2011), nurses must undertake regular processes of reflection to understand how their social location, based on personal identities and as a member of a trusted profession, influences the power dynamics in the healthcare setting. In contributing to the literature in this regard I sought to inform nursing practice and influence policies at the educational and institutional levels. Additionally, I aimed to elucidate the "hegemony of nursing care due to unexamined assumptions and ethnocentricity" (Doutrich, Dekker, Spuck, & Hoeksel, 2014, p. 18) as it relates to the delivery of humanitarian nursing care in Haiti. The goal was to influence a transformation in the delivery of humanitarian nursing away from a charity model and towards an emancipatory model.

Including cultural safety with CRT will push the extant nursing and humanitarian literature to consider how the delivery of care by white westerners in Haiti perpetuates hegemonic discourses that serve to disempower recipients of care.

In a highly segregated world, humanitarian nursing provides rare opportunities to subject a pre-dominantly white workforce to a majority and critical "Black gaze" (Henry, 2018, p. 327). Herein lies the opportunity to inform a global theory of anti-racism to guide nursing and humanitarian efforts.

Organization of Proposal

I will begin by first defining and situating terms commonly used in global health discourses to provide for consistency and clarity followed by a definition and brief history of humanitarianism, voluntourism and service-learning. Next is a discussion of concepts commonly used in nursing to address the needs of diverse populations in the U.S. and abroad with examples from the literature. I will transition to provide the reader with a brief history of Haiti to help contextualize the current humanitarian efforts occurring there. I will introduce cultural safety and critical race theory and discuss what they contribute to cultural theorizing and how, when utilized together, they provide a more robust framework than other theories more commonly used in nursing. I will then discuss the concept of power as it relates to the delivery of global health and how these power configurations are mirrored in the interactions between volunteers and recipients of aid with examples from Haiti. I will conclude with a detailed description of the methods that I used to undertake this study.

Terminology

There are a number of terms referring to global inequality and poverty found in the nursing, global health, and humanitarian literature that warrant clarification. Beginning in the 1960's the world was divided into the 'global north and south' with the north representing wealthier nations and the south representing poorer nations (Therien, 1999). From there, new ways of describing global inequality at the country level emerged depending on the paradigmatic viewpoint, largely as it related to economic development. (Therien, 1999). Synonyms for the global south include 'developing nations,' 'developing economies,' and low-to-middle income countries (LMIC). Synonyms for the global north include depictions such as 'developed,' and

'western.' I used the terms Global North and South as this nomenclature references the geopolitical nature of globalization and capitalism (Dados & Connell, 2012).

Humanitarianism

Volunteer work in the aid of others is referred to in a number of different ways, each with slightly unique elements but grounded in similar principles and informed largely by colonialism. For the sake of this analysis, voluntourism and service-learning opportunities will be considered models under the larger concept of humanitarianism.

The definitions of humanitarianism are vast and, even within the field, are rarely agreed upon (Barnett, 2014). For the purposes of this analysis, humanitarian work will refer to non-governmental organizations (NGOs) staffed largely by volunteers. The documentation of humanitarian efforts dates back to 1919 with the Treaty of Versailles (Rysaback-Smith, 2015). Philosophies informing humanitarianism are many, ranging from religious beliefs to ethical considerations to responses to the atrocities of war (Rysaback-Smith, 2015). Generally speaking, there are four principles underpinning humanitarian efforts: neutrality, humanity, impartiality and independence (Rysaback-Smith, 2015). These principles call for humanitarian work to remain free from endorsing any political viewpoints and to render aid whenever, wherever it is needed and to whomever needs it (Rysaback-Smith, 2015). These principles apply to nursing practice as well as care is presumed to be delivered regardless of social, political, economic or historical contexts. Yet it is precisely these factors that are now understood to be the key drivers of health inequities (Marmot, Friel, Bell, Houweling, Taylor, & Commission on Social Determinants of Health, 2008).

Globally there is a shortage of 4.6 million healthcare workers (Dawson, Elliott, & Jackson, 2017). Therefore, health professionals from well-resourced countries have many options

when it comes to volunteer opportunities, whether through disaster relief efforts, educational affiliations, or professional organizations (Bauer, 2017). Approximately 6000 short-term experiences in global health (STEGH) take place annually at a cost of $250 million (Melby, Loh, Evert, Prater, Lin, & Khan, 2016; Murray 2016).

Secular medical volunteerism gained traction in the 1960s with the rise in non-governmental organizations (NGOs) (Bauer, 2017). Healthcare professionals from the Global North travel to the Global South to provide medical care; operating from a western bio-medical paradigm in non-western communities (Bauer, 2017). Two examples of humanitarian interventions are voluntourism and service-learning. Each are discussed in greater detail below.

Voluntourism

The term voluntourism is an amalgamation of key elements of this type of work: volunteering and tourism. Voluntourism is an attractive option for those seeking opportunities for personal development while contributing socially or environmentally to places they are eager to explore. These competing priorities have brought voluntourism under increasing scrutiny. Critics claim voluntourists are motivated by images of the poor, disadvantaged and those in the Global South in need of interventions from more privileged, White westerners (Friedus, 2017). Current models of voluntourism fuel the notion that ills of global poverty can be mitigated by the actions of well-intentioned individuals regardless of skill level or experience (Bauer, 2017).

Romanticism of poverty by volunteers is common as those living in abject poverty are assumed to be ignorant of a better life, and more grateful and free from materialism (Friedus, 2017). This trivialization of the chronic stress of living in poverty evokes neocolonial notions of the naivete of the poor and allows for westerners, regardless of skill level or content expertise, to

"help." Implicit is the belief that westerners are inherently smarter and more capable of meeting the needs of a community than the people who live and work there every day (Friedus, 2017).

Service-learning

The National Service Learning Clearinghouse defines service-learning as "a teaching and learning strategy that integrates meaningful community service with instruction and reflection to enrich the learning experiences, teach civic responsibility and strengthen communities" (as cited in Groh, Stallwood, & Daniels, 2011, p. 400). From the onset in the late 1960's through the following decade, most service-learning opportunities were affiliated with youth groups and volunteer organizations (Groh, Stallwood & Daniels, 2011). This changed in the 1980s when the federal government allocated money to integrate service-learning opportunities into colleges and universities (Groh, Stallwood & Daniels, 2011). Beginning in the mid-1990's, service-learning became an integral part of nursing curricula. Service-learning is considered a pedagogical strategy in which nursing students actively engage in leadership opportunities and integrate social justice into their practice (Groh, Stallwood & Daniels, 2011). What sets service-learning apart from other types of humanitarian endeavors is the role of reflective practice to enhance critical thinking skills (Brown & Schmidt, 2016). Brown & Schmidt (2016) caution that service-learning is potentially being misrepresented in the nursing literature as many authors fail to include explicit details about the reflection component to service-learning activities.

Chapter II: Review of the Literature: Common Concepts and Frameworks

There are several concepts in the literature used to describe the delivery of nursing with attention to culture, the most common include: awareness, sensitivity, humility and competence. Nurses, using any one of these concepts individually and absent a larger critical theory, run the risk of stereotyping and victim blaming (Hestor, 2012). For example, by focusing mainly at the individual and interpersonal levels, cultural sensitivity displaces explicit discussions about systemic racism (Hilario, Browne, & McFadden, 2017).

Cultural humility, while calling for reflection and humility, remains ambiguous as to what practitioners are to be reflecting on and humble about (Hester, 2012). Most individuals entering the healthcare field espouse a belief that they need to deliver care with impartiality. However, without a sufficient understanding of the machinations of racism in everyday society, the ways in which racism is perpetuated in the healthcare system will remain a blind spot (Hestor, 2012). In attempt to provide care regardless of race or ethnic background, healthcare providers might overcompensate ("I don't see color") and subsequently fail to see how social determinants of health affect their patient's opportunities to achieve and maintain optimal health (Hester, 2012).

Cultural competence and the Transcultural Nursing Theory

The mostly widely used concept to guide nursing care to diverse populations is cultural competence (Rajaram & Bockrath, 2014). Cultural competence is closely associated with Leininger's Transcultural Nursing Theory, one of the oldest nursing theories still in use (Leininger, 2002). Madeleine Leininger is considered the foremost nursing scholar on issues of nursing and culture. While earning a PhD in anthropology, Leininger saw a need for nurses to gain skills in providing care for people from diverse cultures. She introduced what became

known as the Transcultural Nursing Theory (TCN) for her doctoral thesis in 1965. “The central purpose of the theory is to discover and explain diverse and universal culturally based care factors influencing the health, well-being, illness, or death of individuals or groups” (Leininger, 2002, p. 190). Leininger distinguishes her theory from other nursing theories in several distinct ways. It was the first to focus on the role of culture in the provision of nursing care. Secondly, it is the most holistic theory in explaining culturally based practices. Third, it was the first nursing theory to explore similarities and differences between cultures globally. Lastly, in addition to its theoretical concepts, the theory includes practical suggestions for providing culturally congruent care (Leininger, 2002).

The Transcultural Nursing Theory solidified a number of assumptions that contemporary nursing theorists find problematic. For example, Leininger (2002) was explicit in stating that her theory was to help nurses examine “Western and non-Western cultures (p. 33).” This nomenclature cemented a “White/Other” dichotomy now imbued with cultural competence. Leininger also described two types of nursing care: professional and generic. Leininger (2002) defined generic care as “folk, lay, indigenous or nonprofessional” (p. 36). This serves to reify a White, European hegemony as to what constitutes knowledge and whose knowledge is presumed to be of value.

Dr. Leininger and her colleagues attempted to address race as proxy for culture by introducing “sub-cultures” into the model. These “sub-cultures” included: sexual orientation, gender identity, class and socio-economic status but implicit is the understanding that there remains a primary cultural identity. This identity continues to be conflated largely with race and ethnicity.

Practicing with cultural competence is predicated on the nurse's ability to learn and understand cultures other than their own in order to predict health behaviors and ultimately health outcomes (Brascoupe & Walters, 2009). When these predictions drive how care is delivered, the complexities of how individuals, families and communities make decisions about life, illness and death become reduced to single narratives and stereotypes (Carter, Lapum, Lavallée, Schindel & Restoule, 2016). Over simplistic narratives also fail to recognize the heterogeneity within groups (Hall & Fields, 2013). By assuming that people of a certain culture share static traits, values, and beliefs, cultural categories became legitimized as objective truths. In reality, these categories are social constructions shaped by history and politics (Kirmayer, 2012). For example, capitalism and individualism are highly regarded in U.S. society and therefore poverty and unemployment become metrics regarded as culturally affiliated (e.g. "culture of poverty). Without an understanding of systemic oppression, nurses may erroneously attribute poor health outcomes to individual or "cultural" behaviors. For example, referring to frequent utilizers of emergency services (emergency rooms, free clinics, food pantries, etc) as "frequent fliers," fails to acknowledge the systemic barriers that keep people in cycles of poverty or under/uninsured status. Or, by labeling patients as "non-compliant," healthcare providers are not taking into account socioeconomic constraints preventing patients from purchasing medications, engaging in daily exercise or other prescribed treatments. In their study Vandenberg and Kalischuk (2014), found that nursing students readily accepted perceived cultural differences without questioning the social, economic and political structures that gave rise to differences.

To be culturally competent means providing linguistically and culturally appropriate care and health education. However, limiting culturally competent care to a set of skills places the emphasis on knowledge attainment as opposed to putting that knowledge into action (Darroch et

al., 2017). It is the practitioner who determines whether they have attained sufficient enough knowledge to be competent. For example, nursing students participating in a service-learning course in Guatemala cited the patience and (perceived) gratitude exhibited by those waiting to be seen in the clinic as evidence that the students had developed cultural competence (Chen, McAdams-Jones, Tay & Packer, 2012). This exemplifies a limitation of the cultural competence model in which the practitioner determines the appropriateness of care given based on intentions and perceptions without ever seeking feedback from the recipients of care (Chen, McAdams-Jones, Tay & Packer, 2012).

An additional short-coming to the cultural competence model is that the gaze remains on the patient as the bearer of culture. This fails to acknowledge that nurses are embedded in the norms and values common to the western, biomedical paradigm (Hestor, 2012). It becomes up to

Cultural safety is the next iteration in cultural theorizing. A more detailed discussion of cultural safety is provided later in this proposal. Cultural awareness, sensitivity and competence are all considered antecedents to cultural safety. Each have valuable tenets but are insufficient as stand-alone concepts to address care to diverse populations. The next section will highlight examples from the literature demonstrating this point.

Humanitarian Literature

Service-learning and Humanitarian Examples

According to O'Handley and Erlinger (2019) what is of critical importance in a service-learning opportunity is that students are provided with the ability to provide direct, hands-on care. There is no discussion on preparing students to work within the scope of their practice or in accordance with local laws. The authors suggest that screening questions for students should include questions about what the student has to offer toward a successful trip and how the trip

will contribute to the student's learning. The authors identify cultural immersion as a key component to the overall experience. For students to gain the most from the experience the authors suggest that students learn key phrases in the language of the host community and to learn the culture (O'Handley & Erlinger 2019). Suggesting that the host community has "a" culture and one language that can be learned serves to homogenize communities, perpetuates an 'us/them' discourse and implicitly conflates culture with race and ethnicity (Mkandawire-Valhmu, 2018). Amerson (2014) suggests choosing a destination based on course objectives. For example, if the objective is to raise awareness of global poverty, then "choosing a less-developed country" is appropriate (p. 177). This approach creates a simplistic dichotomy between high income and low-income nations that minimizes the poverty existent in many low-income communities. Amerson (2014) does not discuss problematizing the rhetoric of "developing" versing "developed" nations nor does she situate the current state of poverty in the context of larger socio-economic, political and historical events. Obscuring the complex factors that contribute to poverty, perpetuates faulty narratives about places perceived as destitute. The realities faced by communities facing abject poverty become divorced from the day to day experiences of Westerners (Müller, 2013).

Several articles cited the importance of reflection on behalf of the students during and after the experience but no guidance was offered on the nature of that reflection (Amerson, 2014; O'Handley and Erlinger; Murray 2016). During a service-learning trip to Guatemala students journaled about their appreciation for access to medical care as a privilege of U.S. citizenship. The authors and students' nursing instructors cited this as evidence that the students were engaging in reflection (Chen, McAdams-Jones, Tay, & Packer, 2012). In fact, this demonstrates that neither the students nor the instructors recognized the social locations that they occupied

within the U.S. that afforded them access to quality healthcare. Similarly, Saenz and Holcomb (2009) state that service-learning courses can be "life-changing" (p. 174) for nursing students who would otherwise would remain unaware of poverty. This further demonstrates how issues of power and privilege remain on the margins of nursing education.

Three studies recommended the use of photography or video journaling to enhance reflective practice for visual learners (Amerson, 2014; Chen, McAdams-Jones, Tay & Packer, 2012; Murray 2016). However, taking photos in these settings can be highly problematic. The Health Insurance Portability and Accountability Act prohibits students from taking pictures in clinical settings in the United States out of respect for patients' dignity and right to privacy. People seeking healthcare anywhere are entitled to the same rights. And yet images of global experiences are rife in blogs and social media. Photographs were encouraged to enhance students' reflections during the service-learning trip to Guatemala. The authors noted that the photographs also made for nice souvenirs for the students. The "American/Guatemalan" (p. 205) language barrier was cited as the reason why consent was not obtained from "the subjects" (p. 205) in the photographs (Chen, McAdams-Jones, Tay & Packer, 2012). Students opined that blurring the faces of people in their photographs did not allow for them to share their full story. This is an example of how, in the absence of critical pedagogies with explicit attention to racism and power dynamics, White privilege can be reinforced during service-learning trips. Brown and Schmidt (2016) would argue that that the work in the Guatemalan example is a misrepresentation of service-learning as reflections were not guided by matters of equity or social justice.

The images of dying AIDS patients and their soon-to-be orphaned children with flies in their eyes are ubiquitous in the calls for humanitarian volunteers (Friedus, 2017). These images are deleterious to both volunteers and the communities in which they work. In the Guatemalan

example, the authors cited a photograph of students holding hands with local children and the number photographs of people (opposed to scenery) as evidence that the students had formed meaningful bonds in the community (Chen, McAdams-Jones, Tay & Packer, 2012). In reality, genuine cultural experiences are rarely achieved and the superficial intimacy between volunteers and children masks the structural nature of inequalities (Friedus, 2017).

A recent study published in The Journal of Transcultural Nursing, (the journal and associated professional organization founded by Madeleine Leinigner), is an example of how faulty assumptions play out in humanitarianism. The article was authored by three doctoral prepared nurses conducting a pilot study with medical professionals preparing to travel to Haiti (Steinke, Riner, & Shieh, 2015). The authors explained that a two-hour cultural sensitivity training increased the providers' levels of cultural competence. However, the background and assumptions underlying this study render the results problematic. For example, Steinke, Riner, & Shieh (2015), state:

Generally, traditional cultures are authoritarian, they can be influenced by supernatural beliefs, the disruption in the balances of vital forces, and the belief that humans are bound by fate, whereas scientific cultures are individualistic, rely on logic, research methodology, statistical analysis, and outcomes (p. 429).

The authors go on to give examples of what Haitians believe with regard to various health conditions and how providers need to understand these beliefs in order to properly educate them. This is an example of what Hester (2012) calls "cultural determinism," where people from culture X always act like X" (p. 285). These assumptions served as the basis for the sensitivity training, which was completely lacking in the provision of any socio-economic, political or historical context.

Haitian Context

A nation of 10.6 million people, Haiti, by most measures of global health is a country struggling to meet the most basic of human needs (Central Intelligence Agency [CIA], 2019). The devolution of Haiti from the "Pearl of the Antilles" to the poorest nation in the Western hemisphere involves a complex web of colonialism, humanitarianism, natural disasters and foreign interference. To extract any one element in an attempt to assign blame for Haiti's economic state is to perpetuate the faulty claims of causality which comprise a significant portion of the popular press and academic literature to date.

History

Colonization of Haiti began in 1491 with the arrival of Christopher Columbus. Described by Columbus as "lovable, tractable, and peaceful," the Taino Indians did not fare well under the new system of peonage (Farmer, 1992). Less than fifty years after Columbus' arrival the native population was all but decimated; tens of thousands perished from disease, brutality and outright slaughter (Farmer, 1992). The growing plantation economy necessitated the replenishing of a populous workforce. By the late 1700s, Haiti was home to almost half of the slaves in the Caribbean (Farmer, 1992). Modern day Haitians are descendants of these slaves brought primarily from the West African nations of Dahomey (Republic of Benin) and Nigeria (Hood, 2018).

Haitian slaves successfully revolted and won their independence from France in 1804. But, fearing similar revolts, the United States first shunned, then politically and economically exploited Haiti through military occupations, pillaging of natural resources and financial assistance programs that decimated the public sector (Farmer, 1992; Sommers, 2015). All of these interventions have culminated in Haiti's dubious distinction as the "poorest nation in the

Western hemisphere." This moniker serves as the rallying cry for scores of humanitarian actors to descend upon Haiti in droves.

A number of scholars attribute Haiti's contemporary political and economic challenges to the impacts of neoliberal policies imposed by foreign entities (Fatton, 2015; O'Connor, Brisson-Boivin, & Ilcan, 2014; Pyles, Svistova, & Ahn, S, 2017; Ramachandran & Walz, 2015; Zanotti, Stephenson & McGehee, 2016). According to Fatton (2015) these policies have relegated Haiti to an "outer-periphery" and subjected the country to a self-appointed international community of non-governmental organizations (NGOs) and "peace keepers" (p. 35). The outer-periphery is maintained by low-end production, wages (if paid at all), that are grossly insufficient to meet basic needs, extremely high unemployment rates, a vast informal sector and lastly, a state unable to maintain sovereignty (Fatton, 2015). Under neoliberal policies, the centralization of services led to a burgeoning of the population in Haiti's capital, Port-au-Prince, as people migrated from the rural areas to find work. Even at the highest levels of operation, a mere eight percent of the population was employed, resulting in an informal economy that dominates Haiti's economy to this day (Dupuy, 2010). Under trade liberalization Haiti, once self-sufficient in agricultural production, became one of the leading importers of U.S. rice and other food items in the world. Displaced farmers relocated to Port-au-Prince or left the country altogether (Dupuy, 2010).

Health Sector

In 1991, 90% of Haitian clinics were operated by mission groups or NGOs (Schuller, 2012). The Haitian state was further weakened by United States policies in the late 1990's which forced the United States Agency for International Development (USAID) to fund NGOs and not the Haitian government (Schuller, 2012). At the time of the devastating earthquake in 2010, approximately 10,000 NGOs were operating in Haiti. Privatization, another tenet of

neoliberalism, resulted in the proliferation of private nursing schools in Haiti. There are approximately 400 nursing schools in Haiti (USAID, 2014) of which only 35 are accredited by the Ministry of Health (Clark, Julmisse, Marcelin, Merry, Tuck & Gagnon, 2015).

Forty percent of the population does not have access to basic health services; less than one half of all children are fully vaccinated and almost a quarter of children under the age of five are stunted (United States Agency International Development [USAID], 2017). Health represents just six percent of government expenditures (USAID, 2017). There are approximately 6.4 nurses, doctors and midwives per 10,000; a ratio woefully below what the World Health Organization deems as adequate (23/10,000) to meet the healthcare needs of a population (Clark, Julmisse, Marcelin, Merry, Tuck & Gagnon, 2015). The nursing shortage in Haiti is linked to a number of factors including out migration of skilled professionals and a lack of investment in education (Clark, Julmisse, Marcelin, Merry, Tuck & Gagnon, 2015). The expatriation rate of Haitian nurses to higher income countries is estimated at 94% (Clark, Julmisse, Marcelin, Merry, Tuck & Gagnon, 2015).

In August 2019, United Nations Children's Fund (UNICEF) reported that the economic and political situation in Haiti had significantly deteriorated over the course of 2019. In February, civil unrest culminated in protests that resulted in a 10-day lockdown of the entire country. Fueling the unrest is double-digit inflation and a depreciation in the value of the national currency by approximately forty percent (United Nations Children's Fund, 2019). Between 2018 and 2019 the number of Haitians facing severe food insecurity doubled, affecting 25% of the population (European Commission, 2019).

Power Relations

Creating caricatures of the "Other" was a strategy of U.S. colonialism/imperialism (Hood, 2018; Sommers, 2016). The unquestioned consumption of these stereotypes remains prevalent in the U.S. (Delgado and Stephancic, 2017). Rarely do the stories spun about the global south originate from the people from and living in the global South (Bell, 2001). In the case of Haiti, Haitian voices have been relegated to the margins and their images created from sensationalized tales (Bell, 2001; Hood, 2018).

The creation of race-based stereotypes began early during the colonization of Haiti and have persisted over time. An early example is found in the writings of Sir Spencer St. John, a British diplomat, who depicted Haitians as uncivilized, cannibalistic and "intolerably stupid" (as cited in Farmer, 1992, p. 238). Despite the subsequent debunking of his alleged claims, St. John's book became a bestseller and he went on to publish a sequel with even more fantastical claims. His views of the Black inhabitants of Haiti can be summed up with this statement:

As a rule, the abler a negro is, the more wicked and corrupt he appears…I now agree with those who deny that the negro could ever originate a civilization, and that with the best of education he remains an inferior type of man. (as cited in Hood, 2018, p. 6).

In the wake of the 2010 earthquake in Haiti, one in which it is estimated over 200,000 lives were lost, the media zeroed in on the common narrative of Haiti as a 'pitiful state.' Despair and turmoil became synonyms for Haiti. In contrast to Haiti's despair and turmoil were the images of compassion and the appeals to the best of human nature as depicted in western media. These dichotomies were not new but had been planted, cemented and reinforced firmly in the U.S. psyche for centuries. Balaji (2011) makes a point in his article to distinguish between empathy – a value laden emotion (equity) and sympathy – an emotion in which the "pitying hold

power over the pitied" (p. 251). Representations of Haitians and other non-white people groups, stoke images of an exoticized "Other," and help to establish pity, as opposed to social justice, as the predominant emotion driving humanitarian interventions (Müller, 2013).

The days and weeks following the earthquake became a media sensation in large part due to a successful one-dimensional portrayal of 'pitiful' victims amidst all out chaos (Balaji, 2011). This flattening of the actual events made it all the more palatable to a white audience who were then, driven by a sense of charity, eager to donate money (Balaji, 2011). American media outlets continue to portray images that reinforce adult/White and child/Black/Other depictions despite the fact that people of color make up the largest audience of global media (Balaji, 2011). This is an example of how the powerful maintain power by driving the narrative even when in the numerical minority.

Pity, may seem harmless and even compassionate but in reality, it strengthens positions of power and privilege (Balaji, 2011). Despite the best of intentions, compassion can easily morph into a mechanism of oppression as stereotypes drive perceptions of local capabilities (Barnett, 2014). Balaji (2011) rightfully asks that if the objects of our pity were seen any other way would that not mean we would then have to view them as equals? Just as critical race theory contends (Delgado & Stephancic, 2017), race continues to underpin most of our daily discourses as well as the emotions evoked by images of suffering, thereby racializing our collective responses (Balaji, 2011). This particular form of pity highlights the power dynamics that have long conferred white privilege at the expense of the racialized 'Other.' While subtle in everyday life, these dynamics become more overt in the aftermath of catastrophic events like the Haiti earthquake (Balaji, 2011). Mars (2016) study of Swedish citizens volunteering in the aid of migrant refugees is further demonstration of the intersection of good intentions and the privileges of social location.

The volunteers made mention of the comforts that they were giving up in order to engage in relief work. This demonstrates the power volunteers have in choosing whether or not to subject themselves to discomfort (Mars, 2016). This positions the volunteers squarely in the role of altruistic helper in contrast to the refugees' roles as victim (Mårs, 2016).

To mass audiences witnessing large catastrophes, expressions of empathy are more socially acceptable than apathy. As in the Mars (2016) study, volunteers saw themselves as compassionate; driven in part out of guilt for a history of colonialism which created the inequities that gave to these circumstances (Mårs, 2016). However, the volunteers' acts, when motivated by guilt, should not be viewed as empathic but rather an extenuation of the unequal relationship between those who are in a place of suffering and those who are not (Mårs, 2016). Critical race theorists Delgado & Stefancic (2017) refer to this as "the empathy fallacy" (p. 33) whereby audiences rarely have meaningful interactions with victims who occupy social locations very different from their own. Without the critical questions that cultural safety and critical race theory require us to consider, these experiences can serve to only deepen problematic beliefs and stereotypes. It is here where critical race theory and cultural safety can inform our responses. Both concepts require a proximity in order to elicit the stories or counter-narratives of those experiencing stereotyping or marginalization (Delgado & Stefancic, 2017).

Mirroring Interactions

An article in the Christian Science Monitor (2013) entitled "In Haiti, the laws of physics meet the culture of magic" provides an anecdote in the aftermath of the earthquake as to how these stereotypes and power dynamics continue to play out. Fallon (2013) describes Haitians as "benignly stubborn, corrupt and backward (para 20)…remarkably strong, work site camaraderie is deep, and displays of physical prowess abundant" (para 8). Throughout the article he

infantilizes Haitians and easily dismisses local knowledge and expertise as little more than amusing.

Another example is in an article by Murray (2016). In addition to holding a PhD, Dr. Murray is an advanced practice nurse and has traveled extensively in impoverished countries providing pediatric health care services. In his recent publication, Murray (2016) extols the value of short-term medical mission trips stating that they are "undoubtedly of great value" (p. 22), in that they provide not only much needed services but can instill hope in the community and that the communities are grateful for the help. Murray provides no evidence in the form of quotes from actual community members to support this claim. This is an example of how the power structures dictating humanitarian efforts result in the "silencing and neglect of the recipients" (Barnett, 2014, p. 14). Research eliciting the voice of the community in which help is received paints a different picture. An anthropologist, Beckett describes humanitarian care from the Haitian point of view in the aftermath of the 2010 earthquake. Beckett quotes a community leader in an internal displacement camp "All of these foreigners—why are they here? They come and go. They wave food all around. We sniff at it but we don't get it. They treat us like animals. Haitians are dogs now" (p. 36). Beckett explains that among Haitians, dependency on fellow humans is part of what it means to be human but the way in which humanitarian care is delivered is dehumanizing.

Frameworks: Cultural Safety and Critical Race Theory

Cultural safety (CS) coupled with Critical Race Theory (CRT) provide a useful framework with which to explore the interactions between nurses from the Global North and citizens of the Global South in the context of humanitarianism. This concept (CS) and the larger theory (CRT), with explicit attention paid to power dynamics, are particularly salient in this

context as interactions between humanitarian actors and their beneficiaries are deeply influenced by the remnants of colonialism.

Cultural Safety

The concept of cultural safety derives from post-colonial New Zealand. A study commissioned by the Ministry of Health in the 1980's revealed that, despite unalienable Treaty rights, the Native Maori were experiencing significant health disparities compared to their counterparts of European descent (Papps & Ramsden,1996). In response to these disparities, Maori nurses led by nurse scholar Irapheti Ramsden, called for a paradigm shift in the delivery of healthcare services (Ramsden, 1993). Ramsden introduced the concept of cultural safety in her dissertation and by 1992, it was a required component of all nursing and midwifery curricula in New Zealand (Papps & Ramsden, 1996). The Nursing Council of New Zealand (2011) defines cultural safety as a process by which:

The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognize the impact that his or her personal culture has on professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual (p. 7).

In providing humanitarian nursing care in Haiti, nurses are working in a context rife with health inequities and heavily influenced by centuries of power dynamics between Haiti and the United States. Thus concepts that draw attention to root causes are required for nurses to meet their ethical mandates to address health inequities.

The concept of cultural safety is grounded in several key tenets; each are discussed next.

Definition of Culture

Cultural safety defines culture in the broadest sense to include the multiple identities individuals embody (Darroch et al., 2017). Such identities include (but are not limited to): gender identity, sexual orientation, educational attainment, religion, and socioeconomic status. This is important, because conflating culture with race and ethnicity obscures the wide ranging and fluid nature of characteristics that define human beings at any given time (Drevdahl, 2018). Ramsden (1993), in constructing cultural safety, recognized that nursing care cannot be provided irrespective of the multiple identities that patients embody. How we view ourselves, what we hold most dear and the daily transactions in which we engage to preserve what is most important are at the core of human existence.

Strength-based

Cultural safety is a strengths-based approach which focuses on improvements in health and health outcomes (Nursing Council of New Zealand, 2011). This is a retort to the western biomedical paradigm which focuses primarily on symptoms, illness and disease (Reimer-Kirkham, Baumbusch, Schultz & Anderson, 2007).

Self-reflection

To practice with cultural safety requires the nurse to acknowledge that differences in health beliefs and practices are influenced by a number of cultural identities as defined above. Practicing with cultural safety requires that nurses not only acknowledge differences in values, beliefs, and traditions but respect them as equally valid as their own (Hughes & Farrow, 2007; Mkandawire-Valhmu, 2018; Papps & Ramsden, 1996; Phiri, Dietch & Bonner, 2011; Randall, Munns & Shield, 2013, Woods, 2010). A model utilizing cultural safety developed by Woods and Schwass includes a set of mnemonics, the "3 Rs," which stand for revise, respect and rights

(Anderson et al., 2003; Richardson, Yarwood & Richardson, 2017). In this context, respect refers to the practitioner respecting, preserving and nurturing patients' unique experiences while simultaneously recognizing that they are situated in larger cultural contexts (Anderson et. al, Harrowing, Mill, Spiers, Kulig, & Kipp 2010; Richardson, Yarwood & Richardson, 2017).

Patients are not the only bearers of culture but the nurse is as well and therefore must be aware of his/her/their own worldviews and social locations (Ramsden, 1993). This requires ongoing personal reflections in order for the nurse to continually recognize his/her/their own cultural realities. The nurse must be able to not only acknowledge these realities but also appreciate how they may affect their interactions with patients at any given time.

Attention to Power

In addition to personal reflections the nurse must undertake power analyses of institutional and societal structures. In market-based healthcare, systems are biased toward the healthcare provider and create unequal dynamics between the provider and patient ((Nursing Council of New Zealand, 2011). The institutionalization of "competence" within the medical field was one way for practitioners to establish a standard of expertise. This was key to the professionalization of many disciplines within the biomedical paradigm (Kirmayer, 2012). "Competent" practitioners thereby have the authority over those (namely patients) deemed less competent allowing for the provider to dictate how and which services are provided (Kirmayer, 2012).

Historical and Political Contexts

Inequalities in the healthcare system are microcosms of inequalities in the larger society. These inequalities date back to the colonial project in which racialized hierarchies were established to subjugate non-white populations. Native Americans experienced diseases

introduced by colonists, sometimes the result of incidental contact and other times the result of purposeful exposure, for which they had no prior immunity or treatments (Struthers & Lowe, 2013). As a result, Native Americans sought medical care from the colonists. Seizing upon the opportunity, the colonists negotiated an exchange of land as means of payment for the medical services rendered (Struthers & Lowe, 2013). In Haiti, French colonists used medicine in order extract more labor from slaves and to create a subjective narrative about the experiences of slave illness. This served to quell slave resistance and protect slave owners from revenge (real or imagined) sought by the slaves (Brodwin, 1996). Volunteer medical groups have roots in missionary work and colonization. Doctors from European nations were deployed to Africa to tend to the troops and Christian beliefs about the uncivilized native served as reason for white European to impose their values (Bauer, 2017; Melby, Loh, Evert, Prater, Lin, & Khan, 2016).

Patient's Perspective

A tenet unique to cultural safety in relation to other cultural concepts, is that the evaluation of culturally safe practice is determined solely by the patient. The recognition that the patient's perspective is of the utmost importance began with Ramsden's introduction of the concept and has remained a constant theme in the literature and in practice by culturally safe nurses (Brown, Middleton, Fereday & Pincombe 2016; Crameri, Barrett, Latham & Whyte, 2015; Papps & Ramsden, 1996; Richardson, Yarwood & Richardson, 2017; Woods, 2010). When culturally safe care takes place, the patient will feel empowered to engage in shared decision-making with the care provider (Josewsk, 2012; Main, McCallin & Smith, 2006). The dismantling of power imbalances in individual nurse/patient interactions is one step toward achieving health equity.

Orientation to Praxis

Cultural safety has its roots in critical and emancipatory perspectives and as such an orientation toward practice is an inherent component of work undertaken with this lens (Doutrich, Dekker, Spuck, & Hoeksel, 2014; Duke, Connor, & McEldowney, 2009). Nursing scholars who are well versed in cultural safety see it as a lens through which knowledge can be translated into nursing practice as the converging vulnerabilities affecting patients are illuminated (Browne, Varcoe, Smye, Reimer-Kirkham, Lynman Wong, 2009).

Critical Race Theory

Critical Race Theory (CRT) derives from legal studies, and is a movement by scholars and activists interested in analyzing and ultimately reconfiguring the relationship between race, racism and power (Delgado & Stephancic, 2017). Critical race theory is grounded in several key assumptions.

The Nature of 'Race'

First and foremost, central to CRT is the understanding that race is a social construct and has no basis in genetics (Gillborn, 2015). Historians documented the invention of race during the 16th century as a way of describing different people groups in North America (Smedley & Smedley, 2005). The invention of race was a way of categorizing human differences to justify the enslavement of Africans. To subjugate humans to slavery ran counter to the prevailing philosophies of Christianity, freedom and democracy (Smedley & Smedley, 2005). Therefore, the relegation of Africans to something less than human was necessary to establish and maintain political and social hierarchies.

From the days of colonialism until the 20-century, scientists were commissioned to validate fabled beliefs about human differences based in racial ideology (Smedley & Smedley,

2005). Research ranging from measuring skulls and brain size and the administration of intelligence tests set out to prove the inferiority of 'non-white' races (Smedley & Smedley, 2005). At the turn of the 21st century the Human Genome Project was completed providing evidence that there are no genetic distinctions between races (Duster, 2015). Of particular interest to critical race scholars is how, in light of this information, the notion of immutable differences based on categories of race still persists (Delgado & Stephancic, 2017). "The USA is the only country in the world that, as public health policy, does not operate on the assumption of the single standard human" (Duster 2015, p.4).

In understanding race as a social construct, critical race theorists also recognize "whiteness" as a category that comes with its own set of socially ascribed traits. The experiences of white people are considered the 'norm' and baseline from which all others are measured and often, according to this power-holding group, fall short (Gillborn, 2015). To be clear, CRT is not an indictment of white *people* but rather a critique of the *systems* that have been created by white people to privilege white people (Gillborn, 2015).

Ubiquity of Racism

Critical race theory reframes our understanding of prejudice and discrimination from personal biases and individual acts to phenomena that are insidious and structural in nature (Blanchet Garneau, Browne & Varcoe, 2018). Critical race theorists understand white supremacy does not exist on the fringes of society but is embedded in the everyday order of modern day U.S. society (Henry, 2018). Even individuals who outwardly decry racism become complicit in its perpetuation as the mechanisms of structural racism become normalized and invisible to the dominant society (Blanchet Garneau, Browne & Varcoe, 2018).

Centering on the Margins

Critical race scholars believe that understanding the lived experience of people experiencing racism is essential to knowledge development. This knowledge is often elicited through the use of stories for use to counter dominant narratives about people of color (Delgado & Stephancic, 2017). In this framework, the voices of those relegated to the margins of society become the center from which knowledge is gained in an effort to dismantle racist structures (Delgado & Stephancic, 2017). In addition, honoring the lived experience as valid knowledge can unleash individual and collective agency necessary to break cycles of oppression rooted in institutionalized "isms"(Collins, 2000).

Race Consciousness

Critical race theory, challenges the dominant narrative that nursing and humanitarianism make with regard to objectivity and colorblindness. Critical race theorists aim to dismantle (neo)liberal discourses, including colorblindness and meritocracy, by making explicit the role of race/racism in contemporary society (Delgado & Stephancic, 2017). The concept of colorblindness is part of a (neo)liberal ideology allowing white people to explain racism and racial phenomena while at the same time denying its oppressive realities (Bonilla-Silva, 1997). Meritocracy, or "the American Dream" whereby individuals are successful because of intrinsic motivation and hard work, was initially an economic principle that has permeated all aspects of U.S. life (Keshavjee, 2014). This perspective, a hallmark of neoliberalism, does not consider the existence of structural racism as a factor that hinders opportunities for minority communities (Bailey, Krieger, Agénor, Graves, Linos, & Bassett, 2017). Critical race theorists challenge a revisionist history in which everyone, by way of living in the United States, begins from a level

playing field and are therefore afforded the same opportunities to reach their full potential (Delgado & Stephancic, 2017; Gillborn, 2015).

Intersectionality

While racism is central to exploring power dynamics using critical race theory, CRT scholars recognize how identity categories overlap and the various power configurations they confer because of the context in which they occur (Van Herk, Smith & Andrew, 2011). Intersectionality theory, deriving from Black feminist scholarship, emphasizes that the root causes of marginalization cannot be reduced to one specific oppression (e.g. race, class or gender), but rather must include an overall analysis of how power functions to create a matrix of intersecting oppressions (Collins, 2000). Thus, intersectionality challenges the notion of established binaries that have come to dominate nursing and humanitarian discourses. This is particularly relevant in humanitarian discourses that tend to homogenize people in the Global Soth as simply poor.

The African American Policy Forum's definition of intersectionality is helpful in applying this concept in practice:

Intersectionality is a concept that enables us to recognize the fact that perceived group membership can make people vulnerable to various forms of bias, yet because we are simultaneously members of many groups, our complex identities can shape the specific way we each experience that bias. For example, men and women can often experience racism differently, just as women of different races can experience sexism differently, and so on (as cited in Gillborn, 2015, p. 278).

These intersections need to be acknowledged when looking to reconfigure systems in favor of a more equitable society (Gillborn, 2015).

Critical Race Theory and Cultural Safety

Congruent with investigations of transcultural pedagogies in nursing, there is an opportunity for the addition of more critical discourses to the cultural competence model; including explicit inclusion of racism and other forms of structural violence (Blanchet Garneau, Browne & Varcoe, 2018). Critical race theory in conjunction with cultural safety provide a robust framework; each adding vital components that are absent when each is used independently.

Within nursing there is a need to reframe racism as a structural phenomenon as opposed to narratives that depict it as an individual attitude, bias or character flaw (Blanchet Garneau, Browne & Varcoe, 2018). Browne, Varcoe, Smye, Kirkham-Reimer, Lynam and Wong (2009) worry that the term "cultural safety" is ambiguous enough to sugar coat or gloss over issues of race and racism. Engaging with critical race theory does not allow for this to happen as race and racism are at the center of all inquiry. The documentation and explicit discussion of inequitable power relations are normalized when utilizing CRT and CS.

Centering on the margins is a key component of critical race theory. Utilizing cultural safety is respecting this tenet. This concept, developed from the vantage point of the colonized, challenges notions of culture, power, knowledge and truth as commonly understood and taught in U.S. nursing schools.

The ethical views provided by critical theories and concepts, like CRT and CS, remind us to keep the oft-masked power relations influencing our interactions squarely in the purview of our practice (Anderson, Rodney, Reimer-Kirkham, Browne, Khan, & Lynam, 2009). The gaze is shifted from the essentialized "Other" inward. Nurses must acknowledge the power they are afforded by way of their education and the value placed on the care that they offer.

As CRT and CS inform us, these power relations are not limited to those between the proverbial us and a racialized Other as dictated by traditional narratives of the global north in relation to the global south. Rather an intersectionality lens, as key to both CRT and CS, allows nurses to consider the fluid and dynamic nature of human identity as well as the historical and time-bound contexts that contribute to individual and collective experiences of health, wellness, illness and dying. (Van Herk, Smith & Andrew, 2011).

Conclusion

While nursing has embraced the incorporation of cultural considerations into the delivery of care, the traditional model of cultural competence has proven inadequate in the deconstruction of discourses that perpetuate inequities as evidenced by burgeoning disparities. The western, bio-medical, positivist paradigm to healthcare delivery is failing within and across U.S. borders for populations experiencing marginalization. Nowhere is this more true than in Haiti where thousands of humanitarian healthcare workers have been volunteering for decades and yet meaningful change has remained elusive.

Explicit explorations of the social construction of race and its role in creating and maintaining power structures are essential in nursing and humanitarian discourses. Nursing would be well-served to engage critical race theory and cultural safety to better understand how humanitarian nursing and service-learning opportunities operate against a backdrop of white supremacy (Henry, 2018). The tenets of CRT and CS together offer tools to engage in a nuanced understanding of the relationship between culture and heath; an unpacking of the “dynamics of oppression and privilege” (p.1454) with the ultimate goal of dismantling structural inequities, like racism (Blanchet Garneau, Browne & Varcoe, 2018).

In the context of Haiti, critical race theory and cultural safety will assist volunteers in seeing Haitians not as a monolithic group, but rather as individuals with fluid and dynamic identities who share collective experiences. The power-sharing and orientation to praxis aspects of CRT and CS demand that knowledge about Haiti, its history, and the legacy of colonialism, be used to deliver humanitarian and nursing care in partnership with local communities. If humanitarian spaces, currently occupied by the beneficiaries of white privilege, are emancipated, then perhaps health can truly be realized as a human right and health inequities eliminated.

Chapter III: Methods

This study was guided by Critical Race Theory (CRT) incorporating the concept of cultural safety (CS). The study was conducted in two parts. First, I analyzed blog posts in the public domain written by nurses in the United States (U.S.) who have participated in a volunteer medical trip to Haiti. Secondly, I conducted face-to-face interviews with U.S. nurses who have completed at least one volunteer medical trip to Haiti. Each of these parts is discussed in greater detail below. I intended to also conduct focus-group interviews conducted in Haiti to gain the Haitian perspective. I was unable to travel to Haiti during the course of this study due to political instability in Haiti and the COVID-19 pandemic.

Part 1: Netnography

Known as netnography, the study of culture and community originating from online interactions has grown exponentially since its inception in the 1990s (Costello, McDermott, & Wallace, 2017). A Google Scholar search from 2015 – 2019 using the term "netnography" yielded 5,420 results; just slightly less than 2000 for the entire two and a half decades prior. Additional searches (2015-2019) adding another search term relevant to my study yielded the following results: netnography and health = 2790; netnography and culture = 4610; and netnography and humanitarianism = 31.

Despite the physical separateness of the researcher from the participants, netnography is an avenue through which to socially and emotionally engage participants (Costello, McDermott, & Wallace, 2017). Data originating online has a number of advantages over data obtained via traditional research (Burles & Bally, 2018). First, what online authors share reflects what is of importance to them and not prompted by the interests of the researcher. Secondly, the unobtrusive nature of netnography helps to control for reaction bias that can occur when

participants are aware that they are being studied. As unsolicited and naturally occurring, the accounts shared by online authors have the potential to elucidate in-depth meaning to personal experiences (Burles & Bally, 2018).

Ethics of Netnography

The American Psychological Association, The British Psychological Society and the Association of Internet Researchers have published guidance documents for research conducted online (Roberts, 2015). One of the most widely debated issues is that of consent. Absent strict guidelines, researchers are asked to consider the sensitivity of their research and whether the content is in the public domain in determining whether or not consent is necessary (Burles & Bally, 2018). There are a number of steps that I will outline in the Institutional Review Board application to address ethical issues associated with netnography.

The website from which analyzed blog posts are considered public domain as they were 1) accessible to the general public, 2) the posts by members are not password protected nor do they require viewers to register with the organization, 3) the topics shared on the website are not considered highly sensitive, and 4) the intended audience is other nurses who are looking to engage in humanitarian work.

I remained mindful of the unintended consequences of using blog posts to critique current discourses within the humanitarian nursing sector. These nurses, not unlike myself, are engaging in this work with best of intentions of helping others experiencing poor health and are doing so using the tools with which their nursing education has equipped them. Therefore, I took steps to protect the anonymity of the bloggers as suggested in the guidance documents. First, I did not use the name of the website from which I retrieved the blog posts (Roberts, 2015). I paraphrased and created composites stories based on the common phrases and themes contained in the blog

posts (Burles & Bally, 2018; Roberts, 2015). Lastly, I used search engines to check my composite stories and quotes for traceability (Burles & Bally, 2018; Roberts, 2015).

Part 3: Semi-structured Interviews

As qualitative methods became more common, health researchers increasingly used the in-depth interview to recreate experiences related to health and the delivery of healthcare as perceived by the participant (Dicicco-Bloom & Crabtree, 2006). In-depth interviewing is a means by which researchers demonstrate humility and a genuine interest in the story of another human being (Seidman, 2006). Semi-structured interviews are the most common format used in qualitative research. Semi-structured interviews are designed using a set of scripted, open-ended questions (Dicicco-Bloom & Crabtree, 2006). The researcher might introduce additional questions as the interview is taking place. This type of interview is most often used for single one-on-one interviews and can last anywhere between 30 minutes to several hours (Dicicco-Bloom & Crabtree, 2006).

The interview begins from the moment of introductions. Establishing rapport with the interviewee is essential to a quality interview. Dicicco-Bloom & Crabtree (2006), describe the phases that generally transpire in the process of establishing rapport. The first stage, apprehension, is the result of the unfamiliarity of the interview setting for both researcher and participant (Dicicco-Bloom & Crabtree, 2006). The goal moving through this phase is to encourage the interviewee to share their story openly (Dicicco-Bloom & Crabtree, 2006). To facilitate progression through this stage, the interviewer may repeat the initial question placing emphasis on certain aspects. The interviewer should allow ample time for the interviewee to think about the question before responding (Yeo, Legard, Keegan, Ward, Nicholls & Lewis, 2014). The interviewer can also reflect back to the participant using the participant's own words,

being careful not to summarize (Yeo, Legard, Keegan, Ward, Nicholls & Lewis, 2014). This allows for clarification without leading the respondent to give the desired responses or making assumptions (Dicicco-Bloom & Crabtree, 2006).

The second phase is exploration and occurs when the interviewee becomes more engaged and a sense of bonding and sharing occurs between the interviewer and interviewee (Dicicco-Bloom & Crabtree, 2006). The interviewee should be the one doing most of the talking at this point. The interviewer is engaging in active listening; listening intently while keeping the overall objectives in mind, asking probing questions or redirecting when necessary (Yeo, Legard, Keegan, Ward, Nicholls & Lewis, 2014). Next, the co-operative stage is one where trust is such that the participant feels comfortable correcting the interviewer as the interviewer engages in clarification (Dicicco-Bloom & Crabtree, 2006). This is also the stage during which the researcher may ask questions of a more sensitive nature (Dicicco-Bloom & Crabtree, 2006). As the time allotted for the interview approaches, the interviewer can signal to the interviewee that there are a few minutes remaining and ask if there are any additional thoughts or comments to be shared (Yeo, Legard, Keegan, Ward, Nicholls & Lewis, 2014).

Ethics

Despite numerous theoretical perspectives and methodologies in qualitative inquiry, researchers agree upon a set of ethical guidelines and codes including: obtaining informed consent, conducting research free from coercion and unreasonable requests, preparing for unintended risks and preserving confidentiality (Webster, Lewis, & Brown, 2014).

Consent (Appendix).

Written consent was obtained from participants prior to the start of each interview. Participants were informed of: the purpose of the study, measures to ensure confidentiality, and

that participation is strictly voluntary. Participants were also informed that they had the right to stop the interview at any time without repercussion. They were also informed that they had a right to not respond to any questions if they choose not to.

Confidentiality.

I assiged each interviewee a number to which all of their responses will be associated. No other identifiable information will be connected to their statements. The audio recordings were kept in my possession of researcher and saved to a password-protected computer. The transcribed interviews were stored on a password protected computer and accessible only to myself and the research committee. The transcribed interviews were deleted upon completion of the study.

Potential Risks.

One ethical consideration is the risk of unintended harm to the participant (Dicicco-Bloom & Crabtree, 2006). The interviewer's role is to engage in active listening, elicit stories and reflect back to the interviewee what they're learning. As this reflection occurs the interviewee may experience unexpected thoughts or emotions (Dicicco-Bloom & Crabtree, 2006). For example, if the interviewee witnessed a bad outcome or experienced extreme poverty for the first time and had not processed these events, the interview may trigger unexpected reactions. Without adequate support and follow up, these reactions may result in emotional distress for the participant. The researcher needs to be prepared to provide resources for psychological support (Dicicco-Bloom & Crabtree, 2006). In the case of my study, this included providing the participant with resources to further process these experiences with a mental health professional, clergy member or other trusted person well versed in health, social, and economic disparities. No such incidents occurred over the course of the study.

Transparency.

Another ethical concern involves how clearly the intent of the research study is communicated to participants (Dicicco-Bloom & Crabtree, 2006). This poses unique ethical dilemmas for me as the researcher and a member of the culture-sharing group. First, it was not my intent to elicit these stories from nurses, who are certainly well-intentioned in their efforts, only to publicly shame them for holding views that are rife in nursing practice. Secondly, it was important for me to share my own personal journey so as not to sound self-righteous or hypocritical. It was a delicate balance to inform the participants of the nature of my research while not positioning them to alter their responses to sound politically correct.

Recruitment

Nurses who have participated in a least one volunteer trip to Haiti were recruited to participate in an individual interview from websites that offered volunteer experiences for nurses (e.g., Project Medicare, Community Health Initiative Haiti, Mission of Hope Haiti, One Nurse at a Time). As the researcher, I emailed the volunteer coordinators at each of these organizations to request assistance with participant recruitment. I conducted virtual, on camera interviews with 16 participants and two interviews via phone. Ritchie, Lewis, Nicholls & Ormston (2014) cite numerous qualitative scholars who advise that sample sizes for individual interviews should number between 12 and 60. These interviews were audio-recorded and transcribed by the researcher.

Demographic Data

The following demographic data was be collected: age, highest nursing degree held, years in practice, practice setting, gender, race/ethnicity, and history of international volunteer experiences (nursing related).

Anticipated Sample Demographics.

I anticipated that the study sample would be comprised primarily of white, females holding a baccalaureate degree or higher in nursing and working in the hospital setting. This was based on the results of the National Council of State Boards of Nursing (2018) nursing workforce survey. According to the survey, ninety-one percent of registered nurses identified as female, the majority of whom (64%) had, at minimum, a baccalaureate degree. Racial and ethnic minorities account for approximately 19% of the nursing workforce despite comprising 39% of the U.S. population in 2017 (National Council of State Boards of Nursing, 2018). Fifty-five percent of the responding registered nurses reported the hospital setting as their place of primary place of employment (National Council of State Boards of Nursing, 2018).

Interview Guide

I used the following questions and prompts during the semi-structured interviews with participants:

Question 1: Tell me about your decision to volunteer in Haiti. Prompts: Why was that important for you to do?

Question 2: Tell me about your experience volunteering in Haiti. Prompts: What was the setting in which you worked? What was your primary role?

Question 3: Tell me how you came to volunteer with the X organization?

Question 4: How did you prepare for your trip?

Question 5: How did your experience compare to what you were expecting?

Question 6: What is your understanding of the relationship between Haiti and the United States?

Question 7: What was your experience as a white nurse working in a majority black country?

Question 6: Tell me about your experiences in the United States working with patients of backgrounds different from your own? Prompts: What are the demographics of patients you work with? Describe what providing culturally competent care looks like.

Question 7: What, in your opinion are the most important factors impacting health?

Question 8: As nurses, what do you feel our responsibility is in improving the health in our patients, our communities and globally?

Data Analysis

Each part of this study involved analyzing texts (blog posts) and transcripts of individual and interviews. I utilized thematic analysis as the method of analysis.

Thematic analysis involves the identification of shared patterns of behavior or language exhibited by the participants, which the researcher then categorizes into themes (Aronson, 1995; Creswell, 2007). Leininger (1985) stated that identifying themes is "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (as cited in Aronson, 1995, p. 2). The next step is to organize all of the data according to these themes. Themes are expounded upon and further grouped into sub-themes (Aronson, 1995). Patterns become obvious to the researcher as themes and sub-themes are catalogued; ultimately providing a comprehensive picture of the culture-sharing group (Aronson, 1995). In order to make a case for the selection of themes, the researcher incorporates what is known about the phenomenon from the literature (Aronson, 1995). It is at this point that the researcher begins to tell the overall story. This "cultural portrait" (Creswell, 2007, p. 72) reflects the voice of the participants (etic), the researcher (emic) and the extant literature. In the case of my study, the

goal was to engage the reader with a compelling narrative that ultimately causes them to challenge the dominant narratives dictating the delivery of nursing care in Haiti.

Scientific Rigor

In 1985, Lincoln and Guba introduced new terminology, namely trustworthiness, in an effort to reconcile the longstanding tension between qualitative methods and quantitative standards of scientific rigor (Denzin & Lincoln, 2018). The standards associated with trustworthiness are still widely used by qualitative researchers and guided my research. I describe each component next.

Transferability

Also referred to as "fit," transferability is achieved when the research findings meet three criteria: context, meaningfulness, and data-derived. In terms of context, the findings of the study should be applicable to settings outside of the original study site (Sandelowski, 1986). Researchers conducting a similar study or practitioners looking to implement the recommendations in comparable settings can expect to experience similar results (Sandelowski, 1986). Collecting detailed demographic information from the study participants enhanced the transferability for my findings.

Meaningfulness has been achieved when the researcher presents a cogent, believable and relatable story that speaks to the reader (Sandelowski, 1986). Feedback from my committee members, whose professional expertise include working with diverse populations and teaching critical theories, was an indication of transferability.

Lastly, data-derived means that the findings can be supported by the experiences of the participants, including those that may deviate from what is seemingly a "typical" experience (Sandelowski, 1986).

Dependability

Dependability is determined by how thoroughly the researcher has documented all of the research decisions (Hall & Stevens, 1991). Written decision trails provide the reader with the rationale for each of the decisions and interpretations made by the author throughout the research process (Denzin & Lincoln, 2018). This allows the reader to ascertain whether the conclusions and recommendations are congruent with the theoretical framework(s) and are supported by the data (Hall & Stevens, 1991).

Credibility

Credibility refers to the ability of the researcher to present a cogent, believable and relatable story that speaks to the reader. The reader is transported into the world of the author and is able to see the experience from their vantage point (Ellis, Adams & Bochner, 2011). The use of triangulation is a method I used to enhance credibility.

Triangulation.

Researcher and evaluation expert Michael Quinn Patton (1999) describes the value in triangulation as based on, "the premise that no single method ever adequately solves the problem of rival explanations" (p. 1192). I utilized two types of triangulation as described by Patton (1999): theory and sources triangulation. Source triangulation involves the use of multiple sources such as: observation, reflection, interviews, literature reviews, and assemblage of other artifacts (Chang, 2016; Patton, 1999). Using multiple sources of data enhances the collection of rich, authentic, and trustworthy data (Hall & Stevens, 1991; Chang, 2016). In the case of my study was achieved by interviewing nurses analyzing blog posts.

Theory triangulation involves the use theoretical frameworks that derive from different disciplines. I utilized critical race theory (legal studies) and cultural safety (nursing) to guide this

study. I discussed the advantages of using CRT and CS together in the first two chapters of my proposal.

Chapter IV

Manuscript 1: Humanitarian nursing in Haiti: An analysis of blog posts from nurse volunteer

The first manuscript reports the findings of blog posts from nurse volunteers in Haiti It is formatted based on the author's guidelines for *The Journal of Sustainable*

Title. Humanitarian nursing in Haiti: An analysis of blog posts from nurse volunteers

Key words: humanitarian, cultural safety, critical race theory, nursing

Manuscript 1: Humanitarian nursing in Haiti: An analysis of blog posts from nurse volunteer

Abstract (200 words)

Haiti has been labeled with the dubious distinction as the "republic of non-governmental organizations." Its proximity to the United States along with ubiquitous U.S. media images of desperate Haitians in need of saving make Haiti a frequent destination for humanitarian groups. Nurses comprise the largest segment of the global health and humanitarian workforce. This qualitative study the concept cultural safety (CS) and critical race theory (CRT) which have been underutilized in exploring humanitarian nursing. Cultural safety (CS) and critical race theory (CRT), pay attention to the structural nature of inequities and offer a framework to explore and address global health inequities. This research is a qualitative thematic analysis of blog posts from 33 nurses who have traveled to Haiti in a volunteer capacity. Each minor theme: racialized Other, beneficence and superiority of knowledge and expertise, are supported by 3 subthemes each, all of which support the major theme of White Savior Complex This study adds to the literature by demonstrating how social constructions of race create and maintain power structures in humanitarian settings. This article makes recommendations as to how the theoretical framework can inform nursing practice in the humanitarian setting with attention to racialized power differentials.

There is a long history of citizens of the United States participating in volunteer humanitarian efforts across professions. Of these professions, nurses comprise the largest segment of humanitarian volunteers (Dawson, Elliott, & Jackson, 2017). Globally, there is a shortage of 4.6 million healthcare workers (Dawson, Elliott, & Jackson, 2017). Health professionals from well-resourced countries thus have many options when it comes to volunteer opportunities, whether through disaster relief efforts, educational affiliations or professional organizations (Bauer, 2017). Approximately 6000 short-term experiences in global health

(STEGH) take place annually at an expense of $250 million to volunteers (Melby, Loh, Evert, Prater, Lin, & Khan, 2016; Murray, 2016).

The majority of empirical and theoretical work critiquing the value of short-term humanitarian work derives from the social sciences (St-Amant, Ward-Griffin, Bermna, & Vainio-Mattila, 2018). A common concern regarding volunteer humanitarian efforts is the power imbalances existent between the volunteers and the communities that are the supposed beneficiaries of volunteer efforts (St-Amant, Ward-Griffin, Bermna, & Vainio-Mattila, 2018).

Despite the high numbers of nurses who participate in short-term humanitarian efforts, nursing as a profession is yet to fully engage in similar critiques (St-Amant, Ward-Griffin, Bermna, & Vainio-Mattila, 2018). This article will offer ways in which critical race theory and cultural safety can prepare nurses for work in settings rife with power differentials stemming from colonialism.

Throughout this article, I will use the terms "Global North and Global South" as these terms mark a shift from a focus on development or cultural differences (underdeveloped, Third World) to one that denotes the geopolitical nature of marginalization (Dados & Connell, 2012).

White Savior Complex as coined by Cole (2012) is the overall theme of the findings in this study. I will begin by providing context to humanitarian nursing in Haiti. I will explain why the most useful frameworks are critical race theory and cultural safety in undertaking this study. I will articulate my methodology including an explanation of the vantage point and multiple identities from which I undertook this research. My findings expose remnants of colonial ideologies that cast volunteers from the Global North as beneficent and necessary and communities in the Global South as perpetually dependent. The recommendations from this

study include practical questions that organizations and potential volunteers can ask in preparation for humanitarian efforts.

Haitian Context

Haiti is a nation of 10.2 million occupying the island of Hispaniola with its neighbor, the Dominican Republic. Its beleaguered past stemming from colonialism is evident in its modern-day health outcomes. Forty percent of the population does not have access to basic health services; less than one half of all children are fully vaccinated and almost a quarter of children under the age of five are stunted; low height for age because of malnutrition (United States Agency for International Development [USAID], 2020). Stunting can lead to delays in childhood that impact growth and development across the lifespan. Healthcare represents just six percent of government expenditures as opposed to almost 10% by higher income countries (USAID, 2017). There are approximately 6.0 nurses, doctors and midwives per 10,000 (USAID, 2020); a ratio woefully below what the World Health Organization deems as adequate (23/10,000) to meet the healthcare needs of a population the size of Haiti (Clark, Julmisse, Marcelin, Merry, Tuck & Gagnon, 2015).

The lack of healthcare infrastructure is in part the result of decades of neoliberal policies imposed on Haiti by the International Monetary Fund and World Bank (Schuller, 2012). In 1991, 90% of clinics were operated by mission groups or non-governmental organizations (NGO) (Schuller, 2012). The Haitian state was further weakened by United States policies in the late 1990's which forced USAID to fund NGOs and not the Haitian government (Schuller, 2012). At the time of the devastating earthquake in 2010 it was estimated that at least 10,000 NGOs were operating in Haiti.

In the wake of the 2010 earthquake in Haiti, one in which it is estimated that over 200,000 lives were lost. Despair and turmoil became synonymous with Haiti. Popular press contrasted Haiti's despair and turmoil with the images of compassion and appeals to the best of human nature on the part of volunteers rushing to help. Representations of Haitians and other non-white people groups stoked images of the exoticized "Other," and helped to establish pity, as opposed to empathy, as the predominant emotion driving humanitarian interventions (Müller, 2013). Similar narratives re-emerged following the assassination of President Moise in 2021 and the 7.0 earthquake that struck Haiti just weeks after.

The days and weeks following the 2010 earthquake became a media sensation in large part due to a successful one-dimensional portrayal of "pitiful" victims amidst all out chaos (Balaji, 2011). Pity may seem harmless and even compassionate but in reality, it strengthens positions of power and privilege (Balaji, 2011). Despite the best of intentions, compassion can easily morph into a mechanism of oppression, as stereotypes drive perceptions of local capacity (Barnett, 2014). Race continues to underpin most of our daily discourses as well as the emotions evoked by images of suffering, thereby racializing our collective responses (Balaji, 2011). This particular form of pity highlights the power dynamics that have long conferred white privilege at the expense of the racialized "Other." While subtle in everyday life, these dynamics become more overt in the aftermath of catastrophic events like the 2010 and 2021 earthquakes in Haiti (Balaji, 2011) and the assassination of the Haitian president in 2021.

The purpose of the larger study from which this article draws was to explore how nurses' worldviews influence their professional role in addressing health inequities through international, volunteer services activities. Specific aims include: 1) Explore the motivation, implicit and explicit, that inform nurses' desire to work in a low-income country, specifically Haiti, 2) analyze

nurses' understanding of health equity in the delivery of care in Haiti, and 3) explore nurses' values, beliefs and attitudes toward patients of different racial and ethnic backgrounds. This study was conducted in two parts: 1) semi-structured interviews with a group of 19 nurses and 2) analysis of blog posts written by a different group of 33 nurses. Both parts of the study were conducted with U.S. nurses who had made at least one trip to Haiti in a volunteer capacity. This article focuses on the second part of the study and summarizes the findings the analysis of the blog posts. The findings from the individual interviews with 19 nurses who have participated in volunteer work in Haiti are reported elsewhere. The findings of this study reveal elements of White Savior Complex.

In order to conduct the analysis of the blog posts I utilized a method known as netnography. Netnography is the study of culture and community originating from online interactions. This method has grown exponentially since its inception in the 1990s (Costello, McDermott, & Wallace, 2017).

Despite the physical separateness of the researcher from the participants, netnography is an avenue through which one can socially and emotionally engage participants (Costello, McDermott, & Wallace, 2017). Data originating online has a number of advantages over data obtained using traditional research (Burles & Bally, 2018). First, what online authors share reflect what is of importance to them and not prompted by the interests of the researcher. Secondly, the unobtrusive nature of netnography helps to control for reaction bias that can occur when participants are aware that they are being studied. As unsolicited and naturally occurring, the accounts shared by online authors have the potential to elucidate in-depth meaning to personal experiences (Burles & Bally, 2018).

Theoretical Underpinnings

I conducted this study utilizing two concepts that together, have been underutilized in exploring humanitarianism, critical race theory and cultural safety. There is a paucity of research utilizing critical race theory in the context of the Global South and yet it offers valuable insights as to the permeability of racism across borders (Harrowing, Mill, Spiers, Kulig and Kipp, 2010; Henry, 2018). Cultural safety is a concept specific to nursing and explores issues of power and privilege.

Cultural Safety

Cultural safety is a concept widely used in the nursing literature in New Zealand, Australia and Canada and is gaining traction in the United States. The concept of cultural safety was conceived by Maori nurse scholar, Irihapeti Ramsden as a means of shifting the nursing paradigm to better address the gross inequities suffered by the native New Zealand peoples as a direct result of colonialism (Ramsden, 1993). Utilizing this concept requires continual reflection on the part of the nurse as to the power dynamics inherent in the healthcare setting. This also involves nurses' acknowledgment that these power differentials are the result of centuries of social, political and historical injustices solidifying a "White/Other" dichotomy. In providing humanitarian nursing care in Haiti, nurses are working in a context rife with health inequities and heavily influenced by centuries of power dynamics between Haiti and the United States. Thus, concepts that draw attention to root causes are required for nurses to meet their ethical mandates to address health inequities.

Critical Race Theory

Critical Race Theory (CRT) derives from legal studies, and is a movement by scholars and activists interested in analyzing and ultimately reconfiguring the relationship between race,

racism and power (Delgado & Stephancic, 2017). Critical race theory is grounded in several key assumptions.

The Nature of 'Race'

At the turn of the 21st century the Human Genome Project was completed, providing evidence that there are no genetic distinctions between races (Duster, 2015). Of particular interest to critical race scholars is how, in light of this information, the notion of immutable differences based on categories of race still persists (Delgado & Stephancic, 2017).

In understanding race as a social construct, critical race theorists also recognize "whiteness" as a category that comes with its own set of socially ascribed traits. In a racialized society like the United States, critical race theorists contend that the experiences of white people are considered the standard from which all others are measured and often, according to this power-holding group, fall short (Gillborn, 2015). To be clear, CRT is not an indictment of white *people* but rather a critique of the *systems* that have been created by white people to privilege white people (Gillborn, 2015).

Ubiquity of Racism

Critical race theory reframes our understanding of prejudice and discrimination from personal biases and individual acts to phenomena that are insidious and structural in nature (Blanchet Garneau, Browne & Varcoe, 2018). Critical race theorists understand that white supremacy does not exist on the fringes of society but is embedded in the everyday order of modern-day U.S. society (Henry, 2018). Even individuals who outwardly decry racism become complicit in its perpetuation as the mechanisms of structural racism become normalized and invisible to the dominant society (Blanchet Garneau, Browne & Varcoe, 2018). The insidious

nature of colorblind racism is evidenced in the claim by healthcare providers that they do not "see race" and are incapable of providing differential care to patients of a differing race.

Centering on the Margins

Critical race scholars believe that understanding the lived experience of people experiencing racism is essential to knowledge development. This knowledge is often elicited through the use of stories centered on the voices of populations most affected by racism to counter dominant narratives about people of color (Delgado & Stephancic, 2017). In this framework, the voices of populations relegated to the margins of society become the center from which knowledge is generated in an effort to dismantle racist structures (Delgado & Stephancic, 2017). In addition, honoring the lived experience as valid knowledge can unleash individual and collective agency necessary to breaking cycles of oppression rooted in institutionalized "isms"(Collins, 2000).

Intersectionality

While racism is central to exploring power dynamics using critical race theory, CRT scholars recognize the many ways in which humans identify themselves and how these identities overlap (Van Herk, Smith & Andrew, 2011). Intersectionality theory, deriving from Black feminist scholarship, emphasizes that the root causes of marginalization cannot be reduced to one specific oppression (e.g. racism classism or gender-based), but must include an overall analysis of how power functions to create a matrix of intersecting oppressions (Collins, 2000). Thus, intersectionality challenges the notion of established binaries that have come to dominate nursing and humanitarian discourses. This is particularly relevant in humanitarian discourses that tend to homogenize people in LMICs as simply poor. These intersections need to be acknowledged when looking to reconfigure systems in favor of a more equitable society (Gillborn, 2015)

Cultural safety coupled with critical race theory, with explicit attention paid to power dynamics, are particularly salient in this context given the lasting influence of colonialism on the interactions between humanitarian actors and the communities to which they travel.

The discourses around humanitarian experiences demonstrate how negative and racist stereotypes are promulgated by volunteers lacking in an understanding of the political and historical contexts in which they are operating (Thomas & Luba, 2017). Here is where critical race theory and cultural safety, by way of their epistemological origins, offer alternative perspectives. Johnstone and Kanitsaki (2002) note that cultural safety is distinguished from concepts derived from the transcultural nursing movement in the U.S. in that it originated from the vantage-point of colonized peoples, namely the Maori of New Zealand. This directly aligns with CRTs philosophy of eliciting counter-narratives and privileging the voice of populations that have been historically marginalized ((Delgado & Stephancic, 2017).

Positionality

To acknowledge one's positionality is to recognize how our perspectives are influenced by the fluid and dynamic ways in which we identify ourselves and the multiples contexts in which those identities intersect (Kezar & Lester, 2010). What Heron (2007) states about positionality is that we must be willing to place ourselves squarely in the midst of the issues we wish to explore. As a white woman, and a critical race theorist, I must be willing to implicate my own actions in the perpetuation of white supremacy culture.

When I first volunteered in Haiti in 2005, I too went with the notion of 'helping.' I made light of the fact that I knew nothing about Haiti before traveling there. I helped to prep for our trip by dosing medications into plastic baggies and gathering donations for items that would be discarded here but, I presumed, surely needed there. While in Haiti, I took pictures

indiscriminately. I came home and shared my experience about these people in a poor and corrupt country and reinforced the "poor but so happy and grateful" tropes that now give me pause. My first trips to Haiti were early in my nursing career but I had my public health background to know just enough that something much larger was at play. I understood social determinants of health but was still ignorant of my white privilege. As my work in Haiti continues, my ignorance is gradually giving way to a crucial reckoning, my arrogance replaced by humility. My research is another step in my journey toward becoming anti-racist.

Methods

Design

Data Collection

The study was approved by the University of Wisconsin-Milwaukee Institutional Review Board prior to data collection. Thirty-three blog posts by 33 different authors were retrieved from websites representing six volunteer organizations. These websites are considered as being in the public domain. A website is considered public domain when 1) it is accessible to the general public, 2) the posts are not password protected nor do they require viewers to register with the organization, 3) the topics shared on the website are not considered highly sensitive, and 4) the intended audience is other nurses who are looking to engage in humanitarian work.

Per The American Psychological Association, The British Psychological Society and the Association of Internet Researchers guidance documents for research conducted online (Roberts, 2015), consent from the individual bloggers was not necessary. To protect the bloggers anonymity, I did not use the name of the website from which I collected the blog posts. Additionally, I paraphrased quotes and create composites stories based on the common phrases and themes contained in the blog posts (Burles & Bally, 2018; Roberts, 2015). Lastly, I used

search engines to check my composite stories and quotes for traceability (Burles & Bally, 2018; Roberts, 2015).

The posts ranged in date from 2009 - 2019. Twenty-eight of the thirty-three posts were about experiences after the earthquake on January 12, 2010.

The six sites from which the blogs were retrieved were from the websites of 501(c)(3) organizations, an Internal Revenue Service designation for non-profit status. One of the organizations was established after the 2010 earthquake, the other five prior to this event. All six were established by practicing or retired medical professionals. None of the organizations espoused any specific religious beliefs or affiliations.

Participant Characteristics

Only one of the bloggers disclosed their age (middle-aged); practice settings included the following: ICU/Critical care/ED (4), Med/surg (1), Oncology (1), Maternal-child health (5), Nursing instructor (1), Student (5), Other (2) (too specific as to jeopardize anonymity), unknown (14). Licensure and/or degree held: RN (9), RN/BSN (3), Advanced practice or advanced degree (6), unknown (15). One person stated their nationality as being something other than American; no other bloggers explicitly stated how they identify in terms of race or gender. All but four of the posts had pictures associated with them. Of the photographs where it was clear (by caption) that the author was pictured, all were female and 91% appeared to be White (though of course visual assessment is not a perfect measure of race). This is consistent with the National Council of State Boards of Nursing survey (2020), which shows that 91% of U.S. nurses identify as female and 77% identify as White.

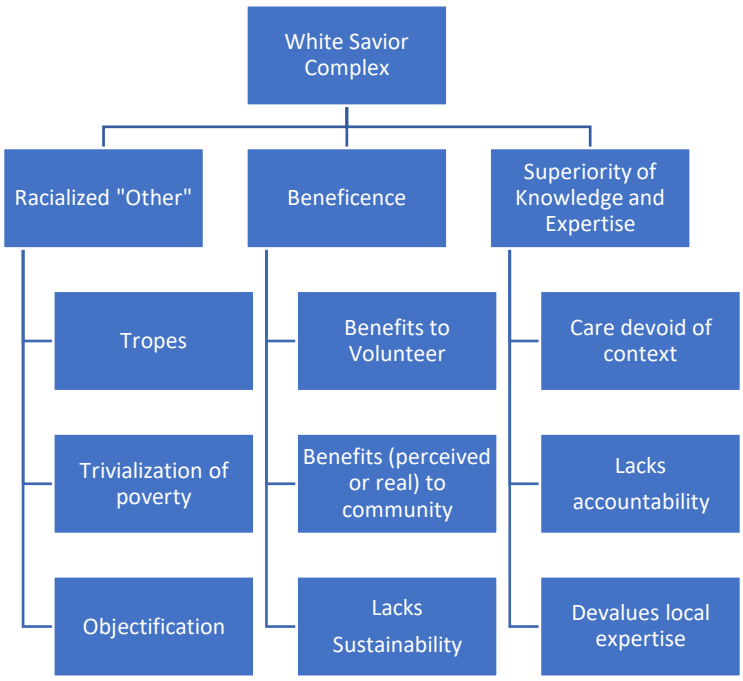
Data analysis

I used thematic analysis as outlined by Ritchie, Lewis, Nicholls, and Ormston (2013) to analyze the blog posts. The steps therein include familiarization, construction of initial thematic framework, indexing and sorting. Researcher and evaluation expert Michael Patton describes two types of triangulation, theory and source triangulation, which I utilized in conducting this research. Source triangulation is the use of multiple sources of data, such as reflection, interviews, and literature reviews (Chang, 2016; Patton, 1999). Using multiple sources of data enhances the collection of rich, authentic, and trustworthy data (Hall & Stevens, 1991; Chang, 2016). In the case of my study, I achieved this by interviewing volunteer nurses, analyzing blog posts from nurse volunteers, reviewing the extant literature and engaging in ongoing self-reflection about my own experiences in the field.

Utilizing theoretical frameworks that derive from different disciplines constitutes theory triangulation. I achieved this by utilizing critical race theory (legal studies) and cultural safety (nursing).

Findings

Using the tenets of cultural safety and critical race theory to guide analysis, the overall theme I identified was "White savior complex" (WSC). Teju Cole coined the terms "white savior industrial complex" as a way of describing white people who provide help to non-white people in a self-serving way (Cole, 2012). I identified 3 subthemes: racialized other, beneficence, and superiority of knowledge and expertise that support the overall theme.



Racialized Other

Tropes

By repeating tropes when sharing their experiences, the bloggers perpetuated common stereotypes about Haiti. These stereotypes serve to maintain white volunteers in a position of superiority.

Despite that the majority of bloggers were White, none of them mentioned race or discussed their experience being a White nurse in a majority Black country.

Narratives analyzed from the 33 bloggers reflected the common tropes associated with Haiti as being: "the poorest country in the Western hemisphere," the desperation of the people and how heart-breaking the volunteers' experiences were.

Trivialization of Abject Poverty

Fifteen bloggers commented on how happy/kind/grateful Haitians are despite their lacking in basic human rights such as safe housing, adequate nutrition and quality medical care. Several commented that this experience made them appreciative of everything they had and that they would try harder once back in the United States to complain less. One nurse commented on how appreciative and nice the people were despite that the services being provided by the volunteers were inadequate to meet their actual needs. Two bloggers commented that Haiti was where they find peace from the stressors of their daily life back in the United States.

Objectification

There were a total of 98 photographs included with the narratives. Only four of the posts did not include a picture; 28 of the 33 blogs with pictures had images of patients. Four of the photos used in four separate blog posts showed a smiling volunteer with a visibly distraught, ill or unconscious patient. There was no mention by the bloggers that they had received permission to take or share the photos. Only twelve blog posts included unidentified people (may or may not have been patients) or were of scenery.

One blogger stated that the highlight of the trip for her occurred just before their departure when her team provided care to those injured in a mass casualty incident. She said that was the time during the trip when she felt truly needed.

Beneficence

In the context of these blog posts, the data suggests that the needs of the volunteers took precedence over the needs of the communities in which they served. These needs ranged from the physical accommodations during the trip to more existential needs such as fulfilling a life-long dream.

Benefits to Volunteer

Twenty-two of the bloggers stated that their trip to Haiti was "life-changing." Two of the bloggers stated that the experience made them better people but did not elaborate further. Of the twenty-two, six stated that this fulfilled a life-long desire to volunteer outside of the United States. A different set of six bloggers stated that they received more than they gave as a result of volunteering. In one post a nurse shared a story of a man who came seeking care after the earthquake. He questioned aloud as to why he survived while so many others had perished. The nurse told him that he had survived so that *he could teach her* about the Haitian people so that she (the nurse) could continue to help them. Another blogger shared how a young victim of the earthquake comforted her as she cried from feelings of pity toward the girl who had lost family members and suffered injuries during the earthquake.

Included in this subtheme were statements regarding the personal sacrifices that volunteers made. For example, nine bloggers commented that the trips were worth it despite their personal sacrifices in terms of physical comfort, time, money and/or time away from family.

Also supporting this sub-theme were comments about the best part of the volunteer experience. Five of the bloggers stated that the lasting friendships that they made with other volunteers was the highlight of their experience.

While the predominant theme focused on the experiences of the volunteers there was one counterexample. One blogger, who did not claim that her trip was life changing, did however reflect on how her experience informed her views on domestic and international politics.

Perceived Benefit to Community

Twenty-six different bloggers discussed how their work and the knowledge that they were able to share was life-saving and "made a difference;" if only for the family with whom

they interacted on the day that the volunteer was working. There was no mention that any of the volunteers conducted any follow up visits with the families after their initial visit.

Seventeen bloggers made mention of their work to educate and improve the skills and knowledge of their Haitian counterparts.

Lacks Sustainability

The word "mission" was used 55 times; the words sustainable or sustainability just three.

One blogger felt that her volunteer group had contributed to reducing violence against women in Haiti by educating Haitian women on the immorality and illegality of rape. One blogger supported this claim by quoting a Black scholar. The author of the quote was referring to quality educational opportunities for Black people.

There was one blogger who talked about the organizations efforts to improve conditions int the community they worked. This group used funds to improve electricity (solar), plumbing and sanitation in the community.

Superiority of Knowledge and Expertise

The nurse volunteers implied that by way of their own education and despite lack of experience, that they held superior skills in comparison to their Haitian counterparts. This was evident when the bloggers failed to acknowledge local expertise and practiced professional skills they had never used before.

Devoid of Context

Twenty-nine bloggers named lack of sanitation, lack of electricity and lack of medical equipment. None of the bloggers contextualized these challenges within the broader sociopolitical realities of Haiti and the complex western-global south relations that inform these

realities. Two bloggers stated that the abject poverty is "to be expected" or is what is common in "the developing world."

Accountability

One nurse blogger stated that she was performing nursing tasks that she had not done since nursing school. Another blogger stated that, despite being a new nursing graduate, after one day in Haiti she felt that she could handle whatever came her way. One blogger encouraged others to volunteer stating that volunteers need not have any medical experience because they will nonetheless have something valuable to offer.

Several bloggers mentioned treating and educating on subjects such as: cholera, tuberculosis, the dangers of starvation and yellow fever (an infection no longer considered endemic to Haiti). None of these illnesses are endemic in the United States and not subjects on which nurses receive in-depth and up-to-date information on in everyday practice. Licensure in the United States requires that nurses practice only in settings in which they've been adequately trained and educated. This is also required by our ethical mandates of beneficence (do good) and non-maleficence (do no harm).

Devalues Local Expertise

One blogger mentioned that after her trip, it was obvious to her that medical personnel were needed in Haiti and so on her return home she began researching medical missions. This implies that she understands the solutions to come from volunteer efforts as opposed to building and sustaining a local workforce.

One blogger talked about how they were supposed to be working with the Haitian staff to improve their skills but it was often impossible as the Haitians seemed to her to take offense.

None of the bloggers mentioned learning anything related to clinical practice or skills from their Haitian counterparts.

One blogger commented on how the local nurses were poorly trained and the facilities were similar to those in other developing countries, thus not only devaluing local expertise but repeating generalizations about conditions in resource-poor areas devoid of any context.

There were two blog posts that stood in stark contrast to others under this sub-theme. Two bloggers recognized the importance of working with the community and not simply in or on behalf of the community. They commented on the importance of involving community members from the initiation of a project and the need to first build trusting relationships with community members. One nurse stated that working alongside her Haitian colleagues was the favorite part of her trip.

Discussion

In a highly segregated world, humanitarian nursing provides a rare opportunity to subject a predominately white workforce to a majority and critical "Black gaze" (Henry, 2018, p. 327). Critical race theory points out how, generally speaking, white people are unaware of the privilege that their whiteness affords them and therefore lack an in-depth appreciation of the social construction of race and the ills of racism (Thomas & Luba, 2018). Rendering aid and assistance by white people, in majority black communities, without attention to race and racism is symbolic of white supremacy and Western domination (Lough & Black, 2015; Thomas & Luba, 2018). Devoid of context, volunteers return to the United States and perpetuate racial tropes and stereotypes in the reproduction of their experiences (Thomas & Luba, 2018). These stereotypes are centuries old and have historically served a political purpose.

Creating caricatures of the "Other" was a strategy of U.S. colonialism (Hood, 2018; Sommers, 2016). Rarely do the stories spun about the Global South originate from the people from, and living in the Global South (Bell, 2001). In the case of Haiti, Haitian voices have been homogenized and relegated to the margins; their images created from sensationalized tales (Bell, 2011; Hood, 2018). An early example is found in the 1884 writings of Sir Spencer St. John, a British diplomat, who depicted Haitians as uncivilized, cannibalistic and "intolerably stupid" (as cited in Farmer, 1992, p. 238). Despite the subsequent debunking of his alleged claims, St. John's book became a bestseller, and he went on to publish a sequel with even more fantastical claims. His views of the Black inhabitants of Haiti can be summed up with this statement: "As a rule, the abler a negro is, the more wicked and corrupt he appears…I now agree with those who deny that the negro could ever originate a civilization, and that with the best of education he remains an inferior type of man" (as cited in Hood, 2018, p. 6).

A 2013 article in the Christian Science Monitor entitled, "In Haiti, the laws of physics meet the culture of magic," provides an example of how, in the aftermath of the earthquake, long-held stereotypes and unequal power dynamics can be perpetuated by volunteers. Fallon traveled to Haiti after the 2010 earthquake to help with reconstruction efforts. He describes Haitians as "benignly stubborn, corrupt and backward (para 20)...remarkably strong, work site camaraderie is deep and displays of physical prowess abundant" (Fallon, 2013, para 8). Throughout the article he infantilizes Haitians and dismisses local knowledge and expertise as little more than amusing.

The newly licensed nurses who blogged about traveling to the countryside with the intent of empowering young women to avoid becoming victims of rape were also perpetuating a century-old trope. Western representations of Haitians as overly sexual, syphilitic and

superstitious date back to the 19th century. These stereotypes proliferated during the US occupation of Haiti 1915-1934 and again during the HIV/AIDS epidemic of the 1980s when Haitians were classified as one of the four high risk "H" groups (along with homosexual, hemophiliacs and heroin addicts) for disease transmission (Farmer, 1992). For these young women, believing rape to be a part of Haitian culture is an example of how racialized stereotypes continue to influence modern day perceptions of Haitian life.

Kinsinger (2009) states the basic definition beneficence is "an act of charity, mercy and kindness" (p. 45). As an act of charity, beneficence is therefore ineffective as a long-term solution to complex problems rooted in inequities. Beneficence is a core ethical principle in nursing. In stark contrast to Haitian communities, the Northern volunteer is cast as the bearer of hope in otherwise hopeless places devoid of any political or historical context (Vorstermans, 2018). By way of their beneficence and superiority, volunteers can move in and out of the Global South subjecting communities to efforts that serve more to gratify the needs of the volunteer than to affect meaningful and sustainable change to unjust systems (Vorstermans, 2018). However, in the context of humanitarianism and in the absence of cultural safety, acts of mercy and charity can come at the expense of autonomy and justice and call into question notions of what constitutes doing good and who actually benefits.

Journalists have written extensively about the "reductive seduction of other people's problems" (Martin, 2016, para. 6). This is the notion that the further away we are, the easier other people's problems are to solve. This distance is afforded not only by geography but by privilege and social location. The presumption that privileged Westerners can "save the world" is fueled by a non-profit industry that appeals to idealistic egos by promising meaningful and transformative experiences (Germann Molz, 2017; Martin, 2106). Engaging in complex work in

unfamiliar communities is not only reckless, it can result in tragic outcomes. Take for example, the work of Saving His Children, founded by American missionary Renee Bach. Bach opened this critical care facility for malnourished children in Uganda despite having no medical training; her highest level of education was a high school diploma. Bach was eventually sued by the Ugandan government following the death of 105 children at her facility (Nurith, 2020).

In reflecting on power and privilege of Western providers in the Global South, physician Andrea Walker recounts a time in which she offered her advice while working in a hospital in Uganda. She suggested that a cesarean section be performed on a woman in labor whose infant was in distress. The local resident physician and anesthetist were hesitant but ultimately deferred to the expertise of Dr. Walker, the Western physician. The cesarean was performed successfully but the infant died in the overnight hours from respiratory distress. Dr. Walker reflected on how her recommendation was given with the best of intentions but also based on her training and resources in the United States. Her lack of context-specific medical knowledge, namely the absence of neonatology services, resulted in the young woman suffering the loss of her child and having to undergo a painful procedure from which she then had to recover.

The ability for nurses to engage in critical self-reflection and to recognize our own social locations is necessary in deconstructing colonial ideologies within and outside of U.S. borders (Cameron, Langdon & Agyeyomah, 2018). Bloggers who commented about how easy and blessed life in the United States is as compared to Haiti also fail to recognize their own social locations and white privilege. For example, one blogger stated that the challenges faced by pregnant women in the U.S. are trivial as compared to women in Haiti. This suggests a lack of awareness of the disparate birth outcomes for women of color in the United States. Between 2000 and 2013, the United States ranked 30th out of 31 member nations in the Organisation for

Economic Co-operation and Development (OECD) in maternal mortality due to the rates of maternal death among Black women. Pregnancy-related mortality for Black women is three to four times higher than their White counterparts (Owens & Fett, 2019). Research for the last two decades implicates structural and institutional racism as adversely affecting Black women's bodies physiologically and genetically, thereby contributing to poor birth outcomes in the United States (Owens & Fett, 2019).

Trivialization of Poverty

Romanticizing of poverty by volunteers is common as those living in abject poverty are assumed to be ignorant of a better life, more grateful and free from materialism (Friedus, 2017). This trivialization of the chronic stress of living in poverty evokes neocolonial notions of the naivete of the poor and allows for westerners, regardless of skill level or content expertise, to "help." It also reinforces unexamined assumptions that abject poverty is naturally occurring as opposed to the result of political, social and economic interference from the Global North. In addition, an oversimplification of the stressors experienced by those living in extreme poverty does not call attention to the lack of systems and resources to adequately address mental health.

A systematic review of the literature conducted by Cénat, McIntee, and Blais-Rochette (2020), elucidates the high rates of mental health disorders among all survivors of the 2010 earthquake in Haiti.These disorders range in severity from mild to moderate depression to severe PTSD and suicidal ideation. Since the 2010 earthquake Haitians have also experienced devastating tropical storms, cholera and COVID epidemics, another earthquake, widespread gang activity and violence and the assassination of a president. Descriptions of Haitians as happy despite their situation is not congruent with what researchers are discovering about the links

between poverty, trauma and mental health (Cénat, Harerimana, Michel, McIntee, Mukunzi, Hajizadeh & Dalexis, 2021; James, Welton-Mitchell, Noel, & James 2020).

The lived experience of those in the Global South is further decried through the use of indiscriminate photography.

Objectification: Use of Photography

Studies recommend the use of photography or video journaling to enhance reflective practice for visual learners (Amerson, 2014; Chen, McAdams-Jones, Tay & Packer, 2012; Murray 2016). However, taking photos in the field during volunteer medical trips can be problematic. The authors of a paper detailing a service-learning trip to Guatemala claimed that photographs made for nice souvenirs for the students and that the "American/Guatemalan" language barrier as the reason why consent could not be obtained from the "subjects" (Amerson & Livingston, 2010, p. 205). Referring to human beings as “subjects” evokes neocolonial representations of non-White persons as the “Other.”

The Health Insurance Portability and Accountability Act prohibits students from taking pictures in clinical settings in the United States out of respect for patients' dignity and right to privacy. People seeking healthcare anywhere should be entitled to the same such rights.

Recommendations

There are a number of steps that nurses and volunteer organizations can take to safeguard that the autonomy and human rights of the communities in which they work are respected. First, nurse volunteers should consider the following questions before volunteering with an organization:

- Whose needs are you trying to serve? Is the organization you will volunteer with more interested in your experience or those of the community?

- What types of health education is being provided by the organization, and is it connected with health educators in the community?
- Is the organization aware of the credentialing process in the host country? Will you be working within your scope of practice according to your licensing body?
- Is the organization providing training on best practices in working with interpreters?
- How is follow up care being provided to those who you treat?

The organizers of volunteer groups should be able to answer the following questions before recruiting volunteers:

- Are you fully aware of the government and non-government health services being provided in the area you are serving?
- Are the skills, knowledge, and expertise of local providers being utilized and acknowledged?
- Does the organization know and adhere to WHO standards of practice for health in under resourced settings?
- Are background checks conducted on all volunteers to protect against possible abuse?
- Does your organization adhere to acceptable pharmaceutical standards and dispensing of unused medications in under resourced settings?
- Is the organization using local/national data to implement services?

Limitations

I chose to summarize statements made by bloggers in their posts as opposed to direct quotes in order to protect their anonymity. This is a limitation of my study. Nevertheless, I

did conduct interviews with nurse volunteers the results of which revealed similar themes thereby enhancing credibility. I explicated the themes sufficiently as to provide the reader with a clear understanding of the sentiments expressed in the posts.

Conclusion

The sentiments expressed in these blog posts revealed that nurses were willing to travel outside of their immediate communities and comfort zones to render help and alleviate suffering in answer to nursing's moral and professional calling. While it is important for nurses to garner a sense of accomplishment and pride in the difficult work that we undertake, it must not come at the expense of humbly acknowledging our limitations.

Taken as whole texts, these posts reveal a troubling theme in which white, mostly women, travel to non-white communities with romanticized notions of saving lives while fulfilling personal and professional goals. They return with an overinflated sense of achievement; of having made a difference in life of the underserved. By engaging in ongoing reflection and using the tenets of cultural safety and critical race theory, nurses have an opportunity to change the paradigm of humanitarian nursing from one of charity to that of social justice. Our work as nurses needs to be contextualized in the broader racist realities that has historically informed volunteer work between Western actors and the Global Sout

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Manuscript 2: Nurses in humanitarian spaces: An exploration of nurses' views in addressing health inequities in Haiti

The second manuscript reports the findings on interviews with nurses who have volunteered in Haiti. It requires formatting based on the author's guidelines for *Advances in Nursing Science* and it responds to the following call for papers:

Anti-racist scholarship

Manuscript due date: April 15, 2022

Nurses in humanitarian spaces: An exploration of nurses' views in addressing health inequities in Haiti

Manuscript 2: Nurses in humanitarian spaces: An exploration of nurses' views in addressing health inequities in Haiti

Abstract

Nurses fill a large void in global healthcare shortages through humanitarian efforts. Haiti is popular venue due to its proximity to the United States and struggles with a national healthcare infrastructure. This qualitative study sought to understand how U.S. nurses viewed their role in decreasing health through humanitarian efforts. Sixteen nurse volunteers were interviewed, and the transcriptions analyzed utilizing critical race theory and cultural safety. The themes revealed undertones of colonialism and White supremacy despite outward expressions of altruism on the part of the nurses. In this article we will discuss how the theoretical frameworks can inform an antiracist approach to nursing care.

Key words: cultural safety, critical race theory, humanitarian, nursing

Statements of Significance

What is known about this topic:

Nurses, using the underpinnings of their education and training, volunteer in large numbers across the globe. Nurses from the Global North are frequently engaging in communities in the Global South. There remains a dearth of literature regarding how the vestiges of colonialism inform these interactions.

What this article adds:

This article helps to elucidate how racialized and colonial ideologies continue to underpin the interactions between nurses from the Global North and communities in the Global South. This article provides recommendations as to how nursing practice and humanitarian organizations can utilize critical race theory and cultural safety to address the root causes of health inequities.

The tumult in the US in 2020 in the aftermath of the murders of George Floyd and Brianna Taylor reignited a racial reckoning across the country in ways not experienced since the Civil Rights Era. All sectors of society were forced to reexamine racial bias and structural violence. Such reckoning within the nursing profession started over a decade ago (Schroeder & DiAngelo, 2010) but prior to 2020 had yet to gain meaningful traction in the decolonization of research, education, and practice. Nursing is a profession bound by a code of ethics and underpinned by the principles of social justice. Resting on the laurels of a professional identity widely admired and trusted in the public sphere can obscure the reality of the nursing profession's ties to colonialism (Bell, 2021). My research sought to examine two spaces largely occupied by White women: nursing and humanitarianism (Bandyopadhyay & Patil, 2017; Bell, 2021). Multi-disciplinary scholarship is replete with explorations of contemporary Whiteness

within racialized societies like the United States and Canada (Henry, 2020). But the ways in which Whiteness transcends borders is critical to understanding the frameworks that perpetuate White supremacy (Henry, 2020).

The United Nations (2021) estimates that 274 million people worldwide will require humanitarian assistance in 2022 marking the highest number in decades. These needs coupled with a global healthcare shortage, provide ample space for healthcare professionals to engage in international volunteer efforts. Given the ethical mandate for nurses to alleviate suffering, it is not surprising that nurses all comprise the largest segment of global health volunteers (Dawson, Elliott, & Jackson, 2017). The remnants of colonialism in nursing and in the humanitarian sector. require close scrutinization as to how the former continues to influence the latter (Bandyopadhyay & Patil, 2017).

I utilized critical race theory and cultural safety to explore the experiences of nurses from the United States volunteering in Haiti. Haiti is the archetypal site for such explorations as the events precipitating the perpetual need for humanitarian aid in Haiti are mired in colonial ideologies, namely racism.

Haitian context

Haiti, a nation of 10.2 million people occupies the western third of the island of Hispanola just over 800 miles from the coast of Florida. It is estimated that over 40% of the population needs humanitarian assistance due to the collapse of the economy, political instability, and the ongoing COVID-19 pandemic (United Nations Office of the Coordination of Humanitarian Affairs, 2021).

Haiti's current political, social, and economic status cannot be understood without an examination of the history of terrorism – in the form of slavery, political exploitation and

economic plunder exacted upon Haiti from the international community (Edmonds, 2013; Sommers, 2015). Viewing Haiti's successful revolution at the beginning of the 19th century as a threat to slavery everywhere, the global powers at the time (U.S, France, England and Holland) refused to recognize Haiti's independence thereby suffocating its economy (Edmonds, 2013). Foreign governments increasingly exerted their control over Haiti's economy and politics over the course of the 19th century (DuBois, 2012). In response to Haiti's victory against French colonists, France imposed indemnity payments on Haiti as compensation for the loss of slave labor. These sanctions would set Haiti on a decades long trajectory of indebtedness to foreign interests at the expense of creating a sustainable infrastructure (DuBois, 2012).

More recently, aid to Haiti from the International Monetary Fund and World Bank was contingent on the adoption of structural adjustment programs. Designed to increase privatization and trade liberalization these policies served to further weaken the Haitian state (Schuller, 2012).

The lack of infrastructure has gravely impacted healthcare services in Haiti. The World Health Organization recommends 23 doctors, nurses, and midwives for every 10,000 people. In Haiti, that ratio is a meager six to every 10,000 (USAID, 2020). The nursing shortage in Haiti is linked to a number of factors including out migration of skilled professionals and lack of investment in education (Clark, Julmisse, Marcelin, Merry, Tuck & Gagnon, 2015). It is estimated that the expatriation rate of Haitian nurses to higher income countries is 94% (Clark, Julmisse, Marcelin, Merry, Tuck & Gagnon, 2015).

All the while, the burgeoning non-profit sector took hold in Haiti creating a disparate and desultory array of services across sectors (DuBois, 2012). At the time of the 2010 earthquake there were an estimated 10,000 non-governmental services operating in the country.

Purpose and Aims

The purpose of this study was to explore how nurses' worldviews influence their professional role in addressing health inequities through international, volunteer service activities. Specific aims include: 1) Explore the motivation, implicit and explicit that inform nurses' desire to work in a low-income country, specifically Haiti, 2) Analyze nurses' understanding of health equity in the delivery of care in Haiti. This article summarizes the findings of one of three parts to this study, the individual interviews with nurses based in the United States (U.S.) who have participated in volunteer work in Haiti. The findings from analyzing blog posts from nurses who have traveled to Haiti with a volunteer organization are reported elsewhere. My study was guided by the tenets central to the concept of cultural safety and critical race theory which are discussed in the next section.

Theoretical Models

Cultural Safety

Cultural safety is a concept that derives from Maori nursing scholars in New Zealand. Its conception was to influence nursing practice in a way as to elucidate the White (descendants of European colonists)/Other (Native Maori) dichotomy that has resulted in gross inequities for the native Maori peoples (Ramdsen,1993). To practice with cultural safety requires the nurse to acknowledge that differences in health beliefs and practices are influenced by any number of cultural identities held by individuals at any given time. Such identities include but are not limited to: race, ethnicity, gender identity, sexual orientation and socioeconomic status. Practicing with cultural safety also requires that nurses not only acknowledge differences in values, beliefs, and traditions but respect them as equally valid as their own (Papps & Ramsden, 1996).

Ramsden (1993) astutely pointed out that patients are not the only bearers of culture but that nurses are as well. Nurses must therefore be aware of their own worldviews and social locations. This requires ongoing reflective practice on the part of the nurse. The nurse must be able to not only acknowledge these realities but also appreciate how they may affect their interactions with patients at any given time.

The abject poverty and health inequities that nurse volunteers bear witness to in Haiti are situated in complex social, political and historical contexts. The use of cultural safety to guide nursing care can guide nurses working in places where health inequities derive from colonialism and neocolonialism.

Critical Race Theory

Critical race theory (CRT) was a movement by legal scholars and activists in the 1970s in response to the erosion of gains made during the civil rights era (Delgado & Stephancic, 2017). Critical race theory has several main tenets all of which serve to support the theory's main assertion, that U.S. society is structured by a racialized hierarchy that benefits White people.

Race as a Social Construct

First and foremost, critical race theorists understand race to be a social construct. Results of the Human Genome Project have shown that there is no scientific evidence of genetic differences between populations of various racial or ethnic identities. Despite this evidence, racialized stratifications persist with deferential power and privilege given to White people (Delgado & Stephancic, 2017).

Structural Racism

Critical race theorists understand that racism is commonplace experience for people of color (Henry, 2019). The machinations of racism are so embedded in everyday society that they

become invisible to the dominant, White society (Blanchet Garneau, Browne & Varcoe, 2018). This failure to recognize structural racism as a reality is what critical race scholars refer to as colorblindness. Colorblind racism is a guise by which White people claim to 'not see race' and therefore cannot be racist (Delgado & Stephancic, 2017). This failure to acknowledge racial differences is also a failure to recognize the power and privilege White people are afforded by way of their location in highly racialized societies.

Intersectionality

Critical race theory centers racism in its exploration of power. But critical race scholars also recognize that root causes of oppression cannot be reduced to a single cause. The theory of intersectionality arose from resistance movements led by various women of color (Wesp, Scheer, Ruiz, Walker, Weitzel, Shaw, & Mkandawire-Valhmu, 2018). Leading critical race scholar and Black feminist, Kimberle Crenshaw coined the term and she, along with her contemporary Patricia Collins, advanced critical thinking on the dynamic nature of systems of oppression (Collins, 2000; Crenshaw, 1989). The concept of intersectionality is important in efforts to dismantle systemic injustices (Gillborn, 2015).

Positionality

Positionality refers to the ability of us as researchers to acknowledge the ways in which we identify. This provides a level of transparency as to how our social location and experiences shape our perspectives as researchers (Kezar & Lester, 2010). This is important in research such as my own where I am both the researcher and a member of the culture sharing group. As a White woman who has participated in volunteer trips to a majority Black country, it incumbent on me to acknowledge the ways in which I have perpetuated white supremacy culture if I wish to interrupt these systems (Heron, 2007). I entered humanitarian work holding many of the same

stereotypes about communities in the Global South. After my first trips to Haiti, I returned and perpetuated common tropes that undermine Haitian capacity thereby contextualizing my experience in favor of the White Savior complex. This research is another step in my journey toward becoming anti-racist. I recognize myself in the stories of all the nurses who were so generous in sharing their experiences.

Methods

Design

Recruitment

The study was approved by the University of Wisconsin-Milwaukee Institutional Review Board prior to data collection. For this study I interviewed 16 nurses; 14 using a video conferencing application and two by phone. To be eligible to participate in an interview, the nurse needed to have participated in at least one medical volunteer trip to Haiti and to have graduated from or be currently enrolled in, a U.S. accredited School/College of Nursing at the time of their trip.

I initiated recruitment by sending emails to 16 organizations that advertised nursing volunteer opportunities to Haiti on their websites. Additional participants were recruited through snowball sampling.

I began recruiting for nurses to interview in early March of 2020. Shortly thereafter, COVID-19 became a global pandemic. As the demand for nurses' time grew exponentially and overseas volunteer trips were suspended indefinitely, it became increasingly difficult to recruit participants. As a public health nurse in a local health department, my own time and resources were stretched thin as the pandemic wore on. I was able to successfully resume my research efforts in the spring of 2021. While I am writing this, COVID-19 remains a global pandemic

with the most recent variant, the Omicron variant, imposing ongoing challenges for communities, the healthcare system as well as the global economy.

Participant Characteristics

All the participants identified as White and non-Hispanic. Three identified as male and 13 as female. This is consistent with the National Council of State Boards of Nursing survey (2020) which shows that 91% of nurses identify as female and 77% identify as White. The ages of the nurses ranged from 23 years of age to 88 with an average age of 55.75. The years in nursing practice ranged from 3 to over 50 with an average of 28 years in practice.

Regarding the highest degree in nursing that participants held in nursing, the responses were as follows: associate degree (1), bachelor's degree (8), master's degree (3) and those with a terminal degree (4). Three of the participants' international experience consisted of one trip to Haiti, five participants had traveled to Haiti multiple times and seven, in addition to Haiti, had participated in other volunteer activities in other countries. The participants' nursing experiences in the United States varied. All were hospital or clinic-based settings with the exception of two participants who were in nursing education for the majority of their careers to date.

Data Collection and Analysis

I conducted two of interviews by phone and 14 using a web-based video platform (Zoom). I recorded and transcribed all of the interviews except for the two interviews by phone. In these two cases I took copious notes, including direct quotes. Participants were asked ten questions aimed at eliciting their experience around three broad themes: their experience in Haiti, their experience with working with patients whose backgrounds are different than their own and, the role of nursing in addressing health inequities. I used the steps for thematic analysis as outlined by Aronson (1995) and Creswell (2007) to analyze the data.

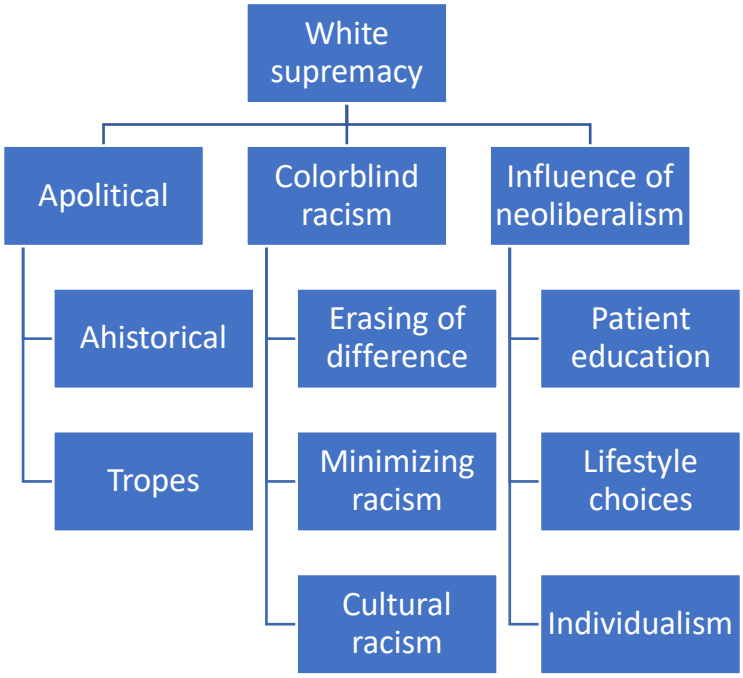
Thematic analysis involves the identification of shared patterns of behavior or language exhibited by the participants, which I then categorized into themes (Aronson, 1995; Creswell, 2007). The next step was to organize all of the data according to these themes. Themes (major and minor) are expounded upon and further grouped into sub-themes (Aronson, 1995). Patterns became obvious as I catalogued the themes and sub-themes; ultimately providing a comprehensive picture of the culture-sharing group (Aronson, 1995). This "cultural portrait" (Creswell, 2007, p. 72) reflects the voice of the participants (etic), the researcher (emic) and the extant literature.

Scientific Rigor

I utilized two types of triangulation as described by Patton (1999): theory and sources triangulation. Source triangulation involves the use of multiple sources such as: observation, reflection, interviews, literature reviews, and assemblage of other artifacts (Patton, 1999). Using multiple sources of data enhances the collection of rich, authentic, and trustworthy data (Hall & Stevens, 1991). I achieved this by interviewing providers of humanitarian medical care and analyzing blog posts. Theory triangulation involves the use of theoretical frameworks that derive from different disciplines. I utilized critical race theory (legal studies) and cultural safety (nursing) to guide the data analysis.

Findings

Guided by the tenets of critical race theory and cultural safety, I identified three minor themes which support the overall major theme of White supremacy. The minor themes: de-politization, colorblind racism and the influence of neoliberalism. These minor themes are supported by sub-themes.



Apolitical approach

Without an understanding of the political and historical contexts in which care was being delivered, the nurses relied on common tropes and oversimplistic understandings of poverty to make sense of the conditions in which they were working and the plight of the people they encountered.

Ahistorical

When asked the question: "What is your understanding of the relationship between Haiti and the United States?" half of the participants directly stated that they "did not know," as articulated in the examples below.

> I knew about the earthquake but I didn't know about the political history um you know, the history of the sugar plantations and the slavery and the you know they're the first successful slavery rebellion in the history of the world. I, you know, still have a lot to learn but I didn't know that when I made my first trip. (participant 5)

....but I haven't been aware of that we have had that much involvement politically... (participant 8)

I don't know a whole ton of political stuff related between the U.S. and Haiti. (participant 12)

Seven of the participants answered this question by talking about Haiti's reliance on the United States for humanitarian aid, particularly following the earthquake in 2010. The first quote is from a participant who has been traveling to Haiti for decades.

Uh, yeah there's of course all kinds of political things but I think as to Haiti in general, leaving out the gangs and everybody else who are ruling areas now is they're very open to NGOs of different types, to help with their economy their health, their literacy, there's a wide variety, if they were to suddenly say we don't want Americans I think their education, their econ, well, a lot of their economy and their healthcare would, uh would drop out. So, they're open, passive relationship I guess you could say for us to be there. (participant 9)

In this quote the participant implies that the United States is responsible for meeting the basic needs of the Haitian population. Implicit in this statement is that the United States is an egalitarian state and Haiti is completely lacking in agency. Another participant said,

We sent a lot of money when the earthquake happened and the money doesn't filter down to those people. They don't get a lot of that because of the corruption, a lot of you know gets to these evil people. but I think that um, we are not as focused on humanitarian ways that we could have an influence on a country that's not very far from us, that we could have a great impact on sharing the wealth that we have as a country. .....we obviously have some kind of relationship but I don't think it's making a difference. We're not meeting their basic needs. (participant 8)

Similarly, this participant does not differentiate between aid rendered following an emergency and complete dependency.

Although they show a lot of independence, when a catastrophe hits they want someone else to fix it. (participant 2)

While not identifying specifics, one participant did acknowledge that there is a complex history of U.S. interference in Haiti.

There's too much history. There's too much you know, uh the United States has has not always I think been a true ally but instead gone in and really tried to take control. I think

> that there are basically 200 or plus um um colonialism that has impacted how we um, interact. (participant 15)

When participants admitted to not knowing about the relationship between the United States and Haiti, many resorted to stating common tropes.

Tropes

Five participants repeated the moniker verbatim that Haiti is "the poorest country in the Western hemisphere."

Four participants commented on the political corruption and/or instability.

> a…. lot of political unrest. I also learned and later on it was a Jeopardy question that I got right that Haiti is the poorest country in the Western Hemisphere. (participant 8)

> I think it's pretty unstable place down there um, I know it is one of the most poorest countries in the Western hemisphere, if not the poorest. (participant 10)

> I don't think they have any um, relationships other than the um the aid that comes there through different groups. They're, they're totally dependent, their government is highly um um suspect highly, always, no matter what regime is in place they're always so corrupt. (participant 3)

Several of the participants relied on the "poor but happy" trope.

> Haitians understand what it means to live without anything. These people in the community they don't have running water they don't have electricity and the children are in the street playing with an empty soda bottle that they've made wheels out of caps and, and they're laughing and they're enjoying themselves and they're playing and they're running around. And to them, this is their world and this is what they know and that has impressed me, like, wow they have nothing but this is what they know and they're still happy. (Participant 1)

> To live somewhere where there are no roads, there is no electricity to every house, um, the whole, it isn't just an area of a city or a unique population, the whole country has its own culture, and yet you could feel that they were happy, their family units were um, intact you know there was a lot of joy in that community. Even though, they, I don't think they have, I, I don't know i felt that (pause) I wasn't aware of the, the difference in culture and I don't know how much they are aware of the, difference in culture you know, unless they've been somewhere else (participant 5)

This trivialization of poverty is also a form of colorblind racism, another common minor theme I identified during text analysis.This minor theme is discussed next.

Colorblind Racism

In answer to the question: “What was your experience as a White person working in a majority Black country?” participants’ comments revealed the common, minor theme of colorblind racism. There are several ways in which colorblind racism can manifest in everyday language. In its truest form, colorblind racism is the claim that White people simply do not see race. This is articulated in the following quotes.

> I didn't feel the White and Blackness. I don't think about it at all. (Participant 2)

> That question kind of, is kind of throwing me off, I haven't, I wouldn't have never even thought about it. (Participant 1)

Another form of colorblind racism is to recognize race but to discount White privilege. This strategy disregards racialized differences by drawing on a common humanity.

Erasing Difference

> I'm comfortable there. I realize when I'm with my African friends, I am, am rarely consciously aware that I'm the only White person in the room. You know they're completely welcoming. I have no fears, no worries. They're pleased that I'm here and hospitable and I have the same experience in Haiti. (Participant 11)

The following quote demonstrates a strategy that White people use when colorblindness is challenged by way of being a minority, as when White people travel to a majority Black country.

> So knowing all of that, and having the mindset that that we are the same. We all bleed red. You know, in the dark we are all the same color (Participant 8)

For this participant, showing common decency and respect was a way to assuage his discomfort.

> So, um for for me, it is it is a little of a, a strained situation um. Know being a White person going into a you know predominately black area that you know you know some people might say, was it caused by oppression, was it caused by whites? It is has pieces in slavery you know, there's always that like, uneasiness I guess to say. Um, not that's to say that people were unfriendly you know. I think people are people wherever you go you know, they were, they were you know if you were kind to them they were kind to you kind of thing but I wouldn't say there was an overtly friendliness or an overt hostility or anything like that. But, uh, you know, there's there's for me it always seemed to me there was a little bit of an undertone you know an uneasiness you know. (participant 9)

Minimizing Racism

Another defense mechanism on the part of White people is to diminish the ills of racism. This participant recognizes that there was a possibility of not being warmly received but dismisses this based on perceived gratitude on the part of Haitians.

> It's never been, I haven't received any like, hostility from the people I care about um, or care for I mean. Um, like when we're over there I, we, we've always just received nothing but gratitude it seems like people are just really grateful that we're there to help them (Participant 7)

In this case, the nurse attributes her discomfort to feeling like a celebrity.

> I mean, we all got looks. It didn't feel weird it was almost kinda like a celebrity level to and like, in some sense and it was kinda weird they were um very grateful that we were there. I didn't feel really different about, and that what was I felt the weirdest about was like the attention that we got from everyone there." (Participant 6)

In the following instances, the nurses minimize racism by reducing racialized differences to mere differences in phenotypes or place of origin.

> I didn't think of me being white and them being black I thought of me being an American and them being Haitian you know. I thought that they (pause) that they seemed to be very much appreciative of everything we did. (Participant 3)

> To care for people that um are there's, there's literally a black and white difference between you, I think there's and to be mindful of that the fact that like some people are going to be leery of you because of how different you look than them (participant 7)

> And I would even hold up a piece of paper next to my skin and I'd say I'm not white. You know, this is white (referring to paper), does this look like me? So, having already having that kind of mindset I did not have any issues with that at all. I did not feel out of place, or a minority per se, um I felt very accepted, (Participant 8)

In contrast to the common defense mechanisms employed to avoid the discomforts of confronting racialization, two participants offered critical reflection. The first quote was in response to being asked about being a White nurse in a majority Black country.

> I definitely had experiences you know when anywhere you go people yell 'blan, blan' in the the street sometimes, you know kids throwing rocks at me on the way to the hospital and people being very unkind in terms of yeah, you're you're white, you're a foreigner, you're not welcome here." And I remember feeling so isolated and so unwelcome and that feeling of unwelcomeness made me think ok, what is it that I represent? What is it that makes me something that is not ok here? (participant 14)

This same participant voiced further reflection between her experiences with a short-term trip and a year-long stay in Haiti.

> I went for 10 days you feel like a hero and when I went for a year it was a completely different experience (somber tone) when you live it day to day, the harshness, the reality, it, of being becoming part of the community and understanding the realities. It's a very very different experience when day to day you, you live and you see things that you can't for the rest of your life unsee. It's a very different experience, um and that changes you and it has forever changed me in the way I look at the world (participant 14)

In answer to the same question, this participant similarly reflected on her privilege in preparation for her trip.

> I thought, well, so before I went that's something um, I felt I have to recognize who I am and my privilege and what my intentions are before I go. I have to be clear with myself, why am i going? I think the other thing for me was recognizing I'm not an expert on your culture, you have to teach me. Um, and allowing them to become the expert and and spend time teaching me. (Participant 15)

Cultural Racism

This minor theme is a form of racism whereby deprivation is attributed to a generalized definition of culture that is implicitly racialized. When asked about working as a nurse in the United States with people of different backgrounds, this participant stated:

> We had a large, um, large ethnic group, Hispanic, the black community, we had you know, a large variety of people who seek primary medical care in the ER. (participant 5)

Several participants talked about the lack of basic human rights like clean water and adequate housing.

> Haitians understand what it means to live without anything. These people in the community they don't have running water they don't have electricity and the children are in the street playing with an empty soda bottle that they've made wheels out of caps and, and they're laughing and they're enjoying themselves and they're playing and they're running around. And to them, this is their world and this is what they know and that has impressed me, like, wow they have nothing but this is what they know and they're still happy. (Participant 1)

> And you know you just see pigs eating in the trash and goats and all that, you know driving through the city. And so you know, and you have to be careful not to make judgments about these people thinking that they don't care about their, their city b/c look at how they just throw trash on the ground. Or They don't care about their children because, that's not the fact at all. These people are just surviving and so there are things in your life when you're surviving that are not a priority you know, you have to prioritize food and water and shelter, basics you know that we all need. So it was really was a good experience of not only having a greater understanding of what people in the world outside of my little world are experiencing but also to be so grateful what God has blessed me with. (participant 8)

Influence of Neoliberalism

This theme is grounded in the assumptions that healthcare is a free market commodity, volunteer efforts serve to improve the marketability of the volunteers and that to be healthy is a result of making good choices.

The participants were asked to speak to what they feel to be the most important factors that influence health and what nurses' responsibilities are in improving the health of patients and communities. The first sub-theme demonstrates nurses' assumption that knowledge will equal behavior change.

Patient Education

> Um, I would say, um, once again education, you know educate patients about how to help themselves. (participant 3)

> I think we can obviously, make sure that our patients understand um their role in their own health (participant 8)

> So, that was a little umm, uh, sad for me that we did not more of an opportunity to give them education to be able to take care of themselves. (participant 9)

In contrast to the individual patient education, four participants emphasized the role of patient advocacy and two felt that political involvement was important in promoting health.

The sub-theme of patient education was closely related to that of the next sub-theme, lifestyle choices.

Lifestyle Choices

Eight of the 16 participants felt that if given the proper education then it would be up to the patient to use that information to make healthy choices.

> Education in health is sorely lacking I mean, there's still people that put Mountain Dew in baby bottles for goodness sake. (participant 7)

> I think people need to be uh partners in their healthcare so they need to understand that you can choose again to have a healthy lifestyle that you can make choices in your life, that God has provided the resources for us. (participant 8)

> I would say, um, once again education, you know educate patients about how to help themselves. Um, well you know, um like life style choices, you know smoking, or um, illicit drug use, or um just um nutritional choices, how to eat uh uh, exercise to keep your weight, to be fit, is huge i think um to impact ones health and um, safety i would say, um, in your lifestyle choices; you know as far as are you gonna run with the the drug crew oryou gonna uh pay attention to your education and move on and up and out. (participant 3)

> You have to be motivated if you want to be healthy and you want to be better and to live longer you need to make smart choices and the only way to do that is to be motivated. (participant 6)

> It's important because um, you, you're under, it's empowering the person, it's empowering the person, um to to be able to be take care of themselves. Whether that is, um, eating the right diet you know. I worked in my home care background, I worked on the cardiac team for awhile and I would see a lot of people in congestive heart failure and you know and a lot a lot of their condition stemmed from poor choices that they made literally at the dining room table, you know. (participant 10)

> So, I think, when I think health I think of diet, exercise and just a general well-being. (participant 12)

Three of the participants identified factors outside of one's locus of control as the most influential on health outcomes such as race and income.

> Well uh you know, being a a nurse and having taught a little bit of public health I would say the social determinants of health. (participant 11)

> So many basic things you know that start a cascade of health inequity before a child is even born (participant 14)

The following two quotes are included as they embody the overall theme of White supremacy on several levels. The participants spoke in terms of an "us" and "them" dichotomy that is implicitly racialized. This was true when referring to their encounters with patients in the United States as well as Haiti.

> I mean Haitians are very, you know, stoic people and they were grateful for everything and coming from an ER where patients are not grateful for a lot of things was like a very pleasant turn of events you know. I think that in the US, there's a sense of entitlement especially in (names city) where I practice. [People] want everything done right away, they don't like wait times, they're not grateful when things are not happening fast enough for them, if they don't get a pill for something they're upset type of thing whereas in Haiti everyone is basically thankful for every little every little thing. It was a very nice breath of fresh air. Coming from, coming from this sense of entitlement here in the U.S., entitlement for healthcare that isn't free you know (participant 6)

> I had not expected them to be so patient and appreciative having been in the emergency room setting for many years and people were grateful but people, Americans have certain expectations you know we, we want what we want when we want it, and we don't like to wait, and we this expectation that we deserve all these things, you know we deserve excellent healthcare we deserve this we deserve that and so going there and experiencing these people not hearing a single complaint, nobody whined and complained (participant 8).

This same participant went on to describe her experience with desegregation in the United States.

> I can remember when the bussing started. We were bussed clear across town to a high school that was predominately dark brown and then all of them were bussed and it was terrible you know! You know, it, it was a horrible, it just caused more friction between us as, as people groups then if they'd just left us where we were. But you know, you

> understand why the leaders wanted to do that because they felt like they were making it more equitable for the underprivileged (used air quotes) instead of raising the standards in their schools you know, you know like it should be even today (participant 8)

The sentiments in the abovementioned quotes by participants six, (a nurse with less than five year of experience) and participant eight, (a nurse with over 15 years of experience), are emblematic of the ways in which nursing continues to engage in racist discourses in the delivery of care. These discourses will be examined in detail inthe next section of this paper.

Discussion

Nursing as a discipline remains nascent in its exploration of concepts that tackle racism head on, like white privilege and structural racism (Bell, 2021a; Louie-Poon, Hilario, Scott, & Olson, 2021). A racial reckoning for the nursing profession started over a decade ago (Schroeder & DiAngelo, 2010) and was recently renewed in the wake of the death of George Floyd (Canty, Nyirati, Taylor, & Chinn, 2022). However, nursing's complacency with covert forms of racism within the discipline to date has quietly reinforced the roots of White supremacy upon which it was largely founded (Louie-Poon, Hilario, Scott, & Olson, 2021). In her review of the nursing literature Bell (2021), explores the construction of nursing's identity and whether there is a connection to "oppressive behavior." Her findings reveal a hegemonic conceptualization of nursing identity resulting from the absence of a critical examination of privilege, heteronormativity, and expressions of difference. In its effort to gain professional respectability and status, the nursing profession has adopted a culturally and politically neutral stance at its own peril.

Similarly, critical explorations of White supremacy in global health remains marginal (Bandyopadhyay, & Patil, 2017) as has power dynamics as a root cause of global health inequities (Kim, Novakovic, Muntaner & Hawkes, 2019).

My findings demonstrate that the "White/Other" dichotomy remains the basic premise from which these nurses understand their interactions with communities of color, within and outside of the United States. Such representations are the philosophical means by which racist structures are upheld (Christian, 2019). As overt expressions of racism have become socially and professionally unacceptable, the nursing profession has adopted seemingly apolitical approaches to care, namely via culture competence and cultural diversity (Schroeder & DiAngelo, 2010).

In this study, I explored the intersection of nursing and humanitarianism by applying a critical race lens coupled with the tenets of cultural safety. My findings elucidated where racist discourses and the depoliticization of nursing care are hindering advancement toward achieving health equity. These findings will be discussed further in the next section. I will offer points at which nurses can engage with critical race theory and cultural safety to interrupt these hegemonic discourses.

Colorblind Racism

The various constructs of colorblind racism allowed for the participants to naturalize and minimize the abject deprivation that they were witnessing. Where a critical examination of Whiteness was lacking, the constructs of colorblind racism filled in the gaps. In order to dispose of racism as a root cause of the gross inequities they were witnessing, the nurses needed to rely on multiple and simultaneously constructs of colorblind racism. Such constructs include minimizing racism - as when the participants invoked the "poor but happy" trope - and attempts at erasing racialized differences. Using multiple constructs at once creates what Bonilla-Silva (2006) refers to as, "an impregnable yet elastic wall" (p. 470). This serves to shield White people from the realities of racism. Creating this metaphorical wall becomes especially necessary in a place such as Haiti where any one construct on its own is not likely to hold up. Whiteness and

White privilege are so ubiquitous in the United States as to become unremarkable. However once White people leave the confines of the physical and ideological Global North, new ways of asserting White supremacy become necessary (Henry, 2020).

Colorblind racism is a recent iteration of its predecessor, cultural racism.

Cultural Racism

The cultural racism construct in the United States dates to the 1960s with the dissemination of Daniel Patrick Moynihan's report, "The Negro Family: The Case for National Action" (Bonilla-Silva, 2006). In it, Moynihan cites the "culture of poverty" framework as evidence that Black marginalization in the United States was due a breakdown in family values and a poor work ethic. As the rationale for marginalization of racial groups based on biological inferiority fell apart, notions of cultural inferiority replaced them (Bonilla-Silva, 2006).

The quotes from participants six and eight at the end of the findings section demonstrate how the multiple constructs are used to together to distract from addressing root causes of health inequities. In sharing her thoughts on desegregation, participant six avoids the use of "Black and White" instead using "dark brown," "us and them." By using air quotes when stating underprivileged, participant six implies that the Black children in segregated schools are not at a structural disadvantage. She then invokes the cultural racism mechanism by stating that "they" simply need to raise their standards.

Furthermore, these two participants minimize the ills of abject poverty, a function of colonialism and racism by casting Haitians as patient and grateful in contrast to the demanding and undeserving "Americans" who they encountered as emergency room nurses. Used here the terms "American" and "patient" are coded language. Black and Hispanic people are less likely

than their White counterparts to have insurance and access to a primary care provider. They are therefore more likely to seek care in the emergency room (Zhang, 2020).

De-politicizing Care

Cultural diversity remains the predominant approach to theorizing about racialized people groups. This approach is a more palatable way for nursing scholars to critique the theoretical foundations of the discipline. This, as opposed to the murkier and socially unacceptable subject of racism (Louie-Poon, Hilario, Scott, & Olson, 2021). My findings offer insight as to the blind spots that are maintained when nursing care is believed to be apolitical and ahistorical.

When nurses fail to consider the larger contexts in which they are working, health equity becomes about providing health education. The onus falls on the patient to then use that information to make good choices that result in better health outcomes. This depoliticized approach has been the predominant ideological underpinning influencing the delivery of healthcare in the United States and globally for decades (Kim, Novakovic, Muntaner, & Hawkes, 2021). An inability to contextualize patients' access (or lack thereof) to care and their experiences with healthcare providers in the United States is an indicator of what biases are perpetuated when care is thought to be apolitical.

Utilization of cultural safety in pedagogy can inform the nursing perspective as it requires ongoing reflection the part of the nurse as to our own social locations and the larger context in which we are providing care. Adding critical race theory makes explicit the social construction of race and the role racism plays in creating and maintaining systems of power.

The Influence of Neoliberalism

The ideology of neoliberalism focuses on meritocracy over collectivity and the private sector over the public. Attributing optimal health to individual behaviors lends credence to a

belief that inequalities are naturally occurring (Kim & Novakovic, 2021). This ideology also dismisses the social, political and historical factors influencing individual agency at any given time. Global health interventions have relied on addressing individual level behaviors and risk factors that lend themselves to technological solutions. An example of this can be found in the interventions outlined in the Millennium Development Goals. This is not to dismiss the advances made by technological solutions such as insecticide-treated bed-nets or vaccines. The concern in recent literature is that such interventions are insufficient in obtaining health equity in the long term (Kim, Novalovic, Muntaner & Hawkes, 2019). Studies out of the United Kingdom suggest that the return on investment for technical fixes may be diminishing. This report calls for a paradigm shift in funding to include community engagement and a focus on the social and political determinants of health (Kim, Novalovic, Muntaner & Hawkes, 2019).

Critical race theory and cultural safety offer a new paradigm to disrupt the hegemonic hold that neoliberalism has on humanitarianism. The ethical views provided by critical theories and concepts, like CRT and CS, remind us to keep the oft-masked power relations influencing our interactions squarely in the purview of our practice (Anderson, Rodney, Reimer-Kirkham, Browne, Khan, & Lynam, 2009). The gaze is shifted from the essentialized "Other" inward. Nurses must acknowledge the power they are afforded by way of their education and the value placed on the care that they offer.

As CRT and CS inform us, these power relations are not limited to those between the proverbial us and a racialized Other as dictated by traditional narratives of the Global North in relation to the Global South. Rather an intersectionality lens, as key to both CRT and CS, allows nurses to consider the fluid and dynamic nature of human identity as well as the historical and

time-bound contexts that contribute to individual and collective experiences of health, wellness, illness and dying. (Van Herk, Smith & Andrew, 2011).

Conclusion

To understand how White supremacy has maintained its pernicious hold across the globe we must accept the malleability and trenchancy of Whiteness over time (Christian, 2019). Whiteness extends beyond the corporeal, to a process that is constantly shape-shifting and reproducing itself resulting in the accumulation of power and privilege (Christian, 2019).

The insidious and ubiquitous nature of white supremacy in the nursing profession warrants a paradigm shift away from skills-based competencies toward a dismantling of taken for granted assumptions (Bell, 2021a). Nurses who are educated using emancipatory theories like critical race theory will be better prepared to address the pervasiveness and permeability of racism across borders.

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Manuscript 3: The role of nurses as allies against racism and discrimination. An analysis of key resistance movements of our time.

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Abstract

The remnants of colonialism manifesting as structural violence, racism, and oppression continue to plague our society as evidenced by the persistence of health inequities, particularly for minority populations in the United States. As a profession bound by moral and ethical mandates, nursing must resist and deconstruct oppression in all its forms. Nurses, informed by critical race theory, intersectionality, and historical trauma, can become formidable allies with marginalized populations in the fight for social justice and health equity.

Key words: ally, critical race theory, historical trauma, intersectionality, structural racism

In January 2017, the American Nurses Association (ANA) issued a formal statement on ethics and human rights.[1] This statement was unequivocal in its call for nurses to uphold human rights and social justice, with a particular emphasis on vulnerable populations. The ANA used the term "formidable" in describing the synergy of ethics, human rights, and nursing, a strong word that emphasizes the seriousness with which this major body that governs the profession of nursing in the United States takes these issues. This is relevant because nurses comprise the largest segment of health care providers who are guided by strict ethical guidelines, placing patients and their unique needs at the center of care.[2] The Institute of Medicine defines patientcentered care as care which is "respectful of, and responsive to, individual patient preferences, needs and values"[3(p6)] and ensures that "patient values guide all clinical decisions."[3(p6)] When nursing duties and loyalties conflict with societal power structures and nurses blindly adhere to policies rooted in structural racism, patients are no longer the center of care. This can result in the dehumanization and marginalization of patients, adversely affecting health outcomes.[4] As feminist nurse scholars, the authors of this theoretical article call upon our nursing colleagues to become formidable allies in the current era of a reinvigorated white supremacist ideology. Similar to scholars in the disciplines of social work and education who are seeking to deconstruct the white patriarchal hegemony of their respective disciplines, we urge nurses to move from "benevolent supporters" to "risk takers."[5(p43)] Becoming formidable allies requires nurses to recognize and acknowledge the role that historical trauma plays in reproducing inequities that manifest as poor health outcomes for specific populations. In this article, we, therefore, discuss how historical trauma has, and continues to, adversely affect health outcomes for specific populations in the United States. Rooted in feminist epistemologies, in addition to a

historical trauma framework, we also draw on critical race theory and intersectionality to explore nursing's mandate to engage in social justice. We discuss nursing's traditional role of advocacy and provide examples of how patients are easily marginalized when fidelity and obligation are centered on institutional hierarchies.[4] We highlight 3 resistance movements: the Black Lives Matter (BLM) movement, Development, Relief, and Education for Alien Minors (DREAMers) Act, and the protest of the Dakota Access Pipeline (DAPL). In our analyses, we look at the history that gave rise to the ascension of these movements. Lastly, we describe the role that nurses might play as formidable allies in supporting such movements given our obligation to enhance the safety, well-being, and ultimately, the health equity of individuals and communities existing on the margins of US society.

POSITIONALITY

A principle central to feminist scholarship is the acknowledgment that there is not one, but many truths, informed by our individual experiences and worldviews.[6] As nurse scholars, we incorporated multiple perspectives in the call to action to decolonize the academy, specifically in nursing scholarship as well as nursing practice and health policy. The ways in which the authors self-identify reflect inclusivity and our intention to privilege traditionally marginalized voices. The authors of this article represent multiple races and ethnicities (white, black, Native American, multiracial, and Latina). Our perspectives are also informed by our social locations representing privilege (race, class, education level, cis-gender, and heterosexual) and marginalization (women of color, queer, and immigrant) in an attempt to articulate a more holistic and inclusive view.

ROLE OF SOCIAL JUSTICE IN PROVIDING NURSING CARE

In the ANA statement on ethics and human rights, there is an emphasis on nursing's obligation and commitment to social justice and the profession's responsibility to integrate principles of justice into nursing and health policy.[1] The debate surrounding the exact meaning of social justice in the context of nursing care is beyond the scope of this article, but the authors of this article adhere to the principles of social justice espoused in the nursing manifesto.[7] At the heart of the philosophy in the nursing manifesto is the ideas that human beings are inherently worthy of dignity and respect. Social justice requires solidarity in the dismantling of any structure that denies basic human rights to anyone by way of their socially ascribed identity.[7] Second generation human rights as articulated in the International Covent on Economic, Social and Cultural Rights call for access to education, health care, and a basic standard of living for all human beings.[8] For these rights to be realized by all people, it will require those in positions of influence to leverage their power within institutions designed to maintain social and political hierarchies.[8] Current efforts to dismantle the Affordable Care Act, for example, have a direct bearing on second generation human rights, as it will affect access to affordable and quality health care. Social justice is far from being realized, as evidenced by the persistence of health inequities, particularly for minority populations. Health inequities are defined as health differences that are socially produced, "systemic in their distribution across the population, and unfair."[9(p1661)]

People belonging to marginalized groups in the United States disproportionately experience health problems such as cardiovascular disease, obesity, diabetes, and inflammatory and autoimmune disorders.[10] These conditions are correlated with the chronic activation of stress hormones experienced by racial minorities facing daily assaults to their humanity and their

dignity.[8] For example, a recent study showed an increase in anxiety levels, depression, eating and sleeping disorders, and poor school performance among children who fear separation from their parents that would result from deportation.[11] These health inequities result from far more than physical manifestations of chronic stress. A landmark report in 2008 correlated health inequities with social and economic determinants of health.[7] For example, approximately 200 million children worldwide are unable to reach their full potential due to adverse events experienced early in life including poverty.[7]

ADVOCACY

International codes of conduct, standards of practice, and nursing curricula include advocacy as a key component to nursing care, the definitions of which are context specific.[12] Advocacy frameworks that are based on principles of social justice adhere to the notion that advocacy is a moral imperative.[13] In this context, advocacy requires that nurses are emphatic in their efforts to address health inequities on behalf of marginalized patients. This implies the recognition that patient rights are human rights and not only legal rights, and that these rights must be protected.[13]

Nursing is largely understood as practicing within the sphere of personal, one-on-one relationships and therefore nurses are privy to the daily injustices experienced by their patients. Because of this proximity, nurses may assume the role of an advocate. At times, however, this may also lead to nurses assuming a position of authority, which can exacerbate existing power differentials and perpetuate an ideology that patients are inherently lacking in agency.[13] Without further examination, this role can perpetuate paternalistic practices in health care, whereby the nurse assumes to know what is in the best interest of their patients.[13] These assumptions are often based on stereotypes embedded in western models of health care.[14] A western-oriented,

individualistic focus limits our ability to get to the root causes of inequities, resulting in solutions that are short-sighted and ineffective in making meaningful systems-level changes.[13,14] Nurses are in a position to expand the role of advocate beyond the individual level to propose and champion policies that create the conditions in which human rights can be realized for everyone. Nevertheless, as mentioned earlier, in order for nurses to do so, they first need to recognize and acknowledge the historical realities of the populations that they serve and how these realities impact health outcomes in contemporary society.

HISTORICAL TRAUMA

Marginalized populations historically subjected to persistent oppressions are vulnerable to experiencing what has been termed "historical trauma." Mental health expert and Native scholar, Dr Brave Heart has been credited with the development of the critical framework of historical trauma to describe the generational impact of the trauma of colonial policies experienced specifically by Indigenous populations.[15] Dr Brave Heart specifically describes historical trauma as a "constellation of characteristics associated with massive cumulative group trauma across generations."[16(p245)] Historical trauma is an interdisciplinary framework that builds upon psychosocial, political/economic, and social/ecological systems frameworks.[17]

The framework of historical trauma has been used by scholars to explain the impact of colonization, historical oppression, psychological trauma, and cultural suppression of Native American, Aboriginal or First Nation, and Indigenous communities. Historical trauma speaks to the unresolved trauma from the devastating effects of colonialism including genocide, loss of land, loss of culture, loss of language, loss of kinship systems, and forcible removal from family and communities.[16] This context of postcolonial suffering and cumulative loss has helped to shed

light on many of the present-day health disparities seen in Native and Indigenous communities today.[16]

Sotero[17] argues that a historical trauma framework is necessary for understanding how and why certain populations have a higher disease burden than others. Four distinct assumptions underpin historical trauma: (1) mass trauma; (2) trauma continuing over an extended period; (3) traumatic events reverberating throughout the population to create a universal experience of trauma; and (4) the consequence of the trauma experience derailing the population from a natural, projected course.[17]

The framework of historical trauma has since evolved over the last few decades to include vulnerable populations, minority groups, and communities other than Native Americans to explain the relationship between present-day health disparities, oppression, and traumatic historical events as well as ongoing structural violence.[18]

CRITICAL RACE THEORY AND INTERSECTIONALITY

Critical race theory and intersectionality provide a powerful underpinning that moves away from the individual-level toward structural-level factors. Critical race theory and intersectionality derive from different disciplines (legal studies and black feminist thought), but when applied to health inequities, similarly acknowledge, name, and seek to dismantle oppressive structures in health care.

Critical race theory starts with the premise that racism is not an aberration, but rather, is embedded in everyday policies, structures, and institutions of American life.[19,21] BonillaSilva[20] used the term "racialized" in describing these systems, which emerged alongside the concept of race and which operate to maintain hierarchical social structures. The result is unequal distribution of resources and power that benefit the oppressing group, also referred to as

structural racism.[20] These power structures stem from white supremacy built on a scientifically debunked notion that a "white race" is genetically superior to nonwhite groups.[21] Public institutions, including health care institutions, are not exempt from these privileging and dominating structures and ideologies. Structural racism permeates throughout public and private sectors creating a matrix of inequities that become deeply embedded in all aspects of everyday life.[10] For example, discriminatory housing laws and segregation create neighborhoods in which people of color disproportionately live in substandard housing, are exposed to environmental toxins, and have limited opportunities for economic advancement.[10] The divestments in these communities make it difficult to attract primary care providers and specialists. As a result, community members have limited access to quality health care facilities, higher clinician to patient ratios, and a greater likelihood of experiencing racially biased care.[10] Yet, medical researchers and health care practitioners have explicitly and implicitly attributed disparate health outcomes of people of color to biological and intellectual inferiority.[22]

Intersectional analysis extends this critical stance, as it elucidates the ways in which social, economic, and political machinations manipulate determinants of health to perpetuate systems of oppression and domination.[23] Intersectional thought is historically rooted in resistance movements by women of color against violence and oppression in the late 19th and early 20th centuries. Crenshaw[24] and Collins[25] contributed early academic scholarship by explaining the tenets of intersectionality, which emphasize focusing on the complex nature of oppression for low-income women of color. Intersectionality theory emphasizes that the root causes of marginalization cannot be traced to one specific social location (race, class, or gender), but rather must include an overall analysis of how power functions to create a matrix of intersecting oppressive processes impacting people occupying multiple marginalized social locations.[23]

Multiple categories of difference (eg, gender, race, and social class) are both created and sustained by structures of domination. These categories of difference create categories of "other" that inform societal norms and standards in our everyday social processes.[23] Intersectionality emphasizes that this matrix of power differentials constrain opportunities for marginalized people, while privileging dominant groups, resulting in a status quo of oppression that is embedded in everyday institutions.[23]

Throughout history, marginalized populations in the United States (and worldwide) have engaged in various forms of resistance to demand reconciliation and restitution for the gross inequities imposed upon them by the ideologies of white supremacy and other systems of domination that have shaped our society.[26] The adverse health outcomes and generations of trauma that they have (and continue to) experienced impact their livelihoods and at times threaten their very existence. In the next section, we discuss key resistance movements of our time that help center our understanding of current health inequities and provide counter-narratives to the dominant tropes ascribed to various communities.

THE BLM MOVEMENT

The BLM movement is a recent example of a resistance movement whose goal is to call attention to and interrupt what is considered institutional and state-sponsored violence against black individuals and black communities. A global network with over 40 chapters, BLM is a social movement focusing on the experiences of black lives in the United States, and dismantling systems that perpetuate the devaluing of black and brown communities and people of color in the United States.[27]

The BLM movement was brought to life by Alicia Garza, Patrisse Cullors, and Opal Tometi—3 radical black women organizers BLM was created in response to the acquittal of

George Zimmerman, a self-appointed neighborhood watch captain, in Sanford, Florida, who shot and killed Trayvon Martin in February 2013. Trayvon was an unarmed African American teenager walking to his father's house (in a middle-class gated community), holding Skittles and an iced tea. The day after the verdict was announced, acquitting Mr Zimmerman, Garza posted the following on Facebook, which she later described as "an impassioned online message, 'essentially a love note to black people.'"[27(p453)] The post read, "Black people, I love you. I love us. Our lives matter."[27(p453)] Shortly thereafter, Tometi, Garza, and Cullors launched the BLM movement using social media. Similar to Trayvon Martin, Michael Brown, an unarmed African American teenager, was shot and killed by a police officer in Ferguson, Missouri, in August 2014. The case sparked national attention and within weeks of Brown's death BLM gained national recognition, as it mobilized the organization of peaceful resistance, connecting more than 500 people from over 18 major cities across the United States.[27]

DREAMers

The Deferred Action for Childhood Arrivals (DACA) program was established in 2012 as a mechanism for undocumented young adults, brought to the United States as minors, to receive temporary work authorizations, 2 years of deportation reprieve and the possibility of renewal.[28] This group is known as DREAMers, as they also form part of the immigrant population eligible to benefit from the federal DREAMers Act,[29] the DREAMers come from around the world with the majority born in Latin America. According to Lopez and Krogstad, ′ [30] most DACA recipients are from Mexico (548 000), followed by El Salvador (25 900), Guatemala (17 700), Honduras (16 100), Peru (7420), South Korea (7310), Brazil (5780), Ecuador (5460), Colombia (5020), and Argentina (3970). Even though DACA recipients are eligible for legal employment, they continue to face limited access to health care, including ineligibility for expanded Medicaid

coverage and insurance through the State Health Insurance Exchanges without federal subsidies.[29]

Castaneda and Melo ~ [31] note that even households eligible for social services avoid enrolling in public health programs out of fear of imprisonment and deportation. This state of fear has caused immigrant parents to isolate their children from support systems such as health care, as some institutions that were previously considered sanctuaries, have become targets of Immigration and Customs Enforcement (ICE) agents.[29] For example, Boggs[32] reported that ICE agents attempted to arrest individuals, merely suspected of being undocumented, at the entrance of their children's school in New Jersey. Other cases involved a woman who was detained by ICE agents while seeking domestic abuse protection at a Texas courthouse[33] and the case of a group of Latino men arrested by ICE agents after leaving a church warming center in Virginia.[34]

THE DAKOTA ACCESS PIPELINE

The 1800-mile, $3.78-billion DAPL carries crude oil beneath 4 states and 2 major rivers near the Standing Rock Indian reservation in North Dakota. Beginning in April 2016, the Standing Rock Sioux and their supporters (also known as the Camp of Sacred Stones) gathered in protest near the pipeline construction site, sparking the creation of the grassroots #NoDAPL movement. Standing Rock Sioux tribal members, other Native Americans, and non-Natives deemed themselves water protectors, and established the Sacred Stone Camp near the pipeline construction site to peacefully protest the construction of the DAPL.[35]

The #NoDAPL movement has been at the center of controversial years-long legal disputes about risks to water safety, colonialism, the eminent domain of the Native American land under the 1868 Fort Laramie Treaty, and placing corporate profits over lives. At the height of the movement, there were reports of protestors being pepper sprayed, shot with rubber bullets,

attacked by dogs, being denied food, water, and medical supplies, threatened by lawsuits, and drenched with cold water during freezing winter temperatures.[36]

The US government has a significant history of placing financial and business interests over Native American rights. Through a continued colonial legal framework, there was minimal inclusion of the tribe during the historical survey, permits were rushed, and plans and notification were not provided until the end of the process when approval for the pipeline was nearly finalized.[37] The Standing Rock Sioux tribe decided to take action after they were made aware of further violations of their land treaty and water rights. After many months of protests, exhaustive efforts by the Standing Rock Sioux, and more than 750 arrests of protestors, the battle of the DAPL ended.[36] Eventually, the camps were shut down and the protesters left. Over 520 000 barrels of crude oil now flow daily through the pipeline, beneath crucial sources of fresh water and through Native sacred lands.[36]

These movements are an indication that populations under constant threat of having their human rights denied are vying to have their voices heard from the margins to which they have been relegated. What the nursing profession can learn from these movements are strategies to harness our collective voices. As the largest body of health care professionals,[2] using nursing organizations is one platform for leveraging our collective power to serve as agents of change in an effort to improve health outcomes particularly among the most marginalized in our society. We speak to the role of the nursing profession in this regard, next.

RESPONSE OF THE NURSING PROFESSION

While the ANA has made statements calling for an end to the separation of immigrant children from their families at the border, for example, on many other issues, professional nurses and their governing bodies have for the most part remained silent. History has shown that our

silence has dire consequences. For example, in 1976, the Government Accounting Office released the results of an investigation into "incidental" tubal ligations or hysterectomies that had been performed during other routine procedures on Native American women, and without the consent of the patient, or with consent under coercion.[37] Records verified that the Indian Health Service (IHS) in 4 southwestern states had performed 3406 sterilizations between 1973 and 1976.[37] During this same period, there was an increase in abortions at IHS clinics. IHS health care professionals, including nurses, used coercive tactics to obtain consent by threatening to withdraw future health care provisions or threatening to take custody of the children of the Native American women involved.[37]

The silence and collusion with violence during colonization, the Tuskegee Syphilis study, and during the Nazi regime are all warnings as to how "suffering has been and is being perpetrated by us [nurses], and that we continue to promote suffering when we remain silent about the political realities that cause it."[38(p255)] One of the ramifications of the Tuskegee Syphilis study specifically, and a clear example of how historical trauma reverberates across generations, is the hesitancy of people of color to participate in research. This has important implications, as proposed health interventions may then not be culturally tailored to effectively meet the unique needs of specific populations when the experiences of those populations are not taken into consideration through research in the development of the said interventions. By advocating for populations that have experienced marginalization and by participating in the various movements that seek to redress experiences of oppression, nurses can help mitigate the distrust that has resulted from these historical events between minority populations and health care professionals. One way that nurses can specifically play a role in ensuring that the experiences of underserved populations are captured in research and inform effective interventions is by becoming involved

in the National Institutes of Health initiative, All of Us, which focuses on precision medicine that values diversity, recognizes the importance of acknowledging individual differences in developing knowledge about various diseases, and thereafter, seeks to ensure the development of effective treatment.[39] Our ultimate goal as nurses should be to center the voices of the most marginalized to ensure that their voices also inform health care practice and policy.

Combining the advocate and ally roles indeed requires nurses to amplify the voices of the communities suffering from systemic injustices. This is in recognition that the lived experiences of marginalization peoples are critical to dismantling oppressive systems and in creating effective and sustainable solutions. Authentic partnerships are those in which historically silenced voices are privileged such that communities are able to promote and advocate for their own needs. Anything short of this model of partnership threatens the human rights of communities on the margins and undermines the efforts of nurses.[8] Nursing advocacy and allyship becomes possible through the active participation in professional and civil organizations as well as to run for political office at the local, state, or national level.

NURSES AS ALLIES

There are a number of examples of nurses, individually and collectively, working as allies with marginalized communities. One example of nurse allyship and activism is the National Nurses United (NNU) organization that stood in solidarity with the #noDAPL water protectors.[40] The NNU is a national professional nursing association and network of volunteer RNs who advocate for safe, accessible, and quality health care for all as a human right. The NNU was vehemently opposed to the treatment of the #NoDAPL protestors, Standing Rock Sioux tribal members, First Nations members, and environmental activists by the police and security guards at the DAPL construction site.[40] In 2016, the NNU publicly condemned physical attacks and

brutal force by police and armed guards, stating that these attacks were "reminiscent of assaults on peaceful protestors during the Civil Rights movement."[40] In response, the NNU deployed nurse volunteers to assist with firstaid needs for those assaulted with pepper spray, physical attacks, dog bites, and other resulting health concerns.[40]

Another example of current nurse activism is the organization Rebellious Nursing Philly, a subgroup of a national Rebellious Nursing movement that began with a conference in 2013. Subsequent to this, Rebellious Nursing Philly began a local chapter and worked on various activism projects, one of which involved work with #BlackLivesMatter movement.[41] The group penned a statement on BLM and submitted a letter to the editor of the New England Journal of Medicine (unpublished) in response to articles about the BLM movement.[41]

Another example of nurse-as-ally includes the efforts of many American nurses and nursing organizations championing immigration justice. Among them is nurse Martha Williams of Weslaco, Texas, who created an area of reciprocity between the United States and Mexico, consisting of a network of free clinics along the border.[42]

Finally, in Arkansas, a nursing student and DACA recipient joined the state's Nursing Student Association and successfully advocated for new legislation to allow DACA recipients to take the National Council Licensure Exam (NCLEX).[43] The representatives of the ANA Membership Assembly recently addressed this issue, recommending that all the states allow the DREAMers to take the licensure examination (NCLEX) without facing barriers, as a supportive measure to diversify the US nursing workforce and ease the nursing shortage.[44]

MOVING FORWARD

As we reflect on our current political climate in the United States as well as in other western countries, we weigh the risks of remaining silent and the inadvertent impact of the

pivotal movements underway. We are moved to call upon nurses to take action and become allies. Informed by the frameworks of historical trauma, intersectionality and critical race theory, we recognize our responsibility to dismantle racism in all its forms— interpersonal, implicit, and structural. Nurses in the United States must recognize that our profession has been developed and continues to operate within the context of colonialism and structural racism. The nursing profession is thus a microcosm of these larger configurations of power.[38,45] By identifying ourselves as professional nurses and allies, we recognize that racism and colonialism are major drivers of health inequities in the United States.[45,46] We must therefore take direct and immediate action on a personal, community, and professional levels, especially because we work within an inherently racist health care system.[8] For white nurses who comprise the majority of the nursing workforce (81%),[47] this involves a serious and ongoing personal commitment to self-reflect and study the concepts and literature concerning white racial literacy.[48] Certain key concepts are critical for white nurses to understand as a part of this personal commitment.

One such concept is white fragility,[48] defined as the behaviors and defensive reactions that white people make when challenged about white supremacy. This defensiveness is a function of white supremacy perpetuating white privilege. White nurse allies must engage with the work of black feminist and critical race scholars to incorporate concepts such as intersectionality and colorblindness into nursing curriculum, practice, and policy. This will serve to improve our understanding of the ways in which white supremacy influences our thinking and actions as we work alongside marginalized communities for justice and liberation. For minority nurses, utilizing the tenets of intersectionality will facilitate reflection on the power they yield by way of their education and profession while not dismissing their experiences with marginalization based on their social location as a minority.[23]

Drawing on our understanding of our professional role as advocate and our history as allies, nurses well positioned to engage in an epistemological shift to focus on becoming allies because as professionals, we have a deep understanding about how to recognize disempowerment or loss of agency. Undergraduate nursing education is one avenue through which critical race scholarship can intervene to bring issues of race, power, and privilege to the fore. Research has shown that nurse educators recognize the importance of addressing structural inequities, specifically racism, but feel unprepared to do so.[49] Collins[50] notes that when any homogenous group dictates whose knowledge is considered valid, other ways of knowing—black feminist thought for example—are further marginalized. If taught in the absence of a critical pedagogy, the taken-for-granted assumptions are accepted without question and a white, European worldview becomes the implicit norm to which all other worldviews are compared and delegitimized.[51] Subaltern epistemologies provide a retort to this Eurocentric stance, and instead contend that knowledge can also be based upon the lived experience, allowing for multiple ways of knowing.[50]

The nurse as ally amplifies the voice of those on the margins in our clinical work, scholarship, and research. In other words, we emphasize the importance of centering in the margins.[19,23] This should not be undertaken from a place of sympathy, but out of our ethical mandate and social responsibility for justice.[1,52] Systems of oppression operate because the individuals operating within these systems do nothing to disrupt the status quo and in so doing collude with racism and injustice. As Young states, "individuals bear responsibility for structural injustice because they contribute by their actions to the processes that produce unjust outcomes."[52(p105)]

DISCUSSION

While current cultural, political, and economic ideologies make it incredibly challenging for nurses to practice in accordance with our moral and ethical mandates, we believe our knowledge, informed by critical race, intersectionality, and a deep understanding of historical trauma make us formidable in the fight for health equity. At the heart of our ethical identity is loyalty to our values, the lengths we are willing to go in order to uphold those values and a critical evaluation of historical complicities and of contemporary events that impact the nursing profession.[3]

Knowledge is inextricably linked with power[53] and, contrary to popular belief, nursing is not a profession void of power.[7] In fact, nurses have the capacity to both exercise and resist power, making nursing care inherently a political activity.[54] Acknowledging historical injustices is critical to understanding how they continue to reverberate in contemporary society. Armed with this knowledge, nursing, as a key profession in health care, has the necessary foundation on which to exercise power in order to improve health outcomes and changes in health policy. By engaging with these movements, as nurses, we become more knowledgeable and more aware of the realities faced by millions of our citizens existing on the margins of US society. More importantly, by privileging the voices of those who have lived experience of racism in the United States, nursing is utilizing epistemologies that have remained on the periphery of nursing education, practice, and policy.

Nursing history is rich with activism and action, built upon the scholarship and praxis of emancipatory nursing.[55] An overview of historical and contemporary nurses dedicated to social justice and activism can be found at https://nursemanifest. com/nursing-activism-project. This website also provides resources for current activism and a catalogue of articles related to nursing

activism. These resources need to be disseminated widely and incorporated into undergraduate and graduate nursing educational curricula, as they provide specific action steps to align nurses with our core professional, ethical, and human rights declarations.

In conclusion, we reiterate the sentiments in the nursing manifesto: “We believe that it is possible to find connection in the midst of alienation, to find inspiration in the midst of cynicism, to find nourishment and meaning in the midst of spiritual impoverishment, to find hope in the midst of despair, to find wholeness in the midst of fragmentation, to find peace in the midst of violence, to find enrichment in the midst of economic idolatry, and to find sovereignty in the midst of constraints.”[7(p79)]

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Chapter V: Discussion and Synthesis

My research sought to explore nurses' understanding of their professional role in addressing health inequities through volunteer experiences with a focus on efforts in Haiti. We utilized the concept of cultural safety along with critical race theory to explore how encounters by a predominately White workforce in a majority Black country were understood.

The findings of this research demonstrate that the nurses approached this work from a place of altruism and out of a sense of personal and professional responsibility to "give back." While undertaken with the best of intentions when viewed through a critical consciousness lens, we identified underlying assumptions on the part of the volunteers that served to perpetuate colonial and neocolonial ideologies. Left unaddressed these assumptions threaten to widen existing inequities.

In this chapter I will analyze and synthesize the findings from three manuscripts and discuss the implications that these findings have for the future of nursing education, practice, and global health policy. In this chapter I will use the terms Global North and South as this nomenclature references the geopolitical nature of globalization and capitalism (Dados & Connell, 2012).

Synthesis of Findings

The overarching goal of our research was to push the extant nursing and humanitarian literature by explicitly addressing issues of racism and power. The findings from the blog post analyses and the interviews revealed that interactions between humanitarian actors from the Global North and citizens of the Global South are rooted in a White/Other dichotomy that dates to colonialism.

Our work adds to the literature in which Henry (2020) posits that racist paradigms are upheld even as White people enter geographies where they are not the racial majority. Colorblindness, as originally understood, becomes unsustainable, irrelevant, and nonsensical when whiteness becomes visible. Henry's (2020) work centers on volunteers in southern Africa. My work adds to his call to add to the geographic dimensions of white supremacy ideology in transit by exploring these concepts in Haiti.

The commonalities in the 51 texts (blog posts and transcribed interviews) that we analyzed indicate several places where CRT coupled with CS can interrupt hegemonic discourses that continue to influence nursing care in the humanitarian setting. These include a depoliticization of humanitarian care, manifestation of neoliberal ideologies, and racist discourses.

Political, Historical and Social Contexts

The current plight of Haitians is the culmination of a violent history of colonialism, occupation, and ongoing exploitation. (Curtis, Jones, Tipene-Leach, Walker, Loring, Paine, & Reid, 2019).

Having arrived without an understanding of the sordid history of U.S. involvement in Haiti, the nurses relied on common tropes and stereotypes to explain the gross inequities they were witnessing. Both sets of data revealed that the nurses knew Haiti to be the poorest country in the Western hemisphere. This became the justification for the abject poverty that they observed. By acquiescing to the notion that this was expected in the Global South, the nurses did not probe for deeper explanations of how these inequities came to be. It was simply accepted as naturally occurring. Instead of being angered, confused or distraught over the scarcity they were witnessing, the nurses responded with pity. When the recipients of care are viewed as a group to

be pitied there is little incentive to offer more than token gestures of kindness. This kindness was extended through the delivery of healthcare that presumably met a patient's acute need in that moment. In turn, a polite smile, a nod of the head or the lack of protesting to having their picture was interpreted as signs of gratitude and appreciation on the part of the Haitian patient. In retelling of their experiences, the nurses frequently boasted about "making a difference," even while admitting it was for just one person. These individual experiences then led the nurses to engage in overgeneralizations and oversimplifications of life in Haiti.

Some critics go as far as to call volunteer humanitarian organizations modern day colonizers (Bandyopadhyay & Patil, 2017).

Racist Discourses

Centuries of distorted and denigrating portrayals of Haitian people as barbaric, uncivilized, and incapable of self-governance persist and serve as justification for the Global North to constantly interfere in all sectors of Haitian society (Sommers, 2015). Such portrayals can be found in the early writings of Christopher Columbus who landed on the island of Hispanola in 1491. In 1884, British diplomat Sir Spencer St. John derided Haitians as intellectually inferior, uncivilized and barbaric (Hood, 2018). These images were unearthed after the 2010 earthquake. Power relations are obscured through visualizations and testimonies that tout equity but ultimately typify paternalism and cast the Global South as perpetually dependent (Zeddies & Millei, 2015). The minimization of abject poverty is also a manifestation of another key theme across the texts, colorblind racism.

Colorblind racism. In the United States Whiteness and White privilege are so pervasive as to be largely invisible. Coupled with neoliberalism which places the individual responsible for their rung in the social hierarchy, colorblind racism is easier to assert in racialized societies. But

as White people enter predominately Black spaces, new ways of upholding White supremacy and denying racism are utilized (Henry 2020). Colorblind racism took on multiple forms including, minimizing racism, attempts to erase racialized differences and attributing inequities to "cultural" differences. Utilizing various forms of colorblind racism in the context of a short-term medical volunteer trip demonstrates the lengths to which White Supremacy contorts itself as a manner of self-preservation. For example, volunteers minimized the devastating effects of racism by invoking the "poor but happy" trope. This serves to both romanticize and trivialize the immense hardship of daily life in the absence of basic human rights such as clean water, adequate housing and a living wage. When referring to their own lives in the United States the nurses considered electricity and running water not as human rights but as 'blessings.' As one nurse said, "if the world falls apart, go to Haiti because they know how to live and not have all of these crazy things that we have." This indicates a lack of self-awareness as to their own social location in the United States. It also deflects from a closer examination as to the conditions, policies and power dynamics that give rise to such inequities.

Nurses attempted to erase racialized differences by calling upon features of common humanity (e.g. "we all bleed red"). Another manifestation of this form of colorblind racism is to divorce skin color from power and privilege. This was evident when the nurses shared that they were being noticed because they looked different, or Haitians weren't used to seeing White people. With one exception, there was not the recognition that Whiteness is representative of a place of stature in the global landscape; particularly in places with a history of colonialism.

Cultural racism is considered a precursor to colorblind racism. This form of racism asserts that inequities derive from certain values, traits, or characteristics that are lacking in groups of people.

The cultural racism construct in the United States dates to the 1960s with the dissemination of Daniel Patrick Moynihan's report, "The Negro Family: The Case for National Action" (Bonilla-Silva, 2006). In it, Moynihan cites the "culture of poverty" framework as evidence that Black marginalization in the United States was due a breakdown in family values and a poor work ethic. As the rationale for marginalization of racial groups based on biological inferiority fell apart, notions of cultural inferiority replaced them (Bonilla-Silva, 2006).

The use of critical theories is valuable to the analyses of these complex global interactions and how these interactions further oppression. Explicit explorations of the social construction of race and its role in creating and maintaining power structures are essential in nursing and humanitarian discourses. Critical race theory requires that racialized stereotypes be replaced with accurate and nuanced portrayals Haitian people. The theory of intersectionality allows for Haitians to be understood not as a monolithic group, but rather as individuals with fluid and dynamic identities who share collective experiences

Next, I explore how the economic-turned-political theory neoliberalism, came to influence interpersonal volunteer experiences (Figure 1) so heavily and how this showed up in my research.

Manifestations of Neoliberalism

Neoliberal Philosophy.

Proponents of neoliberalism maintain that an unfettered free market is optimal and a self-regulating social structure (Baru & Mohan, 2018). According to this ideology, the state has no role in production or services as it causes distortions in the equilibrium of the market. The language, metaphors, and concepts central to neoliberal philosophy are pervasive in all private and public sectors, including healthcare (Baru & Mohan, 2018). Under this philosophy it

becomes increasingly difficult for already marginalized groups to fully participate in civic engagement. This becomes a vicious cycle whereby the rights of all individuals are not fully recognized (Baru & Mohan, 2018).

The tenets of neoliberalism, namely state withdrawal, privatization, and trade liberalization have shown to destabilize already fragile states, including Haiti. Neoliberalism in the global context has privileged consumption and competition over community and cooperation A manifestation of neoliberalism is evident in policies adopted by the World Bank and International Monetary Fund in the form structural adjustment programs.

Structural Adjustment Programs (SAPs)

Structural adjustment programs are macrolevel policies that when adopted allow for indebted nations to become eligible for forms of debt relief, such as loans (Baru & Mohan, 2018). According to Fatton (2015) these policies have relegated Haiti to an "outer periphery" and subject to a self-appointed international community of non-governmental organizations (NGOs). An outer periphery is maintained by low-end production, wages that, if paid at all, are grossly insufficient to meet basic needs, extremely high unemployment rates, a vast informal sector and lastly, a state unable to maintain sovereignty (Fatton, 2015).

Haiti's current relegation to a global outer periphery is evident. Haiti's unemployment rate (est. 2017) is 40.6%; over half of Haiti's workforce is employed in the informal sector, and 70% of workers earn less than the minimum wage. (World Bank Group, 2015). Eighty percent of Haiti's social services were being provided by approximately 10,000 NGOs operating at the time of the 2010 earthquake (Schuller, 2012). With an emphasis on privatization of otherwise public goods, neoliberalism gave rise to the prominence of non-governmental organizations, particularly in resource-poor settings.

Non-governmental Organizations

Non-governmental organizations (NGOs) are considered part of the third sector, the private sector or civil society. Because they operate independent of government, they are thought to be more efficient and more capable of democratization. Non-governmental organizations are considered to serve a dual purpose as they can fill a void resulting from a failure of the state while at the same time minimizing the role of the state.

In her article Pouligny (2005) explains how current definitions of civil society have become too rigidly associated with Western concepts of modernity and neoliberalism. This results in several unintended consequences: 1) outsiders, not recognizing civil society organizations in a local context, have difficulty in establishing meaningful connections with existing arrangements, 2) in purporting to work to build local civil societies, outside NGOs end up collaborating only with other outsiders, and 3) the relationship with local organizations takes on a very uneven, paternalistic, and hierarchical structure.

International strategist and activist, Kristina Delgado states, "The nonprofit and philanthropy sector is really based on privilege, and that implies white privilege a lot of the time" (as cited in Hamad, 2019, p. 114). The insidious nature of White privilege is not limited to the ways in which NGOs interact with communities but within the organizations themselves. A scathing report in 2019 implicated Amnesty International, a highly recognized NGOs across the globe, in creating a toxic work environment rife with bullying and harassment particularly aimed at racial and other minority employees (Hamad, 2019). Similar findings of discrimination have been leveled against Oxfam and Save the Children (Kaschel, 2019). Part of the toxicity is due to pressure placed on employees to perform at levels that sacrifice their own well-being because of the importance of the work. This sense of urgency is a manifestation of White supremacy.

The day-to-day urgency to produce results for funders and maintain power structures undermines the real urgency of addressing health inequities. Toxic work environments that manipulate employee passion and dedication, resulting in employee mental, physical and moral burnout are antithetical to authentic efforts to dismantle unjust systems (Okun, 2021).

Volunteers.

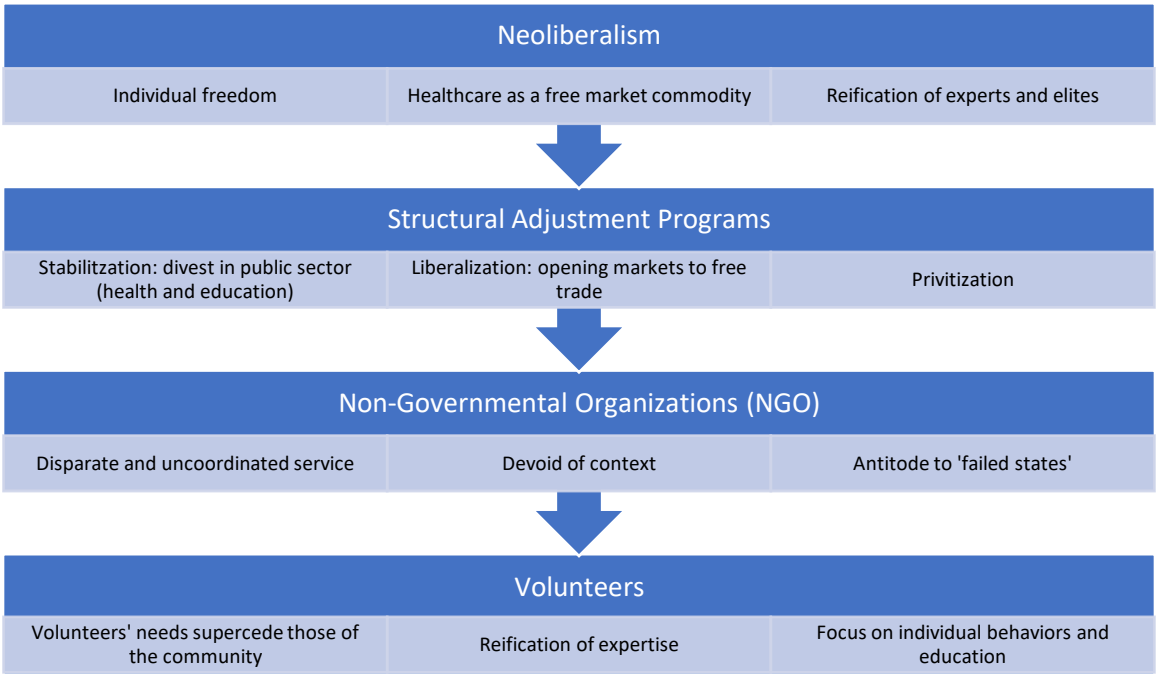
The tenets of neoliberal ideology were evident in the interviews and in the blog posts in two ways: humanitarianism from a consumer approach and health as a function of meritocracy. This consumerist approach serves to reinforce the neoliberal agenda as volunteers' needs for self-fulfillment, resume-boosting, and adventure take precedence over the needs of the community (St-Amant, Ward-Griffin, Berman, & Vainio-Mattila, 2018). The following five tag lines came from volunteer websites from which I retrieved the nurses' blogs: "(name of organization) helps respond to the need of nurses," "making a difference," (name of organization) allows providers to re-connect with why they decided to practice medicine, and "volunteering not only helps advance our mission but also benefits our individual volunteers, like you. Collaborating with us can help you develop your skill set, build experience and make contacts."

In fact, analysis of both sets of dataF revealed that the volunteers needs took precedence over the needs of the communities in which they served. These needs ranged from the physical accommodations during the trip to more existential needs such as fulfilling a life-long dream.

Volunteers can move freely in and out of the Global South not as new colonizers but under the guise of a good global citizen (Ziddies & Millei, 2015).

Figure 1

Title



Nursing Practice

Nursing Identity

If nursing is prepared to identify and acknowledge the vestiges of the legacy of racism and colonialism persistent in nursing education, practice, and research (Louie-Poon, Hilario, Scott, & Olson, 2021) we must then be willing to reimagine and redefine our professional identity. Stereotypes of nurses abound, largely generated by the machinations of a White patriarchal and capitalist society. Take for example the authoritarian (oppressive) Nurse Ratched, the hypersexualized (patriarchal) "naughty nurse" or the angelic (Christian, White) angel of mercy. As nursing continues to vie for a spot in the medical hierarchy we must ask, what internalizations do we embrace and at what cost (Bell & van Daalen-Smith, 2021)?

Nursing as an art is defined by the central concept of caring (Smith and Foth, 2021). Caring is equated with providing unbiased care and confers a degree of innocence to nurses,

feeding the ‘angel of mercy’ narrative. But as discussed throughout this chapter, this apoliticization of nursing care comes at the cost of genuine reflexivity regarding individual and systemic collusion with White supremacy (Bell & van Daalen-Smith, 2021). In her book, White Tears, Brown Scars, Hamad (2019) explores the concept of innocence as an incarnation of colonial (White) femininity. The portrayal of “White woman (e.g. nurse) as innocent” is at the crux of White supremacy that is complicit in harm to the racialized Other (Hamad, 2019). This is especially relevant to nurses in the humanitarian space where the work is often lauded as “doing God’s work”.

Nursing as a science is defined by evidence and competency-based practices. These concepts fit squarely into the biomedical and neoliberal paradigm (Smith & Foth, 2021). Here too we must ask how is the evidence base determined? Whose knowledge is privileged? Nursing in early efforts to legitimize itself as a scientific discipline, adopted positivist and Eurocentric frameworks. This leaves little room for reflective practice or voices of the altern.

The reimagining of the nursing profession can begin at the very least, in the first semester of the nursing curriculum with a comprehensive examination of its history utilizing the tenets of CRT and CS. Nursing icons and established nursing theories can still be heralded for contributions to nursing science while also framing the work within political, historical and social contexts. For example, cultural competency remains the predominant framework guiding nurses in providing care to diverse populations (Rajaram & Bockrath, 2014). Competencies imply a set of technical skills that can be objectively learned and mastered. The definition of culture has remained relatively static within this framework. Culture is conflated with race and ethnicity; Whiteness is assumed to be culturally neutral and belongs only to the racialized “Other” (Rajaram & Bockrath, 2014). The insights of antiracist activists and scholars informing

the Overdue Reckoning project provide concrete principles from which nursing can move toward becoming an antiracist discipline and discussed in the next section (Canty, Nyirati, Taylor, & Chinn, 2022).

These guidelines are congruent with tenets of critical race theory and cultural safety. For example, principle three calls for a privileging of the voices of nurses of color. In so doing, nursing education stands to gain important perspectives that have heretofore been largely silenced (Canty, Nyirati, Taylor, & Chinn, 2022). Black feminist epistemology provides a retort to the positivist stance, and instead contends that knowledge is based upon the lived experience, allowing for multiple truths (Collins, 2000). Students, from entry into the program through graduation, should be exposed to alternate ways of knowing and provided the space to question the assumptions underpinning professional nursing practice. This means more than a guest lecture or one-time presentation. Rather, Black scholarship should be infused throughout the curriculum in the multiple forms that represent subaltern voices: music, poetry, and literature (Collins, 2000). Also, the concepts originating from Black scholarship that inform contemporary nursing practice, namely interdisciplinary practice and intersectionality, need to be credited to the Black scholars who introduced them, and their scholarly writing included as assigned readings alongside traditional nurse theorists.

Advocate or accomplice? If nursing is to claim to be undeniably antiracist, is there is no stance too radical, an action too controversial to undertake (Bell & van Daalen-Smith, 2021). Paynter et al., (2020) is calling for nursing to undertake "abolition as a nursing intervention" where abolition is the path to redressing the "structural determinants of harm" (p. 471).

Principle seven calls for nurses to engage in acts of resistance (Canty, Nyirati, Taylor, & Chinn, 2022). Resistance is a cornerstone in efforts to dismantle racialized hierarchies (Christian,

2019). The manuscript entitled “The role of nurses as allies against racism and discrimination. An analysis of key resistance movements of our time” was published in Advances in Nursing Science in 2020. This manuscript was authored by women of multiple racial identities, ethnicities and other social locations representing both privilege and marginalization. Utilizing critical theories, including critical race theory, three key resistance movements: Black Lives Matter (BLM), the Deferred Action for Childhood Arrivals (DREAMers) and protests of the Dakota Access Pipeline (DAPL) were highlighted. The historical contexts that gave rise to these movements were explored in this manuscript. Providing historical context to contemporary efforts aligns with the principles of both critical race theory and cultural safety.

“If there’s not a change there’s not going to be a change. If there are not other people like myself who are brave enough to have a voice for other people…. a lot of people are afraid to speak out” (Soboroff, 2020, 2:28. These are the words nurse Dawn Wooten, the whistleblower in the allegation of abuses occurring at the Irwin County Detention Center, a private prison holding immigrants detained by Immigrations and Custom Enforcement. Ms. Wooten exposed the abuses of power in which physicians were conducting hysterectomies on women with limited or no consent and blatantly ignoring COVID-19 protocols. Her action sparked swift policy change within the Homeland Security Department. But nurse Wooten, who identifies as a Black women and single mother of five, was left to start a GoFundMe page. She is now unemployed and claims her status as a whistleblower is preventing her from getting hired.

Resisting oppression against people of color cannot rest on the shoulders of people of color. Nurses educated in emancipatory and antiracist pedagogies will be better prepared to act as allies or accomplices in such instances. Nurses as cohesive resistors can be a formidable force against institutionalized abuses of power.

Global Health Policy

The focus of non-governmental organizations should support and build capacity of the local community as opposed to emphasizing service provision (St-Amant, Ward-Griffin, Bermna, & Vainio-Mattila, 2018). A case study by Senat, Barron, Boano, Carpi, Leon, and Meaney (2017) demonstrated one of the most promising models in terms of effective delivery of humanitarian services. A private sector initiative funded by Habitat for Humanity (HFM), the urban development project in Simon Pele Haiti, offers a template from which the public sector can learn. This project was HFH's first venture into urban revitalization in Haiti and was undertaken in response to community feedback following the 2010 earthquake. This project was guided by three overarching principles: 1) a holistic, multi-year approach, 2) large-scale community capacity building, and 3) infrastructure (roads, streetlights, drainage etc., (Senat, Barron, Boano, Carpi, Leon, and Meaney, 2017). Since its inception, this project has demonstrated success in meeting its goals. The lessons learned provide valuable information for donors. Such lessons include:

1. A crucial component to capacity building is to support local governance structures and community-based organizations,
2. Engage in activities that involve communities at every phase; this will serve to strengthen community connections and increase the likelihood of sustainability,
3. Provide full transparency in all aspects of the project including finances, and
4. Allow for the full range of voices, perspectives, and experiences to inform how priorities are established.

Inarguably as one of the most powerful actors in global development, The United States Agency for International Development (USAID) has the potential to significantly impact

progress toward strengthening local healthcare systems. Applicants wishing to receive USAID funding for health initiatives in Haiti need to be able to demonstrate the following in their grant proposals:

1. Applicants will have undertaken an assessment of the impact of their project proposals on the local healthcare delivery systems(s). This could include a Health Impact Assessment (HIA). Health Impact Assessments are a tool that provide a means to conduct an evidence-based analysis of the potential risks and benefits of a proposed policy or intervention (Bourcier, Charbonneau, Cahill, & Dannenberg, 2014).

2. Applicants must demonstrate authentic community engagement with local healthcare providers. This includes input at all stages of program development from the needs assessment through evaluation utilizing a Community Based Participatory Research approach.

3. For every dollar requested for investment in United States contracted services, a matching dollar needs to be invested in strengthening the local healthcare nursing workforce through the provision of continuing education opportunities.

For too long foreign assistance has been complicit in perpetuating inequities between the donor and recipient entities (Schuller, 2012). A new model of humanitarian assistance is needed to hold donors accountable to the communities they intend to serve.

Limitations

This research was not without its limitations. The study was to have included focus group interviews in Haiti with Haitians who had received medical services from U.S. volunteer groups. Unfortunately, those focus group interviews did not take place. Political unrest coupled with the COVID-19 pandemic rendered traveling to Haiti unsafe; for both myself and for the communities to which I intended to travel. The voices of the recipients of humanitarian efforts

are essential is fully understanding the perceptions and impact of humanitarian efforts delivered by the United States in Haiti. As soon as it is deemed safe to travel to Haiti, I will resume my research and conduct the focus group interviews.

The sudden and prolonged impact of the COVID-19 pandemic served as a limitation in a number of ways. First, it affected my ability to recruit as the demand on nurses' time grew exponentially and human efforts were put on an indefinite hiatus, thus limiting my interviews to 18. The demands of my own time and energy as a public health nurse during the pandemic limited my ability to attend to my scholarly work.

Conclusion

The purpose of this dissertation was to explore humanitarian nursing with a focus on racialized power differentials. The legacy of colonialism and the ways in which it has informed nursing practice in the United States remains a specter threatening to undermine efforts to address health inequities across borders. The results of this work show the ways current cultural theories are operationalized warrants a paradigm shift with attention to racialized power differentials. The tenets of CRT and CS together offer tools to engage in a nuanced understanding of the relationship between structural inequalities (e.g. racism) and health.

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Appendices

APPENDIX A : INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY of WISCONSIN
UWMILWAUKEE
Department of University Safety & Assurances

Melody Harries
IRB Administrator
Institutional Review Board
Engelmann 270
P. O. Box 413
Milwaukee, WI 53201-0413
(414) 229-3182 *phone*
(414) 229-6729 *fax*

uwm.edu/irb
harries@uwm.edu

New Study - Notice of IRB Exempt Status

Date: January 10, 2020

To: Lucy Mkandawire-Valhmu
Dept: Nursing

CC: Jennifer Weitzel

IRB #: 20.121
Title: Cultural safety and the provision of humanitarian care in Haiti

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has been granted Exempt Status under Category 2 as governed by 45 CFR 46.104(d).

This protocol has been approved as exempt for three years and IRB approval will expire on January 9, 2023. Before the expiration date, you will receive an email explaining how to either keep the study open or close it. If the study is completed before the expiration date, you may notify the IRB by sending an email to irbinfo@uwm.edu with the study number and the status.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. The principal investigator is responsible for adhering to the policies and guidelines set forth by the UWM IRB, maintaining proper documentation of study records and promptly reporting to the IRB any adverse events which require reporting. The principal investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

As Principal Investigator, it is also your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., FERPA, Radiation Safety, UWM Data Security, UW System policy on Prizes, Awards and Gifts, state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation, and best wishes for a successful project.

Respectfully,
Melody Harries
Melody Harries
IRB Administrator

APPENDIX B: SCREENING QUESTIONS

Screening questions individual interview participants:

1. Did you graduate from or are currently enrolled in a U.S. accredited School/College of Nursing?

2. Are you currently licensed to practice nursing?

3. Were you licensed to practice nursing at the time of your travel to Haiti?

4. Were you enrolled in a U.S. accredited School/College of Nursing at the time of your travel to Haiti?

APPENDIX C: RECRUITMENT EMAIL

Subject: Request for participation in research study

Study Title: Cultural safety and the provision of humanitarian care in Haiti

My name is Jennifer Weitzel and I am a doctoral student in nursing at the University of Wisconsin - Milwaukee. I am seeking nurses or nursing students who have traveled to Haiti with a volunteer medical group to participate in my dissertation study. My study aims to understand how nurses' understand their role in addressing health inequities in Haiti. This is a qualitative study that will require one virtual individual interview that will be scheduled at a time that is convenient for the participant. I am requesting your help in sharing this opportunity to participate with your organization's volunteers.

Anyone who is interested in participating can contact me via email, jweitzel@uwm.edu or by phone, 608-213-1301.

Thank you,

Jennifer Weitzel, MS,RN

APPENDIX D: DEMOGRAPHIC SCREENING

Demographic Data Individual interviews:

1. Age:
2. Highest nursing degree held,
3. Years in practice,
4. Practice setting,
5. Gender,
6. Race and ethnicity
7. History of international volunteer experiences (nursing related).

APPENDIX E: INTERVIEW GUIDE

Interview Questions Individual Interviews:

Question 1: Tell me about your decision to volunteer in Haiti. Prompts: Why was that important for you to do?

Question 2: Tell me about your experience volunteering in Haiti. Prompts: What was the setting in which you worked? What was your primary role?

Question 3: Tell me how you came to volunteer with the X organization?

Question 4: How did you prepare for your trip?

Question 5: How did your experience compare to what you were expecting?

Question 6: What is your understanding of the relationship between Haiti and the United States?

Question 7: What was your experience as a white nurse working in a majority black country?

Question 8: Tell me about your experiences in the United States working with patients of backgrounds different from your own? Prompts: What are the demographics of patients you work with? Describe what providing culturally competent care looks like.

Question 9: What, in your opinion are the most important factors impacting health?

Question 10: As nurses, what do you feel our responsibility is in improving the health in our patients, our communities and globally?

Curriculum Vitae

Jennifer Weitzel
jweitzel@uwm.edu

Nurse scholar dedicated to addressing health equity at the local, national, and global levels. Practice and research grounded in social justice, inclusivity, centering at the margins and reflective practice.

Education

- Bachelor of Science – Bacteriology

University of Wisconsin – Madison 1993

- Bachelor of Science – Nursing

University of Wisconsin – Madison 1998

- Global Health Certificate

University of Wisconsin – Madison 2008

- Masters of Science – Nursing

University of Wisconsin – Madison May 2010

Professional Experience

Public Health Nurse – Ho-Chunk Nation Health Department 1999 – 2005

- Provided public health nursing services to Ho-Chunk nation tribal members residing in a five county service area including but not limited to: antenatal care, immunizations, communicable disease follow up, chronic disease management, health education, physical assessments, referrals and case management
- Supervised unlicensed supportive and personal care workers
- Precepted undergraduate nursing students

Public Health Nurse – Public Health Madison & Dane County 2005 – 2021

- Program planning and evaluation
- Agency coordinator for students and interns
- Preceptor for Area Health Education Consortium interns
- Preceptor for Masters of Public Health students
- Preceptor for undergraduate nursing students
- Facilitated agency wide internal assessment regarding capacity to address health inequities in Dane County
- Neighborhood level emergency preparedness project
- Community assessment
- Public health nursing interventions at neighborhood and systems levels
- Grant writing
- Communicable disease follow up
- Nurse-Family Partnership Supervisor

Clinic Nurse – Group Health Cooperative 2001 – 2009

- Provide phone triage to patients calling into acute care
- Provide direct patient care to patients utilizing the urgent care

Clinical Instructor – Edgewood College School of Nursing 2007 – 2015

- Instructor for Nursing 461: Nursing Care with Aggregates (undergraduate)

- Student advising
- Conduct lectures/facilitate discussion regarding current public health issues
- Course development
- Instructor for Nursing 810: Population Health and Health Policy (doctoral students)

Ebola Recruiter - Partners in Health November 2014 - June 2015
Conducted phone interviews with candidates applying to deploy to West Africa to work in Ebola Treatment Units.

Deputy Directory, Sauk County Health Department August 2021-present

Presentations

- Neighborhood and Community Preparedness (2007). Tenth Annual Public Health Nursing Conference, Stevens Point WI
- Public Health Nursing in Haiti (2008). Eleventh Annual Public Health Nursing Conference, Stevens Point WI
- P.L.A.N. – Preparedness through Linking All Neighbors (2009). Public Health Preparedness Summit, San Diego CA
- Preparedness through Building Social Capital (2009). Understanding and Overcoming Poverty in Wisconsin conference, Wausau WI
- Emergency Preparedness, Health Equity and Social Capital (2009). Panel discussion: Tales from Planet Earth film festival, Madison WI
- Wisconsin Student Nurses Association (2010). Keynote Speaker: Global Health Nursing, Madison WI
- The Haiti Earthquake (2010). Janesville Area Retired Educators Monthly meeting , Janesville WI
- Using Case Studies to Understand Health Equity and Environmental Health (2012). Wisconsin Environmental Health Association Annual Conference, Madison WI
- Health Equity (2012). Statewide New Public Health Worker Orientation, Wausau WI
- Addressing health inequities through cultural safety (2017). Transcultural Nursing Society Annual Conference. New Orleans, LA (international).

Grants

- National Association of County and City Health Officials, "Addressing Health Equity and Social Justice through Emergency Preparedness" 2007
- City of Madison, "Emerging Neighborhoods" 2008
- Dane County Medical Society 2009
- Wisconsin of Department of Children and Families, "Maternal, Child, Infant, Home Visiting" 2015 and 2017 (co-author)

Organizations

- Wisconsin Public Health Association, Board member, 2008 - 2010
- Haiti Medical Mission of Wisconsin, 2007 - 2010
- Health Ministries for Haiti, Inc, Co-founder and President, 2006 - Present

• National Association of County and City Health Officials – Health Equity and Social Justice Committee Member, 2011-Present
• Fellow at the National Leadership Academy for the Public's Health; Centers for Disease Control and Prevention and Center for Health Leadership and Practice, 2013-Present

Awards
• 2010 University of WI Nurses' Alumni Association Outstanding Service Award
• 2014 Society of Practitioners of Health Impact Assessment Model Report for: "Alcohol Outlet Density Ordinance Review of City Staff Recommendations"

Publications

Mkandawire-Valhmu, L., **Weitzel, J**., Dressel, A., Neiman, T., Hafez, S., Olukotun, O., ... & Morgan, S. (2019). Enhancing cultural safety among undergraduate nursing students through watching documentaries. *Nursing inquiry*, *26*(1), e12270.

Heitzman, M., **Weitzel, J.**, Kroll, S., & Zabler, B. (2019). Client experiences in a prenatal home visiting program: A prenatal care coordination program evaluation. *Public Health Nursing*.

Olukotun, O., Mkandawire-Vahlmu, L., Kreuziger, S. B., Dressel, A., Wesp, L., Sima, C., ... & Kako, P. (2018). Preparing culturally safe student nurses: An analysis of undergraduate cultural diversity course reflections. *Journal of Professional Nursing*, *34*(4), 245-252.

Wesp, L. M., Scheer, V., Ruiz, A., Walker, K., **Weitzel, J**., Shaw, L., ... & Mkandawire-Valhmu, L. (2018). An Emancipatory Approach to Cultural Competency: The Application of Critical Race, Postcolonial, and Intersectionality Theories. *Advances in Nursing Science*, *41*(4), 316-326.

Possible benefits	• [List individual benefits (if any).] • [List benefits to a larger group or society (such as helping understand more about xyz).] **[Don't** include compensation here; you'll describe that below.]
Estimated number of participants	[insert #. If needed, add explanation or description of different groups, e.g. 40 teachers and 300 students]

How long will it take?	[insert the total time commitment for the participant]
Costs	[Describe. **Examples:** None **– or –** You'll pay for your own transportation and parking]
Compensation	[Describe. **Examples:** None **– or –** $10 Amazon gift card **– or –** 1 hour extra credit] [Use the following if participants are paid through UWM accounts payable, and you have NOT requested level 3 confidentiality] Due to UWM policy and IRS regulations, we may have to collect your name, address, social security / tax ID number, and signature to give you this compensation.
If I don't want to be in this study, are there other options? [If the only alternative is not to participate, delete this row.]	Instead of participating, you can [insert alternative(s)] **Example:** Instead of participating, you can earn the same amount of extra credit by answering questions 1-2 on page 394 of your textbook.
Future research	De-identified (all identifying information removed) data / biospecimens may be shared with other researchers. You won't be told specific details about these future research studies. **– or –** Your data / biospecimens won't be used or shared for any future research studies.
Recordings / Photographs [Delete this row if n/a]	We will record / photograph you. The recordings / photographs will be used for [explain].

	The recording / photography is optional. **– or –** The recording / photography is necessary to this research. If you do not want to be recorded / photographed, you should not be in this study.
Removal from the study [Delete this row if n/a]	[Describe any circumstances that would result in a participant being removed from the study. **Example:** In order for our data to be useful, it is important that you attend every mindfulness session. If you miss a session and can't reschedule, we'll have to take you out of the study.]
Gene sequencing [Delete this row if not using biospecimens]	The specimens you provide will be used in genetic research. This research may include whole genome sequencing. [explain specifically what genetic research will be done in clear, easy to understand language.] **– or –** Your specimens will not be used for any genetic research or gene sequencing.
Funding source [Delete this row if n/a]	[insert funding source]
Financial profits [Delete this row if no biospecimens, or if no commercial profits are expected to result from the research]	If the researcher / sponsor earns financial profits from using your biospecimens in this research, these profits will / won't be shared with you.

[Use if more than minimal risk. Edit for the specific potential risks in your research] What if I am harmed because I was in this study?
If you're harmed from being in this study, let us know. If it's an emergency, get help from 911 or your doctor right away and tell us afterward. We can help you find resources if you need psychological help. You or your insurance will have to pay for all costs of any treatment you need.

Where will data be stored?	[Explain] **Examples:** On our computers **– or –** In my office at UWM
How long will it be kept?	[insert amount of time]

Who can see my data?	**Why?**	**Type of data**
The researchers	To conduct the study and analyze the data	[State the kind of data you will collect/keep, with a brief explanation what that means.] **Examples:** Identifiable (with your name included) **– or –** Coded (names removed and labeled with a study ID) **– or –** De-identified (no names, birthdate, address, etc. attached to the data)
The IRB (Institutional Review Board) at UWM	To ensure we're following laws and ethical guidelines	[This should be the same as above.]

The Office for Human Research Protections (OHRP) or other federal agencies		
Anyone (public)	If we share our findings in publications or presentations [use if applicable] Our funding agency requires us to make our dataset public so other researchers can use it.	[State the kind of data that will be included in dissemination of your work, or in public datasets.] **Examples:** • Aggregate (grouped) data • De-identified (no names, birthdate, address, etc.) • If we quote you, we'll use a pseudonym (fake name)
Amazon [delete this row if not an MTurk survey]	Because they own the MTurk internal software, and to issue payment	• MTurk worker IDs • There is a possibility Amazon could link your worker ID (and associated personal information) with your survey responses.
Include additional rows if there is anyone else who might access the data. Describe the purpose of this disclosure and what type of data (identifiable, de-identified, etc.).		•

Contact information:

For questions about the research	[insert Researcher name(s)]	[insert phone & email, or other best contact method]
For questions about your rights as a research participant	IRB (Institutional Review Board; provides ethics oversight)	414-229-3173 / irbinfo@uwm.edu
For complaints or problems	[insert Researcher name(s)]	[insert contact information]
	IRB	414-229-3173 / irbinfo@uwm.edu

Signatures

If you have had all your questions answered and would like to participate in this study, sign on the lines below. Remember, your participation is completely voluntary, and you're free to withdraw from the study at any time.

_____

Name of Participant (print)

_____ _____

Signature of Participant Date

[Use if minors or individuals with a Legally Authorized Representative may be enrolled] If participant is a minor or requires a Legally Authorized Representative:

_____

Name of Parent, Guardian or Legally Authorized Representative (print)

_____ _____

Signature of Parent, Guardian or Legally Authorized Representative Date

[Use if the researcher will obtain informed consent in person]

_____

Name of Researcher obtaining consent (print)

_____ _____

Signature of Researcher obtaining consent Date