

## LaRon Nelson – Canada’s Rising Star in Global Health



**LaRon Nelson,\* RN, NP, PhD**, is clinically trained in the primary care of families, with an emphasis on the care of adolescents. He has practised in various community-based settings, including a local public health STI clinic and correctional facility, and an adolescent health clinic. He was the first African-American man to receive a doctoral degree in nursing from the University of Rochester in May 2010. Dr. Nelson’s program of research involves the development of integrated biomedical, behavioural and social/structural interventions for the prevention of HIV and other sexually transmissible infections among socially marginalized groups within African and African Diaspora communities. His current research focuses on understanding how autonomy, supportive counselling strategies, gender-equitable attitudes and the promotion of socio-culturally and developmentally relevant co-parenting can help reduce STI/HIV risk behaviours among non-married adolescent parents in Toronto, Ontario and New York, New York.

---

\* At the time of this interview, Dr. Nelson announced his imminent departure from the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto to assume the position of assistant dean for global & community affairs at the College of Nursing, University of South Florida.

In 2011, Dr. Nelson was inducted as a Distinguished Practitioner in the US National Academies of Practice. He has received numerous other awards for his community-based research and clinical practice, including Canada's Rising Star in Global Health award. Dr. Nelson's research has been funded by Grand Challenges Canada, the National Institutes of Health and the Centers for Disease Control and Prevention.

Editor-in-Chief Lynn Nagle recently spoke with Dr. Nelson.

**Q: Can you tell our readers about your nursing background and your research interests?**

**A:** I began my clinical practice [as an RN] in public health nursing, working for a local health department in a sexually transmitted infection (STI) clinic. When I became a nurse practitioner I worked in an adolescent health unit of an urban community health centre. Ultimately, I became the associate director for Public Health for Rochester, Monroe County, New York. My clinical practice and my research have always been focused in community health and public health, specifically, working to prevent STIs, including HIV.

**Q: Was there anything in particular that drew you to that area of focus?**

**A:** No. I get that question often and I have not been able to pinpoint exactly what it was. I was drawn to work related to how HIV affected communities outside the hospital. I'd been interested in this particular clinical population, with a focus on groups who were pushed to social margins and with life complexities that placed them at risk for STIs. In the city where I was working, many of these groups were low-income Blacks and Latinos.

**Q: Do you think there's an opportunity for us to do something different in terms of preparing nurses to work with these populations?**

**A:** What I've learned from being a leader in public health and a nurse educator is that there can be a significant disconnect between nurses and some of the people to whom we provide care. Not everyone gets exposed to the issues we deal with in public health. We do teach nurses how to treat human response to illness, but in terms of understanding people's social context and how that influences the illness experience, we could do a better job at helping nurses to understand that aspect. There are opportunities in nursing education to address some of those issues.

**Q: In terms of your clinical research, you've received recognition recently for some of the work you are doing, particularly in Ghana. Can you describe your current research?**

**A:** I conduct research in African and African-descendent communities in the United States, Canada and Ghana. The research is mostly focused on individuals at high risk for HIV and mostly with men who have sex with men (MSM). From

a public health perspective, it is difficult to raise the health status of a community unless you deal with the people who suffer the worst health outcomes. If we focus all our attention on the people who are doing well, even if we get them to do better it doesn't do much to improve the health status of communities because these people are already doing okay. For sure, we need to maintain the health status of those who are well, but it's the communities who are faring really badly that need to be prioritized for intervention in order for the overall health status of the community to improve.

I was always interested in the people experiencing the worst health outcomes, particularly Black MSM. Without figuring out what's happening with this particular community, we can't make population-level improvements in the HIV epidemic. It is a similar pattern all around the world.

**Q: In the research that you've done thus far, has there been any pivotal turning point or key learning that's evolved from your research?**

**A:** I have also worked with adolescent parents, and in the beginning, it was mostly with women. I always found the experience of women fascinating, but so much so that I think I ignored the perspectives and experiences of the male partners, even though most of the majority of the women that I study have male partners. I ignored the men for a long time. But then, when I started talking to men and fathers, it really changed my approach and caused me to consider this issue of gender more seriously – how gender plays out in terms of men's response to women and how women respond to men and to themselves. The gender analysis is even applicable in research with MSM as a standpoint from which to examine how they respond to one another based on different types of gender identities and roles that are often assumed, and how rigid expectations associated with gender roles can place some at risk for HIV and other STIs.

It even applies to how people – men and women – respond to me as a male nurse. Understanding how gender is so interwoven into all our different health interactions, whether it's provider-patient or patients and their environment, has really made me pay much more attention to it in my work. In the literature, people have, I think, played on this, suggesting that, for example, men might respond better to men or women might respond better to men because men may command respect or authority. This leads to the creation of interventions or clinical strategies that presume gender, stereotypes, biases and resultant disparities are “natural” – instead of considering that maybe there are socially sanctioned factors at play that disenfranchise women. More often than not, I've seen gender-specific strategies that reinforce so-called women's roles or stereotypical men's roles; however, I'd like to see more work that challenges gender norms.

In my research I see gender roles linked to too many other things. Reinforcing these stereotypes has an impact on the clinical encounter and how men understand and deal with women, how women also respond and understand men in situations, and how women and men understand and deal with themselves. As a nurse doing research with women and men, I am very conscious of what it means for me to be a man (and how others may experience me), because I know it's not just about the research or clinical interaction but the residual effects that may emerge in later interactions that they have with others.

**Q: Can you talk a bit about your work in Ghana?**

**A:** The Kumasi and Accra Project to Prevent AIDS (KAPPA) is underway in three different communities in Ghana – Kumasi, Accra and Manya Krobo. In this research, we are trying to create a multi-level HIV prevention strategy within the healthcare system, utilizing nurses and peers and other healthcare workers. The intervention strategy that we develop must address men most at risk for HIV infection, which in Ghana are men who have sex with other men. The complexity of KAPPA is similar to the complexity of the epidemics among Black MSM in Canada and the United States in that instead of living in “gay villages” like Chelsea (New York), Castro (San Francisco) or Church–Wellesley (Toronto), most of the men at highest risk for HIV in Ghana just live within the overall mainstream communities; many of them don't identify as “gay,” and some maintain romantic relationships with female partners, up to and including marriage. That makes it much more challenging to create a prevention strategy, because you're not just dealing with men who have primary relationships with other men. You're dealing with men who have relationships with other men that are mechanically high-risk because of the sexual modes through which HIV is transmitted. But the strategy must also accommodate men who may have very strong primary relationships with women who may be placed at risk through, for example, condom non-use.

Then again, gender comes into play in terms of how men understand their responsibilities to their female partners versus their male partners or whether they care because it's “just women.” Those attitudes still come into play even though we're doing research with MSM. We are trying to determine what the nurse's role might be in managing these different types of risks. Some changes will be needed in how we educate nurses to deal with people in these situations. How does a nurse practise in a way that allows men to be forthcoming about their sexual habits? If the men do not feel safe or comfortable discussing the high-risk behaviours they have engaged in, then the nurse cannot develop an appropriate intervention or plan of care. We also need to determine how the health system is structured – how we designate or identify networks of healthcare providers and facilities where MSM may be able to go for the services they need.

Luckily, we've been engaged with Ghanaian community leaders as well as leaders and healthcare providers in their public health system, so they're well aware of the challenges. We hope we can develop a strategy that can address some of our early findings from the KAPPA study.

**Q: How did your work in Ghana arise in the first place?**

**A:** It was coincidental. I was at a conference in Ghana in 2009 and there were some folks [living in Accra] who had heard about me. They came to the conference and they asked for our help, saying, "HIV is out of control among this group [MSM]; there's not enough being done." When George Bush was president of the United States, his administration promoted the "ABC model" – Abstain, Be Faithful or Use Condoms. All countries receiving funding from the States had to adopt that model, but it wasn't evidence-based nor was it based on Ghanaian cultural norms. People were saying: "This isn't working for us; we need help." So that was how I came to be involved. My first reaction was, "Oh, I live in Canada. There's the University of Ghana here, you could just talk to them about doing some research." But the people we talked to said, "This is an opportunity for you to make some headway on this issue in Ghana." For whatever reason, the research and public health momentum just wasn't picking up, possibly because of hostilities and because the issue is politically controversial. They asked us to do it because they felt they had run out of options within their own country.

When we tried to get this initiative funded, funding agencies said, "This is very noble, but it's never going to happen. You won't be able to find these men; they'll never talk to you. You'll have all types of problems from police and the government." After about two years, we finally got funded through Grand Challenges Canada. Part of the challenge with some of the funders was that they were not accustomed to a nurse researcher going to West Africa doing HIV/AIDS research that was so high-risk and controversial. I think that was partly why they thought it could not be done. They underestimated the degree to which nurses could lead in ways where other health professionals had been unsuccessful in the past. I hope [the KAPPA project] will be a model for the rest of the region.

**Q: Have you encountered any of the political or government interference that people predicted would occur?**

**A:** We have not – mostly because instead of skirting around the issue, we just went into it head on. We approached the village chiefs and we went to community leaders and we said, "This is what we hear is happening. We want to try to help, and we want your permission and support." People were very supportive because we didn't come in as amazing, super Canadian researchers who were going to save Ghana – I think that was what they saw the past. Instead, we said, "We have some

skills, we know some things and we think we can be useful.” So while the government and political leaders haven’t expressed outright support because the issue is controversial, they have not blocked us and there’s been no attempt to sabotage the process. It’s been very much a partnership that, I think, has allowed us to avoid some of the roadblocks that other [foreign] researchers have experienced.

**Q: Do you have a team based in Ghana, and are they locals?**

**A:** We have a team of about 16 who are divided among the three cities in Ghana, and they are managing the study.

**Q: Are they nurses?**

**A:** No. Most of our partners are physicians, because they are the heads of the HIV/AIDS directorates. Once we finish the data analysis, we know that based on what we learn from the men in these communities, we’re going to have to design an intervention that involves the nurses who actually provide much of the front-line care. That’s the next step, to figure out what can be done in clinical settings that, we hope, nurses will be willing to implement. That will involve some attitudinal changes around how they deal with men in this situation.

**Q: Have you started to think about future research that would actually involve some interventions that you’ve started to construct?**

**A:** One of the things that we thought about was developing a diagnostic device to detect STIs – gonorrhoea and chlamydia, specifically – at least to start, based on nanotechnology that could be done rapidly, in the field, without a lab. If the device could be stabilized to work in a hot, dusty environment like Ghana’s, then we could screen people who are asymptomatic. This approach would have two goals: first, finding a way that we could screen people that is less invasive than a swab and more efficient than doing urine and cultures. We could begin to treat patients immediately. Treating STIs lessens people’s risk of HIV, and we wouldn’t even have to wait for them to develop symptoms if we had a test that worked for asymptomatic patients.

Secondly, getting people to come to clinics is an issue, and even if they show up at the clinic, chances are they aren’t going to tell you everything. So if we could come up with devices that allow us to go to where these men are, that would be a first step.

If the device were developed and tested in Ghana, we could make it a part of the intervention, and it could generate revenue that would help sustain the program. That’s always an issue, too – even if we come up with these things, how will the government be able to afford it? We envision this intervention, this device, as something that could be sold on the world market, so it wouldn’t be limited to just Ghana.

**Q: So you think your work in Ghana is potentially generalizable to other communities worldwide?**

**A:** I think the process in Ghana is likely very different from other countries, even in West Africa, because of the culture. However, I think what's important is the way outsiders approach communities with regard to very sensitive topics in ways that engage them. I think our process could be replicated in many places across the African continent, but also within the city of Toronto. You need to consider how to replicate the research model in other places where the researcher and the target population come from very different perspectives. It's not easy, but I think if people are willing to engage in that process, the knowledge could yield major clinical benefits.

**Q: Do you have any nurse colleagues in Ghana who will pick up this project when you're done?**

**A:** We haven't identified anybody yet, but one of the things we're thinking about is how to build capability and capacity for nurses to be more involved in research. As in some other countries, I don't know that nurses in Ghana have been able to demonstrate or be involved in leading research. Even some of my partners there, I think, were surprised to learn that I'm a nurse. This project is just one idea, and we believe that there are lots of opportunities for innovations that nurses could make happen. We've been talking with Ghana Health Services about working with their training colleges for nurses and their university, so that we can engage nurses more in developing research capacity, but also actually in leading research in the country. At present, most research is led by physicians. As part of our ongoing discussions, this is something that we hope to make a long-term strategy.

**Q: Do you have any specific advice to offer other nurse researchers or nurse leaders in being involved in an international research venture such as this?**

**A:** If I had to offer some advice, I would say, "Spend as much time as you can trying to understand the culture and having the people understand you." Because one thing that slowed us in the beginning was my logic, being very Canadian, and I didn't realize that. I didn't understand how the Ghanaian people were making sense of things they were saying or doing, because they just didn't make sense to me, and I'm sure my ideas didn't make sense to them. It took us quite a while to realize that we just reason differently. We had to understand each other's reasoning before we could get to a place where we were able to move forward.

The first few times we had clashes, it looked like things were going to fall apart – until we realized that we just had fundamentally different ways of seeing the world. It's not that nursing researchers' ideas are not respected in other places, it's just that nurses have to be open to the idea that people may not understand ideas the same way that nurses understand them.

**Q: It sounds like it’s a lot about finding common ground and understandings.**

**A:** Yes. It takes a long time, and it’s frustrating, but once you get it, everything is smooth sailing from there. It’s just those first few months of trying to find common ground and hoping that they believe in what you are trying to do as much as you do. The researcher needs to say, “Okay, let me just make sure you understand where I’m coming from,” and the people must be comfortable enough to say, “No, not only do I not get it, I don’t agree with it.” Then the real process of reaching shared understanding starts to happen.

**Q: Any final thoughts that you want to leave with our readers?**

**A:** Our idea was considered very bold. Nobody had tried this before because it just was too “outside the box.” I would encourage readers to pursue bold ideas even if it’s hard to find funding initially, because I think those high-risk ideas are potentially the ones that may have the biggest impact. I think that’s the type of innovation that we’re going to need to improve health in communities around the world. I think nurses see so much all the time that can lead to new healthcare solutions. We believe that KAPPA has the potential for a huge impact if we can develop the motivation and desire in a population that’s been so hindered for so long. We know we wouldn’t have gotten this close if we had not committed ourselves to this bold, crazy, impossible idea.

For more information about the KAPPA project, go to: <http://www.youtube.com/watch?v=zpLXtaF1R7s>.

**“Strengths-based nursing leadership for strengths-based nursing care.”**

more on page 38