PUBLIC HEALTH NURSES' COMMUNITY DEVELOPMENT PRACTICE WITH WOMEN IN HIGH-RISK ENVIRONMENTS

by

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A thesis submitted in conformity with the requirements of the degree of Doctor of Philosophy
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ABSTRACT

This dissertation contributes to a deeper understanding of the complex community development practice of public health nurses working with women in high-risk environments. It explicates how the economic and sociopolitical context of the health care setting posed barriers for the nurses’ practice and how they negotiated these constraints.

Through a feminist, ethnographic inquiry (over a 14 month period) that included interviews (30), participant-observation (76 hours), document analysis, and personal reflective journalling, the practice knowledge of 13 public health nurses was articulated.

Three meta themes emerged from the data. Being in Community characterized the nurses’ practice of community development as a multidimensional concept rooted in a philosophy and process of empowerment for social justice and health. They valued their practice as a unique and essential beginning step with marginalised women, “starting where the women are”, and progressing from personal empowerment, to a group of women, to a community of women and community empowerment. Regardless of an individual, group, or community focus, the values and ways of practising were more similar than different. Building trusting relationships, establishing connections with community resources, and measuring progress were core factors in the nurses’ community development model. Praxis and an extensive repertoire of roles, strategies, and complex contextual and relational knowledge were needed to negotiate uncertain partnerships and to catalyse significant transitions for the women.

The Contested Terrain: Social Construction of Public Health Nursing highlighted constraints on the nurses’ autonomy and practice by larger organizational processes and the nurses’ everyday work environment. Ethical conflict, moral distress, job dissatisfaction, and increased invisibility in community development work were significant consequences.

Creating Space for Possibility reflected the factors that influenced the nurses’ evolving community development consciousness and their strategies for sustaining meaning.
and negotiating barriers for themselves and for the marginalised women.

This study establishes public health nurses' unique contribution to community development and to primary health care. It confirms the need for critical and feminist, ethnographic research to uncover the impact of economic and sociopolitical factors on public health nursing practice and policy and practice changes that decrease health-damaging conditions for disadvantaged women.
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CHAPTER ONE
INTRODUCTION

The problems this study addresses are the invisibility and misperceptions of the profoundly important work of public health nurses. Public health nurses' work is often misunderstood by the public, public administrators, and politicians, when it is noticed at all. This study contributes to a deeper understanding of the complex everyday community development practice of public health nurses working with disadvantaged women from the standpoint of the nurses. To achieve this understanding, the nurses' community development practice expertise is examined within the social, political, and economic context in which it is embedded.

An interpretive inquiry that makes use of feminist perspectives and an ethnographic approach guides this study. It is an inquiry that is positioned centrally within feminist scholarship and addresses the complex reality of women's experience and situation. The inquiry challenges a perception of public health nurses as victims of a patriarchal structure and elucidates their personal agency in negotiating multiple constraints on their practice.

The experiences of 13 public health nurses in a large urban Department of Public Health (also referred to as department) in Southern Ontario is the focus of the inquiry. The data collection process spanned 14 months and consisted of 30 formal interviews, 76 hours of participant-observation, document review, and personal reflective journaling. Through a process of thematic analysis, multiple themes emerged to explicate the nurses' community development practice. In this first chapter I outline: the research problem, purpose of the study, study significance, and the research questions. Next, I provide an account of my personal perspective that led me to this particular investigation. The chapter concludes with a description of the layout of this dissertation.

Statement of Problem

From the late seventies to the early nineties, public and professional rhetoric called for a move toward primary health care and an expanded health promotion and community development approach to health care practice. This new direction was expected to promote equity and social justice globally and locally (Epp, 1986; World Health Organization [WHO], 1978, 1984). Professional nursing organizations proclaimed nursing's central role in
such a movement as the aim coincided with nursing’s goal to foster optimal health for individuals and communities.

Public health nursing has more than a century-long legacy of addressing broad inequities in health and building capacity with people who are marginalized by their life circumstances (Hayward, Ciliska, Mitchell, Thomas, Underwood, & Rafael, 1993; Reutter, Neufeld, & Harrison, 1995; Zerwekh, 1991b, 1992a, 1992b). Health professionals with expertise in working with disadvantaged populations and in working collaboratively for health and social justice are needed to address the primary health care mandate.

Paradoxically, public health nurses who have the necessary specialized knowledge and skills for an expanded health promotion and community development practice find themselves a professional group at risk and increasingly invisible to and devalued by the public, professional colleagues, public health administration, and politicians (Hayward et al.; Zerwekh, 1993).

Invisibility and devaluing poses significant consequences for the credibility and continuance of public health nursing as a valued and specialized field in promoting community capacity and primary health care. More importantly, it jeopardizes the health of vulnerable populations, particularly women in high-risk environments1, who are the majority of the population traditionally served by public health nurses. Typically, public health nurses work in three broad domains. The first domain is a variety of community settings, which include the home, schools, community health clinics, community centres, hospital attachments, street outreach, and coalitions. The second domain is through client affiliation, which includes individuals, families, groups, and community associations. Thirdly, public health nurses work in a wide array of mandated and innovative programs and services aimed at health promotion, disease prevention, and health protection.

Existing research that describes the cultural practice and competencies of public health nurses is limited (Chalmers & Gregory, 1995, 2000; Clarke, 1995; Hayward et al.,

_________________________
1 High-risk environments include psycho social and/or socioenvironmental risk environments in which groups or communities are at greater risk because of: isolation, lack of or poor social networks, low perceived power, self-blame, poverty, lack of affordable housing, or access to food, low educational or occupational status, dangerous/stressful work, discrimination (racism, sexism, ageism, etc.), violence, and low political or economic power (Labonte, 1993b).
1993; Zerwekh, 1992b). The empiricist methods, particularly epidemiological science, which are commonly used in public health research do not enhance understanding of the various knowledge forms of public health (Baum, 1995), including the complex cultural practice of public health nurses. Moreover, issues of broad-based health promotion and community development present additional research challenges. These challenges stem from the complex and interactive nature of the structural and change processes inherent in health promotion and community development activities that can take place at the individual, group, organizational, and community level. Research challenges also include the difficulty in separating process and effectiveness outcomes (Eng & Parker, 1994; Israel, Checkoway, Schulz, & Zimmerman, 1994; Ploeg, Dobbins, Hayward, Ciliska, Thomas, & Underwood, 1995; Wallerstein, Sanchez-Merke, & Dow, 1998). The “outcomes movement” in research claims to shift the conceptualization of research and health policy to a primary focus on health outcomes or effectiveness research. However, some authors (e.g., Labonte, 1995 and Robertson, 1998) are concerned that the outcomes movement will re-medicalize health and health care by placing decreased emphasis on developing knowledge that will facilitate change in the health care structures and processes.

In addition to the limitations of epidemiological and outcome research, the expectations of a community development practice present additional challenges for the nursing discipline. Some claim that there is lack of agreement in the nursing field as to the essence of nursing (Johnson, 1994) and questions of who is the client, what is valued knowledge (Jacobs-Kramer & Chinn, 1988) and what are acceptable strategies for nurses to use in helping people reach their optimal health and achieve social justice. The nursing discipline has been slow to investigate and validate knowledge forms additional to empiric science. Interpretative science and emancipatory research have been overshadowed by empirical science as publicly acclaimed knowledge in nursing (Cody, 1994; Jacobs-Kramer & Chinn; Johnson; Stevens & Hall, 1992). Nurses are being challenged to attempt changes at the community and societal levels rather than solely at the individual, group, and family unit level (Anderson, 1998; Butterfield, 1990; Drevdahl, 1995; Kleffel, 1991; Stevens & Hall). Importantly, this challenge includes changing practice through research and advocating for policies that are aimed at decreasing poverty and the effects of poverty on health status (Blackburn, 1991; Drevdahl; Williamson & Reutter, 1999). It has also been recommended that nurses shift from an ethnocentric notion of professionalism to culturally sensitive health
care by critically reflecting on their practice, questioning the basis of theorizing, and by challenging the institutional practices that perpetuate social injustice and inequity for women (Anderson, 1990, 1998; Anderson, Blue, & Lau, 1991; Leuning, 1994; Wuest, 1994).

Generally, community health nursing's practice has not been the subject of close study as has hospital-based nursing. Indeed, community health nursing research is limited and consists of many gaps and challenges (Chalmers & Gregory, 1995, 2000). Most of the research that does exist has examined public health nursing with selective lenses and defined public health nurses' work in ways that do not allow us to see important aspects of their work and the complex context of their practice. Gender inequality in the public health work environment is identified as a significant influencing factor in the minimization of public health nurses' contributions in public health (Donner, Semogas, & Blythe, 1994; Fee & Korstad, 1992; MacMillan, 1994; Rafael, 1997; Stevens & Hall, 1992). Historically, public health nursing has been controlled by local, provincial, and larger social, economic, and political forces, in large part as a result of the nurses' status as employees in government agencies and their status as women, since public health nurses are predominantly female (Donner et al.; Rafael; Stevens & Hall). It is proposed that the dominant hegemony and inequitable, gender-related, hierarchal structures of power in society are perpetuated in the public health work environment, thereby excluding public health nurses in a meaningful way from the decision making process (Fee & Korstad; MacMillan; Stevens & Hall). Donner et al., state that many features of the oppressive hierarchal and bureaucratic structures of the hospital system have been transferred to the community workplace, with community health nurses generally having little control over their work environments and work lives, and being subject to the pervasive stereotypes of nursing.

Stevens and Hall (1992), along with other researchers, claim that critical and feminist approaches are needed to examine public health nursing with the intent of uncovering the nurses' taken-for-granted values, perceptions, and oppressive influences. Critical and feminist examinations of public health nursing practice are aimed at fostering change of

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Community health nursing is an umbrella term that includes several specific areas of nursing in the community setting, each as a specialized field of practice (King, Harrison, & Reutter, 1995; Williams, 1991), i.e., public health nursing, home health nursing, occupational health nursing, community mental health nursing, and nurse practitioner.
institutional structures, processes, and policies that constrain public health nurses’ effectiveness and the individual and community empowerment of the community members they serve (Reutter et al., 1995; Stevens & Hall). While there has been extensive research in many fields of study related to primary health care, health promotion, and community development, there is a paucity of research that has focussed on public health nursing and community development practice (Chalmers & Gregory, 1995, 2000). There is even less research on their community development practice with women living in high-risk environments. Furthermore, there is very little research that considers the nurses’ voices and ways of knowing, and limited research that considers the social organization3 of their practice. Research that does not consider the larger sociopolitical context of the public health nurses’ practice positions the nurses outside the intersection of power relations that constitute their identities as practitioners and defines what they hope to accomplish (Stevens & Hall). Therefore, research that reveals the public health nurses’ expertise in community development practice and within the social, economic, and political context in which it is embedded is needed (Craig, 1991; Hayward et al., 1993; Reutter et al.; Stevens & Hall).

Statement of Purpose

My purpose in conducting this feminist inquiry is to understand and make explicit the values, knowledge, skills, and realities of public health nurses’ practice in a community development process with women living in high-risk environments. The study is based on the premise that public health nurses’ community development practice and subjective expertise can and needs to be examined and interpreted, and done so within their particular discursive frameworks. I uncover assumptions they hold, ambiguities they see, and anxieties they experience in relation to their practice. Instances of community development and partnership are revealed in stories and observations of the nurses’ practice. I also explore the way in which the public health nurses negotiate their own value as women and public health nurses and the effect this had on their ability to partner with their women clients to allow individual and community empowerment to occur. Additionally, the taken-for-granted image of public

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3 Social organization refers to relations and processes outside one’s lived experiences and beyond their power of control, which are not fully apparent but organize their everyday world (Smith, 1987).
health nursing and the cultural-political context of the nurses' practice is examined. This research, through the nurses' narratives, exposes how the larger economic and sociopolitical structures and processes of the health care environment, specifically in a large, urban Department of Public Health (which employed the nurse participants), affected the nurses' practice. I examine how the various discourses influenced the presentation of health-related concerns to the nurses, imposed contradictions and constraints on their work with women in high-risk environments, and affected social justice and equity for the women clients and their families. I also explore how the public health nurses resisted the constraints on their practice, so as to allow possibilities for themselves and the women they served.

Significance of the Study

Public health nursing and health care practice have many challenges, contradictions, and conflicts that are not amenable to one solution. Through this study, an examination of the multiple realities that reside in the everyday practice of public health nurses are brought into the public domain for viewing. Practice knowledge is difficult to articulate, but its cultivation as a concept and as a form of inquiry is fundamental to health promotion and community development practice (Leuning, 1994), as well as advancement of public health nursing and nursing science in general (Gadow, 1990; Moch, 1990).

Significantly this research, which began in September 1996, started at a time in the careers of the nurses in this study when community development and advocacy work were sanctioned as a major mandate of their Department of Public Health and, therefore, were expected components of their practice. As the study unfolded over a 14-month period (until December 1997), there was a significant shift of priorities in the department related to changing ideologies in government at all levels and subsequent budget cutbacks and redirection away from broad-based health promotion, community development, and health care for high-risk populations. This shifting of priorities presented the public health nurses with significantly contradictory directives. On one hand the nurses were encouraged to adopt a community development way of practising, but they were also required to deliver mandatory programs developed by the Ministry of Health.

Elucidation of public health nurses' practice, through an examination of their conscious personal knowledge and their taken-for-granted "tacit" knowledge, identifies their contributions to the health promotion and community development discourse. Additionally,
due to the focus of this study, the nurses' contributions to the health of women living in high-risk environments is evident. This deeper knowledge establishes their credibility in contributing to health public policy and community well-being. Indeed, data emerging from this study are relevant to the public health nurses finding their voice and bridging the gap between the reality and the perception of public health nursing as inflexible in approach and unresponsive to the changing health care needs. The findings of this study also contribute to the education of nursing students and the further development of nursing and feminist science.

Research Questions

Given the general nature of the problem as described to this point, questions that guided my investigation with the participants are identified as follows:

1. What is the nature of the public health nurses' community development practice?
2. What is the practical context in which this practice happens with women living in high-risk environments?
3. What is the social, political, and economic context in which the practice occurs?
4. How do the nurses negotiate constraints on their community development practice?

Following from the literature review in Chapter Two, specific issues and questions that guided the data collection and data analysis process are identified in Appendix C.

Personal Perspective

The motivation for this study comes from my professional experience as a nurse, a university nurse-educator, and a researcher. The major force, however, is rooted in my value system and in reflection of my commitment to social justice and a liberating partnership with students in educational practice. I agree with the belief that "the personal is political" and that:

every aspect of our personal circumstances as women, and as nurses, grows out of and creates larger political realities in the world...therefore, a praxis is needed of thoughtful reflection and action that occurs in synchrony, in the direction of transforming the world. (Chinn, 1989, p. 73)

I practised for several years in public health nursing in Southern Ontario, both as a staff nurse and as a district supervisor. In the 1970s and early 1980s, I worked as a public
health nurse in the Department of Public Health under study here. Currently, I teach community health nursing in the university setting. For the last 15 years, I have initiated and participated in educational changes that coincide with the WHO’s (1978) directive for the goal of “Health for All by the Year 2000.” My educational practice is also influenced by the Canadian Public Health Association (CPHA) (1990) document titled Community Health- Public Health Nursing in Canada: Preparation and Practice. This document outlines the roles and activities of practising community health nurses with respect to primary health care, health promotion, and community development. Knowledge of community development and adoption of the role of community developer are key expectations noted for community/public health nurses.

As an educator, I am also influenced by the report of the Working Group on Educational Requirements of Community Health Nurses (Health & Welfare Canada [H &W C], Minister of Supply & Services, 1991). The report recommends that knowledge and skills in community development and population-based approaches to health are essential for community health nurses and are therefore a necessary component of university nursing education. The recommendations highlight the need for employers, educators and community health nurses to collaborate in reducing the gap between practice and knowledge. University educators are challenged to strengthen the content and skills development in community health nursing courses related to primary health care, health promotion, and community development.

As educators, we need more knowledge, understanding and skill in the strategies that are necessary in primary health care and not merely a command of the academic rhetoric. I realize that I am complicit in the characterization and maintenance of nursing as divided between two worlds: the world of academia - the “high hard ground,” and the world of practice - the “swampy lowlands” (Schon, 1983). It is understood that nursing’s traditional, behaviouristic approach to education espouses formalized knowledge as “knowing that”; yet, knowledge of practice (“knowing how”) is personal and practical and dependent on contextualized experience (Maevé, 1994). Maevé submits that frequently the knowledge base that is proposed as the core of nursing does not meet the reality of practice which is complex, unstable, uncertain, and fraught with multiple value conflicts and constant change. I support Maevé’s view that much of nursing lies in personal relationships and is accomplished from an “in-between” stance of the nurse and a “web of connections.” In our role as educators, we
fail to prepare students for this reality. These multiple connections occur between the public health nurse and the client (individual, family, aggregate, community), with other health professionals, institutional systems, bureaucrats, family, friends, and other community associations.

I was involved for several years in preventative and rehabilitative cardiovascular research. A major part of this effort has focussed on adult women living with heart disease. My research with this population led me to the belief that it is not so much the particulars of cardiovascular problems as it is a broad range of factors that affect women’s achievement of optimum health. These factors span a range of cultural, psychological, socioenvironmental, health care system, and political factors. There is strong evidence that socioenvironmental and cultural factors, particularly low socioeconomic status, have a significant negative effect on cardiovascular health for men and women (Wilkinson, 1996). These factors are reported to be more serious for women, who may also be subject to gender, racial, class, and age inequality; both in practice and in research approaches to the cardiovascular health issues (Mastroianni, Fader, & Federman, 1994). According to Leuning, (1994), Reutter et al., (1995), and Stevens & Hall, (1992) this inequity in research and practice applies to women’s health in general.

My personal perspective is revisited at different points in my dissertation. In the chapter on methodology, I describe some of my assumptions, feelings, and biases. My situated knowledges are also threaded throughout my discussion of the study findings. Finally, thoughts on my reflexive position through the study are revisited in Chapter Nine, the final chapter.

**Layout of the Thesis**

This thesis is presented in eight chapters. This chapter outlines the research problem, the purpose and significance of the study, my personal perspective for embarking on the inquiry, questions addressed in the study, and the organization of the thesis.

Chapter Two places the inquiry in a theoretical framework by presenting and critiquing relevant theoretical literature, position statements, and empirical research, concluding with a summary that addresses salient issues and gaps in the literature that gave direction to this inquiry.
Chapter Three consists of two parts. In the first section I discuss perspectives on the methodological approach, which includes feminist perspectives and an ethnographic approach that is congruent with the nature and purpose of the study. In the second part I describe the specific methods used for this study, including description of the setting, the participant selection process, the participants’ description, data collection procedures, data analysis and interpretation, ethical considerations, and steps taken to ensure trustworthiness and rigour.

Chapters Four through Seven present and discuss what the participants have to say about their community development practice with women in high-risk environments. In these chapters I discuss in detail the themes that emerged from the research. Excerpts from the participant interviews, participant-observations, and document reviews illustrate the themes. Chapter Four sets the stage for the discussion of the study findings. The three meta themes for the study are introduced, followed by a profile of the public health nurse participants and their everyday practice, and then a profile of their women clients and the high-risk conditions in which they lived.

Chapter Five deals with the nurses’ guiding perspectives on community development and the meaning these perspectives held for them, with particular reference to their relationships with their client community of women living in high-risk environments. The chapter also examines the nurses’ enactment of their community development practice. Strategies the nurses used to partner for health and social justice, ways to eliminate or decrease barriers, and to measure progress over time are discussed.

Chapter Six provides an examination of the nurses’ perceptions of the contradictions and constraints they struggled with in enabling an empowering community development practice with their client community of women.

Chapter Seven is comprised of two parts. First, the influences the nurses described as affecting their evolving community development consciousness are discussed. Second, the strategies they used to resist and negotiate the constraints on their practice, to create professional possibility for themselves and their practice, are considered.

Finally in Chapter Eight the purpose, problem statement, research questions, methodology and methods, and key findings are highlighted. This synopsis is followed with my reflection on the significance of the study for the participants, myself, public health nursing practice, education, and future research. My reflection on the nurses’ contribution to
community development, primary health care, and healthy public policy concludes the dissertation.
CHAPTER TWO
LITERATURE REVIEW

Chapter One presents an introduction to this inquiry. It is now appropriate in this chapter to provide a context that more specifically positions the problem this study addresses, the invisibility of the community development practice of public health nurses with adult women in high-risk environments. There is a vast amount of theoretical literature, position statements, and empirical research that has relevance for this inquiry. I identify two main areas of literature for review here. First, in Part I-Background, theoretical literature and position statements are presented that generally situate the social, political, historical, and professional context in which the public health nurses' community development practice happens. Secondly, literature is reviewed that describes the sociopolitical context of women's health and health promotion, particularly for women in high-risk environments.

In Part II-Public Health Nursing and Community Development, literature is presented that deals more explicitly with empirical research related to public health nursing and community development.

Part I-Background

The discussion in this section addresses the following topics: (a) The “New” Public Health Discourse, (b) The “New” Public Health Discourse and Nursing: Valued Knowledge, (c) Legislation and Public Health Policy Influences, (d) The Influence of Gender Inequality in the Public Health Work Environment, (e) Social Construction of Women's Health and Health Promotion.

The “New” Public Health Discourse

This discussion provides a background to position the concept of community development in the health field. The “new” public health is rooted in a social definition of health and an empowering health promotion/community development process designed in the spirit of promoting social justice and health for all. First, I review the evolution of public health science from the predominant biomedical and epidemiological perspective to a new public health or socioenvironmental health promotion orientation. More particular discussion follows on the concepts of health promotion and community development, and implications
for the health professional, including the public health nurse. Perspectives are also presented on the tensions between public health nursing and the health promotion and community development discourses, and between health promotion and emerging population health models.

**Evolution of Public Health Science**

In Canada, public health has historically been concerned with establishing public policies to control social and environmental conditions that deny access to health (CPHA, 1993). Public health, as an institutional practice, had its origins in Canada in 1833 with the establishment of the Public Health Act. The act was legislated to control infectious diseases and to establish local and provincial boards of health. The City of Toronto established the first Board of Health in Ontario in 1834 (Royce, 1983). The British North American Act of 1867 was the first legislation to promote public health nationally (Allemang, 1995).

Through most of the 20th century, public health science has been rooted primarily within a biomedical model, with epidemiological methods seen as the gold standard for studying public health problems (Baum, 1995). Within this paradigm, health is viewed as the absence of disease and populations are seen as a collection of individuals that could be reduced to its constituent parts and subjected to epidemiological analysis (Baum). Hence, the social, economic, political, environmental, and gender factors of peoples' lives are virtually ignored. In 1976, Beauchamp, in his critique of market-justice, describes public health as highly ethical in nature and a necessary “counter-ethic” to market-justice, a term used to capture a pervasive ideology of individualism that protects the freedom of the powerful and minimizes collective responsibility and action. He positions public health as embedded in a highly political struggle between market-justice on one hand and social justice on the other. He envisioned public health as a social justice enterprise designed to protect the public’s health by recognizing the social and environmental complexity of peoples’ lives. According to Beauchamp, “public goods” and a more equitable distribution of burdens and resources is created and protected through collective efforts by governmental and non-governmental action.

In the latter part of the 20th century, public health broadened its mandate to include a socioenvironmental perspective that acknowledges the sociopolitical complexities of the public health arena and social determinants of health (Labonte, 1993b). While traditional
public health focussed on disease and its causes, and on behaviours of individuals, the new public health discourse not only includes the medical and behavioural approach but has broadened its inquiry and services to recognize the socioenvironmental factors that affect health. This new direction for public health in Canada had its basis in the global challenge that was issued to all countries in 1978 by WHO: to adopt a more socioenvironmental and political view of health and the goal of health for all; now popularly called social determinants of health. Inequality and social injustice in the faces of poverty, illiteracy, discrimination, and geographic disparity are identified as major barriers to health, in both developing and developed countries. In 1986 Jake Epp, the Minister of health declared that reducing inequities as one of the major challenges facing Canada (Epp, 1986). Oppressive social, political, and economic conditions, which are beyond the control of the individual, were recognized as contributing to unequal power relations that result in health-damaging conditions and relations, and oppression of vulnerable groups (Stevens, 1989; Stevens & Hall, 1992). “Vulnerable groups” refers to those who are living in high-risk environments that expose them to health-damaging circumstances.

Central to the new public health movement is primary health care with an emphasis on the principles of equality, social justice, partnership, citizen participation, and power shifting (Epp, 1986; WHO, 1978). Primary health care in the spirit of social justice, is identified as the philosophy and approach to practice that is deemed necessary to reduce inequities and redirect health care toward the goal of health for all (WHO). Primary health care is defined as:

essential care, based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development, in the spirit of self reliance and self development. It is the first level of contact of individuals with the national health system, bringing health as close as possible to where people live and work, and constitutes the first element of a continuous care process. (WHO, p.1)

Primary health care is ideally shaped by social goals, encompasses all aspects of the community, is transdisciplinary, and values citizens and professionals as equal partners in the development of community well-being. Health is conceptualized in this social determinants discourse within a socioenvironmental perspective. This socioenvironmental perspective recognizes that broad prerequisites of health, which include societal structures, are critical
determinants in the achievement of optimal individual and community health and social justice (Labonte, 1993b).

This sociopolitical conceptualization of health represents an alternative to the dominant biomedical health discourse in the Western industrial world and a move away from the "lifestyle" health focus of the 1970s and early 1980s which evolved from the "Health Field" concept of the Marc Lalonde Report, *A New Perspective on the Health of Canadians* (H&WC, 1974). Lifestyle is identified as one of four components of the Health Field concept; the other factors are environment, human biology, and the health care system. These factors are described as synergistically responsible for determining the health status of the individual and community. However, the prevailing view of health professionals and politicians at the time was that individual lifestyle is the major health determinant. Following from this belief, the onus for health is placed on the individual. Thus, the perspective of "blame the victim" or the individual for his/her ill health dominated.

**A "New" Public Health or a "New" Health Promotion**

In 1984, WHO released a landmark document that described the new program in health promotion for Europe. The WHO defines health promotion as a mediating strategy between people and their environments - a positive, dynamic, empowering, and unifying concept that is based in the socioenvironmental approach to health. It was proposed that this broad notion of health promotion would bring together people who recognize that basic resources and prerequisite conditions for health were critical for achieving health. Basic resources or health determinants are defined as: income, shelter, food, information and life skills, a supportive environment, having opportunities for making healthy choices among goods, services and facilities, and positive conditions in economic, physical, social, and cultural environments. Health is defined as:

The extent to which an individual or group is able on the one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment ... health is, therefore seen as a resource for everyday life, not the objective of living. It is a positive concept emphasizing social and personal resources, as well as physical capacity. (WHO, p. 3)

The concept of health promotion, which is rooted in this social explanation of health, is seen as a collective effort to attain health rather than health being identified as the sole responsibility of the individual and/or the health sector. Health promotion is defined as, "the
process of enabling people to increase control over, and to improve their health" (WHO, 1984, p. 3). A commitment to this health promotion approach involves the population as a whole in the context of their everyday lives, fosters action on the determinants of health, combines multiple and complimentary approaches, encourages public participation, and redirects health professionals to the role of nurturing and enabling health promotion. The central basis of practice is proposed as “starting where people are at” and respecting the need for them to be genuinely involved in decisions concerning their health (Mahler, 1985). At the onset, this major philosophical shift in defining health and approaches to health practice was positioned to profoundly influence public health practice and to stimulate a direction toward a “new” public health or termed a “new” health promotion (Robertson & Minkler, 1994) and health care practice in Canada.

Following from this international challenge, the Canadian government released a blueprint document titled, Achieving Health for All: A Framework for Health Promotion (Epp, 1986). The federal government identified the challenging of inequities as a main goal to be addressed. It was declared that this goal is to be achieved by altering many of the traditional beliefs about the concept of health and health promotion, the delivery of health care, the roles of the professionals, and the involvement of community members. The document identified three key health promotion strategies: (a) fostering public participation, (b) strengthening community health services, and (c) co-ordinating healthy public policy.

Concurrent with this government release, the First International Conference on Health Promotion was held in Canada in 1986 with the subsequent presentation of the Ottawa Charter for Health Promotion (WHO, H&WC, & CPHA, 1986). The document reinforces the concepts of health and health promotion proclaimed in the 1984 WHO document on Health Promotion. It is believed that if all government, non-government and voluntary organizations, the World Health Organization, and all other bodies, collaborated in developing strategies for health promotion in the spirit espoused in the Ottawa Charter, then achievement of the primary health care goals and “Health for All by the Year 2000” would become a reality. The charter’s interpretation of the notion of health promotion, extends the dialogue and approaches to health promotion and strengthened the discourse on public health toward a social vision. This discourse moves the emphasis away from a primary focus on the individual, disease prevention, and health promotion programs in which the major emphasis
is the imparting of information for behaviour modification and treatment compliance (Bracht & Kingsbury, 1990; Labonte, 1990; Stachtchenko & Jenicek, 1990).

Over time, health promotion has been variously defined among practitioners, academics, and communities. However, the most prevalent interpretation emphasizes the enablement or empowerment process as previously described by the WHO (1984) and the Ottawa Charter (WHO, H&WC, & CPHA, 1986). Importantly, health promotion embraces both individual and community empowerment and accentuates the significant synergistic role the community plays in influencing the individual’s norms and actions (Bracht & Kingsbury, 1990). This health promotion conceptualization also acknowledges that significant alteration of social structures, preceded or followed by changes in the normative structures of a system, is a critical strategy in addressing inequities and mobilizing toward social action (Thompson & Kinne, 1990). Furthermore, community capacity building through a commitment to the concepts of caring, holism, social-ecology, active citizen participation, and shared power with citizens in egalitarian partnership (individuals, groups, and communities) are deemed essential factors in this approach to health and health promotion (Green & Raeburn, 1990; WHO, H&WC, & CPHA). A continuum of empowering strategies are identified within the health promotion framework that are directed toward planned change that can be exercised by professionals and their organizations (Labonte, 1990). The strategies include: personal empowerment, small group development, community development, coalition advocacy, and political action.

The Ottawa Charter goes further than positioning community development as an empowerment strategy. It proclaims that a community development philosophy and process of strengthening community action is core to a broad, health promotion process. In fact, community development is not a new concept or new to public health. Organized community effort as understood in a community development process is basic to public health philosophy and practice (Bracht, 1990). However, the Ottawa Charter declaration is lauded world wide as a landmark document in refocusing on “community” and social change and reorienting health and health promotion within a community development perspective. Thus, the charter places important emphasis on the environment in which people live and the socioenvironmental risk conditions within it as major factors affecting individual behaviour change and community well-being. According to the Ottawa Charter, community development is said to:
draw on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters and the empowerment of communities, their ownership and control of their own endeavours and destinies. (WHO, H&WC, & CPHA, 1986, p. 3)

In addition to declaring that community action is strengthened through community development processes, the charter lists other actions as essential to health promotion: building healthy public policy, creating supportive environments, developing personal skills, and reorienting health services.

A commitment to community development in health and health promotion practice means that community health professionals revisit their understanding of the concepts of health, health promotion, community, community development, empowerment, citizen participation, and partnership. The new health discourse challenges many prevalent beliefs about these concepts, the delivery of health care, the roles of the health professionals, and the involvement of community members, and consequentially elicits confusion and tension.

Before proceeding with a discussion of the implications for the health professional in general, and specifically the public health nurse, it is appropriate to consider the concept of community development more broadly and the value system and set of practices that are foundational to the concept.

Community Development

The modern community development movement has a long history dating back to the 1930s and the economic hardships of marginal peoples in industrial and underdeveloped countries (Lotz, 1987). It was generally referred to as adult education and was seen as a social invention by governments to promote public participation at the local level so communities could have more control of their destinies. There were important developments in community self-determination and improvements for disadvantaged peoples through the 20th century. Provincially, community development as public policy began in Canada with a study in 1956 of people of Indian ancestry in Manitoba and the involvement of these people in determination of their own destinies (Lotz). Historically, community development in Canada is described as being concerned mainly with problems and development in rural and isolated communities (Lotz; Mitchell-Weaver, 1990). However, community development efforts in rural and urban centres in developing and developed nations met with conflict and
failure in several situations due largely to conflict between the centres of power and people at the margins of society (Lotz). Governments usually decided how public participation would happen under the guise of community development. In 1955, community development was defined by the United Nations as, “a process designed to create economic and social progress for the whole community with its active participation and the fullest reliance upon the community’s initiative” (Lotz, p. 42).

The terms “Healthy Cities” or “Healthy Communities” signify the most recent community development initiatives undertaken by the WHO in 1986 (Chalmers & Bramadat, 1996; Hancock, 1993). The movement has spread across North America and Europe with several Healthy Communities projects in Canada. The goal of these initiatives is to build community well-being and health through collaborative action at the local level (Chalmers & Bramadat).

In 1958, Sanders provided a salient perspective on theories of community development that still hold currency today. Although he stressed the confusion surrounding the meaning of community development, he noted that discussions on community development need to acknowledge, “its rise as a contemporary social force but also take into account its solid but spectacular lineage” (p. 2). He describes its mixed lineage as consisting of programs of economic development and community organization, which includes social welfare and adult education programs. He posits that the difficulty in describing community development theory is that there are two levels of theory to be considered: the practitioner level; “getting the job done,” and the social scientist level; and theorizing, doing research, and then taking the time to apply the research. He represents the challenge as integrating the operational theory of the practitioner with the social scientist’s abstract theorizing. Sanders describes four ways that people speak or write about community development: as a process, a method, a program, and a movement. He relates these understandings to theoretical underpinnings. If the concept is considered as: (a) a process with a focus on the sequence of interactions, then theories of social change are relevant; (b) a method or a means to an end, then theories of social control are applicable; (c) a program that consists of content as well as procedures, then theories of social organization, which include descriptions of leaders, followers, status, norms, roles, etc., need to be invoked; (d) a movement, then theories of political sociology that look at funding acquisition and enabling legislation are pertinent. He also highlights other factors that account for the multidimensional and complex nature of
community development. It generally operates at different levels of geographic focus: the local or community level, the regional or district level, and the national level. He acknowledges the importance of communication theory in this regard. Additionally, he argues that the community development programs differ depending on the types of “functionaries” involved. He describes four types of functionaries: local lay leaders, resident professionals, outside professional organizations, and multipurpose community development workers. He emphasizes that the theory related to occupational sociology is relevant here.

Sanders argues that “no community development program will succeed over the long pull if there is no public acceptance of its functionaries as belonging to a new, but important occupational subcategory” (p. 11). It is clear from Sander’s discussion that community development can not be seen as a simple process either from a theoretical or operational basis. He argues that as the complexity of the concept is truly realized, community development will be respected, “as people working with people, as groups with groups, and the importance of social relationships will not be lost sight of in a hurry to fulfill some material objective or add up impersonal statistics to impress the unwary” (p. 12). Feather (1994) asserts that community development is: (a) a process, where people are involved in self-help and support groups to find power for change; (b) a project, in which professionals work with the community to affect social change; and (c) a philosophy, as the professionals have a democratic belief that people can participate in decisions that affect them, and it may be all of these.

Community development is referred to interchangeably as community development, community organization, community or collective capacity building, and community empowerment. It is regarded as “one of the oldest tools within the helping professions” (Minkler, 1991). A commonly held view is that a commitment to community development means practising within a particular value system and set of practices (Bhattacharyya, 1995; Bracht & Kingsbury, 1990; Labonte, 1990; McKnight, 1987; Minkler; Wallerstein & Bernstein, 1994). Minkler asserts that although there is not a single model of community development, there are several key concepts that apply in affecting change at the community level. She identifies these concepts as: empowerment (individual and community level), community competence (successful community collaboration in meeting their needs), the principles of participation and “starting where people are at” (central tenet and beginning of community ownership and competence), issue selection (needs, wishes, and felt needs that
the community feels strongly about), and creating critical consciousness (Freire’s [1994]) dialogic process of linking people to the larger sociopolitical context).

How the professional understands the concept of “community” is foundational to community development practice. Whether the community is defined as a geographical setting, as a client, as a system, as an issue, in a relational way, and/or politically will determine the assumptions, goals, and relationship with the community and how community development is understood and practised. According to Labonte (1993a; 1997), community is “essentially a contested concept” and needs to be considered as problematic as it has multiple meanings and is generally treated in an uncritical way and atheoretically by professionals and organizations. Defining community in geographic terms or as “community-as-locality” is how it is typically viewed in most community development, empowerment, and health promotion literature. When it is viewed this way or in demographic terms, it defines people’s informal and formal relationships by political jurisdictions and in static ways, such as “community-as-municipality” (Labonte, 1993a). According to Labonte (1997) demographic definitions of community also define the community in static ways according to how statistical data is collected. Identifying communities by identity, such as “poor community” or “women’s community” can also define a community in a static way. Labonte (1997) defines community according to the City of Toronto Department of Public Health’s (1994) definition, “[community] is a group of individuals with a common interest, and an identity of themselves as a group” (p. 90). He argues that practitioners need to be more critical of the concept of community to avoid several pitfalls associated with totalizing of the term. He identifies five pitfalls: (a) romantization, which implies that the community can do no wrong and obscures real and important power inequities among communities; (b) bureaucratization, in which the community’s capacity for empowerment is stifled by the outside professional interests; and (c) antiprofessional, a view that positions the professional as antithetical to the community. The community may be sanctified with attributes that it does not possess. Further, it can leave the community open to exploitation by the government to expect more than is possible from the community. This perspective tends to polarize as we/they and “ignores the formative role that respectfully delivered, useful, and useable services have often played in developing new community organizations and overcoming the isolation of society’s most marginalized” (1997, p. 92). He challenges McKnight’s (1987) position that “resources empower; services do not”; (d) decentralization can render increased
privatization and support growing social inequities as local communities are given decision making over public programs without substantial control over economic resources; and (e) self-help that parallels the calls for decentralization. It can increase voluntarism at the social and economic expense of women.

An understanding of community in a relational and political way, with the goal of creating a sense of community to affect social change, is the basis of the community development definition for several writers (Bhattacharyya, 1995; Israel et al., 1994; Labonte, 1993a; McKnight, 1995; Minkler, 1991; Thompson & Kinne, 1990; Wallerstein & Bernstein, 1994). In this view, community represents a deeply shared identity and code of conduct directed at building solidarity through a strong sense of community and agency of its members who thereby have control of their lives and a sense of freedom that they can change their world (Bhattacharyya). Bhattacharyya submits that solidarity and agency are the essential goals of a community development process and that "the value premise of community development is that people have the right to agency and the distinctive purpose of community development is to safeguard and, where impaired or lost, to reconstruct it" (p. 61). He identifies three overlapping principles that are inherent in community development: self-help, felt need, and citizen participation.

It is important to highlight the contributions of Saul Alinsky to community development theory and practice. He is referred to as the American grandfather of community organization (Labonte, 1989) and pioneer social activist/organizer (Minkler, 1991). According to Reitzes and Reitzes (1980), Alinsky's work on democratic citizen participation is not given the systematic analysis that it deserves. Instead, more emphasis is placed on his radical vocabulary, such as "War on Poverty." Alinsky views the community as the central unit of analysis, arguing that "local communities were not autonomous, self-sufficient units of social structure [as commonly believed] but reflected the social problems and processes of an urban society" (Reitzes & Reitzes, p. 40). He professes that community cohesiveness is accomplished by making local residents aware of the link between their day-to-day routines and the larger social structures. His commitment to broad, grassroots political participation through non-violent conflict strategies has significant implications for how community development is understood and accomplished. He challenges the common view that disenfranchised local residents are apathetic, lack indigenous leaders, and cannot work toward co-operative community action. Alinsky defines community development as
purposive action to access power for marginalized people, through conflict strategies that heighten community ties, to deal with issues that are shared concerns of the residents. He stressed the need for "disorganizing" communities before they can be organized (stirring discontent, creating a dissatisfaction with the status quo); identifying and "freezing" targets that are winnable, specific, and local; and using nonviolent conflict to build community-wide identification and participation" (Minkler, 1991, p. 258). Alinsky regards voluntary organizations as buffers against attempts to exclude local residents from participating in policy decision making that affected them. Several authors agree with Alinsky that community development involves conflict as competing groups struggle over the distribution of power, status, and resources (English & Hicks, 1992; Flick, Reese, Rogers, Fletcher, & Sonn, 1994; Labonte, 1997; Plough & Olafson, 1994). Conflict is regarded in this transformative process as healthy and desirable because it forces discussion on value differences and is a necessary part of movement toward social action and social change (English & Hicks; Labonte, 1993a; Wheeler & Chinn, 1991).

Similarly, John McKnight (1987) supports a relational and political definition of community as the basis of community development, which he terms as individual and collective capacity building. McKnight describes the goal of community development as the development of a cohesive community that actively builds on local strengths. He supports democratic public participation and also challenges the "deficit" perspective that professionals and institutions have toward communities, particularly disadvantaged communities. However, rather than proposing conflict strategies as the way to develop community capacity, McKnight calls for a new vision of community, a vision of regeneration where the fullness of each member is seen as building the capacity of the group. McKnight describes communities as informal, unmanaged environments where people act through consent. He posits that we need a new vision of community that centres our lives in community. He argues that to be in community is to be an active part of self help groups and a "community of association." He proposes that:

A community of association provides a social tool where consent is the primary motivation, interdependence creates holistic environments, people of all capacities and fallibilities are incorporated, quick responses are possible, creativity is multiplied rather than channelled, individualized responses are characteristic, care is able to replace service, and citizenship is possible. (p. 57)
According to Kretzmann and McKnight (1993), our society has weakened communities due to learned dependence created by managed institutions and their professional workers, who underestimate the capacities of individuals and communities, and seek to control people and deliver a service through deficiency models that are referred to as “need-driven dead end.” Following on this premise, they hold that our society is the site of struggle between the community and institutions. As institutions gain power, communities are valued as a commodity and weakened. To counter this situation, McKnight suggests that communities need to respect their collective strengths and minimize professional interference and control over their day-to-day decision making. Further, McKnight and his colleague John Kretzmann (1993) propose a “capacity-focussed model” of community development for professionals to adopt when working with communities. This model focuses on discovering a community’s capacities and assets, and connecting them with one another and to their community of associations to develop solidarity. Every individual in this model is seen as possessing “gifts” and capable of being a full participant in the development process.

Wallerstein and Bernstein (1994), in valuing “community” in a relational and political way, define community development as “a social action process in which individuals and groups act to gain mastery over their lives in the context of claiming their social and political environment” (p. 142). In this participatory empowerment process, people are full participants in naming their problems and their solutions. Community development or community empowerment is appreciated as an interactive change process in which individuals, groups, organizations, and communities become transformed. Wallerstein and Bernstein argue that empowerment is not primarily directed at personal empowerment for individual satisfaction and self-determination in isolation of one’s community and society. In agreement with other writers, they submit that community development needs to be understood as a social change process of individual and community empowerment or transformation that contains both process and outcome goals at various levels of change: individual, group, organization, and community (Israel et al., 1994; Thompson & Kinne, 1990; Wallerstein & Bernstein). Thompson and Kinne submit that a holistic approach based on a systems view of communities is needed to promote social change, as the community itself is the target of change. The change process can begin at any level in the community.

Freire’s (1994) concept of critical consciousness has made a significant contribution to community organization theory and practice. It is described as the basis of community
development by several social scientists (Labonte, 1990; Israel et al., 1994; Minkler, 1992; Minkler & Cox, 1980; Wallerstein & Bernstein, 1994). Critical consciousness implies a dialogic relationship of person to culture that liberates the mind to imagine what might be and to continually question and remake the interpretation of knowledge and reality such that people become subjects of their experience and, therefore, enabled to enhance their human capacity and freedom (Freire). Similar to Alinsky’s view, critical consciousness promotes connectedness of one’s community to society, and a commitment to social responsibility and social justice for all participants (Freire; Israel et al.; Wallerstein & Bernstein). In this dialectic process of critical reflection on the root problems they identify, individuals, groups, and communities collectively develop a plan of action to address the identified issues.

According to Freire in his seminal work “The Pedagogy of the Oppressed” (released in 1970), building “deep” problem-posing dialogue and trust are foundational to building critical consciousness, empowerment, and emancipatory education. Israel et al., suggest that awareness or critical consciousness, as described by Freire, and a commitment to social change is needed to connect the individual, organizational, and community levels of empowerment that are required for social change.

Lather defines the concept of empowerment:

to mean analysing ideas about the causes of powerlessness, recognizing systemic oppressive forces, and acting both individually and collectively to change the conditions of our lives . . . empowerment is a process one undertakes for oneself; it is not something done to or for someone. (pp. 3-4)

In this process, once trust is established, deeper dialogue can develop toward egalitarian partnership and critical consciousness through a process of identifying commonalities, respecting difference, continual dialogue of reflecting on the reifications of the day-to-day by asking critical questions, and taking action for social change (Freire; Wallerstein & Bernstein, 1994). The empowerment process starts at the same point no matter what the level of change; namely, listening to one another, establishing dialogue and trust, and building leadership skills to generate sustainable democratic dialogue that values the individual’s experience (Freire; Minkler, 1991; Wallerstein & Bernstein). However, Minkler concludes from her 12-year community organizing research project with poor seniors in the Tenderloin district in San Francisco that implementing Freire’s liberating dialogue in a “pure form proved difficult and often unrealistic” (p. 311). The seniors were frustrated, as their need for
immediate action on issues of concern in their high-risk environment were not always addressed due to the time given to a problem-posing focus to establish root causes for their problems.

Several models have been developed that recognize community development as a complex change process composed of many change processes. The best known community development model is Rothman and Tropman's model (1987), which includes three models: (a) locality development, (b) social planning, and (c) social action. These models are similar to the planned community change processes identified by Christenson and Robinson (1989): self-help (locality development), technical assistance (social planning), and conflict approaches (social action). Each model is based on different assumptions about the nature of community, the goals of community action, and the orientation to power structures. Thus, they invoke varying change strategies and give direction to different roles for the professional and lay person (Christenson & Robinson). Because each approach has underlying assumptions from which they operate, it is important to make these assumptions explicit, as follows:

**Locality development** is a heavily process-oriented model with the goal of cultivating the community’s capacity and integration, and ability for self-help, with emphasis on consensus and collaboration. The professional role is that of co-ordinator, enabler, and teacher. In contrast, **social planning** is task-oriented and directed at rational-empirical problem solving through data gathering, usually by an outside expert. It is primarily focussed on “expert” power and the delivery of a service. The professional acts as a fact gatherer, analyst, and facilitator. Building capacity and social change is not a priority. **Social action** has both a task and a process agenda. The goal is to change power relations and resources, address social injustices, deprivation, and inequities, and create institutional change through confrontation and negotiation. The main focus is to change the imbalance of power between oppressed or disadvantaged populations and the larger society. The organizing function is therefore as an activist and/or negotiator.

Rothman and Tropman (1987) and Christenson and Robinson (1989) emphasize that some approaches to community development may be appropriate in certain contexts, yet effective community development practice requires a mixing and phasing of locality development (self-help) social planning (technical assistance), and social action (conflict) approaches, as community development is a complex, multi-dimensional social change
process. In addition, these authors claim that practitioners make judgements on what approach is appropriate in what context and, therefore, often mix techniques in a single practice situation. However, Rothman and Tropman state that community organization efforts tend to have a central tendency toward a particular approach. Minkler (1991) takes exception to two points in Rothman and Tropman's model. She finds that the use of the term locality development, referring to geographic community, is too restrictive to the process-orientation that is possible. The second limitation is with reference to technical assistance and its inclusion as a community development model. Her concern is that such reliance on technical assistance is contrary to the basic principles of community development.

Labonte (1993a, 1997) supports the view that community development involves a range of practices and elaborates on the five components that define community development as practised by a health agency. First, he argues that the "doer" of community development in the health field is the health department, or the nonprofit health agency or organization. Second, community development implies an advocacy framework for people who are living in high-risk conditions that compromise their economic and political power. Third, he distinguishes "support group" work, which he terms "defensive self-help" from "community group work" or "offensive self-help." He submits that support group work is not community development because its goal is the creation of equitable power relations within the group, whereas he argues that community development is concerned with looking outward and establishing equitable power relations among community groups and institutions. He identifies support group work as central to what many public health nurses, educators, social workers, and organizations do. He justifies his distinctions as necessary so that community development will not be defined too broadly and therefore lose its meaning. Further, he wants to direct health professionals and their agencies to deal with power relations at a higher social organizational level. Fourthly, he argues for a distinction between community-based programming and community development. Community-based programming as he describes it is synonymous with the social planning model (Rothman & Tropman, 1987) and the technical assistance model (Christenson & Robinson, 1989). In Labonte's community-based programming model, the professional or the agency defines the health problem or the issue, the strategies and time lines, and involves the community members and groups in problem solving. According to Labonte, the desired outcomes are knowledge acquisition and/or behaviour change, and transfer of ongoing program
responsibility from the professional to the local community members and groups. He submits that most public health professionals in Canada are engaged in community-based programming rather than “true” community development. However, he does acknowledge that community-based programming can evolve into a community development program. In his fifth component that defines community development in a health agency context, he posits that self-reliance, rather than achievement of local autonomy, is the most appropriate goal for community development work as it fits with equitable and effective interdependence.

It is apparent from the discussion in this section that the concept of community development is very complex and subject to varying interpretation on theoretical and operational bases. I want to turn now to a discussion of the implications of a shift in practice to a primary focus on community development on the roles and responsibilities of the health professional, and particularly the public health nurse.

**The Role of the Health Professional**

As noted earlier, the roles required for the health professional in the “new” public health are in sharp contrast to the traditional, medical, and behavioural models of practice in our health care system. In these prevailing discourses, the professional names the problem and has major control over the planning, implementation, and evaluation components of the situation, thereby excluding lay persons as “nonexperts” and promoting learned helplessness. In this process, lay people are conditioned to depend on the professional “experts” who assume they (we) know what is best.

In contrast, citizen participation, through a liberating, egalitarian partnership between the professional and individuals, groups and communities, the disadvantaged, and the oppressed, is expected in a community development practice (Labonte, 1990). The basic premise of this community development practice is that “change is more likely to be successful and permanent when the people it affects are involved in initiating and promoting it” (Thompson & Kinne, 1990, p. 46). An altering of structural power inequalities, from “power over” to “power with,” to “power within” is foundational to this change process in which lay community members are respected as active partners in fostering and maintaining their health (Labonte). Thus, the new discourse calls for a holistic, collaborative model of practice that values a “provider-as-partner” role with lay persons and other health
professionals, and which is characterized by reciprocity and equality in the levels of status, control, and responsibility between the professional and the lay person (Stewart, 1990). Additionally, Stewart submits that this partnership requires respect for the experiential knowledge and the expertise of the lay person, ongoing negotiation of the collaborative partnership arrangement, and constant feedback on the professional's involvement.

Critical and feminist theories of partnership relations extend this view to include respect for emancipatory knowledge, which considers the person within the broad cultural-political perspective, and is understood as the language of possibility (Freire, 1994; Stevens & Hall, 1992). This knowledge is basic to the tenets of social justice and equity that are inherent in the philosophy of primary health care and a community development approach to health promotion. A partnership with an emancipatory agenda values an egalitarian and consciousness-raising dialogue leading to critical consciousness (Freire). The empowerment process starts with the professional's self-awareness or development of critical consciousness and learning to surrender their tendency to control (Friere; Sadan & Churchman, 1997; Stevens & Hall). Hoffman and Dupont (1992) argue that:

To be a "community developer" - whether it is only part of a job, an approach to work, or the main focus of one's job description - is one of the most challenging roles anyone can assume. A community developer requires different skills at different times as well as a sense of when it is the right time to pull out. (p. 33)

Labonte (1993a) submits that although community development and partnership are central to the new public health, they lack conceptual clarity and are subsequently misunderstood within public health organizations. In fact, some authors contend that involvement of the professional is not a necessary prerequisite for the empowering process that is central to community development, and moreover, egalitarian partnership is more rhetoric than reality. It is argued that well-meaning professionals can provoke helplessness and not address the broader socioenvironmental conditions due to their disempowering professional practices and programs (Freire, 1994; Grace, 1991; Labonte, 1994a, 1994b; McKnight, 1987; Sadan & Churchman, 1997). This is said to occur as health professionals often are inattentive to issues of power and control, and maintain paternalistic power (Drevdahl, 1995; Lassiter, 1992). Additionally, health professionals are often inattentive to the unequal distribution of resources and opportunities for disadvantaged communities (Eisen, 1994; Labonte, 1994a). Also questioned is how an egalitarian partnership can truly be
implemented, because to approach the community as an equal is to deny differences in race, class, ethnicity, education, and other points of difference between the professional and the community members (Israel et al., 1994; Labonte, 1994a; Meleis, 1992). Labonte (1994b) and Grace assert that there is an empowerment/control dichotomy in the health promotion discourse. Labonte (1994a, p. 88) poses the question, “How can professionals working under its [bureaucracy’s parentage] rubric engage in specific actions that are empowering, that ameliorate inequitable social relationships?” Grace argues that although the professional is committed to giving the community control, the professional often has an a priori agenda that is directive and controlling. It is essential to an empowering process that public health practitioners accept that there are starting differences in status, authority, resources, and legitimacy among themselves, their agency, and community groups (City of Toronto Department of Public Health, 1994).

In contrast to the view that the health professional can create a disempowering process, Labonte and Little (1992) assert that services delivered by front-line health and social service professionals can be very empowering to disadvantaged groups and communities who often mobilize around lack of health and/or social services or access to them. In addition, Jackson, Mitchell, and Wright (1989) contend that service from front-line workers can be empowering if they are supportive in non-controlling ways and represent part of a repertoire of services offered by the agency. Furthermore, an empowering process occurs if the individuals’ autonomy and sense of agency to control their lives are respected, care is culturally sensitive, and the psycho-social and socioenvironmental context of the problem is considered (Jackson et al.). Labonte (1994a) submits that the essence of community development practice is demonstrated when professionals can engage in an empowering practice through “authentic commitment to hearing the experiences of peoples’ lives, understanding their experiences in the words that people use to express them, and negotiating mutual action to improve those situations that people would like to alter” (p. 88).

Sadan and Churchman (1997) assert that the professional can be a critical factor in enabling an empowering process that values egalitarian partnership. They identify two variations of community planning: process-focussed and product-focussed. The process-focussed planner has more potential to be empowering, while the product-focussed planner has the potential to be disempowering. However, they assert that community planning is not all one way but contains both empowerment and disempowerment options.
Indeed, the challenge for the professional is to reverse or minimize the disempowering process and enhance empowering processes by consciously changing their own attitudes and behaviour. Sadan and Churchman explain that:

A commitment to empowerment demands from professionals the same critical consciousness regarding themselves and their work and the same ability to change and adapt themselves to what is necessary, as is required of the rest of the participants in the empowerment process. (p. 13)

In addition to establishing an egalitarian partnership process with the community, the empowering-oriented professional is also expected to create a participatory infrastructure to build co-operation and lay the ground work for community development (Sadan & Churchman).

**Public health nursing.** Public health nursing is a synthesis of public health and nursing science for the purpose of improving the health of populations (Hanchett & Clarke, 1988). This knowledge distinguishes public health nursing from other types of nursing: hospital-based nursing and other types of community health nursing. Public health nurses, as a professional group who are employed in government-funded health departments, are recognized as having a broader mandate than other community health nurses. This mandate includes population-focussed health activities in health promotion, and illness and injury prevention (Cloutier Laffrey & Page, 1989; King et al., 1995), and community development and advocacy for healthy public policy (Butterfield, 1990; CPHA, 1990). Community development in nursing is defined as a “process of involving a community in the identification and reinforcement of those aspects of everyday life, culture, and political activity, which are conducive to health” (CPHA, p. 19). Traditionally, public health nurses have taken both a narrow and a broad view in their nursing practice, balancing the needs of individuals, families, groups, and communities, while drawing on a broad range of practice competencies (Zerwekh, 1991b, 1992a). Additionally, a unique feature of public health nurses’ practice is the direct access afforded to the public through self-referral, i.e., referral through a physician intermediary is not required as it is for virtually all other forms of nursing practice.

Public health nursing as we might think of it today, with a mandate of providing services based within a broad understanding of social and economic determinants of health to
promote and preserve the health of the public, was called such as early as the mid 19th century (Buhler-Wilkerson, 1993; Erickson, 1996; Portnoy & Dumas, 1994; Reverby, 1993; Salmon, 1993). In Canada, the Order of Grey Nuns and the Victorian Order of Nurses (VON) for Canada (established in 1897) were the leaders in public health nursing (Allemang, 1995). These home visiting orders provided care of the ill in their homes, health promotion, and disease prevention services.

Nurse reformer Lillian Wald authored the term “public health nurse” (Buhler-Wilkerson, 1993). Her “Henry Street Visiting Nursing Service,” which she established in 1893, exemplified the extensive public health nursing role she envisioned, which was for all people, not only the poor. Wald’s conceptualization of a paradigm for nursing practice that understood illness within its broad social, economic, and political context, is just as relevant today in our fragmented and complex health care environment and cultural mosaic (Buhler-Wilkerson). In general, the beliefs and work of the early community nurse-reformers included a broad community focus in which building relationships and practising innovative nursing were seen as critical to fostering health care and societal reform to improve the living conditions of the populations who were poor or near poor (Buhler-Wilkerson; Erickson, 1996; Portnoy & Dumas, 1994; Salmon, 1993).

At the turn of the 20th century in North America, many personal and environmental hazards threatened public health: rising immigration, poverty, dangerous industrial work places, transient employment, and inadequate housing. As a result of these conditions, there was a high incidence of tuberculosis in the cities, especially among the poor, along with a high incidence of other infectious diseases, as well as maternal illnesses (Allemang, 1995). Largely for these reasons, a common view among nurses in Canada in the first 30 years of the century was that every nurse needed to be a public health nurse (Allemang). In 1904, the first community nursing position, a “City Tuberculosis Nurse,” was established in the City of Toronto (Royce, 1983). Over time, the City of Toronto public health nursing division became a model for public health nursing in Ontario and across Canada.

Public health nurses’ historic commitment to the “common good,” social justice, promoting health, and reducing inequities, is still current and is basic to the goals of primary health care and consistent with principles of the health promotion and the community development mandate in the Ottawa Charter for Health Promotion (WHO, H&W, & CPHA, 1986). According to several authors, public health nursing has a long record of
addressing broad inequities in health and of building capacity with people who are marginalized by their life circumstances (Hayward et al., 1993; Kristjanson & Chalmers, 1990; Reutter et al., 1995; Zerwekh, 1991b, 1992a, 1992b). The report, *Community Health/Public Health Nursing in Canada: Preparation and Practice* (CPHA, 1990), reinforced the increasing demand for community health nurses to integrate a community development approach to their practice and focus on the more vulnerable in our society. The document describes the community health nursing advocate role as one of helping the socially disadvantaged become aware of issues relevant to their health and to develop resources that would result in equal access to health and health-related services. It also specifies that community health nurses need knowledge and skill in community development and need to adopt the role of community developer. Public health nurses are identified as primary health care practitioners who exercise various professional roles in meeting their responsibility for health promotion and illness prevention: direct care provider, resource person or consultant, group facilitator, educator/trainer, community organizer, and advocate (CPHA).

Furthermore, their practice in the community where people work, live and play, combined with their efforts with vulnerable populations and their expertise at working collaboratively with an extensive network of community partners, positions them uniquely to contribute to the goals of primary health care and community development (CPHA).

Chalmers and Bramadat (1996) concluded from a synthesis of literature in sociology, social psychology, education, and political science that there are four models of community development: economic development, formal and informal educational models, confrontational models, and empowerment models. They critiqued the relevance of each model for community health nursing practice. They propose that the empowerment models have the closest association with community health nursing practice that is based in primary health care and health promotion frameworks. Further, education models that are rooted in Freire’s empowerment education process or “popular education model” of development of critical consciousness are consistent with the empowerment models of community development. Chalmers and Bramadat propose that the emphasis on human and social development, and a holistic approach that is reflected in the empowerment model of community development is consistent with community health nursing’s mandate.

Labonte and Little (1992) produced a background paper for the Registered Nurses Association of British Columbia titled *Determinants of Health: Empowerment Strategies for*
Nursing Practice. A continuum of empowering strategies are identified: personal empowerment, small group development, community organization, coalition building, and political action. The nature of each strategy, and the roles and responsibilities of nurses and the organizations in which they work are identified. The model is based on the premise that professionals and organizations are capable of changing their practice to one of empowerment and partnership with the community. No one professional is expected to have all the skills or time to work at all strategies. The professionals are linked in their community development efforts with other professionals in the organization, with the organization expected to take responsibility for providing the milieu for community development practice.

Nursing's unique contribution in empowering practice is described as beginning with nursing's knowledge and skill with the physical and emotional health of individuals, groups, families, and communities. However, it is suggested that nurses' skills need to expand to include a greater emphasis on the socioenvironmental factors that negatively affect people's health. Labonte and Little (1992) do acknowledge that many nurses already have the "new" skills. The community development continuum was redesigned into a holosphere practice model retaining the five strategies as spheres of practice (Labonte, 1994b). Each point on the continuum or holosphere represents a different level of relationship, process of change, level of social organization, and roles and responsibilities for the professional and the organization. The continuum or holosphere represents a fluid, nonlinear process of gradual and continuous learning and development where people, groups, and organizations move back and forth depending on the issue, resources, interests, and confidence building from successful experiences. These experiences permit progression to a more advanced level of participation in community (Hoffman & Dupont, 1992). Below, the elements of the model are described in detail as the model has particular relevance to this study. The model conceptualizes several activities related to community development. It concurs with Jackson et al's. (1989) community development continuum model that applies to front-line health professional practice.

Personal empowerment (interpersonal change) includes developmental case work that enhances the individual client's sense of control and power. This refers to direct service and is the point on the continuum where most health and social service front-line workers encounter individuals living in high-risk environments. According to Jackson et al. (1989), health professionals start their community development work with individuals, as it keeps
them "grounded" in the situated realities of the people they are working with. Additionally, the one-to-one relationships allow them to develop trusting relationship that permit more complex relationship building to occur. The nurse is expected to have skills in case work, case management, instrumental and therapeutic counselling, personal advocacy, interagency networking, one-to-one education, effective, and validating communication- reflective practice. "There must be a willingness to consider case-work developmentally as a starting point in personal and community transformation" (Labonte & Little, 1992, p. 24).

Small group development (intra-group change) happens when individuals, through group work, discover they are not alone in their isolation and begin to normalize their experiences. The group session is organized around issues and problems unique to the members. It is about improving social support, promoting behaviour change, and providing support for lifestyle choices. Jackson et al. (1989) submit that participation in support groups is a necessary stage in building people's self-confidence and support networks to prepare them to address broader issues. Professional skills include: well-developed group facilitation knowledge and experience, and the ability to move from group facilitator/leader to group resource as the group develops into a self-help group and needs less professional guidance. More specialized skills in critical adult learning are expected, such as "popular education" based on Freire's theories of emancipatory education. An understanding of the dynamics of self-help groups is also valuable. It is a necessary step on the continuum of development for social change.

Community organization (inter-group change) refers to organizing people around issues that are bigger than the group members can deal with alone, and the agency makes choices of which other community to work with. Priority is generally given to those communities with low economic and political power. In Jackson et al.'s. (1989) community development continuum this stage is called "issues identification and campaigns." These authors argue that although movement along the continuum is not necessarily sequential, this step marks the transition from participating on a personal level in groups for survival to looking outward and participating on a social, political, or community level to achieve social action and social change. The skill set is complex, including reaching out into the community to find people around the issue, group development skills, skills at media relations, writing and communicating skills, grantmanship, interagency networking, and mediating between community groups, agencies, and governments.
Coalition advocacy (inter-organizational change) includes lobbying for health public policy, achieving strategic consensus, and collaboration and conflict resolution. Professionals can offer knowledge, analytical skills, and information on how the political and bureaucratic structure function, and agencies can legitimize the health concerns of the coalition and increase the strength of their own political voices to affect public policy. The professional needs to have well-honed lobbying and advocacy expertise, policy analysis, brief writing, public speaking, mediation, media relations, and conflict resolution skills.

Political action (inter-organizational change) is defined as a social movement. The agency is expected to provide support for broad-based social movements, create a vision for a sustained future, and enhance participatory democracy. The same skill set required for coalition advocacy is expected but with a greater understanding of social change and social movements.

Hayward et al's. (1993) document, Public Health Nursing and Health Promotion: A Background Paper for the Systematic Overviews of the Effectiveness of Public Health Nursing Interventions provides an overview of health promotion and public health nursing in Canada. They critique the health promotion discourse in respect to public health nursing. This endeavour was precipitated by the significant shifting of priorities for public health nursing practice through the adoption of health promotion as a central policy in Ontario. With reference to an extensive theoretical and empirical literature review, they conclude that public health nursing ideals and practice are consistent with participatory models of care and community development. Further, they agree that public health nurses make a special contribution due to their traditions of knowledge and ideology, unique place in the social structure, and their practice that includes multiple levels of interventions with different groups, specifically with vulnerable populations. The authors contend that:

They [public health nurses] are in place already working with community organizations, fostering the participation of the least empowered groups, and using unique expertise to assist people to define problems and find potential solutions. They form the concrete link between a policy of empowerment and the participation of individuals. (p. 23)

Along with several nurse researchers, they argue for respect and integration of nursing values, such as caring and advocacy in the health promotion discourse (Edwards, Ciliska, Halbert, & Pond, 1992; Kendall, 1992; Rafael, 1997). Contemporary
conceptualizations of caring in the nursing literature that characterize it as synonymous with advocacy and empowerment (Rafael, 1997) and focussed in a political agenda and social activism (Hagedorn, 1995; Kendall; Moccia, 1988; Rafael) coincide with the relational and political basis of community development.

Further, some nursing scholars argue that community health nurses need to adopt an emancipatory practice to fight persistent oppressive, health-damaging conditions (Butterfield, 1990; Drevdahl, 1995; Hall, Stevens, & Meleis, 1994; Kendall, 1992; Reutter et al., 1995; Stevens & Hall, 1992). They posit that traditional nursing, including public health nursing, generally aligns with the goals of the dominant culture and does not effectively challenge social injustices and inequities of the larger socioenvironmental factors (Drevdahl; Kendall; Meleis). To effectively challenge the oppressive, health-damaging conditions, nurses are asked to go beyond nursing theories and develop theories of practical and political relevance (Drevdahl; Hall et al.; Kendall; Stevens & Hall). Diekelmann (1994) states that nurses need to have a greater sense of professional autonomy, be willing to adopt a facilitative and democratic style of practice, and have greater skills in expanding the range of social identities and possibilities for themselves and the people they serve. Various strategies are identified for public health nurses to make an emancipatory practice a reality: adopting a broader, more comprehensive view of person, environment, and health that includes a relational and political understanding of the community context, and situating their efforts in people’s struggles by letting go of ideal notions of health that do not fit with people’s “lived experiences” (Drevdahl; Stevens & Hall). Nurses are also asked to adopt a model of collaborative practice with lay persons and other health professionals. This collaborative model is characterized by a partnership that values reciprocity and equality in the levels of status, control, and responsibility between the professional and the lay person and ongoing negotiation of the partnership (Stewart, 1990). Further, a participatory and liberating dialogue that happens when critical questions are asked to expose inequities is deemed essential. It is also suggested that instead of helping people cope and adapt to health-damaging circumstances, public health nurses should help them to fight back and work with them to eliminate barriers that impede empowerment. Taking time to build trust, sharing power, valuing story telling, building on strengths and abilities of community members, taking a stand, and acting collectively by forming alliances and coalitions for liberating change are also described as critical strategies (Drevdahl; Hall et al.; Kendall; Stevens &
Hall). Wheeler and Chinn (1991) look at the empowerment process as growth of personal strength in the context of love and respect for others. The essence of these strategies is the building of solidarity of the nurse with community members and within the community itself, and the equality, solidarity, and agency of the community.

**Tensions Between Public Health Nursing, Health Promotion, and Community Development**

Public health nurses who have the necessary specialized knowledge and skills for an expanded health promotion and community development practice find themselves a professional group at risk and increasingly invisible to and devalued by: the public, professional colleagues, public health administration, and politicians (Hayward et al., 1993; Zerwekh, 1993). According to Hayward et al., “public health nurses form a concrete link between a policy of empowerment and the participation of individuals, [but] they are hindered by lack of recognition and a poor perception of their work” (p. 23).

Health promotion is a contested concept that has taken on several conceptual and political meanings over time because the interplay of individual, group, community, and population level strategies is complex, and more significantly, health promotion relates as much to social and political influences as to definitions of health, health determinants, and health care (Hayward et al., 1993). Stevenson and Burke (1992) note that although health promotion is described by some as a movement for social and economic change, in reality, it is not a social movement but a bureaucratic tendency; not a movement against the state but one within it. It could therefore be seen as a discourse that is progressive and espouses collective egalitarianism, but in reality, is appropriated to maintain the status quo and the dominant hegemony. According to Hayward et al.:

> the implied strategies [in health promotion] are [often] neither new nor different from many approaches already familiar to the public health practitioner . . . may be seen as just one expression of a call for new and different voices to be heard . . . to shift established meanings and practices in public health (p. 7).

Moreover, these authors suggest that “when new strategies are given unfamiliar labels and presented in polarized contrast to established practices, the similarities between the old and the new approaches are obscured” (p. 19), thereby risking a distortion of the principles of health promotion/community development. Green and Raeburn (1990) noted that there is a
danger in misreading the Ottawa Charter on Health Promotion and splitting into ideological factions, thereby working against the enablement philosophy of health promotion. Hayward et al., criticize the tendency of non-nursing professionals in the health promotion arena to dismiss public health nursing’s legitimate place in health promotion and community development and contrasts one-to-one strategies as not community development activities. In fact, Green (1995) contradicted his earlier statement on cautioning against misreading the Ottawa Charter when he devalued the credibility of professionals who he perceives as not having academic credentials in health promotion. One can assume that nursing is in this exclusionary status.

The adoption of health promotion as a central policy for Ontario in the Health Promotion and Protection Act (1983), and building community partnership as the core strategy, had a major impact on public health nursing in Ontario, both positively and negatively (Craig, 1991; Hayward et al., 1993; Rafael, 1997). From a negative perspective, due to an increased emphasis on “population-based” strategies, traditional public health nursing roles and responsibilities in one-to-one and family-centred counselling, home visiting, case finding, health teaching, and working with particular populations was questioned, discouraged, or eliminated in some cases. One-to-one strategies and support group work then became contrasted with community organization, coalition advocacy, and political action strategies, rather then seen as points on the same continuum of empowerment and community development with all approaches respected as necessary for community health. In the realities of public health nursing practice, vulnerable populations are not easy to access and do not readily participate in group and community interventions. Therefore, they can be forgotten in a system where community development starts with the community’s solidarity consensus on an issue. This level of social action and readiness for social change usually takes multiple interventions and an extensive investment of time and effort on the part of many professionals and lay persons to encompass disenfranchised populations. According to Labonte (1990):

If we focus only on the individual . . . we risk privatizing-rendering personal- the social and economic underpinnings to poverty and powerlessness . . . But if we only focus on the structural issues, we risk ignoring the immediate pains and personal wounding of the powerless and the people in crisis. (p. 57)
In contrast to this statement, Labonte (1993a; 1997) makes a sharp distinction between community-based programming and community development, and positions community-based programming as the antithesis to community development. He labels most of public health nursing practice as community-based programming. In this framework the micro level of community development, which includes personal empowerment and small group development, becomes contrasted with the macro nature of community development, which includes community organizing, coalition advocacy, and political action. I concur with Hoffman and Dupont’s (1992) view that it is unfortunate that the discourse is caught up in arguing these conceptual underpinnings. They propose that the issue is not that “if an agency defines what it is that needs to be worked on, the result will not be ‘real’ community development [rather] . . . community development is not so much where one begins as about how to proceed and where to proceed to” (p. 39). As advanced by many social scientists in the previous discussion, there is not one model of community development nor should there be one, as it is a complex social change process and it therefore requires a diversity of approaches and phases that do not fit neatly into one model. Further, community development by its very nature includes individual and community empowerment.

Public health nurses profess their commitment to an upstream approach to practice and a broader environmental perspective on individual behaviour (Butterfield, 1990). They also consider community development as integral to their current and future practice (Beddome, Clarke, & Whyte, 1993). However, some nursing scholars state that there is an ideological dilemma for many nurses between the two discourses of individual-focussed beliefs and societal or systems-oriented beliefs (Hamilton & Keyser, 1992). Further, the emphasis on the broader socioenvironmental conditions for health as professed in position papers is not common community health nursing practice (Chalmers & Bramadat, 1996). Although a broader vision of environment is integral to the holistic vision of nursing, health promotion, and community development, the concept of environment is poorly developed in nursing theories to guide practice (Chopoorian, 1986; Stevens, 1989). Most nursing models focus on the individual and family and give minimal emphasis to environment or health promotion. Penders’ (1987) health promotion model is the only nursing model that deals explicitly with health promotion. Equally important, there is very limited empirical examination of the conceptual and practice basis of community development for community health nursing to guide practice.
Although there is an apparent logical relationship between community health nursing’s conceptual basis and the empowerment model of a community development practice, a number of organizational, personal, and community challenges are presented that constrain community health nurses’ community development role (Chalmers & Bramadat, 1996; Hayward et al., 1993; Ploeg et al., 1995). Chalmers and Bramadat argue that the structures of organizations where community health nurses work in public health agencies and community health centres may present significant barriers to community development practice: lack of support in terms of well-articulated policies and the delineation of the boundaries of community health nursing practice; lack of or inadequate resources to support community development work; time conflict with mandated programs; few standards for nurse managers to evaluate the nurses’ performance; reluctance of the organization to share power and authority with nursing staff and the communities; and sanctioning of community health nurses when community health issues become politicized, especially in government-funded community health agencies. These authors claim that “multiple mandates across traditional and community development work may produce role conflict, role overload, burnout, and conflict with the "bottom up" philosophy of community development” (p. 724).

Having appropriate time to do comprehensive community development work is identified as essential to the effectiveness of the effort (Minkler, 1992; Ploeg et al., 1995). Indeed, many public health nurses report finding it difficult to establish major time to focus on the community as the target of practice in a community development process within their expected traditional practice (Chalmers & Bramadat, 1996; Hayward et al., 1993). According to Ploeg et al., supporting structures and processes provided by the employing agencies in the form of department policies, position papers, opportunities for further knowledge and skill development, time for reflection and analysis, time for discussions with peers, time to complete community development work, and adequate funding are considered essential for a community development process to be effective. Chalmers and Bramadat also argue that the use of confrontational strategies that are integral to a conflict approach to community development and social change is problematic for health professionals, including public health nurses who are employees of government-funded organizations, with other styles of decision making.

Chalmers and Bramadat (1996) also describe the nurses themselves as a barrier in promoting community development practice. They explain that although the majority of
Canadian university schools of nursing report that community development is a part of their curriculum, students may have little opportunity to practice community development and to acquire the well-developed collaborative and partnership skills needed for this practice. They posit that despite the professional statements that emphasize the community health nurses’ role in community development, much of the community health nurses’ practice is with individuals and families. In addition, nurses may have varying degrees of support for a broader community development role and prefer to stay at the individual and family level, as it is more consistent with their educational preparation and practice experience. Also, the nurses may not have the necessary knowledge and skills to work with culturally diverse communities. Additionally, Chalmers and Bramadat acknowledge the community itself as problematic because it is often idealized as homogeneous but in reality is very diverse and may naturally be resistant to an outsider who is nurse and a woman.

Concern is expressed in regard to how the new emphasis on community development and community participation may be appropriated by various levels of government, politicians, and employing public health agencies. In the name of health promotion, community ownership, self-determination, and population-based approaches to health, a more strident individualistic, depersonalized, and cost saving perspective could be legitimized in withdrawing professional services on the basis of "community choice," and promoting interventions at the organizational level, rather than the everyday personal level (Anderson 1990; Hayward et al., 1993; Rachlis & Kushner, 1994). As a result, health and community services could be bureaucratized or privatized, left to charity and added to the burden of the informal care system and disenfranchised individuals, particularly women (Anderson; Craig, 1991; Hayward et al.).

**Tensions Between Health Promotion and Population Health**

The discussion would be incomplete on the new public health discourse without considering the tensions between the health promotion and community development discourses and ambiguous understandings of the emergent population health movement. The population health movement in Canada is identified with the Canadian Institute of Advanced Research (CIAR), which was formed in the early 1980s by physicians, health economists, and epidemiologists. Population health, as defined by the CIAR, gained currency at all levels of government in Canada as the decade of the 1990s proceeded. The CIAR’s
conceptualization of population health, which includes social determinants, is represented by Evans and Stoddart (1990) in their paper Producing Health, Consuming Health Care, and reprinted in the book edited by Evans, Barer, and Marmor (1994), Why are Some People Healthy and Others Not? This population health perspective is the target of most of the criticism. According to the CIAR group, population health is conceptualized in an economic and epidemiological framework, in which the key premise is that increased wealth equates with greater population health and that money should be taken out of the health care sector and invested in wealth-producing sectors of the economy to encourage prosperity.

Since the early 1990s intense debate has raged in Canada between the health promotion and population health advocates with an emerging shift in health paradigms, and population health competing with health promotion as the dominant discourse on public health policy and practice (Frank, 1995; Labonte, 1995; Poland, Coburn, Robertson, & Eakin, 1998; Raphael & Bryant, 2000; Robertson, 1998). According to Poland et al., the shift of paradigms represents the replacement of an emphasis on structural determinants of health as proposed in the health promotion model, with a “neutral” population health framework (Poland et al.). It is important to note that in concert with the debate between health promotion and population health, confusion also exists in the health field with the distinction and overlap among the terms population health, community health, and public health. Frank (1995), a member of CIAR, contends that the distinctions are subtle, especially for the public health worker, because population health represents a validation and return to the historical roots of valuing social and economic determinants of health. I would counter that the distinctions hold significant differences and implications for how community health professionals understand and/or are expected to approach their practice.

While health promotion and population health are perceived by some health researchers, public health practitioners, and policy makers as competing discourses, others contend that they hold more similarities than differences. They submit that health promotion and population health have the same objective: to improve the health and well-being of society and reduce inequalities in health between peoples (Dunn & Hayes, 1999). Yet, for several researchers this is where the similarity ends. It is strongly argued that the ways of accomplishing population health within the two discourses are contradictory and conflicted, and present significant challenges for public policy and practice (Labonte, 1995; Poland et al., 1998; Raphael & Bryant, 2000; Robertson, 1998). Major features of the population health
framework are passionately challenged: the conceptualizations of the problems, the solutions, and the implications for public policy (Poland et al.). Labonte, Poland et al., Raphael and Bryant, and Robertson contend that the CIAR's scientists oversimplify the link between wealth and health status and give little attention to the complex social and political relations producing poverty and the myriad of social and political inequities. Additionally, these researchers argue that the discourse is not new, but one that returns to a positivistic, reductionist, epidemiological explanation of health and consequently, the re-medicalization of health. Equally important, the CIAR notion of population health is seen as problematic because it is the antithesis of the core principles of the health promotion discourse; it lacks an explicit value base, ignores issues of participation, equity, community, collaboration, environmental sustainability, and social justice (Poland et al.; Raphael & Bryant; Robertson). Further, it lacks a theory of society and social change, minimizes the problems of poverty, and emphasizes expert knowledge. Poland et al. assert that the CIAR's definition of population health implicitly refers to aggregates of individual. Extending this view, Raphael and Bryant argue that it leads to "context stripping" by removing the health of individuals from its community and societal context.

There is major concern that population health as defined by the CIAR is becoming a prevailing discourse on health because it is being promoted at a time of "fiscal crisis" and provides policy makers a convenient pro-market basis (Poland et al., 1998; Robertson, 1998). Poland et al. and Robertson contend that this market perspective provides a rhetoric for politicians and administrators to dismantle Canada's social safety net and justify major reductions in spending on health determinants and health care in the name of deficit reduction, without reallocating resources to other sectors that could produce health. In so doing, those already compromised by structural inequality are penalized further. Labonte (1995), expressed his concern with the CIAR's population health concept thusly:

If population health eclipses health promotion in bureaucracies, its focus on a critique of health care expenditures in a context of fiscal restraint, its emphasis on epidemiological methods, its economic conservatism and its silence on ecological questions of overall economic scale could unintentionally undermine the fragile legitimacy of empowerment, community development, qualitative research and political advocacy that health promoters have struggled for two decades to obtain. (p. 164)
Poland et al.’s (1998) major criticism is that the CIAR’s definition of population health is based in prosperity rather than equity, encourages an increasing gap between the rich and the poor, and ignores the evidence that inequities in access to health care persist in Canada, with the greatest inequity felt by those people in the lower socioeconomic status. Poland et al., support their position with reference to two recent studies from Berkeley and Harvard universities that present strong evidence that the gap between the rich and the poor is a far greater predictor of population health status than average income in the state. As the gap widens the population health of the nation decreases. Further, Poland et al. argue that another significant limitation in the CIAR’s definition is the lack of gender analysis of health and health care. No attention is paid to the fact that the burden of health care is shifting from the public arena to the private (domestic) domain, particularly to women as unpaid caregivers. The cutbacks in health care resources are felt more profoundly by those workers at the bottom of the status hierarchy in the health care system; “typically these are the less well paid ‘caring’ positions in community-based care, public health nursing, etc-which are overwhelmingly staffed by women” (p. 787).

The CIAR group was instrumental in shaping a Federal document; Strategies for Population Health: Investing in the Health of Canadians (1994). The document was intended to identify broad population health strategies on which federal, provincial, and territorial governments could collaborate. Coincidently, in 1996 the Canadian Public Health Association released an Action Statement for Health Promotion in Canada and restated support for existing documents: the Ottawa Charter for Health Promotion (1986) and Achieving Health for All: A Framework for Health Promotion (Epp, 1986). This document release was precipitated by alarming Canadian statistics of increasing poverty and unemployment, by the federal and provincial governments’ erosion of the social safety net, and by the devolution and/or elimination of health promotion infrastructures across Canada.

In an attempt to integrate the health promotion and population discourses and to diffuse the intense debate among Canadian health researchers, policy makers, and practitioners, Health Canada released the document co-authored by Hamilton and Bhatti (1996), Population Health Promotion: An Integrated Model of Population Health and Health Promotion, in which they established both health promotion and population health as necessary frameworks to reduce inequities in Canada. The model represents an integration of
the Ottawa Charter, the Achieving Health for All document, and the Strategies for Population Health documents.

In 1999, Health Canada released a document, Taking Action on Population Health, in which they defined population health as:

An approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that determine health. (p. 1)

Health Canada supported the 12 determinants of health identified by the CIAR group but went beyond their version of population health, seeing health as a resource for everyday living and calling for a pluralism of data gathering methods that extend beyond a narrow, traditional biomedical approach to research (Raphael & Bryant, 1999). Dunn and Hayes (1999) submit that there is continued confusion about the understandings of population health that can be explained by its evolutionary nature. They acknowledge new evidence that integrates the empiricist and social/theoretical dimensions to explain the relationship of social gradient, and individual and population health status, placing the social structural nature of health as central.

The conceptualization of population health and its translation into policies and practice at the federal, provincial, and local levels of government are seen as variable, evolutionary, and deserving of careful critique due to their highly political context. As this inquiry evolved, the Ontario Ministry of Health’s definition of health promotion and population health, which was framed in economic and epidemiological terms, was observed to exert a significant influence on the community development practice of the public health nurses in this study. Health promotion infrastructures, including public health nursing and our Canadian social safety net, are being dismantled, often in the name of population health policies and approaches. There is increasing poverty, discrimination, and ill health experienced by historically disadvantaged groups, especially low-income women (Statistics Canada, 2000).

Summary

The overall discussion of theoretical literature and position statements in this section is of major significance, as it highlights key concepts that are foundational to this study. This discussion describes the broadening of public health science in the latter part of the 20th
century from a strictly biomedical model to a socioenvironmental model. This new direction for public health in Canada provided an alternative that emphasized a social definition of health, and a health promotion and community development approach. This approach is based in a process that includes a continuum of strategies for personal, group, and community empowerment.

Perspectives on the concept of community development and implications for the health professional, and specifically for the public health nurse, are presented. It is evident from the discussion that community development is not a new concept to public health, nor is it a neutral process, but it is one that is highly complex, political, and subject to varying interpretations on a theoretical and operational basis. The definition of “community” is foundational to how community development is approached. My review of the literature leads me to conclude that a relational and political definition of community within self-help and social action community development models is the preferred approach to improve the socioenvironmental risk conditions for disadvantaged and marginalized communities. This perspective is consistent with the “new” public health, or “new” health promotion. However, community development is not seen as a linear process or one model, but as being multidimensional on many levels: as an interactive change process across individual, group, organization, and community levels; involving several theoretical underpinnings; embracing multiple concepts, which are variously understood, i.e., empowerment, public participation, partnership; involving a myriad of change strategies with corresponding roles and responsibilities for the professional and their organizations; and as a long term process. Citizen participation, social justice, and empowerment are key underlying values that should direct community development practice. Freire’s concept of critical consciousness is shown to contribute significantly to the expected community development practice that is directed by emancipatory goals.

The discussion indicates that although public health nursing is committed to and demonstrates many of the skills expected with a community development practice with vulnerable populations, new challenges are proposed. These challenges include: working with a definition of community, community partnership, and empowerment that is directed more explicitly to social action; valuing experiential knowledge; striving for reciprocity and egalitarian partnership with community members; negotiating issues of difference between the professional and lay person that include disparity of resources on several levels; having a
repertoire of skills to work with community members at different points on the community development continuum; and most importantly, having the time, energy, and commitment to critical consciousness and emancipatory goals that is demanded by all participants in a community development process.

The potential for varying understandings and consequent contradictions and conflict among professionals, administrators, politicians, and the public related to health promotion, community development, and public health nursing is evident. Confusion also abounds on issues identification and macro versus micro community development approaches. In addition, the tensions created by the emergent discourse on population health when it is framed in economic and epidemiologic terms is discussed. Although this literature provides valuable insights on the concept of community development and the role of the health professional and public health nurse, it is evident that research is needed to articulate how community development is practised by public health nurses with disadvantaged populations within the social, economic, and political organization of their practice.

The “New” Public Health Discourse and Nursing: Valued Knowledge

I propose that a critical factor contributing to the invisibility of public health nurses’ work, and particularly their community development practice, is the matter of how knowledge is valued within the nursing community. This inquiry is based on the premise that examination of the multiple realities and the aesthetic, ethical, personal, and emancipatory knowledge that resides in the everyday practice of public health nurses is essential to the visibility and advancement of public health nursing. A basic element of a community development practice is that respect for multiple ways of knowing and the fostering of emancipatory knowledge is essential to counter the social, economic, and political aspects of oppressive, health-damaging conditions (Stevens, 1989; Stevens & Hall, 1992). Emancipatory knowledge describes the language of possibilities and considers the personal within the broad cultural-political perspective (Freire, 1994). The examination of the contextual nature of public health nurses’ practice and their multiple ways of knowing is therefore necessary to explicate their credibility in health promotion and community development practice. However, the valuing of multiple ways of knowing in a community development practice presents challenges for public health nursing.
From the stand point of valued knowledge, there is disagreement in nursing practice, education and research on the essence of nursing (Johnson, 1994). This disagreement is expressed in questions as to who is the client, what is valued knowledge (Jacobs-Kramer & Chinn, 1988), and what are acceptable strategies for nurses to use in helping people reach their optimal health and achieve social justice. Nursing is a human science and a practice profession concerned with the lived world of the human health and illness experience and a human-to-human caring practice (Watson, 1988). Considering that nursing is concerned with finding meaning in the health, healing, and caring process, the capturing of meaning of the lived experience in scientific language is critical to nursing science and practice.

It is relevant to consider the seminal work of Phenix (1964) on the *Realms of Meaning: A Philosophy of the Curriculum for General Education*. His treatise is rooted in the belief that the essence of human nature is the life of meaning and that reflective mediation is the basis of meaning. Rather than envisioning knowledge too narrowly in purely intellectual and logical terms, he claims that full development of human nature requires education in a variety of realms of meaning. He identified six realms of meaning that compose an articulated whole: symbolics or discursive and non-discursive forms of communicating; empirics or explanation and prediction; aesthetics or contemplative perception; synnoetics or personal knowing; ethics or deciding what is right or wrong; and synoptics or comprehensively integrated realms such as history, religion, and philosophy. While symbolics is positioned as the most fundamental of all the realms of meaning, synoptics is seen as the most integrative, as it puts all the realms together into a coherent whole. Phenix also proposed that each meaning realm has its own logic or structural principle and is selected by a discipline. He divided various scholarly disciplines into broad categories of realms of meaning or ways of knowing. He posed the following questions: What does it mean to know in the discipline? How is knowledge gained and validated in the discipline? How does knowledge in one discipline differ from and agree with knowledge in other disciplines?

**Personal Knowing**

According to Phenix (1964), personal knowing is seen as fundamentally important for the meaningfulness of all other forms of knowledge or meaning. It is differentiated from other forms of knowing in that it is subjective, concrete, and necessitates engagement. Personal knowing requires a direct diadic meeting of subject to subject, an intersubjectivity, whereas
symbolics, empirics, and aesthetic ways of knowing require detachment (Phenix). Phenix equates personal knowing to Polanyi's (cited in Phenix) concept of "tacit knowledge," which is described as "unformulated and the basis of making sense of experience, i.e., for understanding...a grasping of disjointed parts with a comprehensive whole" (p. 195). Phenix further describes personal knowing as existential, as it deals "with being itself, that is, with concrete existence...to be is to be in relation" (p. 195). He acknowledges that personal knowing includes relations to others and with oneself, as self is formed in interaction with other and neither is possible without the other. This existential view of personal knowing is expressed in Buber's (1958) notion of the I-Thou relationship. In the I-Thou relationship, one strengthens the other in every possible way that respects the other's freedom to be themself:

Fullness of being exists in relation . . . in which the ideal relation is the I-Thou, which is a primordial reality from which the "I" and "Thou" are derived by abstraction. The "I" and the I-Thou is a connected person with subjectivity. In the I-Thou relationship one affirms and respects the other's being . . . others are set free to be themselves. Persons in relation are concerned for others, seeing their well being, living to serve, to heal, to teach, and to strengthen them in every possible way that does not contradict their freedom. (p. 198)

According to Phenix, the existential attributes associated with personal knowing derive from the notions of freedom and love, central concepts of personal knowledge. Freedom is described by Phenix as the power to be and become through affirming relationships, while love is defined as the "reality of active, caring and responsible relation of an 'I' to a 'Thou'" (p. 198). Phenix links these perspectives to the "phenomenological principle that understanding of persons is possible only if the other is accepted at face value - as he appears - and without bringing to the experience one's own predispositions and judgements" (p. 206).

Carper (1978) identified a typology of patterns or ways of knowing in nursing that is consistent with Phenix's philosophy. She noted that although each pattern of knowing is separate and unique, each is interrelated and interdependent with all the patterns of knowing, and deemed necessary to understand the complexity and diversity of nursing and for mastery in the discipline. Carper described four ways of knowing in nursing: empirics, the science of nursing; aesthetics, the art of nursing; personal knowing, discovery of self-and-other; and ethics, which is moral knowledge. Jacobs-Kramer and Chinn (1988) support Carper's typology for nursing and submit that aesthetic knowledge should be viewed as both a separate knowledge form and the one that synthesizes all the patterns of knowledge. According to
Jacobs-Kramer and Chinn, aesthetic knowledge constitutes knowledge about artful nursing practice. In its separate knowledge form, aesthetic knowledge "enfolds itself with empirical, ethical and personal knowledge to bring about a harmonious and pleasing whole, an artful nursing act" (p. 295). Moreover, these authors assert that aesthetic meaning reveals how the nurse might integrate different knowledge patterns in a variety of practice situations.

The nursing discipline has been slow to follow Carper's lead and investigate and validate knowledge forms additional to empiric science, which is insufficient to address all the issues of nursing practice that are frequently complex and involve a range of knowledge in making clinical decisions (Chinn, 1989; Maeve, 1994). There is agreement that the practice of nursing requires the satisfaction of three elements: emotive, the interpersonal and the relational aspects of nursing; rational, the decision making or critical thinking; and technical, the performance of specific procedures. Interpretative science and emancipatory research have been overshadowed by empirical science as publicly acclaimed knowledge in nursing (Cody, 1994; Jacobs-Kramer & Chinn, 1988; Johnson, 1994; Stevens & Hall, 1992). However, in the past two decades, theorists and researchers have given increased value to the concept of "meaning" and varying knowledge forms, and have advanced its exploration as a goal of nursing (Benner, 1984, 1991; Chinn, 1989; Cody, 1994; Diekelmann, 1994; Gadow, 1990; Jacobs-Kramer & Chinn, 1988; Zerwehk, 1991a; 1991b; 1992a; 1992b).

The primary health care movement had a significant impact on the evolving respect for varying ways of knowing in nursing. International, Canadian national and provincial organizations, along with the Canadian Public Health Association (CPHA [1990]), advocated for a primary health care, health promotion, and community development practice approach, and the nurse's central role in such an empowerment process (International Council of Nurses, 1988; Canadian Nurses Association, 1988; CPHA). These organizations easily took this position as the goal of holistic health that is called for in the new public health discourse is acknowledged as historically the core of nursing practice (Meleis, 1992). In 1985, the Director General of WHO officially acknowledged the leadership role that nurses could play in the implementation of primary health care (Mahler, 1985).

Personal knowledge as described by Phenix (1964) and Carper (1978) is vital to ethical and caring nursing practice that values the concepts of democracy, freedom, care, responsibility, and empowerment as professed in the new public health (Benner & Wruble, 1989; Bevis & Watson, 1989; Carper; Cody, 1994; Condon, 1992; Gadow, 1990; Hamilton &
Personal knowing is described as "discovery of self-and-other, arrived at through reflection, synthesis, perception and connecting with what is known" (Moch, p. 155). Additionally, personal knowledge is acknowledged as the most important requisite for the democratization of the health care system (Watts, 1990). According to Carper, personal knowing is central to an ethic of caring and an authentic relationship that values wholeness and integrity in the personal encounter, and an I-Thou relationship, as moral action presupposes personal maturity and freedom. The nurse is expected to act from critical reflection on prescribed forms of behaviour. Furthermore, Carper argues that:

If nursing is to be more than mechanical and habitual, the capacity to perceive and interpret the subjective experiences of others and to imaginatively project the effects of nursing actions on their lives becomes a necessary skill. (p. 22)

The goal of nursing’s caring practice, which is similar to the goals of health promotion and community development, is wholeness and the enablement of the individual and the community to achieve their optimal health and social justice. According to Chinn (1989), nurses’ caring practice is based on the belief that:

Health is wholeness and the ultimate practice goal is to move people toward health . . . within a framework of wholeness of knowing, . . . integration of all aspects of experience, creating real choices for ourselves and others, and empowerment for all, both as individuals and groups. (p. 73)

Caring in nursing is defined as the basic way of being (Tanner, 1990) and “being connected and having things matter and [caring] works well because it fuses thought, feeling, and action.” (Benner & Wruble, 1989, p.1) The nurses’ “therapeutic use of self,” which is discovery of self and others, and “being-with,” embraces Buber’s (1958) “I-Thou” relationship. It is an essential feature of professional nursing practice and is valued as critical to the promotion of health and social justice (Benner & Wruble, 1989; Gadow, 1990). The nurse strives for an authentic relationship between herself and the people she works with by accepting their freedoms and process of becoming by being open to help people find meaning in their experiences and feel empowered (Benner, 1985). Benner argues that “meaning resides not solely in the individual nor solely within the situation, but is a transaction between the two so that the individual both constitutes the situation and is constituted by the situation” (p. 7).

Her phenomenological research on nurses’ ways of knowing and caring gives validation to
nurses' aesthetic and personal knowing in a caring practice as valuable contributions to nursing science (Benner, 1984, 1991; Johnson, 1994).

It is accepted that nursing practice is contextual and particular to the client situation (individual, family, group, community). Therefore, such a complex practice needs to go beyond a professional code of ethics. It involves choices and actions derived from varied values and judgements on the part of the nurse (Benner, 1991). Therefore, the “lived experience” of the particular other rather than an abstract generalized other is valued. Benner asserts that authentic caring practice can only be learned experientially, as it depends on the everyday practical knowledge of “the good.” This moral, situational, and relational view of caring practice reflects the expectations of mutuality and reciprocity (Benner & Wruble, 1989; Gadow, 1990; Gilligan, 1982; Watson, 1988), which are consistent with the concept of partnership called for in the practice of primary health care and community development (Stevens & Hall, 1992; Stewart, 1990).

However, it is said that nursing is clinging to an ideology of caring that keeps the nurse in the subordinate role and does not value human freedom (Keddy, 1992; Mason, Backer, & Georges, 1991). This view is described as one of “altruism, self-abnegation, and a repetitive labour of love” (Acker, 1994, p. 24). In contrast, my philosophy corresponds with a moral and relational view of caring that reflects the expectations of mutuality and reciprocity (Benner & Wruble, 1989; Gadow, 1990; Gilligan, 1982; Noddings, 1984; Watson, 1989). This perspective supports Gilligan’s view in her conceptualization of a “different voice” that values attachment, engagement, and care as the major emphasis of moral decision making; termed a morality of care and responsibility. Such a moral and relational view of caring coincides with the sense of connectedness or community, compassion, and social justice that is required in a community development practice to allow different voices to be heard and social change to happen.

Moch (1990) identifies attributes of personal knowing that correspond to Phenix and Carper: a valuing of wholeness and integrity in the personal encounter, an I-Thou relationship of passion and commitment. She describes three components to personal knowing: experiential knowledge, becoming aware through participation in the world; interpersonal knowledge, increased awareness through interevaluation of self-other; and intuitive knowledge or tacit knowing, immediate knowing something without the use of reason; a “hands-on” or a “feeling about something.” She accepts that the level of knowledge depends on the degree of

Indeed, personal knowing is claimed to be the most problematic and difficult of the ways of knowing to master, teach, and research (Carper, 1978; Gadow, 1990; Moch, 1990). In striving to accept client freedom, the process of becoming a nurse is frequently confronted with contradictions, as the ideal relationship of I-Thou is said to be wrought with many paradoxes in a world full of contradictions in which freedom and love have various meanings and are, therefore, variously interpreted and possibly denied (Phenix, 1964). Additionally, differences may, and most likely will, exist between the nurse’s own predisposition and judgements and those of the client and others in the client environment.

Carper poses a major question for nursing:

How to respect freedom (power to become without manipulation) within the social and/or professional responsibilities to control or manipulate the environment variables and even the behaviour, of the person who is the patient in order to maintain or restore a steady state [health]? (p. 19)

However, because personal knowing is practical expertise based in social experience and achievable through everyday experience by the ordinary person, it is not deemed credible (Phenix). Gadow adds to this view in her claim that personal knowing is not given the credibility it deserves in nursing due to its subjectivity. She notes that it is largely invisible and when it is made visible, it is quickly objectified. Moreover, it is argued that there is little evidence of systematic development of the concept of personal knowing in nursing, possibly because the concept is difficult to define through language due to its elusive and personal nature (Moch, 1990). Gadow suggests that the language difficulties espoused by Moch can be addressed by “applying existing language in evocative ways . . . a language that elicits in the hearer a resonant experience of knowing akin to the one being experienced” (p. 169). It is strongly emphasized that, although personal knowledge is difficult to articulate, its cultivation as a concept and form of inquiry is critical to nursing science (Gadow; Moch). Carper states that “the risk of commitment involved in personal knowing is what Polanyi calls passionate participation in the act of knowing” (p. 19).

White (1995) adds a fifth way of knowing to Carper's typology: sociopolitical knowing. She argues that this knowledge is essential to the understanding of all others and goes well beyond personal knowing and nurse-client introspection. It is synonymous with
emancipatory knowledge in that it situates nursing practice within the broader social, political, and economic context where nursing and health care happen. Sociopolitical knowing directs nurses to question the taken-for-granted assumptions about their practice, the profession, and health care policies. White conceptualizes it as occurring in the sociopolitical context of the nurse-client relationship and fundamentally concerned with cultural identity; and the sociopolitical context of nursing as a practice profession. Sociopolitical knowing is said to enable the nurse to critique the structures of domination in society that affect the health of persons and communities (Stevens, 1989). White also asserts that sociopolitical knowledge, which frames all other ways of knowing, is an essential part of enabling all concerned to have a voice in the constructions of health and health care, and essential for nursing's future.

Summary

The discussion provides insights on how the multiple realities and various ways of knowing that reside in the everyday community development practice of public health nurses are valued in the nursing community. This discussion also focusses primarily on the meanings of personal knowing and their importance to nursing and community development practice. Although theorists and researchers have advanced the exploration of the concept of meaning and different ways of knowing in the past 20 years, there remains a lack of valuing of interpretive and emancipatory research in nursing. I argue that this limitation, combined with devaluing of personal knowing in nursing, contributes significantly to the invisibility of public health nurses practice. Phenix (1964), Carper (1978), and other nursing scholars agree that personal knowledge is fundamentally important for the meaningfulness of all other forms of knowledge or meaning and needs to be investigated further. Personal knowledge is described as concrete, subjective, valuing wholeness, integrity, authenticity in the personal encounter, and engagement in an existential way through discovery of self-and-other through critical reflection.

Equally important, personal knowing is described as synonymous with an ethical and caring nursing practice, which is situational and relational, and the egalitarian partnership and a sense of connectedness or community and social justice that is the basis of community development practice. Challenges to the notion of personal knowing are discussed. Importantly, the level of personal knowing is contingent on the degree of engagement of the practitioner in the experience and her ability to negotiate multiple contradictions to an
authentic partnership with clients and colleagues. The position is advanced that evidence of the public health nurses' personal knowledge in community development practice, including experiential, interpersonal, and intuitive knowledge, is critical to substantiating the nurses' credibility to themselves, other professionals, and academic communities.

A fifth way of knowing, sociopolitical knowing, which is synonymous with emancipatory knowledge, is also advanced as essential to all other ways of knowing because it enables the nurse and the community members that she works with to have a voice in the constructions of health and health care by making the connections between their day-to-day realities and the larger sociopolitical picture and acting on this knowledge. An aim of this study is to examine the public health nurses' subjective expertise or multiple ways of knowing in their community development work.

**Legislative and Public Health Policy Influences on Public Health Nursing**

*Introduction*

In this section, I want to focus more particularly on the situation in Ontario with respect to the impact of legislation and public health policy influences on public health nursing. In Canada, health care is a shared responsibility of the federal and provincial governments. However, health care, and therefore public health, has always been administered by the provinces. Furthermore, although there are national guidelines that establish standards of practice for community health nurses, the provinces have varying ways of legislating and structuring public health and public health nursing.

There are many sources of legislation and public policy affecting the practice of public health nurses. Most of the sources are provincial, but as previously mentioned, the federal government and international organizations such as WHO have a significant impact on the role of the public health nurse (Epp, 1986; WHO, 1978, 1984; WHO, H&WC, & CPHA, 1986). The next section considers the Ontario model of public health that is relevant to the practice context of this study.

**The Ontario Model of Public Health**

A public health nurse in Ontario “refers to community health nurses who, synthesize knowledge from public health science, and social sciences, and promote, protect and preserve the health of populations (Registered Nurses Association of Ontario [RNAO], 1998). The first
Public health legislation in Ontario was the Public Health Act of 1884, which had legislative authority for public health in Ontario. It required all municipalities to establish local boards of health that were mandated to appoint a medical officer of health and a sanitary inspector (Allemang, 1995). The earliest public health nurses in Ontario were hired by the Department of Education in 1907. However, public health nursing services gradually shifted to the local public health agencies. Public health in Ontario is managed through the Public Health Branch of the Community Health Division of the Ontario Ministry of Health. At the time of this study, public health in Ontario was administered by 42 public health units in six regions (Craig, 1991). The provincial and municipal governments shared funding on a 75/25 or a 40/60 per cent basis. Public health units have traditionally been organized along disciplinary lines so that public health nurses and inspectors report to their respective division directors, but this can vary across public health units. The units may organize along project lines, or in a matrix structure in which both program and disciplinary lines are maintained (Rafael, 1997).

In 1983, the Public Health Act was replaced by the Health Promotion and Protection Act, which was designed to represent a change in public health policy and a shift of public health direction from a predominant focus on control of infectious diseases to a broader mandate of health promotion and health protection. This shift in direction reflected the international and federal directives to adopt a primary health care and health promotion approach to achieve health for all. Paradoxically, in contrast to this shift in focus to a more sociol-ecological model of health, the act strengthened medical control over public health decisions by instituting major change: establishing the position of a provincial Chief Medical Officer of Health and giving the position sweeping powers and directing each public health unit to be headed by a physician, a Medical Officer of Health. In 1987, the positions of Chief Medical Officer of Health and Director of the Public Health Branch were combined. According to Rafael (1997), some nursing leaders were wary of this consolidation of medical power and were concerned by a narrowing of the focus of public health and the increasing medicalization and male dominance of public health as it existed under the Health Promotion and Protection Act.

The act also required each public health unit to provide minimum core programs and services that were developed by the Ministry of Health, and established the minimum educational requirements for public health professionals, including public health nurses (Craig, 1991). The nurses were required to have a baccalaureate degree in nursing or a one-
year, post-RN diploma in public health nursing. The new act represented significant change for public health and public health nursing (Craig), and new policy directives guided public health practice toward greater community involvement and intersectoral cooperation and coordination. Public health practitioners were expected to form partnerships with community members and agencies to develop programs and services.

The Health Promotion and Protection Act was reflected in the Ontario document, Mandatory Health Programs and Services Guidelines (MHPSG) (1989), which was designed to guide public health units in implementing the act. The guidelines stated a three-fold purpose: prevention of disease, health promotion, and health protection, and identified four broad goals: (a) healthy growth and development for the community; (b) healthy lifestyles for individuals, families and the community; (c) reduction of communicable diseases; and (d) ensuring healthy environments. Public participation in community action and partnership with key persons and other vested interest holders was the new way advocated to improve individual, family, and community health. The broad programs and services that were delineated in the MHPSG did not initially appear to imply a major shift of public health activities. However, it became apparent that the public health organizational structures and processes need to be more flexible and open to the communities’ priorities and ensure that their public health staff were committed to the new policy shift (Craig, 1991; Wong, 1993).

Craig identified three concepts as integral to the MHPSG for public health nurses: (a) community orientation, (b) collaborative or interactive learning, and least obvious but very important to community partnership and participation being proposed – (c) holistic knowledge. Similar to Rafael (1997), Craig expresses concern that the Health Promotion and Protection Act and the MHPSG increased medicalization of public health and medical control of public health nursing. Craig notes that a significant feature of the MHPSG for public health nurses was that the definition of the programs required by the guidelines fell to the physicians working for the Public Health Branch of the Ministry of Health. Craig indicated that nine mandatory programs were fully funded by the province, but some of these programs were not applicable to every public health unit. Further, the resources of individual public health units to fund the mandatory services varied greatly.

Shared Direction for Health for Ontario (1987), stressed consumers’ needs for improved access to information so they could act in partnership with health professionals in making decisions about conditions affecting their well-being. This policy evolved from the 1984 WHO directive in line with an ecological perspective on well-being; health professionals would act as facilitators rather than prescribers and engage in a “participatory health model.” The Regulated Health Professions Act increased the number of regulated health professions from five to over 20 and added health promotion to nursing’s scope of practice statement.

Despite provincial dominance of public health, the Canada Health Act (1983) is also a relevant factor in designing public health. The first version of the Canada Health Act identified only physicians as providers of insured services. Lobbying by the Canadian Nurses’ Association resulted in amendments that included other health care professionals as possible providers of insured care. Since the passage of the Canada Health Act, professional nursing in Canada has devoted prominent focus on the development and implementation of primary health care through community health nursing (Rodger & Gallagher, 1995). This emphasis was fuelled by the reports: Achieving Health for All: A Framework for Health Promotion (Epp, 1986) and the Ottawa Charter for Health Promotion (WHO, H&WC, & CPHA, 1986).

Summary

In this section, I review the impact of legislation and public health policy on public health nursing since the inception of public health legislation, paying particular attention to the Ontario situation. Public health nursing in Ontario is mandated by and is deeply affected by health legislation that has evolved between philosophies of approach that have not always been matched with appropriate resources and support. Ontario’s legislation in the form of the Health Promotion and Protection Act (1983) and the Mandatory Health Programs and Services Guidelines (1989) reflect changing models of public health from a narrow focus on control of infectious disease to a broad model of health promotion and health protection, which is designed to coincide with the new directives to adopt primary health care and a health promotion approach. Fostering public participation in community action and forming intersectoral partnership are advanced as the new approaches expected of practitioners to improve individual, family, and community health. Public health organizational structures and processes are not as flexible and open to the communities’ priorities as they need to be to enable public health staff to meet the new mandate. Paradoxically, the new act and the
mandatory guidelines are seen as increasing medicalized control of public health and public health nursing with a narrowed focus. Further, financial and nurse resources expand and contract in sympathy with government fiat with the effect that public health nursing has to accommodate to the situation.

**Gender Inequality in the Public Health Work Environment**

This section considers gender inequality and the contradictions it elicits from society and public health organizational structures and processes for public health nurses and their community development practice. According to Donner et al. (1994), "nursing's past is very much its present" (p. 3). These authors assert that gender inequality in society and the work place can explain much of what is occurring for nurses. They base their claim on the belief that little has changed to dissipate gender inequality for nursing, a profession distinguished as a women's profession that is immersed in the dichotomy of power and powerlessness. The cultural belief in our society that nursing is women's work, that nurses are handmaidens to the physicians, daughters of the institution, and mothers to patients, has accorded nursing a second-class status and trivialized its work (Donner et al.; Stuart, 1993). Stuart argues that the cultural belief that nursing is women's work, akin to mothering and housekeeping, something that is absolutely necessary but is rather unimportant, reinforces the devaluing of nurses and nurse's work. Colliere (1986), in her discussion of “Invisible Care and Invisible Women as Health Care-Providers,” states that historically, anything related to “care” and “nursing” in our society and in the health care system is viewed as inconsequential, as it is said to rely on no fundamental specific knowledge. Therefore, it is taken-for-granted and unworthy because it is said to require lower skills. She suggests that the effects of the dispossession of care-knowledge among women and nurses is invisible care. Colliere challenged nurses to work for a rehabilitation of care-knowledge and make it visible.

Chinn and Wheeler (1985) argue that “nursing practice typically occurs in the oppressive, reductionist milieu of the patriarchal order, the hospital, which does not foster, tolerate, endorse, nor approve nursing practice based on nursing’s own theories and values” (p. 76). It is claimed that the rise of positivist medicine as practised by the medical profession resulted in the decline of the autonomy of other health professionals, such as nursing (Hagell, 1989). Furthermore, Donner et al. (1994) state that many features of the oppressive hierarchal and bureaucratic structures of the hospital system have been transferred to the community
workplace, with community health nurses generally having little control over their work environments and work lives, and being subject to the pervasive stereotypes of nursing.

Historically, public health nursing has been controlled by local, provincial, and larger social, economic, and political forces, in large part as a result of the nurses' status as employees in government agencies and their status as women, since public health nurses are predominately female (Donner et al., 1994; Rafael, 1997; Stevens & Hall, 1992). Further, Donner et al. and Stevens and Hall argue that public health nursing's roles and participation in the health promotion/community development process are subject to some of the same oppressive social, economic, and political structures as their disenfranchised clients' experiences. Anderson (1990) parallels these views in agreeing that the larger social, economic, and political agenda, which is based within the capitalist world system, determines the direction of health care. What is in the best interest of the corporate elite filters down through mechanisms of control to influence the nurses' decision making in their practice. Armstrong (1994) argues that "we live in a dangerous time for women . . . a direct assault on women's gains in caring work" (p. 109, 117). In declaring that the oppressive aspects of caring work are socially constructed, she submits that many of the changes in the health care restructuring are cloaked in feminist language, such as participation and community control, but reality contradicts what feminists value. Instead, many of the changes in the hospital system are having a profoundly negative impact on women's caregiving work inside and outside the hospital. The impact is derived from the increasing emphasis on market-based health care decision making, the medical model, deprofessionalizing and eliminating of the care component of work, and the devaluing and elimination of skilled caring work of nurses. Indeed, it is proposed that the dominant hegemony and inequitable, gender-related, hierarchal structures of power in society are perpetuated in the public health work environment, thereby devaluing public health nurses' caring practice and excluding them in a meaningful way from the decision making process (Fee & Korstad, 1992; MacMillan, 1994; Stevens & Hall). Moreover, Fee and Korstad assert that the values that are the basis of public health are not given the same prominence by society as those used to justify technological medicine.

Nursing has been described as "marginalized", under the control of medicine and paternalistic health care and educational systems (Bent, 1993; Roberts, 1983). Roberts claims that there is a tendency for nurses to become accustomed to the contradictions in their life arising from tensions between nursing and dominant discourses, thus internalizing a state of
marginality and self-deprecation. Additionally, Mason et al. (1991) argue that nurses have assumed a position of marginality within the health care system. These authors describe marginality as "the state of living in two different worlds simultaneously; in this case one (medicine) is regarded by prevailing standards to be superior to the other" (p. 73). According to Hall et al. (1994), marginalization is a concept that pertains to margins and boundary maintenance, the process through which persons are peripherized from the "centre" through their identities, associations, experiences, and environments. These authors argue that marginalization is not, however, equivalent to oppression and the power imbalances that it denotes, but that it is a broader concept that often includes oppression and often occurs simultaneously with oppression. Marginalization is commonly viewed as a way that oppression is made explicit and visible. Further, the devaluing and silencing of voices that differ from the dominant discourse is another distinguishing feature of marginalization (Hall et al.). Additionally, Hall et al. submit that in this state of marginality, nurses may internalize oppressed group behaviour, which would prevent them from valuing and validating women's experiences, from recognizing the existence of ideological, structural, and interpersonal conditions that oppress women, and from desiring to bring about social change. Some authors submit that the response to marginalization is seen in all facets of nursing: in the diminishing quality of nursing work life for the practice-based nurse (Donner et al., 1994), and the prevailing mechanistic world view of nursing education, practice, and research (Diekelmann, 1994).

Street (1992) goes further and broadly situates nursing practice within a "culture of disjuncture, rupture, and contestation . . . in which the intersection of power, politics, knowledge and practice give rise to a contested terrain of conflict and struggle" (p. 2). She asserts that historically, nursing has accepted the superiority of medical and technical knowledge over nursing knowledge. Moreover, she concludes that nurses are complicit in maintaining a "culture of silence" in health care and in a medical culture that produces institutional forms of domination based on race, class, gender, and age. She suggests that this situation may be related to nursing's predominately female identity and subject to the inequalities faced by women in the workforce in general. Smith's (1987) conceptualization of the "relations of ruling" or "ruling apparatus" is helpful in understanding the genesis of this theory of complicitness on the part of nurses. She proposes that a ruling apparatus is operative as "a complex of organized practices . . . as well as discourses in texts that interpenetrate the
multiple sites of power . . . involves a continual transcription of the local and particular actualities of our lives into abstracted and generalized forms” (p. 3). She posits that these discourses, which are not fully apparent, organize women’s everyday world and position women as an invisible, gendered sub-text, as “other,” and marginalized.

It is important to point out at this juncture that although nurses and nursing are immersed in oppressive patriarchal structures, it does not necessarily follow that all nurses and the nursing discipline are oppressed. Some feminist theorists caution against a unitary categorization of women and an essentialized women’s experience, respecting the differentiation of women and how our experiences as women are intersected by our multiple subjectivities (Walkerdine, 1987; Weiler, 1991). According to Walkerdine, “women and girls are not unitary subjects uniquely positioned but, produced as a nexus of subjectivities, in relations of power and resistance . . . continually reproduced, in continual struggle and continually shifting, . . . rendering them at one moment powerful and at another powerless” (p. 166). I propose that nurses’ experiences need to be differentiated and seen in relation to sociopolitical and economic structures, along with their personal sense of agency. Not all nurses are immobilized by oppressive structures, but can be active agents in controlling and changing their lives. Choices are provided and we position ourselves (Jones, 1993). In concert with this view it is argued that the solution to nursing’s marginalization is for nurses to rise beyond this state to a state of integration in which we as nurses give more value to what we do and who we are, recovering our history and building our self esteem and practical consciousness (Hagell, 1989; Mason et al., 1991; Moccia, 1988).

Summary

Nurses in general and public health nurses in particular are predominately female. This discussion presents the argument that gender bias effects this predominately female profession, and is regarded as a significant factor in fostering the invisibility of public health nursing and their community development practice and their exclusion from meaningful public health policy making. Nurses are described as marginalized within the health care hierarchy rather than as valued members of the health professional team. According to some authors presented here, nurses have tended toward complicity in this valuation by failing to properly value their experience as women and as nurses, and by silently accepting their marginal position with respect to the medical discourse, health administration, and politicians.
A more optimistic observation is made that many nurses are not immobilized by dominating forces and are successfully asserting control and affecting change in their professional life as nurses. A plea is made for nurses to give more value to nursing and nursing knowledge to increase self-esteem, to acquire greater power, and to achieve full recognition of value.

**Social Construction of Women’s Health and Health Promotion**

Women in high-risk environments constitute the majority of the population traditionally served by public health nurses. Nurses are challenged to change their practice and attempt changes not only at the individual level but also at the community and societal level. In this context, they are expected to challenge the institutional practices that perpetuate social injustice, inequity, and ill health for women (Anderson, 1990, 1998; Anderson et al., 1991; Leuning, 1994; Wuest, 1993). As the purpose of this study is to understand the public health nurses’ community development practice with women in high-risk environments, it is appropriate to highlight the sociopolitical context of women’s health and health promotion in our North American situation, and specifically our Canadian society.

Over recent years, the meaning of women’s health has come to be understood within the context of women’s experience, steeped in a complex matrix of personal, social, political and cultural dimensions, in contrast to being seen only through an individualistic and biological focus on women’s reproductive capacities (Anderson, 1990; Anderson et al., 1991; Cohen, 1994; Foster, 1994; Leuning, 1994; Reutter et al., 1995; Walters, 1993; Webster & Lipetz, 1986; Wuest, 1993). Webster and Lipetz submit that "women's health is concerned with women both as consumers and providers of health care in multiple settings, and while assuming changing roles" (p. 89).

Primary health care, with an emphasis on the goal of reducing social injustice and inequities, was viewed as a significant movement for expanding the definition and focus on women's health and opening the door globally, for general improvement in women's health (Foster, 1994). However, this empowerment of women and consequent improvement in health has not materialized. There is little political activity in health and broader healthy public policy in regards to women’s health. This situation exists in spite of the acknowledgment of the limits of medicine and the health care sector in improving health, and the espoused commitment by government to primary health care, health promotion, and a goal of reducing inequities for vulnerable populations. Leuning (1994) acknowledged that frightening
problems for women were escalating, marked by excessive neglect in some areas, overzealous concern in others, and blatant ignorance of much of women's experience. Aging, violence against women, poverty, disadvantaged employment, physical and mental ill health, devalued and invisible roles, increased work burden, and limited access to resources have been identified as major issues that have escalated, rather than decreased for women (Leuning; Meleis, 1996). This situation has worsened even further for women as we move into the 21st century (National Council on Welfare [NCW], 1999).

The number of Canadians living in poverty, indeed abject poverty, is growing (NCW, 1999). Abject poverty is defined by Statistics Canada as having incomes of less than 50% of the poverty line income. In Canada, women are disproportionately represented as poor. For example, 57% of single parent mothers under 65 years of age live in poverty, as do 42% of unattached women 65 years of age and older (NCW). Single parent mothers living in poverty had an income of 61% of the poverty line in 1997 (NCW). This statistic varies markedly with the age of the mother; under 25-93%, 25 to 44-55%, and 45 to 65-40%. Furthermore, the duration of poverty varies and appears to be related to gender, family status, visible minority status, and recent immigration (NCW). New immigrants from 1987 onward have experienced the greatest increase and duration of poverty. The percentage of immigrants living in poverty increased from 12% in 1979 to 46% in 1989 for families, and from 37% to 55% for unattached individuals. Our Canadian Aboriginal population is significantly disadvantaged due to incomes well below the poverty line (Reutter & Williamson, 2000). Canadian statistics (NCW) also show that education is a key indicator for poverty with the risk of poverty normally decreasing as a person's education increases. The poverty rate for families led by single mothers with less than a high school diploma was 83%, with the highest rate among all non-high school graduates.

Social conditions, such as income, social status, and income inequality, are considered critical determinants for health (CPHA, 1993; Evans, Barer, & Marmor, 1994; WHO, H&WC, & CPHA, 1986). Growing evidence points to the strong, persistent, and consistently inverse relationship between poverty and individual and population health in Canada, with a significant gradient effect (Evans et al.; Rootman, 1988). The greater the disparity in wealth or income within nations, the greater the health risk for the population as a whole, especially

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4 Poverty is measured by Statistics Canada's Low Cut Offs (NCW, 1999).
for people in the lowest income category (Evans et al.). Women experience the greatest depths of poverty. Moreover, the poor and poorly educated experience greater rates of mortality, illness, and disability compared to those with higher incomes or better education (CPHA, 1993; Reutter et al., 1995; Reutter & Williamson, 2000; Wilkinson, 1996; Williamson & Reutter, 1999). In addition, they experience lower social support, lower healthful living practices, poor living conditions, higher stress levels, and lower feelings of well-being (Cohen, 1994). It is estimated that 22% of premature years of life lost in Canada could be attributed to income differences (Wilkins, Adams, & Brancker, 1989).

In Canada, despite the primary health care efforts of some, inaccessibility to the prerequisites of health and to health services persists as a major problem for the poor, those living in isolated communities, stigmatized populations, and racial and cultural minorities, especially our immigrant population (Anderson, 1990, 1998; Anderson et al., 1991; Reuter, 2000; Reutter et al., 1995). The health of our Canadian Aboriginal population is markedly lower than the Canadian average (Reutter). The challenge of reducing health inequities related to health determinants has major implications for the role of the health professional, including the public health nurse.

It is claimed that women's health needs to be understood within the notions of social production and social construction of health and illness (Walters, 1993), women's day-to-day experience of social inequity, medicalization and caregiving, and the complicitness of health professionals in sustaining the condition of women's "oppression" by reinforcing these institutions of social control (Wuest, 1993). Walters conducted a descriptive exploratory study of 356 Canadian women to examine women's perceptions and priorities with regard to their health, particularly their mental health. Women identified stress, anxiety, and depression as the three main problems. Walters noted that women understood their health in terms of broader social structural influences. Stress, anxiety, and depression are understood in relation to their familial and occupational roles, financial stability, and the structures of class, race, and gender in our society. Explanations of poor health focussed on heavy workloads, their identity, and their social legacy. The women saw mental health problems as strongly social in origin, with a significant impact on physical health such as heart disease and cancer. They also included a recognition of distinctive gender roles and images of women. Walters emphasized that mental health problems were experienced differently depending on the women's socioeconomic status, gendered roles in the family and relationships in the family,
position in the labour market, and their race and ethnic origin. Interestingly, few rejected the structures of patriarchy, such as the medicalization of their concerns, but took them for granted and minimized and normalized them.

Some claim that the inherent risk in health care policies that emphasize citizen participation and ownership is striving toward the goals of self-reliance and self-determination and mirror the ideology of individualism in the capitalistic state, thereby separating the personal from the complexity of sociopolitical and cultural, structural factors (Anderson et al., 1991; Meleis, 1996). Such health care policies can serve, therefore, to accentuate inequity for women and further the institutionalization of women's "oppression" (Wuest, 1993) and the devaluing of women's caring work (Armstrong, 1994). Indeed, several researchers argue that the underlying assumption of many of the health care policies and government health promotion strategies is that women will take on greater caregiving responsibilities (Anderson, 1990, 1998; Anderson et al., 1991; Hayward et al., 1993; Leuning, 1994; Walters, 1994; Wuest). As the shift to "hospital-in-the-home" occurs with increasing frequency and insufficient resources, the assumption by those responsible for allocating resources becomes more obvious; women will undertake more of the responsibility of care in the home and do unpaid caregiver work (Anderson, 1990; Armstrong; Gazer, 1993). Laurence (1992) notes that support structures for women as caregivers are minimal, thus the health of women receiving care and the health of women providing care is at risk. The hegemony of patriarchy coupled with the ideology of familism (care in the home is better than institutional care) is said to foster relationships of domination and subordination, patterns of labour and altruistic caregiving for women, both in society and in the health care system (Armstrong; Glazer; Wuest, 1993), and perpetuates women's marginalization, poverty, and ill health (Meleis; Reutter et al., 1995; Walters, 1993). It is important to emphasize that familism is fundamentally good when it happens with the support of appropriate community resources so as not to enslave the family caregivers.

**Summary**

Women lag behind on every indicator of social and economic status and constitute a larger portion of the poor in Canada, and indeed in all societies. Poverty is an even more serious concern when it is linked with other factors such as being disabled, having minimal education, being a member of a racial or ethnic minority (particularly a member of our
aboriginal population), or an immigrant who is non-English speaking (Anderson, 1990, 1998; Anderson et al., 1991; Cohen, 1994; Reuter, 2000). Given the links between poverty and health and the incidence of poverty, people with low incomes engage with public health nurses frequently, for health promotion, disease prevention, and rehabilitative activities. Above all families, particularly families led by single mothers and unattached older women, who are at significant risk from poverty and its implications, are those who the public health nurses encounter most in their practice.

Summary

In this section, Part I-Background, I provide a review of theoretical literature and position statements that situate the social, political, historical, and professional context in which public health nurses’ community development practice is embedded. Specifically, a review of relevant literature is presented describing the “new” public health discourse, with particular attention to community development and the role of public health nurses, and tensions between health promotion, community development, population health, and public health nursing. I also discuss literature that pertains to the meanings of different ways of knowing, particularly personal knowing and sociopolitical knowing, and their importance to nursing and community development practice. Literature is cited that considers the impact of legislation and public health policy in shaping health care and public health nursing practice in Ontario and the impact of gender inequality in the public health work environment. Finally, I review the sociopolitical context of health and health promotion for women in high-risk environments. In the next section of this chapter, I critique empirical literature on public health nursing and community development practice.

Part II-Public Health Nursing and Community Development

Introduction

While there has been extensive research in many fields of study related to primary health care, health promotion, and community development, research on the links between public health nursing and community development is a relatively neglected area. Research on community development work with women living in high-risk environments is even more rare. There is also a paucity of research that looks at the multidimensional processes of community health nursing practice and the social, economic, and political environments that
significantly influence the public health nurses’ practice. Indeed, the lack of conceptual clarity, theory development, and research in community health nursing, especially related to the community level of practice, is well documented (Chalmers & Gregory, 1995, 2000). Most of the research evidence that does exist pertains to the public health nurses’ traditional practice with individuals and families in the community. For example, researchers have described how public health nurses create common ground, work in partnership to address needs and gain entry, to establish rapport, and promote individual and family well being (Kristjanson & Chalmers, 1990, 1991; Reutter & Ford, 1997; Zerwekh, 1991b, 1992a). Additionally, survey and epidemiological design are common in community health nursing with little emphasis on qualitative, field work-based research that fosters deeper understanding of public health nursing practice through face-to-face interaction with the nurses and hearing their stories in the field.

Not unexpectedly, as I embarked on this analysis I found few studies that examined public health nurses’ community development practice, although this practice has been advocated in professional and government literature since 1986, as part of a “new” public health mandate for Canada. However, evidence increased as the 1990s proceeded. In the following discussion, empirical literature is reviewed in three pertinent areas: (a) Perceived Practice, (b) Perceived Challenges and Tensions with the Health Promotion and Community Development Discourses, and (c) Public Health Nursing and the Community as the Target of Practice. I have chosen to address the empirical literature as follows. Although the researchers studied the findings on perceived practice and challenges with community development practice simultaneously, I present the findings on these topics separately for clarity of meaning and analysis. I begin by examining studies on perceived practice that informed my inquiry, following with a discussion of relevant studies published during and after the course of my study. I then integrate the findings related to perceived challenges and tensions, with the health promotion and community development discourses, without separation by time frame. In the third section, studies related to public health nursing and the community as the target of practice are discussed.

**Perceived Practice**

It is important to acknowledge that of the six studies that were initially identified as relating to this inquiry, three are surveys (Beddome et al., 1993; Chambers, Underwood,
Halbert, Woodward, Heale, & Issacs, 1992; Power, 1995) and three employ qualitative design
(City of Toronto Nursing Practice Committee, 1995; Craig, 1991; Wong, 1993). Two of the
studies specifically address the nurses’ perceptions of the links between public health nursing
and community development practice (City of Toronto Nursing Practice Committee; Power),
while one study looks at the public health nurses’ preferred future with respect to the new
public health mandate for Canada (Beddome et al.). Two studies are designed to specifically
examine the impact on the public health nurses’ practice of the Mandatory Health Programs
and Services Guidelines (MHPSG) (1989) established by the Ontario Ministry of Health
(Craig; Wong). The studies range from Nova Scotia to British Columbia, with the majority (4)
of the studies conducted in Southern Ontario. The following discussion provides further
analysis of these studies.

Beddome et al. (1993) surveyed 229 nurses in British Columbia who had clinical and
administrative responsibilities to define issues that were critical to directing the future of
public health nursing in British Columbia, according to the concepts of primary health care,
health promotion, and community development. They concluded that the public health nurses
had a clear vision of primary health care and could articulate their preferred future that
included taking a lead role in fostering community health and health care reform. Specifically,
the respondents identified a commitment to: the broad prerequisites to health outlined in
primary health care, community development as a key strategy for public participation and
improving community health, a shift in practice from one-to-one to include group work,
partnering with communities, increased intersectoral collaboration at every level, and
adoption of new roles that are facilitative rather than directive. These authors proposed a
conceptual model that synthesized public health and nursing to establish a course with which
to meet public health nursing’s preferred future (Clarke, Beddome, & Whyte, 1993).

Chambers et al. (1994) surveyed 1,849 public health nurses in Southern Ontario to
obtain their perceptions of a changed public health nursing practice that had been directed
toward greater health promotion and community development responsibilities as outlined in
the document, Community Health- Public Health Nursing in Canada: Preparation and Practice
(CPHA, 1990). The nurses reported that their practice was shifting from the role of service
provider and one-to-one, individual care to other types of activities that included a greater
focus on community. The researchers concluded that public health nurses were involved in all
the activities outlined in the CPHA document that are relevant to public health nursing in
Ontario. They also reported that public health nurses are prepared to play a major role in restructuring health care and to make substantial contributions to primary health care and health promotion.

Power (1995) surveyed 72 public health nurses and their managers from across Nova Scotia. Through a self-report questionnaire, she examined the nurses' understandings of community development and the implications of an increased community development emphasis on their current and future practice. The public health nurses were strongly committed to the use of a community development approach and welcomed the concept of shifting to an increased use of a community development practice, which they saw as consistent with their public health nursing philosophy. However, less than 20% saw themselves using the approach in practice due to significant barriers within their work environment.

In 1995, the City of Toronto's Nursing Practice Committee, Community Development and Advocacy Workgroup, and Clinical Teaching Health Unit staff conducted four workshops/focus groups with 96 public health nurses from across the municipality. The purpose was to examine the nurses' perceptions of the links between public health nursing and community development practice. The nurses agreed that they had the necessary knowledge and skills for an expanded community development practice. They identified several factors that enabled them to incorporate more community development into their practice: the similarity of many shared values, beliefs, principles, roles, and activities between public health nursing and community development; the public health nurses' transferrable knowledge, such as health and community assessment skills; knowing appropriate partners, both within and outside the Department of Public Health; and willingness and energy to participate in the conscious evolution of public health nursing practice. Although the public health nurses identified several positive aspects of their practice that linked it to community development work, they described more hindrances than support, from inside and outside the department, that limited their comprehensive community development work.

Craig's (1991) doctoral research on the topic, Changing Health Care Policy: Influences on Community Health Nursing Practice, examined the perceptions of public health nurses from two health units in Ontario in relation to the influence on their practice of the new Ontario public health policy, Mandatory Health Programs and Services Guidelines (MHPSG) (1989). The new guidelines required practitioners to develop, implement, and evaluate
programs and services with extensive community partnership and intersectoral co-operation. As well, the document specified core programs with prescribed guidelines. Multidimensional, qualitative approaches through questionnaires, one-to-one interviews, and group discussions were used. Public health nurses were the primary data sources but nursing administrators of the health units and others related to the context of the public health nurses' practice were interviewed. These included: other health unit professionals, government officials, university faculty members, community representatives, members of professional nursing organizations, and three public health nurses from other health units. The research findings indicated consensus on the changing practice of public health nursing. The nurses preferred a community development process in which they worked in a partnership with a community that they believed had the collective knowledge and skills to effect social change. Although there was variation in the nurses' experiences and comfort with community development, there was agreement that the nurses wanted new skills to enhance their community development practice. They also wanted to develop a clear understanding of community development and the necessary skills to negotiate a collaborative practice among other disciplines and community members. However, the nurses stated that they were hampered by several work-life issues. Craig noted that the nurses' stories revealed a significant contradiction in the new policy; the public health nurses were expected to develop, implement, and evaluate programs in partnership with the community and through intersectoral cooperation, while at the same time implementing the specifically mandated programs of the Ministry of Health.

Wong (1993) also investigated public health nurses' perceptions of the quality of their work life and their perceptions of job satisfaction with respect to the implementation of the MHPSG (1989). Eight public health nurses who were randomly selected from across two urban and two rural health departments in Ontario were interviewed. The nurses reported that they were generally satisfied with their jobs and expressed satisfying and meaningful sentiments about their previous and present roles. Further, there was growing acceptance and inclusion of expanded health promotion and community development roles in their practice. However, similar to Craig's findings, the public health nurses described many constraints and contradictions associated with the mandatory guidelines and the expectations for a more comprehensive community development practice.
In summary, the studies reveal that public health nurses from across Canada are enthusiastic about an expanded health promotion and community development approach to their practice, and profess a vision of public health nursing that includes the principles of primary health care and a desire for involvement in the development of healthy public policy (Beddome et al., 1993; Chalmers et al., 1994; City of Toronto Nursing Practice Committee Report, 1995; Craig, 1991; Power, 1995; Wong, 1993). The public health nurses perceive the principles of primary health care, health promotion, and community development to be a conceptual and practical fit with public health nursing. These studies provide important insight into the perceived practice of Canadian public health nurses with respect to the new public health, with its increased emphasis on health promotion and community development. However, the studies do not provide knowledge on the enactment of community development in the nurses’ everyday practice. This important gap in the research supported the purpose of this inquiry. The findings of these earlier studies are extended by research that I became familiar with as the investigation was underway: research by Leipert (1996), Rafael (1997), Reutter and Ford (1996), and Chalmers, Bramadat, and Andrusyszyn (1998). I review these studies in the following discussion.

In 1996, Leipert conducted a phenomenology study of 11 public health nurses in a large urban health department in British Columbia. The purpose of the study was to examine the values that public health nurses held in relation to community health nursing and primary health care. The nurses valued activities that enabled clients to make informed decisions regarding their health and health care. Further, multidisciplinary collaboration and nurse-client collaboration were highly valued across a wide range of programs: one-to-one, small group, and broad community development programs that were seen as connected. Reaching out to people in their home was seen as an essential beginning step for community development to proceed. The nurses valued collective and individual autonomy as important to their job satisfaction. They valued a health-orientation to their practice with individuals, families, groups, or communities in natural settings such as homes, schools, and communities. They described prerequisites for their community practice as including: broad-based knowledge from a variety of sources; intuitive or experiential knowledge; collegial and administrative supportiveness; and personal assertiveness, flexibility, creativity, risk-taking, and a sense of humour. They believed that heightened visibility and valuing in the community would make their services more competitive and, therefore, foster more government funding.
for their programs. They also advocated for expanded roles that include the community as the
target of practice. The nurses firmly believed that public health nursing would be the way of
the future due to its preventive focus and cost-effectiveness.

Reutter and Ford (1996) conducted in-depth interviews and three focus groups with 17
and 11 public health nurses respectively from urban and rural public health units in Alberta.
The purpose of the study was to explore what the nurses do and how they feel about what they
do within a newly mandated primary health care practice. An important finding was that the
nurses found their work valuable, unique, and enjoyable. These attributes were associated
with several interacting factors: belief their practice was different from other professionals',
as they were able to see the “big picture” due to their broad knowledge base and in-depth
understanding of the community and community resources; working in a variety of settings
and across the lifespan; focussing on illness and injury prevention and health promotion
through the life cycle; belief they made a difference in the lives of their clients and the well-
being of the community; and having the degree of autonomy in their practice that allowed
them to be flexible and innovative in their practice.

Rafael (1997) conducted an oral history of public health nursing in Southern Ontario
between 1980 and 1996. Her participants included 14 public health nurses; 13 public health
stakeholders, including public health administrators and physicians; public health nursing
administrators and educators; and a former federal health minister. Interviews and focus
groups, which included additional public health nurses, were conducted. The purpose of her
study was to make visible the work and struggle of public health nurses amidst the mandated
changes to public health and public health nursing between 1980 and 1996. She proposed that
these changes occurred in large part through fiscal restraints (or retrenchment) and a growing
ideology within the Ministry of Health that did not value traditional public health nursing
work or the vulnerable populations served by public health nurses. Rafael discussed her
findings from the perspective of two ways of delivering public health nursing services: district
nursing or generalist practice, and program-focussed (specialist) practice. The nurses were
involved in either modality between 1980 and 1996. She noted that program-focussed nursing
was more prevalent in the latter years. Public health nurses preferred the district nursing way
of organizing public health nursing. Rafael concluded that the public health nurses were
clearly supportive of an expanded health promotion practice and envisioned their practice as
consistent with the principles and assumptions of primary health care and the new public
health. The nurses identified their strengths in promoting community well-being through their promotion of the health of young families, the elderly, and vulnerable populations. District nursing was described as representing a philosophy of public health that "lives within the souls of public health nurses who remember the legacy of their craft" (p. 147). Within this philosophical position, public health nursing practice is focussed in a broad relational approach to caring for the community as the client; being with the community and in the community. With reference to the nurses' narratives, she described "community-nurse integrality," which is rooted in a caring-healing paradigm as central to nursing and consistent with the core values of health promotion and community development. She posited that this nursing knowledge is the unique dimension that public health nurses bring to the health promotion and community development discourse. She reported that the community-nurse integrality extended to individuals, families, groups, and communities across a variety of settings. Further, these constituents were synergistically linked by the nurses in the development of the health of the community. The nurses identified their preferred practice future as facilitating individual and community empowerment through the use of multiple enabling strategies. However, Rafael reported that the nurses struggled against many barriers in their work setting, in particular the Mandatory Health Programs and Services Guidelines (MHPSG) (1989), the shift to program-focussed nursing, and the lack of value given to the public health nurses' unique knowledge by other health professionals, in public health policies or by public health management.

Chalmers et al. (1998) examined the nature of community health nursing in Manitoba with respect to how it has changed in the last decade, is currently practised, and how it might unfold in the future. The motivation for this study was the authors' interest in exploring the educational preparation required for community health nursing practice at the baccalaureate level. Practising community health nurses (N= 76), administrators (N=37), and community health nursing educators (N=5) were recruited from major urban, rural, and northern settings across Manitoba and interviewed in 27 focus groups. Staff nurses and administrators represented public health agencies, the provincial home care program, a non-government visiting nursing agency, and community health centres. These researchers found more similarities than differences across participants and settings. All the community health nurses expected to function in broader roles than a decade ago. The public health nurses reported working more with groups and in community development. Public health nurses viewed
themselves as more of a resource to the community and responded positively to the change to participative health care. Of significance, all the participants identified a growing need to demonstrate the effectiveness of their interventions. This need was described as a particularly important issue for public health nurses because they saw the outcomes of health promotion as more difficult to measure, and as a consequence, vulnerable populations going unnoticed. Economic constraint was identified as the major factor underlying changes and precipitating significant impacts on their practice. They envisaged community health nursing practice and education as becoming more complex, community development becoming a more important part of the public health nurses’ role, and a greater focus on high-risk and high acuity clients.

In summary, these qualitative studies enhance the earlier research in articulating public health nurses’ commitment to a primary health care practice that includes broad health promotion and community development. They enjoyed and valued their unique practice and saw it as their preferred future. In addition, these studies more specifically described how the nurses viewed their contributions to the community development effort and community health. They regarded one-to-one individual practice and reaching out to people in their home as an essential beginning step for community development work with marginalized people, and connected to small group work and community organizing activities. District nursing or generalist practice was seen as enabling public health nurses to associate with the community in a meaningful way in what Rafael (1997) terms a relationship of “community-nurse integrality.” This knowledge is valued as public health nurses’ unique contribution to the health promotion and community development discourse. Autonomy and freedom to be flexible in designing an innovative practice is highly valued by the public health nurses. It is interesting to note that the Manitoba nurses in Chalmers et al.’s (1998) study predicted a change of focus to targeting high-risk populations, while the public health nurses in Rafael’s (1997) study saw just the opposite emphasis happening in Ontario: a move away from focussing on vulnerable populations.

**Perceived Tensions with the Discourse on Health Promotion and Community Development**

Although the public health nurses in the cited studies valued practice expectations that were re-oriented toward a broader health promotion and community development mandate, they expressed frustration, confusion, and notable tension with integrating this new public
health focus into their public health practice (Beddome et al., 1993; Chalmers et al., 1998; City of Toronto Nursing Practice Committee Report, 1995; Craig, 1991; Leipert, 1996; Power, 1995; Rafael, 1997; Reutter & Ford, 1996; Wong, 1993). One of the main reasons given for this tension was the divergence on what community development involves and the meaning of the community development component of practice for public health nurses (City of Toronto Nursing Practice Committee Report; Craig; Power). The nurses explained that some definitions encompass a broad range of capacity building strategies, while other definitions focus on a community development model that assumes a macro or social change perspective and the challenging of social and economic structures. The nurses stated that although they recognize that a macro perspective for social action is critical for social change, it is not appropriate for all issues and circumstances. It does not help the here and now of a family in crisis - the public health nurses’ first concern in this situation. Public health nurses need to deal with the here and now, but also maintain a macro level perspective in their practice. However, they noted that when a macro level model is the one that is legitimized as the primary mandate for community development in the public health agency, roles and interventions that public health nurses exercise with individuals and groups are devalued (City of Toronto Nursing Practice Committee Report; Rafael). One-to-one and family, developmental case work and small group strategies that account for most of public health nurses’ practice become contrasted with coalition building and political action strategies, rather then seen as points on the same continuum of community development.

Nurses noted that the language used by individuals who study specifically in the health promotion and community development fields differs from the language that public health nurses use to name their practice. This situation creates much confusion and uncertainty for public health nurses as they try to incorporate the language of other disciplines. As a result, the nurses felt that their public health nursing identity was threatened and devalued (City of Toronto Nursing Practice Committee Report, 1995; Craig, 1991; Rafael, 1997). Not surprisingly, public health nurses expressed much concern and confusion about how new terms and strategies are understood among themselves, other professionals, the public, and public health management and policy makers. Although they believed that their practice was generally valued by their clientele, they were concerned that their practice was not well understood in the new public health by the general public and other professionals, such as
physicians and other nurses (Leipert, 1996; Rafael; Reutter & Ford, 1996). They were concerned with the implications of the situation on their time, energy, and job security.

Rafael (1997) described the public health nurses' practice as caught between the competing medical and health promotion discourses. She acknowledged that the ideologies and their influence on public health nursing practice were largely invisible to the narrators in her study. However, the contradictions were evident in their stories as they described the drastic and contradictory changes to their practice over time (i.e., the loss of well baby clinics and responsibility for childhood immunization). It was pointed out that while the public health nurses realize the need to develop further skills in community development, they expressed concern on seeing their identity as nurses being eroded, as particular roles and activities that have historically been part of their practice are segmented off and described with new titles, and eventually assumed by another discipline or nursing group, and/or low paid or non-charging community workers (Chalmers et al., 1998; City of Toronto Nursing Practice Committee Report, 1995; Craig, 1991; Rafael). Rafael provided several examples to substantiate this situation. She noted that public health nurses were asked to develop teaching kits and resources for others and to develop train-the-trainer workshops. In addition, they were expected to network and build coalitions with community groups in the name of community development. Direct services to the community was replaced with indirect contact with community agencies and committee work. Similarly, Chalmers et al. noted that the "hospital replacement model" of moving care to the community (i.e., early discharge programs for new mothers and babies) increased competition of community agencies with the acute care hospital system for health care dollars and generated greater competition among nursing groups. The change also increased the time required for care and teaching in the home.

Another major reason to account for the tension was the nurses' concern for vulnerable and marginalized populations, particularly women and children. Public health nurses expressed a sense of loss caused by the shift away from traditional and familiar practice for the individual, family, and target groups across the life span, to a greater focus on macro, population-based health and collaboration with the community to develop programs that isolated nurse from direct contact (Chambers et al., 1994; City of Toronto Nursing Practice Committee Report, 1995; Craig, 1991; Power, 1995; Rafael, 1997; Reutter & Ford, 1996; Wong, 1993). This shift meant limiting or eliminating practice that included case finding,
home visiting, health education, and support to vulnerable people who are the chronically ill, socially isolated, the elderly, and/or the mentally ill. Indeed, many nurses reported feeling guilty about abandoning disadvantaged individuals and groups whose voices go unheard in the larger community demands for services (Craig; Rafael). Some public health nurses expressed specific concern that group activities should not be regarded as the only method or preferred way of delivering public health programs, because they do not meet the needs of high-risk populations who find it extremely difficult to participate in group activity for many reasons. They regarded vulnerable groups as being negatively affected in many ways by the changed practice (City of Toronto Nursing Practice Committee Report; Rafael; Wong).

Nurses in Rafael’s study reported that the prevailing interpretation of community development in their health departments shifted the public health focus to those who were healthy and empowered enough to identify their collective needs and avail themselves of public health resources, and away from the most vulnerable and marginalized in the community. Beddome et al. (1993) reported that many nurses in their study were ambivalent about the idea of expecting all individuals in general to assume responsibility for their health unless appropriate and sufficient resources were provided to assist them.

Some public health nurses acknowledged that they were not adequately prepared with the advanced knowledge and skill required to assume a macro perspective to community development and its expression in nursing practice (Beddome et al., 1993; Chalmers et al., 1998; Chambers et al., 1994; City of Toronto Nursing Practice Committee Report, 1995; Craig, 1991; Leipert, 1996; Power, 1995; Reutter & Ford, 1996; Wong, 1993). It was suggested by some nurses that the public health agencies were partially responsible for this situation (City of Toronto Nursing Practice Committee Report; Wong). Public health nurses reported that they were not given requested access to “big picture” information on issues and policies, and ongoing support and mentoring to enable them to exercise an enhanced role in community development (Beddome et al.; City of Toronto Nursing Practice Committee Report; Craig; Leipert; Power). Also, nurses from across several studies reported that there was significant constraint on their community development efforts due to time conflicts, lack of visibility and valuing of their work, and limited resources, such as funding, staffing, and administration support in general (Craig; City of Toronto Nursing Practice Committee; Leipert; Power; Rafael, 1997; Reutter & Ford; Wong).
A recurring theme across the studies was that many public health nurses experienced work overload and frustration trying to devote time to focus on the community as the target of practice and a more comprehensive community development practice, while also being expected to meet the expectations of their traditional practice and the mandated programs (Chalmers et al., 1998; Craig, 1991; Leipert, 1996; Rafael, 1997; Reutter & Ford, 1996; Wong, 1993). Reuter and Ford identified two factors that contributed to the demanding and stressful nature of the public health nurses’ work: the complexity of the client situation, and inadequate and insufficient time to do what they believed needed to be done. Time management was described as the greatest stressor for these nurses. Working with people with mental illness and people who were significantly socially and economically disadvantaged was perceived as the most demanding due to the limited resources to address their clients’ multiple needs, limitations of their nursing skills to meet the needs of the mentally ill, and through the intense time commitment and doubt as to whether they made a difference. Similarly, Chalmers et al. (1998) identified that the participants in their study identified a major issue as the change in their clients’ profile over time. The public health nurses reported that they found health care being fragmented; for example, their comprehensive approach to family-focussed public health was being lost as high-risk groups were being targeted. Generally all the participants, who represented a broad range of community health nurses at the staff and administrative level and community health nurse educators, noted that the combination of increasing complexity of care that required more specialized knowledge and the growing number of people in compromised social and economic situations significantly increased the demands on community health nursing. As a consequence, the public health staff nurses and administrators found it difficult to think futuristically in general due to the immediate work demands that caused work overload and job dissatisfaction.

An important organizational constraint that could explain the nurses’ dissatisfaction in their practice was the reorganization of the delivery of public health nursing from generalist to specialty or program-focussed practice (City of Toronto Nursing Practice Committee Report, 1995; Craig, 1991; Power, 1995; Rafael, 1997). Across Canada, at a time when more effort and advanced competency was demanded in an obvious community development approach to practice and policy, many public health administrations reorganized public health nursing, under the rationale of increased efficiency, into specialty practice termed “program-focus.” In a program-focus way of organizing practice, programs are clustered according to their
common purpose for ease of planning, management, coordination, and delivery, e.g., Family Health, School Health, or according to age groups, such as the Healthy Parents/Healthy Children (0-4 years) program. Although public health administrators varied with interpretation of program-focus, this reorganization had the effect of moving public health nursing away from generalized, district/community work and "neighbourhood nursing" to a greater emphasis on standardized, mandated programs. This managerial decision caused fragmentation of services and gave priority within the health units to the provision of programs with quantifiable yearly targets and proven effectiveness, and deflected priorities from the ideals of primary health care, health promotion, and community development. Public health nurses asserted that they did not have the flexibility to fully commit to a macro perspective of community development because program-focussed nursing consumed so much of their time, and because there was limited support and limited resources in the public health organization to promote their community development work (City of Toronto Nursing Practice Committee Report; Craig; Power; Rafael). Power reported that the public health nurses in her study felt that the public health organization had not changed its philosophy, organizational structure, and processes to coincide with the new public health direction and remained highly patriarchal.

Further conceptual and politically resistive forces to health promotion/community development for the public health nurses were identified as: other community agencies and their resistance to changed public health nursing practice, the varying comfort level and expertise of public health nurses with a community development approach to their practice, reluctance of some public health nurses to let go of some traditional practice, reluctance of health unit administration to relinquish some control and to provide essential support, and an increasingly competitive climate for projects and money among community agencies (City of Toronto Nursing Practice Committee Report, 1995; Craig, 1991; Leipert, 1996; Power, 1995; Wong, 1993).

Furthermore, public health nurses acknowledged that their collective opinions and expertise are undervalued and underutilized, their activities and jobs are threatened by decreased funding to public health, they are perceived as somehow lacking in credibility, and increasingly have become invisible within the new policy thrust of "health for all" (Chalmers et al., 1998; Leipert, 1996; Rafael, 1997; Reutter & Ford, 1996; Wong, 1993). Moreover, public health nurses reported that they are challenged by their employers, professional
colleagues and the provincial governments to defend their central place in health care reform and their ability to perform the roles necessary to achieve primary health care and health promotion goals (City of Toronto Nursing Practice Committee Report; Leipert; Wong). Public health nurses in Chalmers et al.'s study stated that as a result of not receiving credit for their investment in community development projects, and due to the trend away from direct care, they were less visible in the community. As a consequence of this situation, they believed that they were less apt to be called on by the community and to facilitate community development programs. Other salient issues that were identified in the studies were: difficulty setting priorities due to work and role overload, being caught between the competing health promotion and medical discourses, the challenge of evaluating their effectiveness as public health nurses in an environment that places greater value on quantifiable measures, and given the growing invisibility of their practice, marketing and receiving credibility for their contributions (Rafael; Reutter & Ford).

As noted earlier, three of the studies addressed the Mandatory Health Programs and Services Guidelines (MHPSG) (1989) that were established by the Ontario Ministry of Health to coincide with the new directions proposed in the Health Promotion and Protection Act (1983). The guidelines were designed to standardize minimum public health programs across the province and to organize services according to programs (Craig, 1991; Rafael, 1997; Wong, 1993). As public health nurses constitute the largest group of public health practitioners, their compliance with the new policy directive in the guidelines was essential to its success (Craig; Rafael). Rafael reported that public health nurses challenged early drafts of the 1989 guidelines because the document defined the roles of numerous public health professionals but omitted public health nurses. The final product did not refer specifically to any disciplines. It was argued that prior to these guidelines, public health nurses had significant autonomy in their practice; the new guidelines were restrictive in some ways for the practitioners and vulnerable populations (Craig; Rafael; Wong). This situation was seen as being in sharp contrast to the espoused Health Promotion and Protection Act directives toward a broader health promotion and community development mandate that coincided with the directives from the Ottawa Charter for Health Promotion for reducing inequities and social injustice.

Rafael's (1997) oral history of public health nurses in Southern Ontario revealed that significant changes had occurred in the scope of practice of public health nurses between 1980
and 1996. Although the public health nurses applauded the redirection of the act and public health policy toward a greater emphasis on population-focused health promotion, they were concerned with the narrowing or elimination of their traditional services through individual and family approaches to vulnerable peoples, and with the loss of public health nursing positions. Further, a nursing voice in decision making was lost as senior nurse manager positions were eliminated. Of major significance was the decrease or withdrawal of many one-to-one services and home visiting. The decrease or elimination of these services was felt by individuals, families, and vulnerable populations such as persons with mental health concerns, the elderly, pre-and post-natal mothers and their families, and school children. The expected change was framed by local public health units as necessary to coincide with the Ontario Ministry of Health’s population health and community development direction. Therefore, several individual and family-centred services were replaced with group activities and an increased emphasis on collaborative and coalition building activities with community volunteer and professional resources. It was argued that this imposed change, along with other factors generated particularly by the MHPSG, resulted in changing the type of public health nursing service, reducing the nurses’ autonomy in their practice, and increasing misunderstanding of the nature and value of public health nursing work (Rafael; Wong, 1993). Further, the changes were perceived as inducing a fragmentation of community services, and having a significantly negative impact for vulnerable and marginalized populations. At the same time that the MHPSG directives were being implemented, public health units in Ontario underwent significant budget cuts and public health nursing’s focus was narrowed yet again (Rafael). More nursing positions were lost or replaced by non-clinical public health workers, and medical control over public health and public health nursing greatly increased. The new policy directives combined with the realities of the social, economic, and political organization of the public health nurses’ practice had a significant demoralizing impact on the nurses (City of Toronto Nursing Practice Committee Report, 1995; Craig, 1991; Rafael, 1997). At a time of health care transition, constraint, and subsequent staff reduction in public health organizations, public health nurses in Ontario not unexpectedly reported low morale, a sense of loss and uncertainty.

In November 1997, the MHPSG were revised and the burden of loss added to. The new guidelines represented a further narrowing of public health nursing’s focus in promoting public health and social justice (Registered Nurses Association of Ontario [RNAO], 1998).
There was significant deletion of programs such as: prevention of violence against women and children; mental health promotion that included suicide prevention and stress management; health promotion activities for aging populations, and injury and disease prevention in general. Further reductions occurred in programs aimed at issues related to mitigating financial stress, homelessness, manifestations of poverty, and accessibility to health care. Emphasis was also given to inclusion of lay health care workers without stipulating that professional public health nursing services provide comprehensive assessment (RNAO).

Summary

As I embarked on this study, public health nurses from across Canada reported many impediments to an expanded health promotion and community development practice. These constraints and contradictions were primarily associated with organizational constraints in the nurses' everyday practice prompted by economic cutbacks. In fact, this situation has become more intense as the 1990s progressed and is generating an increasingly stressful work environment for public health nurses. Public health nurses express a pervading sense of uncertainty and job dissatisfaction, and feelings of frustration and confusion related to role conflict and overload, loss of autonomy in their practice, and devaluing of their unique contribution. These conditions are exacerbated by the incongruence of program-focussed models for the delivery of public health nursing with a community development agenda (for some public health nursing jurisdictions); working in more complex client situations, yet having increasing gaps in resources and services; loss of public health nursing leadership; lack of perceived support and direction within the health departments; increasing lack of understanding and visibility of public health nursing; and ultimately concern for the future of public health nursing. Generally, the uncertainty and stress are related to health care budget reductions in a period of increasing fiscal constraint and health care reorganization within the Canadian health care system and the impact on nurses and the vulnerable populations they serve. The Ontario nurses also attribute the stress and uncertainty to the Ontario Ministry of Health and growing confusion and conflict related to the Mandatory Health Programs and Services Guidelines (1989, 1997). It is apparent that a study of public health nurses' community development practice must include an examination of the quality of the nurses'
work environment and the impact of the larger social, economic, and political influences upon it.

**Public Health Nursing and the Community as the Target of Practice**

An extensive literature review uncovered only a few studies that examined the community as the target of practice for the public health nurse. No studies were forthcoming that looked specifically at public health nurses' community development practice with women in high-risk environments. This overall lack of research on public health nurses’ community development work is well documented (Chalmers & Gregory, 1995, 2000; Ploeg, 1995). The seminal work of Ploeg et al. (1995) is relevant to this discussion. Ploeg et al. conducted a systematic overview of research evidence about the effects of community development projects that are within the scope of public health nursing practice and retrieved 133 articles. Further critique was undertaken of these articles using validity or quality criteria that considered descriptions of the projects, participants and context; issue identification; planning phase; action phase; information gathering or evaluation phase; and analysis. This process elicited 17 relevant community development studies. In their assessment, the researchers used Labonte's (1993a) definitions of community development and community-based programming (previously defined) and the distinguishing feature of these models, “the degree to which community members, rather than professionals name the problem, or the issue and plan strategies to address the issue” (p. 3). The researchers also employed Rothman’s (1974) and Christenson’s and Robinson’s (1989) models of community development as a guide in their critiques.

All of the projects reviewed reflected a mixing and phasing of different approaches to community development according to Rothman’s and Christenson’s models. Four projects were judged to be strong community development ones. These studies involved seniors and adults and dealt with issues such as nutrition and access to food, safety in the face of crime, and recreation and environmental health. Strong projects varied in their use levels of analysis of change; however, all the strong projects included individual and community level analysis of social change. For example Flynn, Rider, and Ray’s (1991) “Healthy Cities” project involved six cities in Indiana that were working to identify and respond to issues arising from high-risk conditions of poverty and powerlessness in each city. Their analysis included the reference to the *Ottawa Charter for Health Promotion*, Bandura’s Social Learning Theory, and
Etzioni’s Social Change Model in their analysis. Minkler’s (1992) Tenderloin Seniors’ Outreach Project involved low income seniors living in single room occupancy hotels in San Francisco. The conceptual basis consisted of Bandura’s Social Learning Theory, Paulo Freire’s philosophy and methodology of liberating dialogue through critical reflection, and Saul Alinsky’s community organizing approaches.

Public health nurses were identified as the professionals in three of the projects (Picard et al., 1993; Rutherford & Campbell, 1993; Stotts, 1991). In Picard’s project, two groups of seniors in Sudbury, Ontario, worked with public health nurses to deal with identified needs for a caregiver support group, a “meals on wheels” program, and a foot care clinic. In Rutherford and Campbell’s project, public health nurses were concerned with high-risk socioenvironmental conditions in two working class communities in Calgary. The main issues concerned the low socioeconomic status of the residents and associated with a high rate of people receiving social assistance, high unemployment with young adults, the high occurrence single parent households, and a high crime rate. The nurses worked in partnership with other professionals to help establish community alliances for parents. The alliances enabled the communities to learn to work together, to build leadership and solidarity, and to develop programs to correct inequities, such as a baby sitting co-op and an outlet for a food bank. Dimmock’s framework on group development was used to analyze the communities’ cohesiveness and growth around the issues. Public health nurses in the Stott’s project used the Salmon public health nursing model to assist two American cities to lobby for a city ordinance related to smoking.

Ploeg et al. (1995) concluded that all of the 17 community development projects that were retrieved in their systematic review described professional roles that are identified within the scope of public health nursing practice in the document Community Health/Public Health Nursing in Canada (CPHA, 1990). According to Ploeg et al., "a role played by the professionals is that of capacity building, or facilitating the development of knowledge, skills, and self-reliance of community residents and the groups as a whole" (p. 16). In most studies there was much flexibility, individuality, and change over time in how the professional exercised a repertoire of roles. However, the professional tended to use a broader range of roles in the stronger projects. In these projects, the professional adopted the roles of community organizer and educator in the early phases of the projects and eventually assumed the role of a resource person to the community. Public health nurses exercised roles as
consultant (Picard et al., 1993; Rutherford & Campbell, 1993; Stotts, 1991); group facilitator, educator/trainer, and advocate (Picard; Rutherford & Campbell); and community organizer (Rutherford & Campbell). The processes inherent in these roles were not articulated in their review. Ploeg et al. further concluded that community development efforts in the scope of public health nursing practice can have a positive impact on the health of individuals and communities across a wide variety of indicators.

Two other community development studies merit review. Edwards et al. (1992) conducted an intersectoral, health promotion project in Hamilton, Ontario to improve the health status of immigrants and refugees in the city and to facilitate their entry to the Ontario health care system. In phase one, 95 health promotion sessions on nine topics were given jointly by the project public health nurses and English as a Second Language (ESL) classroom teachers. In phase two, the public health nurses conducted workshops to increase the teachers' ability to integrate health promotion in class content. In the third phase, the public health nurse used a variety of health promotion and community development strategies to strengthen the health advocacy role of a core immigrant group in the city. The public health nurse became active in diverse immigrant planning networks outside of and within the region. She participated in surveys assessing and prioritizing preventive and promoting health needs; initiated and delivered pre-natal classes, support, and community groups; delivered workshops on family violence; identified community resources, and was successful in advocating with the community for a cultural interpreter program. The study demonstrated that public health nursing can be effective with hard-to-reach, vulnerable groups such as new immigrants in increasing their preventive and health promotive practices and in accomplishing individual and community empowerment.

May, Mendelson, and Ferketich (1995) collaborated with a county health department in Arizona in designing a project of community health nursing interventions for four small rural, underserved (primarily Mexican American) communities. The project used the locality model of community development and tested the effectiveness of three interventions: personalized preventive nursing, organized indigenous caregiving through outreach community health care by the community health nurses and promotoras (neighbourhood workers); and community identification of health problems, resources, and solutions. Door-to-door community surveys and interviews with key informants were analyzed to identify community health status, concerns, and goals. The community health nurses and the
promotoras planned strategies, including a health fair. The researchers concluded that a beginning level of community empowerment was evident in the promotoras’ decision making on community priorities, planning, and responsibility in planning a health fair. The impact of the fair on community health could not be evaluated. The community health nurses worked with the promotoras in the roles of resource, educator, advocate, and catalyst.

The qualitative work of Joyce Zerwekh deserves serious consideration for my study purpose. Zerwekh (1991a, 1991b, 1992a, 1992b) initiated the exploration of public health nurses’ personal knowledge and described the unacknowledged competencies of public health nurses through interpretive study of their stories and practical wisdom in their practice with individuals and families. Zerwekh (1991b) asserted that although public health nurses have a long history in capacity building with individuals, families, and communities, "the absence of clear definitions of public health nursing competencies have plagued efforts to demonstrate the need for public health nursing programs" (p. 213). Research similar to Zerwekh’s that examines the community development process and the personal knowledge or wisdom of the public health nurses is not available: this is the particular focus of my investigation.

Zerwekh conducted a phenomenological study using a constant comparative analysis of the narratives of 30 expert public health nurses working with high-risk maternal/child cases in the home setting. The purpose of the study was to reveal the public health nurses’ personal knowledge and competencies in capacity building with high-risk families (1991a, 1991b, 1992a, 1992b). She noted two broad spheres of public health nurse competencies, Family Caregiving (also termed Family Self-Help), and Nurse Preserving (Zerwekh, 1991a, 1991b). She found that public health nurses expressed increasing uncertainty and continual questioning as to whether or not they made a difference. Nurse Preserving was identified as a key competency, as nurses were experiencing increase concern with growing hardships that affect their practice, such as difficult societal conditions and increasing involvement with the most disturbed and vulnerable clients. Zerwekh (1991a) described three Nurse Preserving competencies: struggling with adversity, confronting the threat of violence, and preserving nurse well-being. In preserving well-being, the expert public health nurses know their limits and set achievable goals, close cases, emphasize the smaller victories, and find balance between work and personal life, and the caregiving relationship and friendship.

Zerwekh (1991b) also delineated encompassing competencies, i.e., timing and detecting, that she noted envelop all Family Caregiving activities. Timing includes detecting
the right time to intervene and when to persist, and looking toward the future. In looking to
the future, the nurse anticipates the future in planning her involvement and also guides the
client, who may only live in the present, to plan for the future. Detecting refers to the process
of continually searching for relevant situational clues in the home and family dynamic.

Zerwekh (1991b, 1992b) found that the basis of Family Caregiving is the
encouragement of Family Self-Help, which is consistent with the enablement or empowerment
notion of promoting client choice and self-determination. Empowerment, defined as the
process of "enabling the parent to develop personal capacity and authority to take charge of
everyday family life" (1992 b, p. 102), emerged as the central competency of the public health
nurses in her study sample. Based on her research, Zerwekh (1991b) designed a Family
Caregiving model for public health nursing. She identified four strategies that the public
health nurses employed to encourage the families in self-help: believing that they have
choices and helping them to see that, listening long and carefully, especially to vulnerable
people who feel powerless and need time to articulate their needs, expanding family's vision of
realistic possibilities, and feeding back reality - helping them critically examine their health
choices. She described several competencies which the public health nurse incorporates in her
repertoire of skills to enable Family Self-Help: fostering community by being available,
mobilizing resources, and collaborating with professionals; resolving problems and resolving
crises through an egalitarian perspective on the issue; working through emotions and
fostering family understanding; educating through reflective dialogue; and forceful
competencies for saving children, related to the public health nurse's accountability for child
protection.

Additionally, she described three competencies that are essential to laying the
groundwork for Family Self-Help (1992a): locating the family, building trust, and building
strength. She described these competencies as complex, previously not examined, unrecorded,
and unvalued by the organization; yet essential to the public health nurse's role and the
building of Family Self-Help, especially with vulnerable families. Zerwekh issued the
challenge to practitioners and researchers to further develop a comprehensive profile of the
public health nurse's competencies by clarifying, extending, and modifying the model through
additional qualitative research of public health nurse experts, particularly by way of
participant observation, interviews and the use of multiple investigators. This present study
attempts to address most of these challenges.
In addition, a rich collection of public health nurses' stories, compiled by the Washington State Nursing Network (Zerwekh, Young, Premomo, & Deal, 1993), makes a significant contribution to celebrating the unique work of public health nurses in health and health care.

Summary

Research is limited on public health nursing and the community as the target of practice. No studies were found that specifically examined women in high-risk environments as a community target of practice or public health nurses' community development work with this population. Although the sample characteristics according to gender were not stated, it can be assumed that women were included in the studies that involved community development efforts in communities subject to high-risk circumstances (Edwards et al., 1992; Flynn et al., 1991; May et al., 1995; Minkler, 1992; Rutherford & Campbell, 1993). Across these studies, community health nurses exercised a variety of roles and responsibilities that are consistent with the expectations of a community development practice. Yet, sufficient description was not forthcoming of the actual community development process in terms of the partnerships and issues of power sharing related to status, reciprocity, and control. Further, the assumptions, values, and feelings of the community health nurses and the nurses' ways of knowing in the process, particularly their personal and sociopolitical knowing were not examined. Finally, how the nurses conceptualized community development and the effect of the larger social, economic, and political agenda on their practice was not studied. Zerwekh's research provided important insight into public health nurses' personal knowledge in working with high-risk maternal/child cases in the home setting and lends support to the significance of my study. However, Zerwekh also did not examine the nurses' practice within its social, economic, and political context as I consider important and have attempted to do.

Summary

In this section, Part II - Public Health Nursing and Community Development, I provide a review of empirical literature in three relevant areas: (a) Perceived Practice; (b) Perceived Challenges and Tensions with the Health Promotion and Community Development Discourses; and (c) Public Health Nursing and the Community as the Target of Practice.
Chapter Three provides a detailed description of the methodology and specific methods used in this study.
CHAPTER THREE

METHODOLOGY

Introduction

Methodology is a "theory or analysis of how research should proceed" (Harding, 1987, p. 3), based in philosophical paradigms that guide the researcher in ontological and epistemological ways (Lincoln & Guba, 1985). This study is based on feminist perspectives and an ethnographic approach that is consistent with the study's purpose to understand the complex, everyday community development practice of public health nurses with women in high-risk environments, from the standpoint of the nurses. I explore how the nurses' practices are embedded in the social relations of the larger social, political, and economic organizational context. Through a reflexive process that makes use of an ethnographic approach, filtered through the values and methodological features of a feminist perspective, I aim to uncover and mediate meaning between the voices of public health nurses, myself as researcher, the scientific community, and the broader community.

This chapter has two parts. First, I discuss the feminist and ethnographic orientation that guided this study. Second, I describe the specific methods I used in this inquiry, including: entering the system, participant selection, participants, data collection, data analysis, ethical considerations, and steps taken to ensure the rigour and reflexive quality of the work.

Perspectives on the Methodological Approach

In this section I set out by placing my methodological approach within the ontological and epistemological frameworks of the interpretive and critical paradigms. However, this study is basically an interpretive inquiry in which the central tenet is interest in human choice and meaning in social life (Erickson, 1988). This interpretive study is significantly informed by my readings in critical and feminist theory and research. There are a number of terms that could be applied to the kind of work I am doing. Each term would emphasize some aspects of the work at risk of minimizing others. As I have engaged in and shaped this study, I have become most comfortable with describing my inquiry as feminist research using standard ethnographic techniques to generate the data. My feminist perspective is informed by several authors whose ideas have guided me in my
methodological decisions. In particular, Lather’s (1991) work has been significantly informative. This passage by Lather poignantly captures the nature of my study:

The overt ideological goal of feminist research in the human sciences is to correct both the invisibility and distortion of female experiences in ways relevant to ending women’s unequal social position. This entails the substantial task of making gender a fundamental category for our understanding of the social order. (p. 71)

Following a broad overview of the interpretive and critical paradigms below, I discuss my feminist perspective more specifically, followed by a brief discussion on how I understand ethnography and ethnographic method as it is used in this inquiry. Ethnography has expanded beyond its anthropological origins and meanings. In many ways, this study concurs with how ethnography is frequently used in nursing. This discussion provides a background to the section on specific methods.

**Overview of the Interpretive and Critical Paradigms**

All paradigms or world views can be classified by their ontological, epistemological, and methodological questions (Guba, 1990). I have used insights from the interpretive and critical paradigms to represent the world view that best resonates with my assumptions about truth, reality, relationship of the researcher to the researched, and the nature of the study purpose. Several nurse researchers call for nursing to not only address the health-healing process (Reed, 1995), but to situate itself in the cultural-political context of practice and research that significantly affects nursing’s capacity to promote health and social justice (Allen, 1995; Stevens & Hall, 1992; Thompson, 1987). The interpretive world view, with its goal to link event and context for understanding of peoples’ “lived experience,” guided my study of the nurses’ meaning construction of their experience. The critical paradigm, which is ideologically oriented, guided me in examining the connections between the nurses’ everyday reality and the larger sociopolitical context. Miles and Huberman (1994), submit that:

Realists, interpretivists, critical theorists are closer to the centre with multiple overlaps. The lines between epistemologies have become blurred . . . and an increasing number of researchers now see the world with more pragmatic, ecumenical eyes. Our view . . . it is possible to develop practical standards workable across different perspectives for judging the goodness of conclusions. (p. 5)
Luhtz, Jones, and Kendall (1997) argue that praxis, as a synthesis of the interpretive and the critical paradigms, has been underutilized in nursing inquiries, yet has significant potential for transformative action in nursing practice. To expand the praxis debate, Lutz et al., combine the interpretive paradigm (originating with Heideggerian philosophy and extending toward Gadamer's perspectives of hermeneutics) with critical theory under the concept of critical hermeneutics. They submit that both traditions strive for an understanding of the social world through reflexivity between the researcher and the participants. Additionally, these paradigms support the beliefs that knowledge is socially constructed, there are multiple interpretations of reality, and the researcher and participants are co-creators of knowledge within their political agendas. However, Lutz et al., argue that critical paradigms go further in their praxis-oriented science in constructing emancipatory knowledge. Lather (1991) describes emancipatory research in terms of research-as-praxis in which emancipatory knowledge uncovers the contradictions and the taken-for-grantedness of the status quo. She goes on to suggest that research with an emancipatory agenda holds the potential for possibility through the development of critical consciousness and the ultimate transformation of both the researcher and the participants.

A critical paradigm is not limited, however, to one perspective or method but includes many philosophical perspectives. It is best understood as critical theories, as there is more than one critical theory with a standard set of interpretations for all people. Critical theories, from its early origins, was concerned with domination by the ideology of elite systems that limit human freedom. This theoretical perspective is based on the assumptions that humans are typically dominated by hegemonic forces and that secrecy is a given of oppressive structural relations (Stevens, 1989). Further, critical theories attempt to examine and explain the relations of dominance through critical reflection and to demystify the ideology that rationalizes unequal power relations (Stevens). Enlightenment about ideologies through this critique will lead to empowerment (social transformation through education) and emancipation (people can freely direct their life) (Powers & Knapp, 1995). A feminist perspective that is rooted within the interpretive and critical paradigms has fundamental importance in guiding this research inquiry. My feminist perspective and the implications for how it directed the research process is outlined below.
Feminist Perspectives

Valuing women's lived experience and building solidarity is critical to nursing, which is a predominately female occupation that has historically struggled for identity, autonomy, and accountability over the profession (Bent, 1993), and social justice in health care (Stevens & Hall, 1992). A prevailing view among feminist nursing scholars is that the combination of the emancipatory world views of critical and feminist theories has the potential to extend nursing practice and research toward a transformative agenda (Allen, 1995; Campbell & Bunting, 1991; Stevens & Hall, 1992; Thompson, 1987).

Feminist theories can be thought of as a family of theories, consisting of a broad range of positions that by their very nature include disagreement on philosophy and strategies (Campbell & Bunting, 1991). Scholars such as Campbell and Bunting, and Stevens and Hall (1992) argue that it is more appropriate to speak of feminisms because women's experiences are pluralistic and vary naturally according to how each woman chooses publically to represent her sentiments, ideas, and political commitments (e.g., an African-American feminist). Yet, there are tenets that are central to all feminisms: full recognition of the value of women and their everyday lived experiences; believing that women are subject to domination due to gender and androcentric bias; making the connection of the women's experience to the ideological, structural, and interpersonal conditions that dominate women; and producing and valuing theory and research for rather than about women (Bent, 1993; Campbell & Bunting; Hall & Stevens, 1991; Powers & Knapp, 1995; Smith, 1987; Stevens & Hall). Further, feminist theory is equally interested in knowledge to improve the condition of any one woman and the emancipation of all humanity, or of particular groups (Bent; Campbell & Bunting).

Some feminist positions have been criticized for designating structural processes and practices as sovereign, and polarizing and essentializing power as accruing to those who have it and those who do not, thus creating victims of dominate discourses (Foucault, 1980; Weedon, 1997). This position fails to answer two questions: How does one exercise agency and autonomy within a model of fixed power sites? and How does this theoretical position enable emancipation from oppressive forces? This quandary led me to delve into the works of post structuralist theorists, particularly feminist post structuralists and the work of Michel Foucault. These perspectives helped extend my feminist view. Insights on notions of
discourse, power, the social construction of knowledge, resistance, agency, and subjectivities illuminated my inquiry in important ways.

It is acknowledged that “feminism and post structuralism are particularly relevant to nursing because they incorporate the concepts of the female experience and power” (Doering, 1992, p. 25). Bloom (1998) argues that an important concept in feminist narrative (modern and post modern) is that there is a subject who has agency. Agency refers to “the capacity [of people] to create, reproduce, change, and live according to their own meaning systems, the power effectively to define themselves as opposed to being defined by others” (Bhattacharyya, 1995, p. 61).

Foucault's theory on discourse, power, and knowledge has contributed significantly to the concept of agency and, therefore, to emancipatory theory and politics. Discourse is understood to operate through language and is expressed in written or oral form and in the social practices of everyday life. The concept ranges from the most narrow text-linguistic description to the macro concept, which refers to dialogic practices that give cultural meaning to the world in the context of social power (Foucault, 1980; Mills, 1997; Outhwaite & Bottomore, 1994; Weedon, 1997). According to Foucault, discourse inheres in discursive formations or relations of power that take on regulated, institutional forms, such as law, education, family, health systems, etc. Individual ignorance of relations of power/knowledge is an important condition for the maintenance of hegemonic power. It is argued that these discursive frameworks systematically organize knowledge and power; and, therefore, social practices, forms of identity, and cultural meaning, and repress alternative discourses (Foucault; Weedon). In this context, ideological struggles and competing, contradictory, or misleading discourses are always emerging (Mills, 1997).

Through his theory of discourse, Foucault was instrumental in conceptualizing a model of power that characterizes it as fluid, relational, and productive (Mills, 1997; Sawicki, 1991; Weedon, 1997). Power is also described within this model as local, particular, resisting, embedded in a complex web of discursive relations, and at the site of subjectivities and intersubjectivities (Foucault, 1980; Sawicki; Weedon). Sawicki argues that while she, along with other feminists, criticize Foucault’s androcentrism in his notion of power/knowledge, they find his discourses and methods useful for feminist criticism. She submits that Foucault provided an alternative way to view and evaluate theories of self and society for new understandings and freedom. She notes that the overall intention of her writings in
"Disciplining Foucault: Feminism, Power, and the Body" is to describe a Foucauldian feminism that is a pluralistic and emancipatory radical politic. This radical pluralism challenges hegemonic power structures through a relational and dynamic model of identity that posits that identity is constantly in formation in the everyday experiences. Sawicki belongs to a group of feminist scholars who, in appropriating Foucault, acknowledge domination by hegemonic forces. These scholars focus primarily on cultures of resistance to these power/knowledge frameworks and ways that individuals can constitute local knowledge by resisting and creating new possibilities for themselves. Discourses and practices of struggle and resistance are key to Foucault's notion of power (Sawicki). "Where there is power there is resistance" (Mills, p. 42). This relational, resisting, and productive model of power is useful in helping one look at ways in which subject positions are produced and reproduced; and ways to produce them, rather than repressing subject positions and not allowing more possibilities for the individual as an active agent (Foucault). Sawicki's explanation of Foucault's unique perspective on power/knowledge and subjectivities is captured in the following passage:

His philosophy embraced the theoretical tensions that result from acknowledging that we are both victims and agents within systems of domination, that our discourses can extend relations of domination at the same time that they are critical of them, and that any emancipatory theory bears the traces of its origins in specific realities of power/knowledge. (p. 10)

According to Butler (1990) intentionality, agency, self-reflexivity, and autonomy are integral to these subject positions. Further, accepting that individuals can move into various subject positions allows for greater possibilities for transformation and emancipation because essentialist [fixed] identities are not supported, or because one group is not privileged related to another (Benhabib, 1995; Bloom, 1998; Flax, 1993; Squires, 1993; Weedon, 1997).

I argue that the post structuralist position of refuting essentialism and destabilizing the "self" is relevant to analysis in this study. This conceptualization places the notion of "self" in a less fixed, coherent, and rationalist position that allows the individual to move among various subjectivities. This position allows me to adopt another lens to understand the public health nurses' construction of identity and agency. Public health nurses can position themselves as active agents in their practice by adopting various subjectivities or subject positions to resist and negotiate larger social, economic, and political influences on their practice.
Post modernism and post structural theory is heralded as redefining and liberating research in many positive ways in its refuting of essentialism, objectivism, and universalism (Squires, 1993) and alternatively valuing contextualization and plurality of knowledge (Lather, 1991). Furthermore, a feminist perspective that is informed by critical and post structural theory has significant implications for how research is approached. Such a methodology has an emancipatory agenda of critiquing social structures and social relations, including discursive practices in which power resides (Lather; Sawicki, 1991). This emancipatory research approach not only necessitates a reflexive relationship between the data and the researcher but a reflexivity between the researcher and the research participants (Lather; Street, 1992). According to Lather, "emancipatory social research calls for empowering approaches to research where both the researcher and the researchee become... 'the changer and the changed.'" In this reflexive process, the researcher is both researcher and participant who engages in dialogue with the research participants to construct meaning. This partnership relationship assumes an interactive and nonhierarchical process, which is characterized by authenticity, reciprocity, and intersubjectivity between the researcher and her participants (Lather; Stanley & Wise, 1993). Reciprocity is understood as a "give and take, or a mutual negotiation of meaning and power" (Lather, p. 57).

In this reflexive context a dialogue of collaborative, critical reflection and the intersubjective construction of knowledge is central for consciousness-raising for the researcher and the participants: "problems are posed to enable the nurse to question the tacit ways of knowing and practising nursing...a reconstruction of experience, which is recorded for analysis" (Street, 1992, p. 16). This process constitutes a transformation towards knowledge and action. The intersubjective construction of knowledge should "provide information that women want and need to change the conditions of their lives" (Allen & Baber, 1992, p. 9). Integral to a non-hierarchical research process is the issue of conscious partiality (Mies, 1991). In this process, the researcher is expected to identify with the participants while maintaining a critical and dialectic distance. In so doing, the researcher identifies her own biases as well as her subjective interpretation of the issue under study. This notion of conscious partiality recognizes that the interpretation of the social reality is dependent on the world view of the researcher. Through this deliberate reflexive position, it is anticipated that distorted perceptions are corrected on both sides and consciousness is extended for both the researcher and the participants.
In summary, in this section I provide a broad overview of the interpretive and critical paradigms to identify the worldview that informs the methodology in this study. Following this discussion, I present my feminist perspective and its implications for how research should proceed. The following is a description of the ethnographic approach used in this study.

**Ethnographic Method**

Ethnographic approaches to the study of nursing culture have been implemented for more than three decades (Streubert & Carpenter, 1995). The use of an ethnographic approach, informed by a feminist perspective, is appropriate for this study. Ethnography is always concerned with studying culture and understanding the meaning of actions and events of people (Spradley, 1980). Most commonly it is described under the rubric of interpretive inquiry and is acknowledged as the most basic form of social research "... a particular method or set of methods ... with the ethnographer participating overtly, [or] covertly in peoples’ daily lives for an extended period of time" (Hammersley & Atkinson, 1995, p 1).

This type of ethnography is influenced by ontological and epistemological values and skills of the researcher and of the social group under study. Many variations and critiques of ethnographic research exist today due to multiple theoretical and political positions that challenge the apolitical view of culture that is proposed in traditional ethnography. Postmodernist, critical, and feminist critiques are major influences on positioning ethnographic accounts as partial truths and in directing ethnographers to understand culture; not as a freefloating and neutral concept, but as part of an ideology that controls the culture under study (Clifford, 1986). These philosophies hold ethnographers to be more accountable in recognizing the inequity and power differential that exists in a collaborative research process and the problem of authorial voice (Stacey, 1988). Muecke (1994) points out that "Ethnographies are shaped by the historical circumstances, by the subjectivity and conceptual stance of the ethnographer, as well [as] by the people with whom the ethnographer works ... culture doesn’t hold still for portraits" (p. 195).

Despite the many variations of ethnographies that exist, there are key characteristics: being in the field for long periods of time to participate in the lives of the people under study, reflexivity through the insider view of the participant that is combined with the outsider view of the researcher, and producing a pragmatic outcome for theory and practice (Boyle, 1994). The strength of the fieldwork lies in the triangulation of multiple ways of gathering data:
participant-observation, interviewing, use of written and unwritten sources (Wolcott, 1988), and the production of "thick descriptions" of the culture (Gertz, 1973).

This study employed a "focussed" ethnographic approach that is commonly used in nursing and health ethnographies. Focussed ethnographies (Morse, 1992) have also been termed particularistic ethnography (Boyle, 1994), micro ethnography (Werner & Schoepfle, 1987), or mini ethnography (Leninger, 1985). All such ethnographies are more narrow and focussed than the classic, anthropological ethnography. Focussed ethnographies hold credibility in nursing for several reasons. The studies tend: to be problem-focussed and context-specific; to be time-limited within discrete, social units or processes; to use selected episodes of participant observation; to consist of a combination of structured and unstructured interviews; and to include a limited number of information-rich cases (Muecke, 1994).

I describe an overview of the underlying feminist perspective and ethnographic approach that guided this study. In this next section I discuss the specific methods I used to conduct the research.

**Specific Methods**

The categories discussed in this section are the following: The Setting; Entering the System; Participant Selection; Participants; Data Collection Procedures, including Interviews, Participant Observation, Document Review, My Process Notes and Reflective Journal; Data Analysis and Interpretation; Ethical Considerations; and Ensuring Trustworthiness and Rigour, which addresses Credibility, Transferability, Confirmability, Dependability, and Reflexivity.

**The Setting**

This research study was conducted in a large, urban city in Southern Ontario through the city's Department of Public Health. The department consisted of three health areas: western, northeastern, and downtown health area. Seven district offices were spread across the health areas. The city consisted of a diverse multicultural and dynamic profile with unique demographics. It included a high proportion of immigrants, with a significant number of recent immigrants and a high proportion of people on welfare and/or family benefits support. At the time of the study AIDS, tuberculosis, hepatitis A and B, and violence were significant health issues. Major preventive programs existed to address poor dental health for street
youth, drug use, tobacco consumption with young women 15-19 years, nutritional health, and sexual health.

At the time of the study, the Department of Public Health was mandated by the Province of Ontario to fulfill the requirements of the Health Promotion and Protection Act (1983), the Mandatory Health Programs and Services Guidelines (1989), and the municipality's Board of Health recommendations. The city was regarded as a leader in the advances in health promotion strategies, with a long history of an established community development and advocacy mandate. Further, the city had strategic directions to be the healthiest city possible by the year 2000. Since the early 1990s, community development and advocacy mandate was operational city-wide as a practice methodology.

**Entering the System**

Appleton and King (1997) acknowledge that interpretive inquiry is stimulated and guided by personal intuitive experience, interest, knowledge of the investigation, and the researcher's knowledge of the field. According to Hall and Stevens (1991), establishing trustworthiness of the claims a study generates, and engaging in a reflexive, feminist inquiry, necessitates prefield work. This prefield work allows the researcher to discuss the study purpose, research questions, and entry to the system, and to establish trust and rapport with potential members in the study. I was aware that skilful intuition would be important if I wanted to be accepted as a genuine, sincere, credible, person and researcher. Nurses within the department verbalized in informal conversations with me that they were sceptical of researchers because of a recent research investigation conducted in the department on the community development practice of public health workers. The nurses could not see their practice within the parameters of the definition of community development in the study. All the nurses I spoke with (approximately eight) stated they felt devalued in the inquiry. One nurse described the process as "putting a round peg in a square hole." Additionally, some nurses verbalized that public health nursing was not represented positively or accurately in some of the study findings. Consequently, I anticipated resistance to my proposed study.

Serendipitously, as I was contemplating which direction my doctoral proposal would take, friends who worked as public health nurses in the department in which the study took place suggested I attend a workshop on the topic in one of the district offices, "The Links Between Public Health Nursing and Community Development." I was willing to attend, as I
was teaching community health nursing at the baccalaureate and masters level and was interested in learning the perspective of the nurses in this particular setting. In conjunction with this experience, I talked with several nurses who passionately expressed concern for public health nursing’s lack of visibility and valuing by other professionals, public health administration, policy makers, and politicians on the nurses’ role in community development.

My professional interest in the topic, personal ties with nurse colleagues employed in the Department of Public Health, and my past experience as a public health nurse in the department stimulated me to embark on my study. Several of the public health nurses I interacted with were enthusiastic that I was interested in hearing what they had to say and that I would present their perceptions publicly. Subsequently in the very early stage of my proposal development, a public health nurse-friend organized a dinner party to which she invited four other public health nurses whose experiential knowledge and insight on the topic she valued. The session was instrumental in validating the relevance and complexity of the issue for public health nurses, allowing me the opportunity to build my connections and rapport with “insiders” and giving direction to the research methods.

As my research proposal developed, another dinner party was planned with the same nurses who critiqued and elaborated on my study design. The logistics, and political and ethical delicacies of how to enter the system were also discussed. One of the nurses in this dinner group went on to participate in the study. Erickson (1988) identified entering the system as a complex and ethical process that proceeds from the initial contact to the final write-up of findings, intrinsically linked to the development of trust and rapport. This initial contact with the front-line workers who could be the participants in my study gave me initial “gatekeeper” permission to proceed with the project. This “kitchen table” dialogue with a few of the nurses in the Department of Public Health was fundamental to the study proceeding.

**Participant Selection**

Ethical considerations were threaded throughout the research process and began prior to my entering the system. Participant selection is an integral and critical part of any research study. At the outset, bias can be instilled into the study design and effect the credibility of the findings (Hammersley & Atkinson, 1995; Kvale, 1996; Patton, 1990; Miles & Huberman, 1994). I was aware of this in approaching my setting, yet I was aware pragmatically that I needed participants. Issues of access, building trust and rapport, honesty, mutuality, ethics,
and my subjectivity were paramount considerations as I entered the Department of Public Health. Furthermore, establishing my credibility as a "trusted" person, nurse, and researcher was critical in this inquiry.

Before embarking on participant recruitment and data collection, approval was obtained from my OISE/UT Thesis Advisory Committee, the OISE/UT Ethical Review Committee, and the municipal Department of Public Health Research Review Committee where the study took place. After permission was obtained from the Department of Public Health Research Review Committee, I met with the Director of the Clinical Teaching Unit within the department to discuss my study design and to clarify, elaborate, and verify my data collection process and the recruitment of participants. Through the co-operation and co-ordination of the Director of the Clinical Teaching Unit, I sent a Letter of Introduction (Appendix A) and a flyer, which described the study and details of the recruitment meeting, to the Directors of Nursing and the Nurse Managers, asking to meet with them and interested public health nurses to present and discuss my study. I was invited to visit six of the seven district offices across the municipal health areas to meet with interested public health nurses and elaborate on the study purpose, procedures, and implications. At that time, I distributed the Letter of Introduction and obtained consent from the nurses interested in participating (Appendix B). Several public health nurses attended the recruitment sessions in each of the district offices visited.

The fact that the nurses were mistrusting of how their practice might be represented through my research motivated me to be as honest and clear as possible about the purpose of my study, my definition of community development, the study design, and who I was as a researcher. Erickson (1988) advises that in qualitative research, "the basic principle is to protect the particular interests of especially vulnerable participants in the setting" (p. 141). It is suggested that the researcher be as explicit as possible about the uses of the information and access to it, because it is in the best interest of rigour and the establishment of high trust and rapport in the beginning of the research (Erickson; Glesne & Peshkin, 1992). Honesty and mutuality are also advocated as criteria for establishing rigour in feminist research (Hall & Stevens, 1991). Hall and Stevens argue that being honest and not holding hidden agendas is closely aligned with mutuality and decreasing the power inequities between the researcher and the participants.
My tendency was to be as explicit as possible such that trust and rapport would develop with the participants. I viewed the public health nurses as vulnerable due to their previous research experience and their position as a predominately female, professional group, subject to androcentric bias and hierarchical control in their bureaucratic workplaces. This perception was validated by several accounts: my own experience, discussions with public health nurse friends in the department, and in scientific literature. I was also aware that the written representation of a culture or a selected aspect is a political act that carries a serious intellectual and moral responsibility on the part of the researcher joining the fieldwork and culture (Van Maanen, 1988). Erickson (1988) notes that research participants' "personal and institutional reputations are at stake in their portrayal by the researcher in the report" (p. 154). Stacey (1988) also cautions that ethnographers need to be vigilant about the exploitation of the participants with the greater intimacy expected in a reflexive research process. One of the key principles in feminist research is to foster their empowerment and to establish trust in the research claims. The process of creating a dialectic between the contradictions presented by the participants and synthesis of these perceptions, which is a principle of the feminist methodology in this study, can be stressful and threatening to the participants. For all of these points, I was mindful of balancing the need to protect the nurses in their vulnerabilities and not be exploitive with being true to the principles of the study methodology. I also did not want to create unnecessary stress and expectations as a researcher, but to engage in a reciprocal, reflexive process to the extent possible that would benefit them, myself, other public health nurses, and knowledge development in nursing.

I believe that other factors, in addition to the ones previously mentioned, contributed to my participant selection process and the obtaining of participants. I had worked as a public health nurse in the department and retained a good reputation. I had received support from public health nurse peers and friends in the department, and also had some "insider" knowledge of the department. The fact that I was an "outsider" to the system may have been perceived by the nurses as some "safe" distancing from their everyday reality. Additionally, I explained that I would not intrude in their established relationships in the community and with co-workers. The nature of the study, methods of data collection and analysis, and ethical considerations were discussed. I also provided a broad definition of community development that allowed the nurses to see their practice represented. This last point was one of the issues that accounted for most of the dialogue in the sessions to allay suspicions that I did not have a
hidden agenda with a fixed definition of community development that excluded public health nursing or devalued their practice.

"Purposive sampling" was used to select participants. The power of purposive sampling lies in selecting information-rich cases for more in-depth study (Patton, 1990). My aim was to obtain maximum variation in my participants, with nurses working across the district offices involved in various projects and programs, and working with diverse populations. I was also interested in capturing a varied nurse sample with respect to public health nursing experience and ethnic and racial identity. There is no "right" number of participants in purposive sampling. The "sample size" is determined by a combination of factors: acquiring a critical mass of information-rich cases, the researcher's time, and the number of participants who volunteer.

At the time of each district office visit, volunteers were obtained and other names were mentioned by the nurses in attendance ("Oh, you should speak to . . ."). Selection of participants through a "snowballing" technique (Patton, 1990) was encouraged if the nurses' work seemed to fit broadly as community development and if there was encouragement by a few nurses that I invite particular nurses to participate in my study. In these cases I suggested that the nurses ask the peers who were proposing to contact me. "Snowball" sampling led to obtaining most of the participants. Nurses identified other nurses and volunteered to approach them to participate in the study because they perceived them to be involved in a creative, community development practice.

**Participants**

Thirteen public health nurses volunteered to participate in the study. My choice of participants depended on the definition of community development as it applied to their public health nursing practice and their practice with women in high-risk environments. The nurses were expected to be working with adult women in high-risk environments and involved in community development/capacity building with these women, whether in a formed community group or an evolving community development process, which was focussed toward social action and social change. I used a broad definition of community development to allow the nurses to see their practice represented:

A process through which members of the community gain an increase in the control over their lives, as well as the life of the community, by achieving equal access to
participate in the collective decisions about their needs, and in the development and implementation of strategies which utilize their collective power to meet those needs. (City of Toronto, Department of Public Health, 1991, p. 2)

This community development process could occur across an empowerment practice continuum that included: (a) individual and family care, (b) grassroots community mobilization, (c) support group development, (d) community organization, (e) coalition building and advocacy, (f) political action, and (g) community service group development (City of Toronto, 1993). I have described the categories (a) to (f) according to the City of Toronto document, Community Development and Advocacy Operational Plan (p. 3).

*Individual and Family Care:*
The point at which health workers encounter individuals or families (e.g., they are in developmental transitions or those who are ill or in crisis). Activities include individual advocacy, counselling and education, crisis intervention, referral to other agencies and/or community groups, basic support, and most importantly, empathy and affirming trust. When individual and family care is done with an intention to link people together, it is a potential starting point leading to support group development and/or community organizing.

*Grassroots Community Mobilization:*
The point at which health workers encounter individuals or families as members of a community (via door knocking and other individual contact) and work with them to identify issues and begin to form community groups. Linking people together to engage in actions beyond their personal issues related to structural and social change leads to and is a part of community organizing.

*Support Group Development:*
This development occurs when group education programs evolve into self-help, peer support groups that enhance participants’ self-image as capable, worthy, and powerful. The health worker “lets go” of her/his agenda-setting and management of the group. The group begins to decide for itself its content, its process, and its relationship with the health worker. Without the support of a group, many people are unable to participate in efforts for community (broader) change, and may remain unable to participate in efforts for (broader) community change, may remain marginalized and uninvolved. Some support groups meet for very specific reasons for specific time periods. Other support groups that are initially focussed
inward on participants' needs can lead to or transform into group work or community organizing that is focused on broader structural and social change.

Community Organizing:
This strategy is used when community members want to engage in social or structural change. Many community groups may need assistance to mobilize resources effectively and to acquire the knowledge and skills required to initiate local actions and formulate political demands. Some of the community needs assessment, ongoing group development, strategy development, acquisition of funding, and to learn how to involve community members appropriately.

Coalition Building and Advocacy:
Coalition building with other community groups and organizations is often necessary if local community groups are to have an impact on decision makers within institutions and at all levels of government. The development of effective advocacy strategies is a key aspect of coalition work.

Political Action:
This stage represents the point at which elected officials and the political process itself are the primary focus for lobbying and social actions.

Community Service Group Development:
This category was developed in 1993 as an addition to the empowerment continuum. Community service group development pertained to the provision of discrete services to community groups to mobilize resources and acquire knowledge and/or skills that would enable them to sustain their local service (personal communication with public health nurse in the study).

Data Collection Procedures
Once the nurses consented to participate in the study, I arranged to visit them at a location of their choice for either an interview and/or participant-observation. In-depth interviewing, participant-observation, and document analysis were the primary ethnographic methods employed to generate data. I adopted a deliberate and intuitive openness to the public health nurses' social reality, where everything was the subject matter of the inquiry. To ensure that relevant issues were addressed and to stimulate discussion, a set of specific issues/questions arising from the research questions described in Chapter One were used to
elicit the specific experiences, feelings, and situations that were most meaningful to the public health nurses. These research issues and questions (Appendix C) were informed by relevant literature and initial discussions I had with public health nurses in the Department of Public Health about my study purpose, design, and issues around the topic. However, the research questions did not remain static, and the data collection and analysis were dynamic and evolving. I tried to be flexible and critical in questioning my assumptions and perceptions through the research process to "make the strange familiar and the familiar strange" (Erickson, 1988). This stance allowed me to achieve a greater sensitivity and depth of understanding of the context and the contextual meaning of the data. It allowed me to uncover, to a greater extent, the public health nurses' taken-for-granted tacit knowledge and the social and political factors in their day-to-day experience.

The following discussion includes the specific data collection methods and a table that summarizes the methods I used and their credibility as strategies to ensure rigour in the research process.

**Interviews**

My methodological approach of this study warranted in-depth, repeat interviews and an open and flexible approach in using directive and non-directive questioning. Feminist researchers are challenged to develop a conversational style in interviewing that goes beyond standard vocabulary in how we interview, listen, and analyse (Devault, 1990; Oakley, 1981) and to repeat interviews for deeper understanding (Lather, 1991). It is understood that listening needs to be disciplined, personal, and sensitive to difference, to see beyond the words so that space can be created for respondents to give accounts rooted in the realities of their lives. Oakley notes that there is "no intimacy without reciprocity" (p. 49). According to Kvale (1996), interviews are living conversations that are viewed as construction sites of knowledge, characterized by conversation (which moves toward partnership between the researcher and the researchee and negotiated meaning of the situated reality), narrative, language (which is both the medium of knowledge and outcome), context, and the view that knowledge is interrelational and interwoven in webs of networks. Transcripts are, therefore, considered narrative texts that are co-authored.

Thirty taped interviews were conducted over 14 months with 13 public health nurses (approximately 58 hours). After the initial interview with each public health nurse, the degree
to which nurses’ professed practice coincided with the core dimensions of community development theory and practice became more obvious. Based on this, although all nurses were interviewed at least twice, additional interviews (three to four) were conducted with four nurses. The interviews took at least two hours with all but one of the participants. In this one case, the interviews were approximately 30 to 40 minutes in length.

Consistent with the feminist perspective in this study, depth-probing was pursued throughout the data collection process. I used a Reflective Practice Guideline as an additional resource to guide this process (Appendix D). This data-gathering process was integrated in the study to enhance the dialogue, reciprocity, and negotiation in engaging the participants in critical self-reflection, which was anticipated to expand the nurses’ understanding, to enrich the data, and build mutual trust (Fonow & Cook, 1991; Lather, 1991).

Demographic information, i.e., education, length of years in public health nursing, was obtained during the interviews. Racial and ethnic origins were obtained if the nurse disclosed the information during the interviews. The interviews were audiotaped. Taping was not possible during informal and impromptu questioning, conversation, and activity as the context was not convenient for practical and/or ethical considerations. Field notes were made immediately following such events. Observations were also recorded in field notes. Although the audiotaped portion of the interviews was 90 minutes in length, most participants continued talking once the tape stopped. Each participant received a written copy of their formal interviews to read and comment for accuracy and clarification of meaning. I discussed with them the themes that emerged and points of clarification and elaboration in subsequent interviews.

Participant-Observation

Participant-observation is a process of "being a part of social setting . . . learn[ing] first hand how the actions of others correspond to their words; see[ing] patterns of behaviour; experience[ing] the unexpected, as well as the expected; and develop[ing] a quality of trust with your others that motivates them to tell you what otherwise they might not" (Glesne & Peshkin, 1992, p.39). It provides a credible way to be part of the context and further build rapport.

There were 76 hours of participant-observation, with approximately 16 hours of direct involvement in the public health nurses community development activities and approximately
60 hours of participant-observation with several public health personnel at the staff nurse and administrative level in the department. Three public health nurses volunteered to allow me to be present with them in their community development activities. The activities consisted of attendance at a Healthy Beginnings nutritional and support program, a seniors’ coalition meeting, and a pre-natal educational session. Participant-observation ranges across a continuum of roles from strictly an observer role to the role of a full participant. I was prepared to begin as an observer and move along the continuum based on the context of the situation, my comfort level, judgement of myself and that of the public health nurse, and the role involvement that best allowed me to explore and understand the nature of the public health nurses’ practice. Some situations allowed me to participate more actively than others.

Additionally, data were obtained through informal conversations with several public health nurses in the department, formal and informal interviews with administrative consultants in the Clinical Teaching Health Unit in the department, and participation at celebratory, educational, and social events, public health nursing coalition meetings, and community health nursing conferences. These data served to corroborate and challenge the study participants’ reports, allowing me to broaden my perspectives on the public health nurses’ complex, cultural practice.

Document Review

Selective document review and analysis was conducted as deemed relevant to answering the study questions. Some of the key documents are outlined as follows: relevant Ministry of Health documents, i.e., Mandatory Health Programs and Services Guidelines, 1989, 1997; policy papers for the city, DPH, i.e., Community Development and Advocacy Operational Plan (1993), policy statement on Community Development (1991); program guidelines and tools, i.e., Program Focus, Community Development Evaluation Practice Tool, Program Activity Reporting System (PARS): descriptions of public health nursing programs, i.e., Growing Together, Healthy Beginnings, Community Program for Low Income Women; the city Mission Statement (1991); Fact Sheet of Public Health in the City Since 1990 (1997); conceptual frameworks, Values and Beliefs about Public Health Nursing in the City (1990), Reproductive Health Program (1993); Public Health Nursing and Educational Services Program Priority Areas (1996).
I intended to obtain guided reflective journals using the Reflective Practice Guidelines (Appendix D) from at least two public health nurses. I saw this exercise as a valuable resource in gaining more insight into the intersection of the personal and social for the public health nurses, as it could highlight critical experiences, the organization of experiences, use of imagery, use of language, ambiguities, anxieties, interests, and the minutiae of day-to-day social action (Hamersley & Atkinson, 1995). Although the nurses expressed an interest and willingness to complete the journals, the exercise was not tenable in their heavy practice schedule. The content was captured, however, through our repeat in-depth interviews and discussions within the participant-observation activities in which I used the questions of the reflective exercise as a guide for the dialogue.

**My Process Notes and Reflective Journal**

Process notes and a reflective journal were kept throughout the research process to record and critically reflect on my observations, intuition, feelings, interpretations of the data, the social and political realities, and on my activities through the research process. Use of the reflective journal allowed me to be reflexive and to situate myself in the research by having a "critical eye" in identifying frames of interpretation and biases I held that could influence data collection and analysis. Specifically, following the fieldwork experience, I recorded key phrases; any "ah-ha" experiences; the nature of the interaction-time, context, process; features of reflexivity and reciprocity with the participants and the data; apparent inconsistencies and contradictions within the process and between the various participant interactions; and possible themes and relationship to theory, metaphors, and key story lines.

Table 1, which follows, summarizes the data collection methods and some of the strategies used to ensure trustworthiness and rigour of the data.
### Table 1

**Summary of Data Collection Methods and Strategies to Ensure Rigour**

<table>
<thead>
<tr>
<th>METHOD</th>
<th>PURPOSE</th>
<th>METHOD OF RECORDING</th>
<th>STRATEGIES TO IMPROVE RIGOUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview</td>
<td>-trust building</td>
<td>-audiotapes</td>
<td>-repeat interviews</td>
</tr>
<tr>
<td>58 hours</td>
<td>-demographic profile</td>
<td>-transcripts</td>
<td>-sharing typed copy of transcriptions and field notes with participant.</td>
</tr>
<tr>
<td></td>
<td>-to describe public health nurse work process in their words.</td>
<td>-my personal journal notes</td>
<td>-critical analysis of personal journal, participant data and the literature</td>
</tr>
<tr>
<td></td>
<td>-identify relevant opportunities/community development activities for observation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-establish permission from public health nurses to observe these activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant Observation</td>
<td>-trust building</td>
<td>-audiotapes (as appropriate)</td>
<td>-building thick description</td>
</tr>
<tr>
<td>16 hours</td>
<td>-expand depth of data</td>
<td>-field notes</td>
<td>-verification by participants of their data</td>
</tr>
<tr>
<td>(with PHN participants)</td>
<td>-develop greater awareness and sensitivity to cultural context and meaning</td>
<td>-transcripts</td>
<td>-critical analysis of personal journal notes with participant data and the literature</td>
</tr>
<tr>
<td></td>
<td>-expand tacit knowledge</td>
<td>-my personal journal notes</td>
<td></td>
</tr>
<tr>
<td>60 hours</td>
<td>-trust building</td>
<td>-field notes</td>
<td>-critique and corroborate primary data sources</td>
</tr>
<tr>
<td>(with several DPH staff nurse &amp; administrative personnel)</td>
<td>-expand the data</td>
<td>-my personal journal notes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-develop greater awareness and sensitivity to cultural context and meaning</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-corroborate and challenge primary data sources</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-learning how accounts correspond with words</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document Review</td>
<td>-gain insight into how the community development process is described and valued in the DPH.</td>
<td>-review select documents and note comparison to public health nurses' self reports</td>
<td>-building thick description</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-review, compare and analyse with other data sources.</td>
</tr>
</tbody>
</table>

**Data Analysis and Interpretation**

I support the view that in a feminist inquiry a dialectic and rigorous interaction ought to exist between data collection and data analysis to shape the study as it emerges to reflect the complexity of reality and establish trustworthiness of the study findings (Hall & Stevens,
One of the realities of data collection and data analysis is that it is endemically a selective process in which the researcher and the participants selectively determine, consciously or subconsciously, what data will be obtained and the approach to analysis and interpretation (Kvale, 1996; Miles & Huberman, 1994). Miles and Huberman caution that the “challenge is to be explicitly mindful of the purposes of your study and the conceptual lens you are training on it—while allowing yourself to be open to and reeducated by things you didn’t know about or expect to find” (p. 56). Further, Sandelowski (1995) argues that:

Among the most common and serious violations of rule are premature analytical closure and a tenacious and (often unrecognized) commitment to some a priori view of the phenomena under investigation. Among the most common and serious violations of the spirit are cookbook applications of techniques and lack of imaginative play. (p. 371)

I was as vigilant as possible in critiquing my conceptual lens to be representative of the nurses’ social world, to avoid elite bias that is hearing only articulate, well-informed participants, and “going native” (Miles & Huberman). I was able to counter the possibility for elite bias by taking opportunities to interview and converse with other public health nurses and administrative personnel and to participate in department functions and relevant professional outside events. The principles of shared interpretation, maintenance of contextual integrity, and constant comparison guided the data analysis process (Kirby & McKenna, 1989).

Another important issue in qualitative research is how to make sense of large amounts of data and to communicate in a credible way what the data reveals (Miles & Huberman, 1994; Patton, 1990; Sandelowski, 1995). It is generally accepted that there are no standard methods of text analysis but general approaches that draw on the craftsmanship of the researcher. Data preparation and analysis is considered a mechanism for organizing and processing the data to allow a way for data analysis and interpretation (Miles & Huberman; Sandelowski). A variety of approaches to analysis and interpretation, consistent with the study purpose and methodology, were applied in this study to generate meaning and to establish rigour, i.e., Hammersley and Atkinson, 1995; Kvale, 1996; Lincoln and Guba, 1985; Miles and Huberman; Sandelowski.

I was challenged in this process by the need to obtain a sense of the whole and to recount the story of each nurse’s “practice reality.” Further challenges involved
decontextualizing the various aspects of practice into narrative themes and reconstructing the individual stories into a collective, into an abstraction that incorporated them with other experiences, and yet remaining true to the multiple stories of the nurses' practice and the subjective epistemology of this feminist study. I do not believe that there is one public health nursing practice. However, I do hold that there are general roles and activities that are described for public health nurses in government-funded public health agencies. Therefore, it is reasonable to argue that there can be a high degree of similarity of identified practice issues within public health nursing work to reconstruct a collective story.

Furthermore, inherent in this thematic analysis were other questions (Love, 1994): What is a theme? How do I voice a theme? What stories do I relate? How do I relate the stories in a way that preserves "the messy complexities of the practice world, the significance of relationships, the importance of timing and context, and the crucial role of experience for acting skilfully in complex situations" (Smith Battle, Drake, & Diekemper, 1997, p. 76). How do I respect the synergistic relationship of the public health nurses with their women clients/community members, their community resource network, and the social relations of the larger social, economic, and political contexts? I was also aware of my partial knowledge of the situation, and the privileged and ethical position I held as a writer of their stories. I reconstructed their stories to mediate meaning between their voices, myself as researcher, the scientific community, and the community at large.

To some degree, preliminary analysis began immediately in the data collection process itself with clarification of meanings and interpretation as the interviews and participant observation proceeded. Kvale (1996) contends that "interpreting 'as you go'-considerable parts of the analysis are 'pushed forward' into the interview situation itself...the ideal interview is already analysed by the time the tape recorder is turned off" (p. 178). Hammersley and Atkinson (1995) note that analytical concepts often arise spontaneously from the participants as "folk" terms which can be used later in developing the analytic framework.

Analysis continued with listening to the taped interviews, as I read and reread the transcripts and reviewed notes on the participant observations and journal entries to understand emergent themes. I noted comments, queries, and feelings in the margins of the transcripts, underlined and set aside key phrases and salient quotes, noted reference to relevant literature and other data sources, and built theoretical and reflective memos for future analysis. A main objective through the analytical process was to obtain a sense of the whole
before going into deeper analysis across the participants' data. Preliminary coding was started in which codes were given to units of meaning, which either related to the research questions or were close to the nurses' words, or both, and represented the smallest piece of information that could stand alone (Miles & Huberman, 1994). In subsequent fieldwork, through interviews, and participant observation, I took the lead from the nurses' interpretation of their transcripts and their analysis of the practice situations that I attended. The nurses reviewed, validated, and interpreted the data through research process.

After I completed preliminary analysis, secondary or more in-depth and disciplined analysis followed and consisted of several steps. One of the first and key steps was returning to the raw data and the theoretical and reflective notes. This step was done to catalogue and interrogate the data for a sense of the whole by extracting the facts to describe the nurses more contextually and connect the decontextualized or smaller pieces of data to "the whole in which they were embedded" (Sandelowski, 1995), and to portray the character of the nurses' work to make it visible (Smith, 1987). I was then able to describe more thoroughly characteristics of the public health nurses and their practice, the women clientele that they worked with, and their high-risk environments. Story lines were noted and the informational content was expanded. I then went deeper in reconstructing meanings, organizing the data into broad categorizations, and descriptive and interpretive patterns or emergent themes, thus building toward a broad thematic structure (Kvale, 1996; Lincoln & Guba, 1985; Miles & Huberman, 1994). In this process of narrative structuring, Kvale contends that, "in contrast to the decontextualizing of statements by categorization, interpretation reconceptualizes the statements within broader frames of reference (p. 193) . . . into a richer, more condensed and coherent story than the scattered stories of the separate interviews" (p. 199).

**Ethical Considerations**

All reasonable attempts were made throughout the study to enable participants to have comprehensive information about the study purpose, rationale, procedures, time involved, potential risks and benefits, and how the ethical issues of informed consent, confidentiality, and access to data were to be managed. I believe that ethical responsibility and scientific adequacy go hand-in-hand (Erickson, 1988) and that one needs to follow broad ethical guidelines and be in a flexible position to make judgement calls contingent on the context and open communication with participants (Glesne & Peshkin, 1992).
The participants signed a Letter of Consent (Appendix B) after they had read the Letter of Introduction (Appendix A), which outlined the purpose, rationale, procedures, time, commitment, potential risks and benefits, confidentiality, and access to data. These documents clearly gave the participants the right to withdraw from the study at any time without negative consequence. Pseudonyms were used to identify participant data and identifying features were altered. The participants will not be identified as a study participant in any publications or presentations of the research. All tapes of participant conversations were only heard by the investigator and the transcriber and kept in a locked file in the investigator’s home. Participants received a written transcript of their taped interviews for their review. The tapes will be erased when the study is fully completed. No specific findings will be made available to the Department of Public Health. Reasonable attempts were made to protect the identity of the Department of Public Health in which the study took place.

The participant data has been presented according to themes rather than individual cases to protect the nurses’ identity. Although there could be some risk involved for the public health nurses due to the inherent nature of the study to uncover perceived hegemonic power relations, every attempt was made to minimize the risk to the nurses while remaining true to their narratives. It was anticipated that their participation in the study may, however, benefit them by validating their practice and promoting an empowerment process. The findings would contribute to the documentation on the public health nurses’ credibility in primary health care, health promotion, community development, and, specifically their work with adult women in high-risk environments. It could also inform the education of nursing students and further the theoretical development of nursing science.

**Design Limitations**

“Limitations are consistent with the always partial state of your knowing in social research ...” (Glesne & Peshkin, 1992, p. 147). There are limitations that I want to identify here to inform the reader how to interpret my inquiry. These limitations are also referred to in applicable sections throughout the dissertation.

The study represents the views of 13 public health nurses from one Department of Public Health in an urban centre in Southern Ontario. The nurses volunteered to participate in the study and, in most cases, these nurses were also identified by public health nurse peers as being involved in creative community development activities with women in high-risk
environments. Therefore, this is an account of a select group of public health nurses who may have different perspectives to other public health nurses in the department, to public health nurses in general, and to public health management. However, it is important to note that hearing from these nurses who were involved in community development work corresponds with the purpose of the study. The intent of the study is to understand how public health nurses interpret and experience community development practice with women in high-risk environments. Insights from this study could have some generalizability in a similar context to this study design.

Another limitation is my effectiveness in immersing in the public health nurses’ everyday practice as an “insider.” I am new to feminist methodology and to an ethnographic approach. Consistent with a feminist perspective, negotiation and meaning of power in an egalitarian, nonhierarchical process with the participants is expected through the data collection, analysis, and interpretation process. I attempted to engage in this process to the extent possible in “becoming” a feminist researcher. An ongoing challenge was being sensitive to what constituted a practical and ethical reciprocal and reflexive relationship in the context of the public health nurses’ practice and my position as a doctoral researcher. The discussion in the section in this chapter on reflexivity elaborates further on my efforts to be true to the expectations of a feminist methodology.

At the beginning of this study, I fully intended to obtain “thick descriptions” of the data through participant observation, in-depth interviewing, document review, and corroboration with other data sources. The 14-month period that I was involved in fieldwork in the Department of Public Health allowed me to conduct 30 in-depth interviews with the public health nurse participants. This time in the field also provided the opportunity to see how the nurses’ community development process evolved over time and the contextual factors that influenced their community development work. However, I was not able to access the participant-observation opportunities with the public health nurses as I had originally intended. A few reasons could account for this situation. I did not live in the area under study and travelled to the setting approximately every 2 months, staying for 5 to 10 days. Participant-observation was not always easy to arrange at these times. Permission for me to be a participant observer was the decision of the nurses and the group and/or community they worked with. In some cases permission was not received. This is understandable and illustrates one of the many challenges in using this approach with marginalized populations.
Most of the community residents that the nurses worked with in their community development activities were marginalized by society. My presence could be perceived as exploitive and damaging to the trusting relationships that the nurses were developing and/or trying to sustain. I attempted to obtain as much fieldwork data from other appropriate sources to substantiate the nurses' narratives and my insights on their practice. The 14-month time frame was significantly helpful in allowing me time to establish relationships with key people in the department and to gain more “insider” knowledge. This data was invaluable in assisting me in corroborating the public health nurses’ data.

Finally, my interpretations of the nurses’ narratives is only one possible account. It is an account of a period in time, a “snapshot” of the nurses’ practice world, created by myself as the researcher and the public health nurses in the study. I respect the view that my subjectivities and values as a researcher shape the story that is told of the community development practice of the nurses with women in high-risk environments. Although sincere effort was made to seek out other data sources, my primary objective as a feminist researcher is to hear the narratives of the nurses within their discursive contexts while minimizing exploitation of them.

**Ensuring Trustworthiness and Rigour**

Establishing trustworthiness and rigour of the research process and ethnographical authority is critical, particularly for a feminist inquiry, due to the focus on reflexivity and intersubjectivity (Hall & Stevens, 1991; Lather, 1991). Subjectivity is integral to the research inquiry. A common critique of interpretive and feminist research is that “it faces the danger of rampant subjectivity where one finds only what one is predisposed to look for” (Lather). Lincoln and Guba’s (1985) four criteria for assessing trustworthiness and rigour in qualitative studies are commonly used as valid standards: credibility, transferability, dependability, and confirmability. Additional criteria are proposed by feminist researchers as more relevant and complete in evaluating research that engages in more intersubjectivity and praxis with a focus on the plurality of women’s concerns and a transformative process (Hall & Stevens; Lather). The notion of research-as-praxis takes the researcher further into the research context and, as such, is the subject of much controversy due to the reciprocal subjectivity required in empowering praxis (Lather). Lather proclaims that “the central task of praxis-oriented researchers becomes conformation of issues of empirical accountability . . . and establishment
of trustworthiness of the data" (p. 52). Hall and Stevens describe 11 criteria to assess feminist research for rigour: dependability, reflexivity, credibility/authenticity, rapport, coherence, complexity, consensus, relevance, honesty and mutuality, naming, and relationability. Several of the criteria overlap with Lincoln and Guba's schema, with the exception of what Hall and Stevens refer to as processual criteria.

The following examination uses Lincoln and Guba's (1985) criteria with the addition of Hall and Stevens' (1991) processual criteria, which are relevant for this study. I have grouped rapport, complexity, consensus, relevance, honesty, and mutuality within the criteria of reflexivity, which is integral at each step of the research process (Hall & Stevens; Lincoln & Guba; Lather, 1991).

As I reflected on my commitment to establish rigour in my research process, I was reminded by Sandelowski's (1993) caution that, as researchers, we should avoid establishing rigour mortis in our zest to establish rigour because it "threaten[s] to take us too far from artfulness, versatility, and sensitivity to meaning and context that make qualitative works of distinction" (p. 1). I attempted to follow her advice to regard the main challenge in ensuring trustworthiness of claims of truth by making my research process visible, audible, and not fixated on rules and procedures that go against the spirit of qualitative research. I was also cognizant of Lincoln and Guba's (1985) notation, "naturalistic criteria of trustworthiness are open-ended; they can never be satisfied to such an extent that the trustworthiness of the inquiry could be labelled unassailable" (p. 329). The criteria employed to assess trustworthiness and rigour are discussed below.

Credibility

The criterion of credibility pertains to the construction of credible and authentic descriptions of the research data (Lincoln & Guba, 1985) and demonstrated unity in the research account, such that the conclusions are consistent with the raw data, and the constructions of the participant's experience can be understood by the participants and outsiders (Hall & Stevens, 1991). My data collection process involved in-depth repeat interviews, participant-observation, selective document review, and my process notes and reflective journal. As previously described, secondary data sources were elicited through formal and informal interviews with other nursing personnel and field observation in several activities, which involved the public health nurses in the study, some of their public health
nurses, public health nursing management, and community resource personnel. This involvement provided a large data set that provided context-rich and meaningful descriptions that could support the credibility of the study findings.

The initial interview was focused on explaining the nature of the project; establishing rapport and trust; re-establishing my credibility as a trusted person, nurse colleague, and researcher; beginning data collection using a set of prompt-questions/issues as a guide; and audiotaping the session. Building a comfort level for myself and the nurses with the presence of the audiotape was also an issue to be resolved. Every attempt was made to ask questions in a nonthreatening and interactive manner. I was aware of the possibility that one can never be sure how questions will be perceived; therefore, I was conscious how I framed my questions. Ongoing analyses of the data guided the interview process. These involved listening to the interview tapes after the interview, reviewing the interview transcripts, and making notes of possible themes, questions, and comments. At the end of the interview, I obtained consent for repeat interview and/or participant observation and clarified that a copy of the interview would be sent in the mail. I asked for their critique of the tape for accuracy and themes they identified. Subsequent interviews built on the previous ones in which preliminary themes that we identified in the transcripts, points for clarification, and elaboration were discussed, along with other questions I proposed with respect to the research questions, validation of themes that were emerging in other nurses' narratives, and issues the nurses brought up for discussion. The nurses were given the opportunity to question and change their transcript record. Minimal changes to the transcripts were requested. Not unexpectedly, all the nurses expressed surprise at how their everyday speaking was captured on tape. I reassured them that I would be identifying and interpreting themes with their input, and grammatical corrections would be made in quotes that would be included in my final thesis report.

Similarly, persistent observation was sought in my participant-observation opportunities. Interestingly, with one nurse the observational experience happened before our first face-to-face meeting and opportunity to get acquainted. Through a telephone conversation prior to my attendance at her community development program, along with our conversation as we travelled together to the program setting, I quickly received initial information to prepare me to enter the program and to participate as a participant-observer.

"Member checking," the process of taking the report back to the informants or counterpart persons to confirm that the participants' voices are captured, is viewed as an
important technique to determine authentic interpretation of the data and, therefore, credibility (Hall & Stevens, 1991; Lather, 1991; Lincoln & Guba, 1985; Sandelowski, 1993). It is also important in alerting the researcher to problem areas and to give the participant an authoritative place in the research (Glesne & Peshkin, 1992). It is recommended that it be conducted throughout the research process. A major way to obtain validation is return of the taped interviews to the participants and to discuss the research and participant’s construction of the data. As previously noted, this step was integral to this research project. My descriptive notes and preliminary analysis of the participant-observation sessions were also discussed in subsequent interviews. Formal and informal meetings took place with the nurses to discuss and critique emerging themes. On one occasion one of the nurses disagreed with one of the thematic representations. This view was not shared by the other nurses, who strongly supported the interpretation. It was apparent that the nurse who disagreed with the abstract conceptualization of the nurses’ experiences could not see her concrete experience within the synthesis. This situation lends support to Sandelowski’s argument that member checking can be problematic for several reasons and, therefore, needs to be used judiciously, without compromising the subjective epistemology. She submits that problems arise as “stories . . . are time-bound, interpretive, political, and moral acts” (p. 5). Further, members’ stories are continually changing and may elicit feelings that they no longer have or that they wish to forget; participants and researchers may have different goals and participants may not wish to see their concrete experience synthesized in an abstract theme.

Sandelowski (1993) points out that we have corroboration of our work when the interpretations resonate with similar peoples to the participants under study. I presented some preliminary findings of the study at an international conference on women’s health in January, 2000. The presentation was very well received and the interpretations were supported by the public health nurses in attendance. In October, 2000, I presented the study findings at a national Canadian public health conference and a national Canadian community health nursing conference. Again, the conceptualizations of the public health nurses’ experiences were meaningful to several public health nurses who identified themselves to me. Some of these nurses were employed in the Department of Public Health in the study, though they were not participants in the study. As previously described and illustrated in Table 1, triangulation with the use of multiple data sources was germain to this study.
Transferability

The criterion of transferability allows the reader to judge whether the findings can be transferred to another context (Lincoln & Guba, 1985). Characteristics of the public health nurse participants, the study setting and study design, and the limitations of the study are fully described to permit comparisons and generalization to other public health nursing contexts. “Thick descriptions” are also provided for the reader to draw conclusions on the nature of the culture under study (Gertz, 1973; Lincoln & Guba). Additionally, the interactive data collection and analysis process that was conducted in this study is another way that was used to establish transferability of the findings.

Confirmability

Confirmability refers to describing the study’s general methods and procedures in sufficient depth to allow others to see the decision making process or “audit trail” leading to the specific conclusions. As much as possible, verbatim quotes of the nurses are integrated into the analysis and interpretation to meet these criteria. This method also allows the reader to see how the conclusions are grounded in the data.

This criterion is also concerned with researcher subjectivity and how personal assumptions, values, and biases affected the inquiry. Keeping a reflective journal is one way to ensure this criterion is met. Reflective and analytical notes were made through the research process to describe the methodological issues, questions, comments, directions for the ongoing research, my feelings, and intuitions. The major purpose of the journal was to critique my values and biases in the research process and to be true to the participants’ voices. As I engaged more deeply in this reflective, research process I became more conscious of the values and frames of interpretation that I brought to the inquiry. My intention is to be true to the representation of the nurses’ voices in interpreting the complexity of their everyday practice, using a critical eye to filter my biases and a variety of data sources to corroborate the data and to indicate areas of divergence.
**Dependability**

The criterion of dependability, or referred to as audibility, is similar to confirmability in that it pertains to the presence of an “audit trail.” It refers to quality control: the research questions are clear and the study design is consistent with them, the researcher role and status is described, and proper data collection and data analysis procedures are used. Detailed descriptions are provided of the study methods to allow the reader to ascertain that the research process is reliable.

**Reflexivity**

“For the (feminist) researcher, the responsibility of engaging in a more personal relationship with those researched while collecting ethnographic and narrative data and writing the interpretive research text may be as difficult as it is joyful” (Bloom, 1998, p. 2). This view resonated with my research experience throughout the inquiry. Staying true to the reciprocity, responsiveness, and reflexivity called for in the study methodology was a challenge for me in “becoming” a feminist researcher. Effort was made to be reflexive with the data and the participants in the research process, and in so doing, to reflect and question my prejudices, emotions, and interpretations. Being a woman and a nurse who had worked as a public health nurse in the department where the nurses were employed and being a community health nurse educator were salient features of my subjectivity. Through the research process, I became more conscious of my identity as a woman and a nurse. I also became more aware of my privileged position as a researcher and a tenured, university educator who had greater professional autonomy in my everyday work situation by the nature of my academic status as compared with the public health nurses.

I continually changed roles between “insider” and “outsider,” assuming an insider’s position as I immersed myself in the “lived experiences” of the nurses. My own experience as a public health nurse in the department gave me advantages of knowledge regarding the role and responsibilities generally expected of a public health nurse and allowed me to achieve a greater sensitivity and depth of understanding of the context and contextual meaning of the data. Importantly, my personal experiences gave me understanding of the public health nurses’ taken-for-granted tacit knowledge and the sociopolitical influences in their everyday experiences. I also needed to maintain an outsider’s edge to filter my prejudices.
The reciprocity and reflexivity between myself and the nurses, and for each of us separately, was evident in several ways. With most of the nurses, once the tape recorder was turned off, we continued to talk for 15 to 60 minutes. Reflexivity was notable in the interview and participant-observation process, in which more engagement took place, and as such, a different energy and free-flowing conversation evolved on second and subsequent interactions. Our interactions became more intimate, with greater attention to hearing the nurses’ explicit and tacit knowledge and allowing self-disclosure on both sides. The trusted relationship that evolved with most of the nurses enabled me to probe deeper with more sensitive questions that confronted contradictions in their expressions and stories of their everyday practice. On a number of occasions, I had to step back and look at the feelings I was investing in the process and how this influenced the research process. This process became more acute as the political situation in the Ontario health care environment imposed more constraints on the nurses’ practice and professional integrity. I identified on a personal and professional level with their situation, and as such, experienced a myriad of feelings from anger to sadness at their roles being limited, to joy on their successes. In order to convey a sense of “reflexivity” in practice, it will be helpful to include several passages here from my reflective journal because they poignantly capture the reflexivity and reciprocity in our researcher-participant dynamics.

The following passages are taken directly from my field notes. The first excerpt is one that I wrote after my second interview with Mary Lou, one of the public health nurses. The notation describes how I perceived the reflexive nature of the process and the sharing that was exchanged between us. At the time I used a metaphor “Fighting the Handmaiden’s Legacy” to capture the content of what Mary Lou was describing in the interview with reference to her position in the department.

**Interview #2**

**Mary Lou**

**Field Notes: Reflexivity**

_Fighting the handmaiden’s legacy:_

_Judging from the candidness of our dialogue on both sides, my degree of interpretation, self-disclosure, and Mary Lou’s frankness on the bigger forces affecting public health nursing work, there was a high degree of reflexivity of_
researcher with the literature, and participant. Highly energizing for me and felt we were connecting!

I obviously perceived Mary Lou’s sense of helplessness with the situation and was responding with comments that were designed to give support, hope, and challenge her to consider how she and others like her can act to test her understanding/awareness.

The questions were increasingly more provocative and challenging of the taken-for-granted and the contradictions. I was giving my affirmation of where she was coming from. She risked a lot of sharing as much as she did. It is very heavy stuff, which I am sure she would not want to be literally shared with direct reference to her that could be made.

The second field note was written following my second interview with Jan, one of the public health nurses. It reveals my impressions of our reflexive interaction, as well as the nature of the energy and mutual exchange between us.

Interview #2
Jan
Field Notes: Reflexivity

The second visits so far have been so different to the first in that there is a camaraderie, familiarness, and trust with more revelation on both sides. I think this is what the notion of reciprocalness and nonhierarchicaI is about. I do not feel or see a big distinction between me, the interviewer and her, the interviewee. There is more of a natural flow to the conversation, even though I did prepare with questions from the first interview and the fit with themes emerging in all the interviews. However, Jan did prepare too. I felt more trust in the dynamic of our conversation that the critical issues would be addressed and the new ones could emerge and they certainly did.

She gave me an additional three pages of elaboration on my questions from the first interview as she reflected on the transcript. As well she gave me a copy of the first transcript corrected.

She certainly took her involvement seriously and is an excellent example of reflection on practice and also how I am in intervention in terms of praxis and road to empowerment at the consciousness raising level.
An expected outcome of reflexivity in praxis research is the empowerment of the participants and the researcher. Heightened praxis, with increased awareness of self and their practice and contradictions with the larger sociopolitical context of their practice, was evident across many narratives. This process was obvious in their participation in the interviews and the participant-observation process and in the transcripts, as illustrated in the following narratives:

**Tracey:** It (our interview) helped me too because I've realized what my plans are. Really that was in my head but I really didn't realize them until today. I'm going to write these things down . . .

**Penny:** I'm reading this (the transcript), I'm actually learning the concrete version of what I'm doing. This is very concrete to me as to how I'm thinking. It validates where I'm at and my struggle with not fitting into the nurse role the administration wants. It's concrete now!

I'll do what I have to do to keep my job, but it's not capturing what I'm actually about. The work is not recognized. My interview with you is capturing my thinking and my practice. I was just reading it and thinking it's almost like a fight for me to do what I do to develop as a professional. I'm doing it on my own with some support from the system, but not a lot.

The following excerpt reflects the reciprocal process that occurred across several researcher-participant interactions and its empowering effect on me as an individual, educator, and researcher.

**Interview #2**

**Mary**

**Transcript: Reflexivity**

_Mary:_ At this informal network, we met you. And look what happened. As you're talking to me, yes, I wasn't even going to go to the conference. I wouldn't be thinking this if you hadn't spoken.

**Researcher:** It's this whole thing of collective energy [she noted this concept earlier in the transcript]. My doing this research was seeded by this collective energy because I wouldn't have felt strong enough being outside the system to get involved. As exhausting as it is when I come up here, I feel so energized, even though I find the
politics overwhelming. I feel hope because you as public health nurses have overcome major struggles before. As Carolyn says, convergence and serendipity will happen. You already have some natural events that you as public health nurses have laid down which will be opportunities.

Mary: We are energizing together, a collective group of peers, pretty committed over five to six years. We energize you. You energize us back. We made use of you when we knew you were doing research. We wanted to hear what you were researching. We wanted to know what was new. Then we inspired you back by just talking about what we did, what we do. We all showed up for a free meal and took the opportunity on our own time to energize you back. It helped you, but it also helped us because we love the process of sitting in a group. It feels odd to have a tape recorder. It's nice, too, because you at least don't sit there and ask those stereotypic questions, the ones on a paper and you can't ask anything else.

Researcher: Then there is the free flow.

Mary: Oh, it's wonderful.

Researcher: With the second level interviews, I have faith that we will get to the crux of what is important. I find the second interviews are a different kind of energy. It's sort of letting go and let things be and see where it goes.

Mary: Your questions are thought provoking. Sometimes we just talk and it has a life of its own.

Additionally, throughout the research process there was a nonhierarchical and respectful exchange of professional, and in some cases, personal experiences, sharing academic literature and conceptual interpretations, extending invitations to me to attend educational events and social occasions, and emotional and affirmation support. Over time, a collegial friendship developed with a couple of the participants outside the formal research process. Yet, I believe I was able to balance the intimacy of a feminist, ethnographic research approach with the distance needed to ask critical questions and ensure trustworthiness of the data. I emerged from the experience more deeply committed to a feminist world view and call to action.
Summary

In this chapter, I provide a detailed account of the feminist and ethnographic approach that guided this study. Additionally, specific methods are described: entering the system, selecting participants, generating and analysing the data, ensuring ethical standards, and establishing the trustworthiness and reflexive quality of the research process.
CHAPTER FOUR

SETTING THE STAGE

Introduction

This chapter restates the purpose of the study, presents the three meta themes reconstructed from the data, and describes the organization of the related discussions in Chapters Five, Six, and Seven. The fundamental context of this study - the public health nurses, their women clientele, and their high-risk environment - frames the discussion.

The purpose of this feminist, ethnographic inquiry is to make explicit the values, knowledge, skills, and realities of public health nurses' practice in a community development process with, and programs for, adult women in high-risk environments. My work uncovers instances in the nurses' practice that constitutes, for them, notions of community development and partnership. Issues of status, reciprocity, and responsibility are evident in the public health nurses' relations with women clients/community members and with community partners. The larger economic and social structures of health care and community settings influence the presentation of health-related concerns to public health nurses, and impose contradictions and constraints on their practice. The public health nurses create space for possibility for themselves and ultimately for their women clients/community members.

The reconstructions of the data indicate that the public health nurses play a vital role in primary health care, health promotion, and community development with women and their families living in high-risk environments. Through a commitment to the inherent principles of these concepts and a definition of health that includes broad determinants of health, they influence the achievement of health and social justice for these women and their families, who were live in health-damaging circumstances and are marginalized in significant ways. The constitution of community development for the public health nurses' practice within the "new" public health and within the social organization of the Ontario health care environment (specifically within an urban Department of Public Health) became more apparent through the study. The community development practice of the public health nurses is more complex than I thought it to be when I began this inquiry. The literature indicates that there is substantial divergence on the meaning of community development and that community development is enmeshed in varying definitions of community, health, and health promotion from numerous, and often competing, professional, and political
discourses. Furthermore, because it embodies an interactive process of change, it consists of complex relationships of individual, group, community, and population strategies and their associated power dynamics. Hearing first-hand from public health nurses what community development means both contradicted and supported the literature. Public health nurses' community development practice with women in high-risk environments needs to be understood as an interconnection of the social organization of their practice in a government-funded, public health department, mediated by the nurses' sense of agency, their interpretation and implementation of their community development work, and the women's readiness for personal and community empowerment. In my study, all these aspects co-mingled in synergistic relations of power, which allowed possibility or imposed constraints on the nurses' empowering practice with the women and their families. The examination of the nurses' experiences in relation to the larger social and political relations of power reveals that these forces exercise significant control over their practice by allowing or disallowing them to become knowers and subjects in their experience.

As I moved in a dialectic process between the nurses' transcripts, my reconstructions of their stories, and theoretical and empirical literature, three meta themes emerged: (a) Being in Community; (b) The Contested Terrain: Social Construction of Public Health Nursing; and (c) Creating Space for Possibility. These themes, which are illustrated in Figure 1, purposefully proceed from the particular and "lived reality" of the nurses' practice in the community to an examination of the difference in meaning of this practice to the nurses and to the larger structural context. This difference constructs a contested terrain for public health nursing practice. I conclude with an examination of how the nurses negotiate and mediate within the contested terrain, to make room for how they wish to practice. These themes are discussed in Chapters Five, Six, and Seven. Although the synergistic relation of the themes and sub themes of the nurses' everyday practice will be apparent, I have organized the themes into three separate chapters for purposes of analysis and discussion.

The theme of Being in Community is explored in Chapter Five. I begin with this theme because it is the most important and fundamental concept in understanding the nature of the public health nurses' community development practice. Moreover, consistent with a feminist perspective, it grounds the discussion in the situational context of the nurses' experiences with their community of women and is expressed from the nurses' standpoint. The expression "being in community" was explicitly used by some nurses, yet it echoed
Figure 1. Schematic representation of **Meta Themes**: Being in Community; Contested Terrain: Social Construction of Public Health Nursing; Creating Space for Possibility.
through all their stories, capturing the essence of the nurses' empowerment practice with adult women clients/community members. This discussion encompasses not only the way in which the nurses articulated a sense of community development, but also the manner in which their perceptions of community development were translated into strategies for their practice to foster partnership for health and social justice.

I examine the theme of *The Contested Terrain: Social Construction of Public Health Nursing* in Chapter Six. This was a consistent and dominant theme that developed a crescendo over the life of the study, as the municipal and provincial political backdrop was rapidly and constantly shifting. Salient questions on the economic and sociopolitical structures of the larger systems of health and the wider community settings are examined, with particular attention paid to the Ontario Ministry of Health, and the Department of Public Health as the nurses' employer. The participant data reveal that the social organization of these structures and processes influence the presentation of health issues, and pose constraints and challenges on the public health nurses' practice. This theme also represents the nurses' struggle to help their women clientele move toward individual and community empowerment, while they as public health nurses also struggle to attain and/or maintain integrity and to experience community empowerment for themselves.

In Chapter Seven, the theme of *Creating Space for Possibility* is explored. Creating space transcends the micro and macro contexts of the nurses' practice. The nurses' integrity and practical knowledge, and consequent ability to create space for their vision of their practice emerge as critical to their ability to discern and name situations, to design strategies, and limit and/or negotiate the constraints on their practice.

The vast literature on community development spans several fields of study, is complex, at times rhetorical, sometimes political, and at other times out of step with the realities of day-to-day public health nursing. The public health nurses' perspectives and stories of their community development practice differ from some of the acclaimed literature on community development. Clearly, as a researcher I have a role to play in interpreting what the nurses are saying, contrasting it with credible literature, and in identifying and organizing themes. I have chosen to handle the reconstruction of the data in the following way. In Chapters Five, Six, and Seven when the three meta themes are examined, I present them first from the standpoint of the public health nurses, a standard interpretive and feminist practice. Following this discussion, a synopsis of what the nurses said is given and contrasted with
empirical and theoretical literature. In Chapter Eight, I discuss final reflections and implications for practice, education, and research. Interview data is offered throughout the discussions on the themes to enable the reader to obtain a sense of the nurses' descriptions and the context of their practice. Some segments from their transcripts are repeated for different dimensions of analysis.

To understand the nature of the nurses' practice and their involvement in community development processes, it is necessary first to understand the context of their practice, as this is the main function of this chapter. A fundamental element of this study is to understand the conditions in which the public health nurses' women clients/community members lived and in which the nurses practice. Additionally, it is important to have a perspective on the public health nurses themselves, including a general overview of their everyday practice. In the following section, I profile the public health nurses in this study, and examine how health issues and problems are presented and understood by them. I follow this discussion with a profile of the nurses' women clients/community members and their high-risk environments.

The Fundamental Context

The Public Health Nurses and the Presentation of Health Issues: District Nursing

Introduction

The present study focuses on listening to the nurses' voices, and recognizing the value and relevance of what they say about the visible and invisible nature of their practice. Understanding the nature of the public health nurses' community development practice can be assisted by understanding the practical context of the nurses' work: how it is structured and how the nurses are expected to function within this structure. This section offers three perspectives. First, it offers a general profile of the public health nurses who participated in the study. Second, the notion of district nursing as it is constituted for the nurses in this study is explored, including the administrative structure and process of work assignments. Included here is a profile of the common and unique aspects of the nurses' assignments. In some cases, I have specifically described the nurses' community development programs, while in other cases I have collated the programs/projects and spoken about them collectively. Finally, building on this description, I explain how the public health nurses in the study describe the presentation of health issues in their everyday practice.
Public Health Nurses' Profile

Through the process of purposeful sampling, 13 public health nurses volunteered to participate in the study. The public health nurses had from 2 to 30 years of nursing experience with the municipal Department of Public Health in this study, with an average of 13 years of practice. Eleven of the nurses had greater than eight years of public health nursing experience with the Department of Public Health, and came to the department with prior experience in other areas of nursing and health care. Two nurses had two and three years' experience, respectively, with the department and no previous nursing experience. However, they did have other work experience.

At the time of the study, 12 of the nurses practised as district public health nurses. One nurse was a mental health nurse-consultant who conducted independent practice and acted as a resource to the public health nurses in three district offices in one of the designated district health areas in the department's organizational structure. She worked alongside the public health nurses in their district work; however, she was given more freedom to define her practice. She identified herself as a public health nurse/mental health nurse and saw herself as a legitimate participant in the study. Prior to her two-year assignment as a mental health consultant, she worked as a public health nurse for eight years with the Department of Public Health.

All the nurses had a baccalaureate degree in nursing, and two had Master of Nursing degrees. Two of the nurses had held managerial positions for up to two years in public health nursing programs with the Department of Public Health. One nurse identified her racial origin, while another nurse described herself with reference to her ethnic identity. My original intent in selecting a sample was to obtain public health nurses from a range of racial and ethnic identities.

District Nursing

At the time of the study, the nurses worked in generalist practice, commonly understood as district nursing or neighbourhood nursing. This is not only a way to deliver services in geographic teams, but also a philosophy of public health nursing that focuses on the whole community, addressing health issues across the life span. Two months before this study commenced, the nursing division of the Department of Public Health returned to
district nursing from program-focus nursing. The issue of specialization, or program-focused nursing, which narrows the focus of community nursing, had its origins in the mid 80s, with directives from the Ontario Ministry of Health, Public Health Branch, that they would provide program-based funding for provincial health units (Underwood, Woodcox, Van Berkel, Black, & Ploeg, 1991). Several factors have been identified to justify organizing public health nursing in a program-focused practice. These factors include: narrowing the focus of nursing allows for greater in-depth knowledge of a particular clinical population, allows for integration of theory and research into practice, reduces the multiplicity of clinical demands and role strain, and meets the public's demand that public health nurses be knowledgeable about health issues (Underwood et al.).

Programs in program-focused nursing in the Department of Public Health were clustered according to their common purpose, for ease of planning, management, coordination, and delivery. Within program-focus, activities were organized in six program foci: Healthy Parents/Healthy Children (zero to four years of age), Healthy Children and Adolescents (5 to 19 years of age), Healthy Adults (20+ years of age), Communicable Disease Control and Screening, Environmental Health, and Oral Health. The public health nurses in this study were assigned to the first three foci. Only nurses in the Healthy Children and Adolescents program had school assignments.

With the return to district nursing, all the nurses were expected to assume at least one school attachment, along with other district nursing assignments. Within district nursing, a broad approach to caring for the community and "being in community" was taken. The nurses' practice included a wide range of assigned and innovative work. In some situations community was very clearly defined, usually in geographic terms, while in other situations it was diffused, and defined relationally and contextually around a health issue and/or special population such as nutrition and support programs for pre- and post-natal women, and street outreach.

As previously described in Chapter One, the roles of the public health nurses in district nursing can vary depending on the nurses' interests, skills, and the community issues. The nurses' practice was also influenced by the directives from the Ontario Ministry of Health and the Mandatory Health Programs and Services Guidelines (MPHSG) (1989). In this study, similarities were common across the nurses' assigned practice, with the exception of the mental health nurse, who was not assigned to schools or hospital health service. The
nurses worked with individuals, families, groups, and communities across a broad range of practices: individual and family developmental case work, which took place in the home; health centres and other agencies; liaison and service coalitions; school assignments; programming for aggregates; small group development; coalition building; and political advocacy. In addition, some nurses were involved in research endeavours and committee work related to their practice.

The nurses' activities within their practice assignments were diverse: program creation, planning, implementation, and evaluation; teaching activities, group work, making referrals, networking, consulting, counseling, negotiating, advocating, and community planning. A basic expectation was that the nurses would strive to establish mutuality with their women clients/community workers in their assignments, consistent with the provider-as-partner and "power with" principle of a health promotion/community development practice, rather than "provider as expert" and "power-over" approach (Labonte, 1990).

All the public health nurses in this study were assigned to at least one school, individual and family case work with diverse populations in the home setting, nursing team management responsibilities, and a variety of other practice activities. Most of the nurses were involved in a rich variety of innovative liaison and group practice with various disciplines and community agencies; some of these activities were designated by nursing management as community development programs. The nurses helped initiate and develop several of the programs as a result of their determination to push the boundaries of their traditional assignments to coincide with their values and vision of a community development practice.

In addition to their individual and family case management in the home setting, their practice took place in street outreach, a shelter for abused women, a senior citizens' housing complex, school assignments, individual and group pre-/post-natal nutrition and support programs, women's drop-in centres, and community parenting programs: "When Baby Comes Home" (newborn to six months), "Nobody's Perfect" (two to four years), and "Ready or Not" (8 to 12 years). All the nurses had clients who were participants in the department's "Healthiest Babies Possible" program, a one-to-one nutrition and support program offered in a home setting to women on social assistance who were at less than 28 weeks gestation. A dietician and a public health nurse would visit the women. The dietician would do "24-hour recalls" with them, and assess their diet and recommend appropriate changes. Milk coupons
and vitamins could be given. The public health nurse would be involved in counseling and referral on psycho-social, financial, housing, and other issues; pre-/post-natal teaching, building social connections in and outside the home; in many cases promoting Children's Aid as a resource; and referring to the "Healthy Beginnings" nutrition and support programs. The program ended after the first post-natal visit by the public health nurse.

**Community development programs.** Some of the unique characteristics of the multiple activities the nurses engaged in daily, which were explicitly defined by the nurses as community development programs or projects, require emphasis here to further contextualize the nurses' practice and to enhance understanding of the themes that emerge from their stories. These descriptions include the nurses' activities in liaison attachments to women's centres, a high school, and participation in a series of pre-/post-natal nutrition and support programs; the "Growing Together" research project, the "Community Links" program for low-income women; and a seniors' community action project.

Three of the nurses were assigned to women's centres, which provided a safe haven for women from violence and provided numerous resources to overcome the health-damaging circumstances of their high-risk environments. The first of these centres was a grassroots organization that provided a safe haven and a gathering place to protect women against violence, but not in the capacity of a shelter. The centre served a large population of women who were without partners and raising children on their own, who may have been abused or victimized, disadvantaged, with limited supports, problematic children, social or mental health problems, or requiring multiple services in the community. The women came from all over the municipality and tended to be regular attendees. The program provided hot meals, legal and social services, tangible aid in the form of food banks and clothing exchanges, play opportunities for children, advocacy work through letter writing campaigns to politicians, links to multiple community services, professional literature, and a newsletter. The centre consistently functioned within a very tight budget and often changed location because of limited funds. Most of the funding was received from private sources, and some came from the United Way and the city.

One of the nurses participating in this study was involved in a privately funded shelter for abused women and their children. The nurse described the shelter as one which was "always under the gun" due to its precarious funding base. At the time of the study, it
had been open for three to four years, providing 24-hour, intense case-management care. It could accommodate 33 people who could stay up to two months. The program provided a safe environment where the women connected and received support from each other; with counselors from a variety of ethnic and professional backgrounds; with housing, legal aid, and social services personnel; and with other health and community services. The nurse was mainly involved in individual counseling and education around various health issues, advocating on behalf of the women with other professionals, and creating and linking the women with other community resources.

Another nurse was involved with a drop-in centre for low income women and an outreach program for socially isolated women living in rooming houses, boarding homes, and on the street. The organization's strict policies on confidentiality, non-discrimination, and anti-racism provided protection for participants. The centre was open daily and provided a safe place to go during the day. It offered information and referrals for emergency shelter, education, legal aid, employment, doctors, therapists, housing, welfare, and drug and alcohol treatment; crisis intervention; practical help, such as hot lunches, haircuts, laundry, and shower facilities, telephones, condoms, some clothing, and access to a nurse and a dentist; and some structured and unstructured recreational programming. Outreach group participants met one afternoon per week, and transportation was provided for those who required it.

Three of the public health nurses in this study were assigned to what is commonly called Healthy Beginnings programs, which are pre-/post-natal nutrition and support group programs, or food supplement programs for pre- and post-natal mothers. All programs were interdisciplinary, with the public health nurse as an essential participant. Two of the Healthy Beginnings programs were similar in program design. They were joint ventures of the Department of Public Health, the metro food bank, and the community health centres, respectively. In addition, one of the Healthy Beginnings programs received Brighter Futures Federal funding. With their goal of healthy parents-healthy children, the programs promoted nutrition and supportive-educative activities to high-risk pregnant women, utilizing a community development approach to program planning. The programs were held once a week, and included public health nurses and a dietician who educated on diverse topics related to pre-natal care, labour and delivery, breast-feeding, baby care, social services, nutrition, food demonstrations, and some craft work. There was also access to a clothing bay, and the food bank provided food vouchers for milk, bags of food, and transit tokens. The
programs could have 30 to 60 women attending weekly. Most of the women were pre-natal, however, post-natal women were permitted to attend for up to three months. Both programs had advisory committees in which one of the public health nurses or dieticians, and/or public health nurse manager attended. The programs provided educational literature in several languages and had interpretive resources available to the program.

The third project had unique features that identified it as an exceptional model for pre-/post-natal nutrition and support programs. It was a collaborative community development project of a women's health centre, Creating Together Parent-Child Drop-in, and the Department of Public Health. In 1993, the project received funding from Health Canada's Community Action Program for Children (CAPC) and underwent evaluative screening in 1999. The program served pregnant women and families with young children who were socially isolated, economically distressed, and lived in the catchment areas of the health centre and the Department of Public Health, Western Health Area, particularly for residents of the South Haven community. The project evolved from the need identified by community residents and agencies, and was based in a population health approach and community development philosophy of practice, with the motto "it takes a whole village to raise a child." The South Haven community was reported to have an increasingly high proportion of low income families living in poverty: 80% of the women and their families lived on less than $18,000 per year; two thirds spent more than half their incomes on rent; over 80% of the women served were born outside of Canada and were recent immigrants, most of whom did not speak English; one in four had a history of abuse; and two thirds had a high school or post secondary education but could not find work because of racial, language, cultural, and financial barriers and lack of affordable day care. The project utilized multiple resources to meet their objectives: full-time coordinator, outreach worker, child care and parent relief staff, interviewers, and a pre-natal educator. Staff from partner agencies included four public health nurses, a public health dietician, community development workers, health promoters, community kitchen facilitators, secretarial and clerical support, counsellors and therapists, and program managers and directors. The program also interfaced with other municipal and provincial community agencies and personnel, and had an advisory committee.

The program offered a wide range of accessible, supportive, non-judgmental primary health and child care services through three program options: (a) the South Haven Pre-/post-
natal Nutrition and Support program, which provided health and social support services, and food supplements to pregnant and post-partum women. The public health nurses' main role was exercised here. (b) The Parent Relief program provided respite for children of parents under stress. (c) The participant-responsive activities provided support such as assessment, counselling and teaching; assisted referrals to public health nursing, medical care, Healthy Babies Possible program (for women under 28 weeks gestation), and other supportive community resources. These supportive resources included: crisis intervention and advocacy; material assistance of emergency food help, clothing, baby supplies; compassionate visiting when hospitalized at the hospital in the catchment area or entry to a women's shelter; and supportive accompaniment to medical providers, legal centres, and parent-child drop-in centres to individuals and groups of pregnant women, and parents with young children. There were several group services and supports, such as on-site child care, educational sessions, parenting support programs, and community celebration events. There were many reported benefits and outcomes for the women and their children, i.e., for the women - increased knowledge, support service use, and breast-feeding; for the babies increased gestation (about 37 weeks) and increased birth weight. All outreach program descriptions and educational resources have been translated into the five major languages used in the South Haven community: Spanish, Tamil, Polish, Vietnamese, and Portuguese.

Another unique program for low income women, which one of the public health nurses was involved in at the time of this study, was the Community Links program. This program was a coalition of eight agencies in the city, which received federal money. The public health nurse acted as a consultant to the program and assisted the women participants in building their resources and networks, training them to run programs to enhance self-concept and physical fitness, and at their request, helping them to write proposals for new funding. Many of the women had been participants in an earlier model program that the public health nurse facilitated to enhance the self-concept and physical fitness level of disadvantaged women in the metropolitan area. Although the original program was developed and implemented through the Family Services Association, this particular public health nurse piloted the program through the Department of Public Health.

The program had five components: (a) an introductory session to set achievable goals, (b) weekly meetings to teach fitness tips and activities, (c) home fitness options for participants to do on their own with the encouragement of the buddy system, (d) child care to
make the program more accessible, and (e) a final meeting to celebrate achievements and establish ongoing goals. The program consisted of 12 sessions, with each being divided into warm-up, learning, activity, and support components. In order to serve all the participants' fitness needs, the program focussed on three aspects of wellness: physical, psychological, and social. Program costs were kept at a minimum by enlisting volunteer fitness instructors and child care workers, and by encouraging low income women to assist with program design. The program was very successful, with a completion rate of 85%. Most of the women improved their eating habits, felt more energetic, enjoyed improved sleeping patterns, knew more about community and how to get involved, felt that their fitness levels had improved, and felt that they had improved their communication with their children.

Two of the nurses were involved with the Growing Together project. This project was a partnership between the Department of Public Health and a centre for children's mental health, with the primary focus on parent/child attachment, facilitating the growth of the parenting relationship, and adjustment to parenting. The project was started at an agency-based level rather than a grassroots level of community development. The community catchment area was described as one of the most densely populated resident blocks in Canada, with a high population of new immigrant families from diverse cultural and racial backgrounds. Many families lived in the depths of poverty and were undocumented immigrants without English as the first language. The multidisciplinary team, under the direction of an advisory committee, consisted of six public health nurses (two full-time equivalents), child psychologists, infant mental health specialists, developmental psychologists, developmental pediatricians, psychiatrists, social workers, students, and very skilled volunteers. The project was mandated to conduct community-based, interventional research in a unique multidisciplinary way. The program represented an intense nursing commitment in terms of practice and participation in research activities. The public health nurses provided the entry point for the centre for children's mental health to multi-challenged families in their own community. The nurses received the birth registration, contacted all moms, and once they obtained informed consent, conducted an initial post-natal assessment. The nurses brought many skills and resources to the partnership: experience doing physical assessments, working in the community with high-risk families, parenting programs, pre/post-natal knowledge and educational skills, doing Community Kitchen programs, the Life With Baby program, the Healthiest Babies Possible program, knowledge and skill, energy,
and much community expertise in multidisciplinary and interdisciplinary health promotion practice.

In the high school assignment, the public health nurse developed a strong working relationship with the school staff: the principal, guidance counsellors, social worker, physical education teacher and other classroom teachers, and students. The nurse offered health education programs related to the school curriculum and school community needs, on such topics as drugs, alcohol, tobacco, sexuality, and pre-/post-natal nutrition. She either delivered the program or provided resources necessary for the teacher. More individual, one-to-one involvement with students took place in the high schools, providing supportive counselling, health promotion, and/or referral to outside resources. The public health nurse was a member of the school team that met to discuss student issues and program planning. The nurse played a major role as a liaison between the school, the neighbourhood, and the wider community.

One of the public health nurses was involved in a community development initiative at a seniors citizen housing complex under the jurisdiction of the Metro Housing Corporation. This was a coalition of senior residents from the complex and several community agencies that were meaningful for the building of capacity with the seniors in the complex. The project was initiated by this public health nurse, one of her nurse peers, a resident in the seniors complex, and an occupational therapist who practised out of the community health centre in the area. The nurses worked in partnership with the residents and the community agencies in community organizing around issues the seniors identified.

How Their Day-to-Day Work Was Organized and Managed

As previously described, the nurses' practice was a combination of prescribed and innovative work. Many of the programs the nurses described were, in reality, programs that they initiated themselves and/or were instrumental in initiating along with other professionals and community workers. The nurse was a key participant in creating her practice world. However, as Chapter One explains, the Ontario Ministry of Health's organizational structure and processes and the nurses' employer, the Department of Public Health, exercised significant external control over the nurses' possibilities for individual and community empowering practice. The nurses were part of geographical departmental teams that functioned autonomously in three health areas across the city. Each departmental team consisted of nursing, environmental health, administrative services, and financial services.
Major policy decisions were processed through the departmental management team in the district health area, to and from the director's level (four directors) and the Medical Officer of Health.

As Chapter One discusses, the Health Protection and Promotion Act (1983) and the Ontario Ministry of Health, Mandatory Health Programs and Services Guidelines (MHPSG) (1989) provided the broader provincial framework for directing public health at the local or municipal government level in Ontario. The nurses' interpretation of the effect of the guidelines on their practice varied with some interpreting them literally, while others gave themselves a wider interpretation. Indeed, the guidelines had a significant impact on the nurses' day-to-day practice and professional autonomy, as discussed in further detail in Chapters Six and Seven. Since completion of the data collection phase of this study, the Ontario Ministry of Health introduced a revised version of MHPSG (1997).

Furthermore, the nurses' work was mandated by various policy documents of the municipal Board of Health, the Department of Public Health, and the department's job description for a district public health nurse. In addition, the nurse manager's philosophy and interpretation of public health nursing practice in respect to department policies and team nursing strongly directed the nurses' practice. The nurse manager was ultimately responsible for the overall assignment of the public health nurse within the district office. The nurses repeatedly explained how the structure of their job allowed, or did not allow, community development opportunities to begin or proceed to the next step. Many nurses expressed the view that the public health nurse may have intended to be more obviously involved in community development activities, but the opportunities did not exist in their work situation, and creating those opportunities took a great deal of time and effort. The nurse manager was portrayed as having significant power as a gatekeeper of the public health nurses' community development work, because public health nursing was so dependent on the politics of the health environment. This view is exemplified in one nurse's comments.

*Jennifer: You may be at a point of community organizing or coalition building and the population is such that, that [stage] needs to happen but the department staff needs and overtime may stop it.*

Within the district office, team nursing was also designed to assist in the management of the work that came through Intake, i.e., case work referrals and program requests. Referrals through nursing team intake came from many sources, including doctors, nurses,
social workers, the public, staff in drop-in centres, hospitals, hostels, and other community agencies. Although the nurse manager was responsible for the nurses' initial and ongoing assignment, the nurses were expected to assume other assignments through Intake.

The nurse was also expected to be team leader in her district office for a two- to four-month period, with responsibility for checking the cases that come in, along with program requests, then presenting them at a team meeting once a week. Urgent/emergency referrals were given to the nurse assigned to 24-hour emergency coverage. All the nurses took turns doing 24-hour coverage and acting as Intake nurse with responsibility for screening Intake work and doing initial follow-up.

The nurses also described the work they were invited to participate in and work they created themselves in a manner that emphasized how the context of their duties, both in terms of clientele and geography, had a significant effect on their day-to-day activities. One nurse explained that in her district, which consisted of exceptionally high-risk populations, "you never know what was going to come through the door." She described her practice in this context as "crisis nursing." This situation was common for most of the nurses in the study.

**Getting legitimacy-earning passage.** A recurring theme that arose was the intense efforts and time all nurses in the study invested to "get legitimacy and earn passage" to create, or be invited to participate in, multidisciplinary, community development projects. Although all the nurses made the effort to some degree, some nurses were more committed and determined to be invited into these interdisciplinary and interagency community development programs than others. They were determined to push the edges of traditional public health nursing. Several factors were described as significant in determining the extent of their involvement in community development programs. These factors included: their position as public health nurses or a mental health nurse consultant, their community nursing experience and particular expertise at building partnerships and networks, their skill at selling themselves and taking risks, being business-like, building up successes with highly complex families and situations, and being aggressive in "searching out" their clientele. Some nurses noted that reinforcers may not be present to enable community development; either their female clients did not see themselves as a community of women and/or were
resistant to community development approaches, or the nurse manager stopped the project from going forward.

All the nurses stated that their practice was frequently curtailed due to a distorted image of the public health nurse by the public and other professionals. It was evident in their narratives, which are elaborated on in Chapter Six, that the public and professional communities' perception made a difference in what health issues and clientele came their way, what people expected, and what freedom they were given to exercise their views of community development practice. In contrast to the challenge of overcoming these negative perceptions, two nurses noted that key reason why the Department of Public Health was invited to participate in the Growing Together program was the positive image of public health nursing held by the professionals involved in the program. The value ascribed to the knowledge and skills of public health nurses dealing with complex, high-risk families was recognized. Moreover, the nurses were seen as gatekeepers to a special population of women and children living in high-risk environments in the municipality.

The nurse who held the position as a mental health nurse consultant explained that she was allowed greater freedom to do community development work as compared to a public health nurse, and her work was presented to the public differently than the work of the public health nurse. She did not depend on the traditional intake of cases through team management, but built her connections over time by independently selling what she could offer. For example, she described a situation in which the city was under pressure from the community to get involved in what the community saw as a major need: working with people living in hostels and rooming houses. Since she had extensive experience working with street people, she was invited to participate in the project to look at street outreach with homeless people and prostitutes. Her practice covered a broad range of work, from mental health problem cases, to issues surrounding mental health clients, to working with homeless people on the street and in rooming houses. In her practice, she was expected to do more group work than the public health nurses. She engaged in several community development and advocacy projects, conducted community educational programs and did less one-to-one work than the public health nurses. At the time of the study, she was involved in four community development projects: Affordable Housing, Downtown Community Breakfast program, Street Outreach, and Drop-in-Community program for people with mental health problems.

Several public health nurses described examples in which they went beyond the work
the nurse manager assigned to them and beyond the caseload they received through Intake, to find women in need and involve them in one-to-one and/or informal and formal group situations, and to participate in community development and advocacy projects. Since the women clients/community members were exceptionally disadvantaged by a multiple of circumstances, the nurses were motivated to be more creative in finding the women, building supportive networks with nurse peers and other resources; and creating new roles, resources, programs, group associations, and coalitions of community members and agencies. To illustrate, one of the interviewees described her desire to create more programs for pre-natal women and her efforts to advocate, along with her supervisor, for a regular liaison assignment in addition to the "special" pre-natal classes she was conducting at a community health centre.

**Catherine:** *I went there [women's drop-in centre] initially to assess the needs of the population. Even though I was to be going there once a week for two hours a day to provide post-natal and parenting support, I found I evolved a role that was broader over time.*

Another nurse described how she practised in her liaison attachment at the women's centre where she was assigned to build connectedness and credibility over time with the women clients to create a "community of women." This vignette captures how the nurse skillfully strategized to build connections with and for the women to gain greater situated understanding of the women's lives and enable their responsiveness to community:

**Jan:** *Saw a lot of women on a weekly basis and saw consistently. Saw some for one year and took on as cases and kept a record. Those I couldn't take on the caseload I referred to other public health nurses or neighbourhood services. Call it case finding.*

*When I saw them at [the centre] it gave me the flexibility in terms of contacts. I might see them in their homes and see them at the centre. It gave me more flexibility in my practice of nursing — through that mechanism I was able to learn more about the community as a whole.*

All the nurses described how their background experience with a particular population helped to increase their visibility and credibility with the women clientele and other professionals. Subsequently, these nurses would be invited to get involved in various projects, which opened the door for other projects and resource people to come in:
Elaine: If people know you, they see you every so often, or can leave you a message, then they'll ask you about different things. And that usually takes a good year into a situation for them to ask for help, or to say "What do you do?"

Once you've worked with them it opens up a whole number of doors. AIDS educators, sexual health educators, STD personnel are able to come in more freely, because I've been able to open the door for them.

Additionally, some nurses described the groundwork they did over time, to sell themselves, to be invited, and eventually to participate in creating programs. The groundwork was extensive, with many of the following activities evident across various nurses' stories: building trusting relationships with women, other professionals, and community workers over many years; going beyond prescribed Department of Public Health programs; working as a team with nurse managers and nurse peers; providing the nurse managers with data to support proposed innovative activity and relating actions to client outcomes within the department's public health mandate; seeking out cases at team intake that allowed them to follow clients in the home setting and also at the women's centres or at the schools; and building up success stories with highly complex families.

The nurses explained that as their visibility and credibility grew, their network built exponentially. Despite the traditional structuring of district assignment of work, the nurses' practical and relational knowledge, and skillfulness in challenging the prescribed boundaries of their practice created enhanced opportunities for their community development practice. The following passages poignantly highlight the view expressed by many nurses in the study that gaining legitimacy and passage into community development projects was strongly influenced by the nurses' vision, their skills in networking and getting to know the community, and their perseverance:

Penny: Part of it is I was there at the right time. I had the right resources. There was a vision. Part of it is taking a risk, part of it is being a salesperson.

Mary Lou: Those nurses who are a bit more aggressive, in getting out and networking with various agencies and people in the neighbourhood, in the area they work in, tend to get known very well. You have to prove yourself with the community that you actually know what you're doing.
You can't just take your caseload that you get in the office, go out, do your one-to-one work, come back, chart your stuff, and sit at your desk. You have to be out getting to know the community and being quite aggressive.

I've had to learn to run up and down and beat bushes through my course of experience in public health.

The Women and Their High-Risk Environments

The public health nurses in this study worked with women who lived in the city's core. The women ranged in age from their mid teens to later adulthood. One of the nurses also worked with senior citizens who were members of a tenant association in a Metropolitan Housing Complex.

Along with identified health-related issues and problems, these women covered a wide spectrum of circumstances described within the definitions of high-risk environments and extreme vulnerability. Most were low income, single, either on social assistance or were "the working poor." Some were recent immigrants, undocumented immigrants, prostitutes, the homeless, and recent parolees. Some were suffering from drug addiction or were at risk due to mental illness. They experienced various psychological and socio-environmental risk factors, in many cases alienation and despair, which coincided with their lived reality.

Amidst the myriad needs exhibited by the women, certain themes recurred with regularity throughout the interviews. Most lived chaotic lives and lived in the depths of poverty with what one nurse described as "bottomless needs." Many of the women were economically distressed and the working poor. They toiled at menial jobs outside the home and were also expected to shoulder a heavy responsibility for care of their homes, husbands, and children. Many had no personal power over their lives and families, and bore the brunt of anger from their spouse. Isolation was a problem due to language and culture differences. Many of the women's children suffered from developmental deprivation due to lack of proper stimulation and nutrition.

Another recurring theme was the housing situation. For many, their housing situation was unstable for reasons relating to mental health and financial insecurity. The nurses explained that women who were referred to hostels were not necessarily given a priority for public housing, while undocumented immigrants were not eligible for public housing at all.
The shortage of adequate and affordable housing was critical for these women and their families. Many women had been on waiting lists for public housing for years.

Public housing in the city is generally located in high-risk areas. One of the nurses described the housing complex where she practised:

Jennifer: This is the most densely populated block in Canada. There are lots of high-rises or “vertical environments.” The area is high risk. If you don't have vehicular traffic, you can't support commercial and retail businesses. Things that draw the population to the street level. And you actually need vehicular and pedestrian traffic to protect against violence. You don't have the mother's watchful eye as she's hanging out the laundry. The telephone or the clothesline had sent that information ahead. And there's a real protection in that against violence. Kids here can't play. People don't feel safe going to do their grocery shopping, elevators from hell - so over-crowded - breaking down, high incidence of asthma and allergies, rodents, roaches, absolutely gritty environment. Roaches are a fact of life. They were falling off the ceiling.

Many of the programs and services offered by public health nurses are pre- and post-natal in nature. The pre- and post-natal activities focussed on women of diverse cultural, racial, and ethnic backgrounds, including First Nations and recent immigrants. The majority of women were single, low income parents. Some were women from multigenerational, high-risk situations and lacked education, social skills, and confidence; some suffered mental instability, depression, and drug addiction; and most had little or no support for their pregnancy, labour and delivery, and post-natal care. Many of the women needed education on infant care and parenting skills, including breast-feeding, infant stimulation, child care, life skills, and confidence building. Some also required psychiatric services. According to one of the public health nurses, "some women are not really mentally ill, but are certainly disturbed." Another nurse noted that, "many were victims of some kind of abuse and may, in turn, be abusive." The nurses also commented that in some of the relationships, the men were very controlling of the women. Consequently, these women felt isolated by their partners and were socially introverted. The nurses also reported that there was a great deal of verbal, mental, emotional, and substance abuse. Many of the pregnant women had already had a child apprehended by the Children's Aid Society and were pregnant again. Furthermore, in some cases the nurses needed to refer the women to Children's Aid in the pre-natal period.
Many of the women encountered by the nurses in the pre- and post-natal classes were suffering from hunger, as well. This problem had a distinct impact on this element of the public health nurses' work. For example, several nurses noted that they were "using food as a bringing together motive in the area," and that they often "enticed [the women] with food vouchers and food supplements." This practice was not simply instituted to attract women to the program, but to give them food they felt was needed to provide for a healthy pregnancy: "The women were so hungry they couldn't sit still. We had to feed them because this is part of the group, that they receive something to eat." "For some women – when they came to the program, generally their first need and the first reason they went, was that they need food. It was the bottom line, they needed to eat."

Another large segment of women that the public health nurse saw through the pre-natal and post-natal home visits, pre-natal classes, Healthy Beginnings group programs, and school referrals were immigrants. They were of many nationalities: Sri Lankan, Filipino, West Indian, Pakistani, Portuguese, Tamil, Nigerian, Somali, and Ethiopian. One nurse's comments summarized many of the issues for these women:

**Mary**: They have to get used to coming outside of their home, being social in an English-speaking setting, coming to a group. For many these are not cultural norms for them; being autonomous, not having husbands speak for them. Coming out in winter and dressing their babies . . . incredible hurdles. Language is a big barrier for many of these women. Only 25% of the immigrants speak English in their own homes. Because of this and cultural differences, interaction with others is difficult. In some communities, the women are very fatigued due to the number of children they care for. Many are from war-torn countries and there is evidence of post-traumatic stress among this population. Some suffer from depression and have trouble affording medication for their illness.

The nurses reported that the undocumented immigrants faced even more daunting obstacles. They were poor, often coming from cultures where women have little or no status and few rights. They were often scapegoats for their husbands' and family failures, often abused and blamed for their husbands' abuse by family members, and were fearful of going to the shelters due to their undocumented status and poor knowledge of English. As a result of their undocumented status, they did not have access to health care, their children could not attend school, and they were ineligible for public housing, however poor it may have been.
Suffering from depression and fatigue, their lives were truly isolated. Amidst their negative life circumstance, one nurse's comment on her perception of positive elements of these women's circumstances was enlightening:

Kay: Part of their thinking is that where they are coming from is worse. So that they are willing to put up with sort of running and hiding and trying to get services because it's better. If they don't have OHIP, the Community Health Centre will handle a percentage of it. The hospitals aren't going to turn them away if they appear in the ER but they do have to pay some kind of bill.

Another nurse, who reported on her community development project with senior citizens, gave a description of the high-risk environment that she perceived for the senior citizens. She reported that they lived in a "concrete jungle." They were on low, fixed incomes and faced multiple challenges in their everyday lives. They lived in varying degrees of isolation for a variety of reasons. Many had not mastered the language and were unable to articulate their fears and needs. Many had physical and mental health problems, and did not have the same supports that their better-off counterparts had. Since they lived in a low income area, they had real fears for their safety. One resident associated this fear with the "drug trade and thugs in their neighbourhood and walking their corridors." The lack of affordable and convenient transportation also contributed to their isolation.

The nurse in the high-school environment dealt with teenage health issues. She noted that the students came from diverse cultural backgrounds. Many of the students were from poor families and single-parent families. Pregnancy, poverty, racial and cultural prejudice, and consequential poor self-esteem were significant issues. Some students participated in group activities, but most with multiple issues needed to be seen on a one-to-one basis by the public health nurse.

Summary

This study was conducted with 13 public health nurses from a large, urban, government-funded Department of Public Health in Southern Ontario. The nurses had an average of 13 years experience in public health nursing. Eleven nurses were employed for more than eight years in the Department of Public Health. All the nurses had a baccalaureate degree in nursing and two had graduate nursing preparation.
The nurses' practice is defined interchangeably as generalist practice, district nursing, or neighbourhood nursing. The philosophy of nursing in this generalist practice-delivery model is population-focused nursing. In such a model, the focus is on the whole community with a broad approach to caring for the "community" and for nursing in the community. The public health nurses assume an individual, family, aggregate, and community client focus across a wide range of issues through the life span. They also undertake assigned and innovative activities within a psycho-social and socioenvironmental perspective. Within a geographic definition of community that is prescribed according to districts and/or neighbourhoods, community is also defined relationally and contextually around a health issue and/or special population. Some of the programs the nurses were involved in were labelled by the department as community development, but all the nurses describe much of their practice as community development. The difference is important because community development in general attracted resources while nursing activities that were not designated as community development did not receive the support the nurses expected.

The organization of the nurses' day-to-day practice was directed by several factors: the Ministry of Health's Health Promotion and Protection Act (1983) and the Mandatory Health Programs and Services Guidelines (1989) provided the broader provincial framework, policy directives from the municipal Board of Health and the Department of Public Health, the scope and practice defined for a public health nurse according to the department's job description, the nurse managers' interpretation of public health nursing practice within the policy directives, team nursing within the district office, and referrals that "come through the door." Indeed, the public health nurses are also significant participants in creating their practice world. Many of the innovative programs that the nurses describe are ones they initiated alone or with their colleagues. Many of the nurses in the study give themselves a wide interpretation of the mandatory program guidelines and also invest significant effort and time to "get legitimacy and earn passage" in order to be invited to participate in multidisciplinary, community development projects through invitation. They push the boundaries of traditional public health nursing. All the nurses engage in "case finding" or outreaching to find women who are disadvantaged due to multiple psychosocial and/or socioenvironmental conditions that pose significant hazards to their health and that of their families. They involve the women in one-to-one, informal and/or formal groups, and community development and advocacy projects. They feel compelled to reach out to this
community of women because of realities that pose a myriad of health concerns.

Most of the women and families the nurses describe in their narratives live on the fringes of society and are marginalized as different, outsiders, and "other." They live in a complex matrix of socioeconomic and cultural circumstances that limit their possibilities for health and health care: poverty; limited education; unstable housing; and social isolation related to financial, linguistic, racial, ethnic, mental health, and cultural factors. This situation is even more acute for recent immigrants, particularly the undocumented immigrants. The lives of many of the women are chaotic and they move from one crisis to another. Adding to these circumstances, most of the women have health-related issues: pregnancy, substance abuse, and/or mental health problems. The nurses are challenged to mobilize these women's strengths to improve their health, and achieve degrees of personal and community empowerment. The nurses pursue their goals by situating themselves in the women's struggles, helping them to meet their basic tangible and emotional needs, and challenging and negotiating barriers that limit the women's access to health care and achievement of social justice and health.

Clearly, the environment within which these public health nurses work and their women clients live is high-risk. Without access to suitable housing and health care, and severely limited by economic, cultural, and social constraints, the women who form the nurses' client base require distinctive types of health service that transcend the boundaries set by traditional, medical-biological definitions of health. In order to work effectively in this environment, the nurses need to negotiate both a complex array of constraints imposed by their organizational context and relationships with their clients. They are also need to establish distinctive, respectful, and trusting relationships with the women to help improve their general health and welfare and build community capacity. The nurses build relationships through a wide repertoire of innovative and flexible individual and community programs, covering issues of abuse, nutrition, pre- and post-natal care, and health care access for documented and undocumented immigrants. As will be shown in the following chapters, building a level of therapeutic trust and respect between the public health nurse and women living in high-risk circumstances is essential to the public health nurses' perspectives and practice of community development.
CHAPTER FIVE
BEING IN COMMUNITY

Introduction

Securing compassionate justice . . . requires both actions and understandings that will help people address the relations of power that limit the expression of agency and possibility in their lives. (Simon, 1992, p. 26)

In the next three chapters, I discuss the themes that arose from the public health nurses’ expressions about and my observations of their practice. As described in Chapter Four, there are three meta or broad themes: Being in Community, The Contested Terrain: Social Construction of Public Health Nursing, and Creating Space for Possibility. The themes are not discrete but are dynamic, multidimensional, and transcend each other.

Within the meta theme of Being in Community, two broad categories are apparent. These categories arose from a combination of the research questions asked and the information provided by the data. The two categories are: The Meaning of Community Development, and Enacting Community Development Over Time. Inherent across the two categories is the expression of the nurses’ valuing of and ways of thinking about their women clients/community members, as well as extensive evidence of their own practical knowledge and relational skills.

The Meaning of Community Development is discussed in Part I of this chapter. An understanding of the fundamental context of the public health nurses’ practice (discussed in Chapter Four) and of the meaning and enactment of the public health nurses’ community development practice (discussed in Part II of this chapter) provides a basis for the critical exploration of the nurses’ values, assumptions, and perceived barriers to their practice (discussed in Chapter Six), and for discussion of their responses to these constraints (in Chapter Seven).

Part I - The Meaning of Community Development

The Meaning of Community Development concerns the nurses’ guiding perspectives on community development and the meaning it holds for them. Included in this discussion are the nurses’ values, beliefs, definitions, understandings, feelings, and general assumptions about community development and, more specifically, community development and public
health nursing in the context of their work with women in high-risk environments. This category consists of four sub themes: (a) Empowering for Social Justice and Health: The Soul of the Matter; (b) Correcting Inequitable, Health-Damaging Conditions; (c) Working Within a Complex Change Process; “Weaving a Tapestry”; and (d) Time and Intense Work. A schematic representation of the meaning of community development and its emergent themes is illustrated in Figure 2. I discuss these themes below and expand on them further in Part II of this chapter, in the discussion on the enactment of community development over time.

**Empowerment for Social Justice and Health: The Soul of the Matter**

The nurses’ expressions and my observations of their practice indicate that a concept of community development, firmly rooted in empowerment for social justice and health and building on women’s strengths, informs their guiding values, vision, and practice. This approach is evident as an underlying philosophical premise and is the spirit that directs their practice. Community development is about connecting, engaging, negotiating, valuing diversity, knowing self, risk-taking, and being present in the moment.

For all nurses, the passion of their beliefs in community development, social justice, and their professional identity creates a vision, “a way of being” that motivates them in their efforts to enable the women they support in high-risk environments. Often, the nurses expressed their values and vision in metaphoric terms. In the words of one of the nurses contemplating the basis of her practice, it is “how one tills the soil.” It starts with a mindset that is committed to social action and social change as the driving force. Many of the metaphors, and affective and cognitive expressions that the nurses used to describe their relationship with the women and their engagement in community development practice portray an experience of creation and communion. As nurses and women, they felt that this partnership is an integral part of the energy required for growth and change. The nurses used terms such as a “birthing,” a “two-way kind of dance,” a “kneading and weaving” to describe the relationship with the women. The women were understood as a “community of women” and a “community of interest.” This understanding coincides with Freire’s definition of “community” as an affinity of interest (Labonte, 1987). Although the women generally were enduring major health-damaging conditions, the nurses strongly related to the women as counterparts to their own struggle for community and empowerment, drawing mainly on
Figure 2. Schematic representation of *The Meaning of Community Development*
- Narrative Themes
their own life crises and struggle for social justice and possibility as women, as mothers, and as public health nurses. The nurses demonstrated a responsiveness to the women’s situations. The following narratives describe the nurses’ commitment to building the women’s strengths, the women’s social connections with each other, and their commitment to supporting women in building capacity as a “community of women.” Moreover, in the first vignette, the nurse indicates a mutuality, or partnership position, which is dependent upon the women being heard and the nurse being valued for her expertise (but not as the expert):

**Kristen:** It’s working with and helping those in the community to find their own strengths . . . and facilitating, helping to facilitate what they need to do with what it is they want, what they think they need for themselves. Helping them to discover ways that they can get that, can make it happen. Adding what I can from the perspective of being a public health nurse - what I can offer in terms of resources, information they need . . . things that are directed by the people that have the need.

*It is supporting community, highlighting community strengths and helping them see what their strengths are as a community of women.*

**Joan:** I like to think of individuals in the community who come together with common needs, and they will make connections with each other and they will pursue issues, such as housing, with each other and get the support they need from each other. I don’t know if you would consider the fact that people make social connections with each other as part of community development: I see that as a priority for the women.

All the nurses demonstrated a way of being in the community that valued the capacity of the women to live and create according to their own meaning systems, and recognized their responsibility as public health nurses to work with the women to help them gain control of their lives. Consequently community development, which was commonly understood as capacity building if named at all, was not one component or project in their practice, but a way of being in the community that permeated their lives. Capacity building, which was understood variously by the nurses, described how they practiced, whether in a one-to-one situation, with small groups, or in community coalitions across a variety of practice settings and situations.
Correcting Inequitable Health Damaging Conditions

Central to primary health care, health promotion and community development practice are the challenging of inequities, the altering of structural power inequalities, and the valuing of diversity. The public health nurses' practice was purposefully directed at correcting inequitable, health-damaging conditions that they perceived as a major cause of the marginalization of the women, placing them at a significant disadvantage. Commitment to the women and challenging the social and health inequity that negatively affected the women's health and that of their children were major factors motivating the nurses' practice. The goal of helping women overcome their oppressive circumstances to find self-worth and a sense of community was consistently expressed in various ways across the nurses' stories:

Catherine: It is trying to show that they are important and have something to contribute . . . to speak out, say what they need to and go get it . . . [this is] the essence " [of community development].

Jan: I worry most about their spirit, people who feel their life has no purpose, no meaning and they just drift or coast aren't focused and don't see the potential life has to offer.

One nurse also identified the greatest motivator of her practice to be: "women: women in society, and women in oppression."

The nurses broadly defined health as a resource for living, with social justice and health as the ultimate goal. Their professed definition is based in the "new" public health that included a socioenvironmental paradigm of health and a focus on a broad-based health promotion, community development, and population-focused practice. The nurses' commitment to the new public health was evident in their individual, group, family, and/or community interactions. However, the nurses experienced tension between the traditional and the newer conceptualization of public health and public health nursing. Their predominant socialization in the nursing culture, the social organization of public health nursing within the Ontario Ministry of Health's Mandatory Health Programs and Services Guidelines (MHPSG) (1989), and the Department of Public Health's implementation of the guidelines supports a mainly traditional perspective for the public health nurse within a series of prescribed programs and services. Counter to these influences, the nurses were motivated by recent theoretical perspectives in community health nursing and suggested practice, along with
revised Department of Public Health policies on health promotion and community development. These factors legitimize a health promotion practice for public health nurses with a primary emphasis on the "collective" and community development approaches.

The nurses recognized that until the significantly disadvantaged women they worked with overcame their personal and social hurdles, it was difficult for them to focus on either preventive health information and practices, or the task of internalizing a collective consciousness to look outward to social action and social change. For example, the nurses asserted that primary prevention activities such as doctor appointments, breast self-examinations, and standardized education programs were often not a priority for the women as a result of their disadvantaged situations.

Although the term "holistic" was used generally to describe their practice, some obvious variation existed in the breadth and depth of its meaning, and in its application across settings and contexts. The common holistic definition of health is reflected in the following comments:

**Tracey:** I deal with their health issues. The shelter is asking me not to counsel them in terms of their abuse issues because that is what they [the shelter staff] do. But often when I'm talking to them about their health concerns, it is all connected. So they will talk to me a bit about the abuse issues. I redirect them back to the counsellors, but I also listen. You can't just treat an arm and a leg. You treat the whole person. So that is what I do.

**Mary Lou:** We work with people around a lot of psychological, sociological, and mental issues. I don't have an agenda. Other people on the team have agendas, telling them about the health centre, about AIDS, handing out condoms. I have a different mind set, a different role. I talk to the women about their feelings, what is happening on the street, experiences with violence. I listen for tips on what they want to talk about.

The following interview excerpts highlight how some nurses interpreted context and circumstances as defining their holistic practice and the roles and strategies they adopted in such circumstances. One nurse, in expressing her commitment to a socioenvironmental definition of health, framed her approach within the view of "health as a business," and herself as a more stand alone "salesperson":

**Penny:** "I use the words that get me in. Those words [nurturing and caring] in a
Another nurse, in the context of her work at a women’s drop-in-centre, described herself as the “health person” and her practice as “holistic,” yet defined health as “medical knowledge mainly.”

**Kim:** I’m the health person, get the condoms. I’m not doing outreach here. I’m getting their questions answered in terms of their health. [1] see health as medical knowledge mainly. I identify with them when they bring up symptoms. Right now, it is gathering people together to increase their knowledge. I am helping them with how they talk to their doctor and increasing their awareness of community resources. It is easy for me to assess and satisfy their immediate needs, and meet their basic needs and later mature issues. I start where the women are.

Kim explained that this preference toward a biomedical and traditional definition of health and the directive, educative role that she adopted at the women’s centre was strongly influenced by several factors. It was influenced by the roles that other health professionals exercised, in particular the nursing personnel; the crisis nature of the work; and the barriers to her practice, which she perceived to be associated with the image that the staff held of public health nurses. She explained that the nurse practitioner, who was employed by the centre, practised from a community development perspective and was significantly involved in community outreach and community planning directed at political action. She noted that on beginning her assignment at the centre, she did not see much one-to-one or group health education happening, either through face-to-face contact or through health promotional bulletin boards. Therefore, she saw her focus on traditional health education as a way that she could contribute and build her visibility and credibility, both with the women who came to the centre and with the staff. It took one year for the staff and the women to accept her and lower the barriers inhibiting the expansion of her practice.

The nurses’ understanding of the urgency and extent of the women’s health concerns and the need to deal with presenting crisis situations was also an integral aspect of the nurses’ holistic definition of health and community development work. This unique feature of their conceptualization was demonstrated repeatedly in the stories of their practice. The nurses perceived themselves as one of the women’s main connections to the resources for health, both in terms of primary and secondary prevention and health promotion, and the formal health care system for medical problems. The expressions “crisis work,” “crisis
nursing," "intensive care," and "people in crisis" were used by many nurses to explain this nature of their work. These terms refer to the acute, extensive, and continuing nature of their practice with this population of women. To illustrate:

**Catherine:** *Nursing in this community is like crisis nursing. You never knew what was going to come through the door. In other areas [other districts in the city] with more middle class people, they may have a lot of problems, but they have things that will back them up. They can cover up some of their problems. These people can't.*

**Carolyn:** *Intensive care doesn't just happen in ICUs. If you are prepared to be a factor in a family getting over a hump, you can't sit back and say, "Well now, what is it you were going to do next?" If you are part of the team, you are part of the team. My work doesn't stop at 4:30, because it depends on my clients' needs.*

The complexity of the public health nurses' practice demanded an extensive repertoire of roles and strategies. As is more evident in Part II, they integrated these roles and strategies in their practice in a manner consistent with the view that community development is not an isolated phenomenon when social change is the goal. My observations of the nurses' practice and of their expressions reveal that the various roles and strategies they adopted depended not only on their conceptualization of health, health promotion, and community development, but also on the women's situated realities. They adopted directive roles with the specific intent of eliminating or altering negative risk factors for particular target conditions, such as cardiovascular problems or high-risk situations involving child abuse. In other situations, they embraced broader community development roles or participatory/collaborative roles, such as resource, guide, facilitator, enabler, consultant, and catalyst. They also performed as educators, counsellors, health promoters, visionaries, risk-takers, negotiators, salespersons, advocates, nurturers, companions, and witnesses. Not surprisingly, they described themselves as "holistic practitioners."

Additionally, all the nurses were frequently consulted for advice on personal health issues by other professionals and staff with whom they worked in their various settings. In several instances, the nurses were expected to be a liaison with the city bureaucracy and intervene on behalf of the staff and their women clients.
Working Within a Complex Change Process: Weaving a Tapestry

"Kneading and Weaving"

Many nurses believed that public health nursing practice, both theoretically and experientially, is framed within a community development way of practising. They perceived community development as a complex change process of individual, group, and community strategies, and not just social action with a ready-made group or multi-agency coalitions. It was portrayed as anything but linear - a "puzzle," a "tapestry," a "team effort," and as a "kneading and weaving" process. The nurses emphasized that their empowerment practice frequently moved backward and forward, upward and downward among individual, group, and community associations. These metaphors describe images that portray for the nurses the complexity and intricacy of engaging in the women's realities in authentic relations to allow individual and community development to arise.

Several nurses stated that the complex, contextual knowledge and relational skills that were needed on the part of the nurse, "the feelings of it, the full-bodiedness of the role in supporting the members to achieve the goal," was not captured in the professional literature or in evaluation tools they were asked to complete on their community development work. They asserted that the tensions, politics, feelings, and delicate nuances that went on in the "in-between spaces," in the dynamics of relationship building, was very much the reality of their community development practice. It goes far beyond simple answers to simple evaluation questions.

One nurse used the image of "kneading and weaving" a tapestry to illustrate work in the "in-between spaces" that she insisted is necessary with disenfranchised people.

Carolyn: There are a few activities that relate to the in-between spaces like linking people and aspects of support, encouragement, and reassurance, linking the group with other outside agencies and groups, facilitating, collaboration within partnerships.

It's weaving. These are women in a society that does not recognize [them] as having any power. This one lady had been so pushed down. We sat and wept together two years ago when she came to the program. It is kneading and weaving. They are different actions.

In-between spaces - we talk about people falling through the gaps, falling
through the cracks, and talking about the social net.

Most of the nurses professed the belief that building personal and community capacities toward social action and social change is the preferred mechanism for change. They also valued the ideal course of community development as the shifting of power relations and the looking outward toward the collective, "working together to help women take back their lives." In so doing, they assumed the role of collaborator with the women in many situations so they could challenge the larger system. All the nurses highlighted the political nature of community development and identified multiple power relations of their practice. However, the nurses demonstrated varying degrees of sociopolitical knowing and consequent engagement in the shifting of power relations for social change. The degree to which the nurses engaged in the shifting of power relations was conditioned by the organizational context, their sense of agency, their ability to enable capacity building beyond the individual and small group situation, and their women clientele's readiness for personal and community empowerment.

Several nurses' narratives spoke about the intimate and relational expertise that public health nurses brought to their practice, which was assumed to be different from other public health workers, especially nonnurse community health officers. They saw authentic, relational expertise as essential in allowing the shift of power relations in partnering with clients and co-workers to promote social change. Being respectful and genuine, and situating oneself in the intimacy of the women's lives in a provider-as-partner role were seen as core threads in community development work. They believed that in doing this, they could go the next step toward promoting recovery and possibility for their vulnerable clientele.

In the following story, the nurse used an analogy of bathing someone to highlight the provider-as-partner stance that she believed was essential in community development practice. She saw the nurse as part of the "illusive" community, making things happen and giving a safety net. She emphasized that the nurses' ability to carry out many "intimate, assistive kinds of moments" that can be accumulative in facilitating change is uniquely nursing. She believed that the thread of being respectful, genuine, and situating oneself in the clients' lives as a partner, through the simplest of nursing acts - "the bath," is basic to the much more complex process of community development.

Carolyn: As you've been speaking, an image went by me.

How public health nurses create these power relations. I was thinking of the
simple act of being part of bathing someone who couldn’t do it for herself, let’s say a post-natal mom, perinatal care. If you just think power relations in that context, great intimacy takes place, because the person is naked and the most vulnerable parts of their body are bared. There is a phrase . . . “Nurse, if I show you my nakedness, don’t let me feel ashamed.” This is one.

If one has a low key and not a routinized way of proceeding with that kind of an act of assistance, it’s not routinized, but it’s done in a way that is matter of fact recognition that this is a basic human need and I, at this point, can be helpful with it. It doesn’t call attention to what is going on but leads to the next moment, which in most cases is human recovery.

I believe there is a thread that when one functions in some of these community development ways . . . being part of filling out an application [for funding] . . . “I never did it before, and you help me sort it through.” That is like a bath. [You’re vulnerable.]

There is a quietness that nurses bring to those intimate, assistive kind of moments where you do something that you know is needed, and it will lead somewhere but it’s not a big deal. If you string a lot of those moments together in a public health nursing kind of role, maybe something big will come up. Maybe healing or maybe growth. There is something very core that is nursing. It isn’t medicine. It isn’t a zoom in, cut, medicate or whatever it may be. It’s a different kind of role.

The nurse positioned her work as uniquely different from the work of the community health officer. All the nurses believed that the public health nurses’ contribution is unique because they are present in the early, intimate, and trust-building phase of relating to the women, one-to-one, in all of their vulnerabilities. They valued this step in relationship building as a beginning and a unique and essential step in community development work.

Several nurses discussed their guiding perspectives on community development with reference to the contradictions to their views, and the external valuing of their practice resulting from the duality of the position. The following comment illustrates the general view of most of the nurses concerning these contradictions and their definition of community development. Their community development definition traced progress from one-to-one, to a group of women, to a group of women, to a community of women:

Penny: What is pure community development? Why label it? If it is working, if it
empowers a certain community...? The community development officer and the public health nurses' approaches are different. Some are trying to make community developers a profession. They want a clear professional [sense] that no one else can do this work. I think that I'm helping the community. Maybe it is not community development. I don't care what you call it. I don't fight with labels. Am I doing community development? Yes, because of what the community is telling me. From one-on-one, to a group of women, a group of women to a community. That's how community development starts. But community development is nursing. Just because they coin the word "community development," it is no one's domain. We've been doing it all along. We do it every day. But we are not letting go of our projects. We are watching them bloom.

One nurse, in contrasting her assignments at a shelter for abused women and a tenant association at a senior citizen housing complex, asserted that there were two different types or stages of community development: "interagency" and "working from the bottom up."

However, she asserted that the basic values and ways that she practised in each stage were more similar than different:

**Tracey:** There are two different types of community development - or just different stages. There is the interagency type and then there are other types. The type they do at the shelter is at the beginning stages. It's like working from the bottom up. At the [senior's complex] it's interagency, not one-to-one counselling. Yet, there are plans that I want to set out at the shelter [that fit with community development].

She explained that at the seniors complex, she worked with a coalition of agency personnel and senior citizens. She noted that there were more similarities than differences in how she valued and practised in the different assignments. In both cases, she started with the peoples' needs to "give power to the women to build their capacity... just coming from what they need. It has to be dictated by the tenants and the women." She stressed that she did not define her activities at the senior's housing complex as community development and those activities at the shelter for abused women as not fitting with community development work. She believed that because the department valued formal involvement with interagency coalitions and broad-based political action as community development activities, her interagency activities at the senior's complex were legitimized as a community development program, but her practice at the shelter that included her building of informal networks and
coalitions was not considered community development. As such, she perceived that her practice at the shelter did not receive the resources it should have received in terms of nurse-assigned time and valuing of the work. She emphasized that a community development approach, which included more resources, was needed to enable community empowerment of the women coming to the shelter. Tracey expressed insight consistent with the basic values of community development, but she questioned her beliefs and her practice to some degree because she did not perceive her views as affirmed by the department administration and policy statements on community development.

The Challenge of Building Authentic Partnerships — Individually and in Group

In general, the nurses noted that it is a significant challenge to initiate and sustain an authentic partnership and subsequent individual, group, and community change due to the sheer magnitude of the women’s issues. Earning the trust of the women is a significant challenge. The nurses stated that a large number of the women they worked with found group activity difficult and were “not group-ready.” As such, they required extensive one-to-one work by the public health nurses, and other professional and non-professional support persons to build the necessary trust, self-esteem, capacity for connection, and group readiness. The nurses appreciated that the women had more urgent life issues, that there tended to be great diversity among the women, and that most of the women were not accustomed to group situations and felt uncomfortable in them. Therefore, health promotion was far from their immediate concern. In this regard, one nurse discussed her own strategy as knowing when and how to act with the women she worked with at the shelter:

Tracey: The other thing about teaching a group there [at the shelter], often the women are so distracted by everything else that is going on: loss of their children, or not having any money, or no jobs, that having a group [teaching session] on self-breast examination isn’t a priority for them. So I have to capture them when they have to be there. It’s not the same as teaching them when they want to be there.

The nurses who worked with the pre-natal group programs reported that most of the women who attended to the programs came to receive the food and clothing available through the program. These programs could include two to four public health nurses, depending on the number of women who attended the programs, a nutritionist in some cases, a co-ordinator, and various other volunteers and professionals. It was a challenge for the
nurses and the other health professionals to structure the program to accommodate the women’s tangible needs while introducing pre-natal and post-natal education, assessing and addressing their health issues, building relationships with the women, helping them to build relationships with other women, and to connect with resources in the community.

A nurse who worked with a unique population of women requiring pre-natal education through “special classes” indicated that the women who came to the sessions had many more issues to contend with beyond learning needs related to pre-natal and post-natal care. The simple problem of hunger among the women presented a considerable obstacle:

Catherine: [They had] such needs that they really had a very difficult time in group. I would have women come who were so hungry they couldn’t sit still. We had to feed them, because this is part of the group [practice]; that they receive something to eat.

Most women were on social assistance, many did not live with or were not supported by the baby’s father or their family, many required assistance of Children’s Aid, some were terrified that they would lose their baby to its father, and most felt out of place in the regular pre-natal classes the Department of Public Health and the Healthy Beginnings pre-natal group programs offered. She reported that some women came to socialize because “they were isolated and were not ready to go off and have a pre-natal class.”

The women’s circumstances also presented a significant challenge for the nurse in building group process and cohesiveness. The nurse felt it was important that the women found peer support and became a group and a community. The nurse commented that some of the assembled women never functioned as a group, while others did.

Catherine: It was hard to attend to the needs of the women because generally you were doing a group session, but there were women who wanted to ask questions and needed extra help and it was hard doing it. Sometimes I’d have a lot more than five to seven women in one session. This is very difficult. You just can’t be all over. It’s impossible. In some of the classes, there were some people who had been in very difficult situations. One girl lost her husband to cancer during her pregnancy. She mentioned this in class. One other women began to talk about her difficulties. I stayed with her for quite a while. We had just lost one - the girl died in having her baby. I didn’t tell the class. This particular group did not bond well.

But of the other women, not the homeless ones, who attended on a more regular basis, they did become a group. It didn’t seem to matter if they spoke a lot of
English. Some of them were functionally illiterate. They were economically not in a very good situation, maybe a single parent. Some had a university degree. All together, they had a common bond between them. They were having a baby. That is what kept them together. They would be very supportive of each other. If one was in distress, the others came to her assistance.

Only one of the public health nurses interviewed facilitated these special classes. She explained that she invested a lot of herself and did extra work to stay connected with the women and to make connections for them. She was challenged, however, by the lack of support to assist her in attending to the women in a more holistic manner. She explained that she could not go further with the women in following up from the sessions, because she did not have the physical and emotional strength. Managing the group process and the prescribed learning tasks consumed her energy.

I had occasion to attend one of the pre-natal sessions and came away with a greater understanding of the circumstances and practice culture that this public health nurse had to work within. The incongruencies between the ideal supportive-educative environment for pre-natal care and the situated reality for this public health nurse were sharply obvious. The following excerpt represents my unedited field notes on the session.

**Pre-natal session, May 5, 1997:** I don’t know how to describe this session other than as chaos. As I arrived, the public health nurse explained that today the topic was on breastfeeding. There was to be a video, however, the equipment in the centre didn’t work and the one at the district office next door was booked. The session was held in the family/play room of the centre. It was colourful with comfortable furniture and lots of windows. It was not set up with health posters on the wall and other resources for the women. It was clearly only an available space. There were also two children playing all around the session as their moms were in the class. They were cute but continually screaming and making as much noise as they possibly could. It was interesting that the moms seemed to close them out until they could see that it was bothering some. However, I was amazed at their tolerance and denial of the interruption. I certainly minded the confusion as did the public health nurse leading the group.

It was obvious that the children’s presence distracted the nurse yet she was gracious. There was also another public health nurse present who was picking up on the assignment, shadowing. I was surprised that there wasn’t babysitting for the children by
a volunteer at the centre, especially as these programs were put on under their auspices. Apparently this was the sixth session and there had not been babysitting. I would insist! I had such a headache throughout the session and after.

The moms were a mixed group representing various ethno-racial cultures, low socioeconomic backgrounds, most single and for three of the five, it was their second pregnancy. The irony of the nurse doing relaxation with the women lying on the floors on mats while the children ran around screaming. Some of the women commented later that they fell asleep. How could they?! One of the women was experiencing labour pains and was due in two days. Another woman was due in one week. At break time I got to talk to the women and find out a little more about them: their struggling personal situations and inadequate supports. As I left, the nurse was smiling and in continuous dialogue with the women related to their individual situation.

Many of the women the nurses worked with were illiterate or could not speak or understand English well, because they were recent immigrants. This posed a major challenge for the nurses. Furthermore, the women were generally unfamiliar with the Ontario health care system and the availability of community resources. Within this situation there were compounding issues, such as the use of translators and the realization that many women were undocumented immigrants. Translators were regarded as a positive resource but one that the nurses viewed cautiously. The interpreters could accompany the public health nurse and the women to health appointments, be included in one-to-one counselling and teaching, and group education sessions. The nurses expressed concern about confidentiality, the delicacy with which sensitive material was interpreted to the women, the accuracy of the transmitted information, and concern that the interpreters were “giving information on the side.” The nurses also found that by the very nature of their translation work, the translators were disruptive in the one-to-one and group sessions.

The following example and discussion illustrate this complex cultural and sensitive context that was commonplace in the nurses' practice in general. In this illustration on teaching about sexually transmitted diseases (STD), the nurse was involved in a difficult, confidential, and delicate situation of educating and counselling on STD and abuse while helping the woman realize that her partner gave her the STD. She also had to conduct the session through a translator. What came through in the nurse's expression of the situation and the dialogue is the nurse's cultural sensitivity, respect, genuineness, and non-judgmental
approach in remaining connected to the woman’s reality while challenging her to see beyond it.

Tracey: *I was talking to a woman from Poland about sexually transmitted diseases, and that was an issue for her. I was talking through a translator with her and she was very uptight about my talking to her, very uptight, and through the translator. I tried to make her feel more comfortable. In terms of the sexually transmitted diseases, she thought she got it from the shelter. I had to tell her that wasn’t the case. “Your partner had this. He knew he had it. He didn’t tell you. That’s not your fault.” So trying to support her through that . . . was difficult . . . because she was uncomfortable with the topic. She needed more information so she could make a decision about what she needed to do.*

Some nurses noted other challenges to their expanded health promotion and community development practice: *“husbands who are suspicious,” “men who are controlling and abusive of the women they are in relationships with,”* and *“the resistance from the women to a community development approach.”* In addition, one nurse stated that she valued and affirmed the experiential knowledge of the women volunteers who had progressed through the Healthy Beginnings program, yet she was cautious about them giving advice and information to other women beyond their ability.

**Time and Intense Work**

The factors of time and intense work are integral to the nurses’ descriptions of the complex and intense nature of their practice, particularly in honoring a commitment to a community development approach. The significant emphasis that all nurses placed on these factors merits a separate theme and discussion. The nurses identified “time” and “intense work” as issues that gave important meaning to their community development work with women in very high-risk circumstances. These terms were applied whether the nurses referred to a one-to-one, group, liaison attachment, coalition situations, or community programs. Their descriptions of the issues highlight the varying nature of the time, and the physical and emotional energy required for community development work. Additionally, the power that time represented and exercised in enabling the nurses to engage more fully in community empowerment with the women was apparent. The nurses’ words also accentuate how the notion of time and community development work was conditioned by the social
organization of their practice, the nurses’ sense of agency, and their willingness to engage in community development work.

Time was described variously as “a long process,” “little time to work,” “lot of time up front,” “time to build trust,” “intense amount of time,” “a slow and accumulative process,” and as “many, many steps over a long period of time.” Behind the descriptors of time and intense work lies a complexity of visible and invisible activities, feelings, values, tensions, and power issues, which are illustrated through the following elaboration of the theme.

“A Lot of Time Up-Front”

Several nurses described the major initial investment of time required to build interagency and community member coalitions: “Meeting in small groups, setting agendas, trying to get things going, preparing proposals for buy-in, and trying to organize ongoing meetings.” However, one nurse explained that the time she spent in this “up-front” work to build a formal coalition was far less than the time she invested in her one-to-one practice at the shelter for abused women, counselling, teaching, and building informal networks. The latter required five times more time than the former.

“There’s the Physical Time”

Generally, the assigned time that was prescribed for an activity did not match the physical time required, which was amplified by the emotional and physical intensity of the nurses’ engagement in their assignments. To do the work they thought was needed to build the strength of the women and their families, the nurses framed their perceptions of time within the diverse nature of their generalist practice. The following comments reflect this reality:

**Carolyn:** Intensive care doesn’t just happen in ICUs. If you are prepared to be a factor in a family getting over a hump, you can’t sit back and say, “Well, now what is it you were going to do next?” If you are part of the team, you are part of the team. My work doesn’t stop at 4:30, because it depends on my client’s needs.

**Jan:** There’s the physical time that I was at the centre [two hours/week]. But the time commitment to them was greater than that... an extra 30 hours for
the Nobody's Perfect program, advocacy work, planning time to meet with co-facilitators to set up the program, lunch time sessions to "catch the women," and post, group planning.

Mary: Time and intense work go into the outreach and getting them to the point of readiness for a group and then into social action and social change . . . is quite significant. You work with women directly and work with other resources around cases.

The last nurse's comment referred to her involvement in a designated community development project, which she described as a "heavv nursing commitment" and a busy one. In addition, she stated that she carried a school assignment, which added time that she didn't feel she had available.

One nurse who participated in a nutrition and support pre-natal group program, the Health Beginnings program, described the intensity of the time commitment within this assignment, which she asserted only accounted for part of her activities as a public health nurse. Her workload also included one school attachment, case load management, membership on a Healthy Beginnings Program Committee, and completion of additional written documentation for the Healthy Beginnings program:

Kay: An intense amount of time invested in the women's program; lots of extra work flowing from the contacts in the program. The [interdisciplinary] meetings are extremely long, and the women have so many issues, abuse, housing, etc. After the program I make a lot of referrals, with the women's permission.

The words of another nurse were helpful in illustrating the interrelationship of time, energy, skill, and competency that was demanded of the nurses over a long period of time in their health promotion practice. Using her particular practice situation of conducting pre-natal classes, she commented that the time she invested went far beyond the weekly time allotment for the activity assigned by her nurse manager. She stated that she had taught these pre-natal special classes for 16 years and had missed only one class. Her annual teaching program comprised five series per year, consisting of seven sessions per series, and the series spanned most of the year. Her commitment included preparation time and a continuous search for new audio-visual materials to verbally and visually educate the women, many of whom could not read or write, some of whom were recent immigrants, and had difficulty understanding and writing English.
Little Time for Long Term Work: Building Trust, Credibility, and Networks

Some of the nurses, who worked with the women through agencies such as a shelter for abused women and various drop-in centres, noted that as the turnover of the women was frequent, they had little time to work with the women and help them to address their many health issues. The term "crisis work" was used to describe their efforts in these situations. The nurses repeatedly stressed that a long-term commitment was prerequisite to effectively contributing to the personal and community empowerment of and among the women. All the nurses also emphasized the importance of having sufficient time to work on building trust, credibility, and networks in their practice. They noted that in this process, the nurse was also building trust and credibility with her co-workers, getting to know resources, proving herself, and then connecting the women to these resources. This process was very demanding in time, interaction, emotional energy, and physical work, as reflected in the following comments:

Elaine: It takes a good year into the situation for them [school personnel] to ask for help.

Joan: The most challenging aspect of working with these women is building connections with them to establish trust and acceptance and then hopefully in time to get them group-ready.

Tracey: Often times I make a lot of phone calls, appointments through the week to accompany people or trying to make room when the women need to see me. I try to have time or push things up. It's heavy. It's a heavy assignment.

My assignment is half day a week [at shelter for abused women], yet I'm doing way more than half a day a week. I'm setting up an appointment for a pregnant woman to talk with a social worker at the hospital so she can pay $500 instead of $2,000 for her stay in the hospital. This is a lot to pay when you don't have any money. I have to take time to set up the appointment. Hopefully down the road she'll be getting welfare.

More and more when I see one woman, I seem to be following her a lot longer than I was in the beginning. It's many times and many issues. So the liaison sheets, the charting is getting more intensive in terms of case management. Because once you get the trust, they are willing to divulge more. So they keep coming back and saying
this is another issue.

Thus, time was one of the chief obstacles hindering the public health nurses' ability to fulfill their own perception of what was required for truly effective community development work. Time was required not only to build up networks among the nurses themselves, but also to inspire a sense of trust and respect with their clients, an important prerequisite to informing the women and inspiring a sense of self and community empowerment. Without these networks and the resulting relationships of mutual respect and inspiration between the women and the nurses, the credibility of the public health nurses' projects suffered.

Not Having Legitimized Time

The following nurse's comments typified the general view among the nurses that recognition and legitimization of time for greater freedom and flexibility in their community development practice was needed to support their ability to inspire community empowerment. In fact, several nurses identified a lack of officially legitimized time as a limitation in their ability to affect social change, a project with which they asserted took more time and effort as a result of the community development nature of their work and the many problems faced by the individuals and families they had as clientele. Conventional approaches to public health nursing did not allow for this complexity. One nurse described this view by comparing her role as a public health nurse to that of another department employee, a community health officer, whose role as a designated community developer was legitimized differently and over a longer period of time in the social change process.

Jan: When you are working with the community to effect change, you can't expect change to happen overnight. And that was the other limitation to my role there and why I thought that at least if there was a Community Health Officer there. . . I'm assuming their role is legitimized over a longer period of time, or to at least get to a certain level where it's agreeable with both the community developer and the organization.

Part II- Enacting Community Development Over Time

The Enactment of Community Development Over Time is rooted in the values and vision the nurses hold for their practice, as previously discussed. Enacting their community development practice encompasses the relational context, which includes the nurse, their
women clients/community members, and their community resources. It also includes the strategies the nurses employ in these relationships to partner for social justice and health. I also examine how the nurses eliminate or decrease barriers, how they nurture capacity toward social action and social change, and how the partnership and community development are measured over time.

The Enactment of Community Development includes four themes that can be considered key processes in the public health nurses' community development practice: (a) Building Trusting Relationships for Mutuality and Engagement; (b) Building Connections and Overcoming Barriers to Create a Partnership Milieu; (c) Facilitating the Community's Capacity for Self-Advocacy; and (d) Measuring Progress. These processes and their subthemes that describe a repertoire of roles, strategies, and responsibilities are discussed below and displayed in Figure 3.

**Building Trusting Relationships for Mutuality and Engagement**

The public health nurses in this study describe themselves as a group of health professionals who play a key role in opening doors and laying the groundwork for building trusting relations for community empowerment. Furthermore, they regard themselves as important participants at the “beginning” of the social change process for social justice and health for women in high-risk environments:

**Tracey:** Community development is not new to public health nursing. We have been doing this through our history. Now they [the department] are labelling it as coalition building. So we are at a beginning level. The community health officer is doing full blown community development, and looking at different issues. The public health nurse, just coming from a public health nurse perspective, looks at practical issues, i.e., [with reference to seniors] falls, assessment of senior's health, access to services, health status.

**Kay:** . . . Coalition building, political action and getting women speaking on their own is the ultimate goal of community development. It's much more of a slow, progressive thing. People just do not get there. There are many, many steps before they get there. My interpretation is much more subtle. If you are allowing people to have a say in what goes on, that is the beginning stage of community development.

Further examination of the explicit and implicit meanings associated with the nurses’
Enacting Community Development Over Time

Figure 3. Schematic representation of Enacting Community Development Over Time - Narrative Themes
perception of being at the beginning of the community development process reveal a rich theoretical and practical knowledge, embodied in various roles and strategies for a self-help and social action process for community development. The nurses contend that to build trust for mutuality and partnership with the women, it is essential that they "start where the women are" in their everyday situations, listening to them, and allowing them to be heard. They then can progress to making their perception of them as a "community of women" a reality. The diverse roles and strategies are presented in the following discussion and illustrated in Figure 4 within the rubric of "starting where the women are" and the two processes of (a) "Outreaching to Break Some of the Isolation"; and (b) Authentic Use of Self.

"Starting Where the Women Are: Outreaching to Break Some of the Isolation"

Consistent across all the nurses' stories of their practice is the theme of "starting where the women are" and learning about their lived reality. It was essential for the nurses to start where the women are to build trusting relationships and begin the process for social change and social justice. The concept of "outreaching" was perceived by the nurses as integral to their community development practice. It emerges as a unique and vital contribution that the public health nurses make to the community development process for adult women in high-risk environments. The nurses passionately and consistently expressed the view that the public health nurse was needed to reach out to the women on a one-to-one basis, to acquire insider knowledge of their social worlds, and to see strengths and future possibilities. In so doing, they could be more responsive in working with them, break their isolation, and make the prerequisites for health and health care accessible to them. The nurses stressed that because most of the women were marginalized, they only connected, in most instances, to other resources such as group associations because the public health nurse made the connection happen.

Mandated outreaching. The nurses frequently stated that public health nurses had legitimate involvement with the women in high-risk circumstances due to their primary mandate and responsibilities associated with district nursing, which included such activities and programs as home visiting for Birth Registration Follow-Up, the Healthiest Babies Possible program, and school referrals, to name a few. The public health nurse obtain entry to the home, develop trust, and then attempt to engage with the women and their families.
"Starting Where the Women Are:"

"Outreaching to Break Some of the Isolation"

- Mandated Outreaching
- Beyond Mandated Outreaching

Authentic Use of Self

- Public Relations Work
- Bridging Between One-to-One & Collective Practice
- Being Present, Available, and Giving a Forum to Talk
- Respecting Difference Through Authentic Caring
- Engaging More Deeply: Working with Uncertain Alliances

Figure 4. Schematic representation of strategies for Building Trusting Relationships for Mutuality and Engagement - Narrative Themes
The two nurses in this study who were involved in the Growing Together community development project in the "downtown" area asserted that public health nurses were vital to the project for many reasons. The nurses provided a means of access to services for children and mothers with babies living in very high-risk circumstances, and to professionals at a centre for children’s mental health. The public health nurses were connected with mothers and new babies through the public health programs. The nurses recognized their value as gatekeepers for the centre for children’s mental health’s staff to this special population. They also believed they were valued for their practice skills with this population. However, the nurses did not see their role in this community development project as different than their regular district nursing practice, other than the additional involvement in research activities associated with the project:

**Jennifer:** We are the gatekeepers for the entry point [into the study]. The largest number of people enter the program through us. We get a notice from the hospital when the baby is born, and as part of our assessment program here we contact the family. Universally, we contact prime iperas, first-time moms. In this [district health] area, it has been designated as a high-risk area and for purposes of this study we contact everybody.

There is a heavy nursing commitment to this, although the work we are doing in many ways is exactly the kind of work we do, or could do elsewhere. It is not a change of role specifically. other than I’m participating in some of the research that’s done.

All the public health nurses believed that by their title and designated roles, they were given initial trust and credibility by their clients. Starting with the one-to-one contact with the women, personal empowerment and readiness for group action could progress to the point where the women moved out of the home to the community and then into group programs, to acquire readiness for community political action. They asserted that building trusting relationships and working with community resource people happened concurrently with this process. Consequently, the public health nurses regarded themselves as an essential link in a chain of empowerment steps for women in high-risk environments, not only through their unique point of entry with the community, but also as a result of their extensive web of relationships with their peers, other professionals, and community members. Community development was seen as consisting of many empowering strategies. The following
narratives by two of the nurses in the study illustrate this model for community development, starting with outreaching, a concept that was acclaimed by all the nurses in the study:

Jennifer: The work public health nurses do and have always done has been community development by any other name. Public health nurses may not be involved in the interpretation or the analytical part [through the Community Development and Advocacy Policy and Planning Division], but they are clearly involved in the day-to-day doing.

[The women] will often implicitly trust because it is a nurse as opposed to a social worker or another mom. So we get entry to their home. Then we connect them to Healthiest Babies Possible, Parents Helping Parents programs, and then possibly Life with Baby - Community Kitchens.

This one-to-one work is not only cognitive and affective learning, it is outreach to break some of the isolation.

If you have the linear definition of community development equaling political or social action, then that doesn't look at the complexity. If I'm working in community development, am I not working with people at the point of social action? The bulk of our work as public health nurses is in the earlier part at outreach, personal care, . . . personal empowerment to small group.

It's a reverse pyramid; you're not going to get to the tip of the pyramid if we don't do what we do.

Joan: I have a problem with the term community development. I'm not sure what the problem is. I would rather not get hung up on words such as community development. Maybe I have a bit of an aversion to it, because to me it is the behaviours that are what it is about. If individuals are identifying something that they want to do, something about in their community, that is fine. But I don't think it stops there. It's fine to look at the big picture and have a global perspective of what you would like to be doing, but I still feel quite strongly that the individuals out there in the community who are so disconnected from that, they need a different type of help to get them going in that direction.

Someone has to reach out to them in the first place where they are in their homes and isolated, because so many of these women are isolated. They are either isolated because their partner keeps them that way, or else they have been an
introvert or lack self-confidence, lack social skills, educational background, whatever it may be. Trapped in their own homes because they have got so many kids. It is really hard to get out. A number of these women find groups difficult. They are just not group-ready.

They need one-to one to get them out to do something. They don’t have the confidence that you and I have to go out and get involved in something. So reaching out to them on an individual basis is an absolute. I have worked with the pre-natal, post-natal long enough to see just how much of a positive post-natal experience the women can have when they have connections and support. When they can make contact with other peers who have experienced the same things in life and may be at a better point in their life, they can really make the connection with them and say, “Yes, perhaps I can do this too.” It gives them courage and hope to go on.

Getting individuals out of their home and out into the community and finding out what are the resources out there in the community available to them . . . and facilitate community development.

I have stuck with them when they have shown little progress or change. It’s [community development] a long process. I really like working with women.

Other nurses described the outreaching they did in conjunction with their liaison attachments to women’s health centres: bringing women to the centre, introducing them to the environment, and linking the women with various services when needed.

This story is an excellent illustration of the nurse’s complex and holistic practice, which is embedded in the nurse’s positive valuing of disenfranchised women, cultural sensitivity, and the importance of clinical knowledge, knowing the community, having credibility in the community, trusting relationships, and being prepared to reach out to the women and go the extra mile for the client’s health and social justice. It also highlights the appalling difficulty some of the nurses’ clientele encounter:

Carolyn: . . . Working with a young woman who had a late gestation birth of a stillborn baby. And then shortly after that, she had a stroke, and then she was hospitalized and discharged. I knew this 24-year-old when she was 16 years old with her first child. A referral came to my office. I happened to be the nurse taking the Intake calls. It was a Catholic Children’s Aid Society nurse saying . . . “It’s a very delicate matter. It’s a young woman. I don’t think she’s getting pre-natal care, and
we're working with the family in regard to the seven-year-old, who has mild cerebral palsy and some organizational issues about getting his braces, having the money, getting to appointments, things like that."

I made a home visit. I knocked and there was the young woman's mother, a person my age and she said, "Oh, my goodness, son of a gun, look who is here!" I hadn't seen her in a long time. In the seven years, we bumped into one another twice at street fairs. She said, "Well, how would you know Roberta just lost her baby this morning. Here you come on the scene." Then things unfolded and unfolded. A nightmare had been going on. And slowly they let me into the different aspects of their lives. The woman has a clot, in her neck! She was heparinized and then given Coumadin for maintenance. She has to take dilantin for seizures. It's a very disorganized family setting. Her mother is a closet, medically-addicted person to Valium. Fragmentation beyond belief! And a GP who keeps collecting [money] with each rotation of the revolving door. There have been numerous ER visits over the last two months, the latest one being Sunday. Not only is she in hospital, she's in isolation because there is a lesion on the latest chest x-ray. And this is a Cree family.

I visited her once, Wednesday, when I get a call from the mother. "Oh, Roberta is so downhearted. She is being treated badly by the nurses." So I called Roberta. I speak with the family every single day, sometimes twice a day, which is almost beyond my recording record. So I try to sort out what is going on without having her punished by hospital personnel for complaining.

**Beyond mandated outreaching.** As previously mentioned in Chapter Four under the theme of *Getting Legitimacy and Earning Passage*, several nurses in the study actively went searching for the women beyond the usual ways that cases or issues could be presented in their practice, because the women are "a very high-risk, marginalized group and difficult to reach." They went searching to find the women, to get to know them, and to allow the women to get to know the nurse and to establish trust. Their stories portrayed the nurses' strong commitment to the women and their goal to correct the inequitable circumstances. The significant and creative activities involved in pushing the boundaries of their traditional practice represented outreach beyond their mandate. These efforts are demonstrated in their stories.
One nurse, who carried a caseload of people with mental health problems and was involved in many designated community development projects over several years with the Department of Public Health, shared the following interpretations on her outreach work:

**Mary Lou:** People that I work with tend to be difficult to reach. You can't just stick a sign up some place in a community centre and expect that clients I work with a lot are even going to go to community centres. If they do then, who am I? There's no trust there. That's a big part of the work I do, is developing trust.

I work with a very high-risk, marginalized group of people who I found through my experience don't always feel comfortable coming forward and saying, "We have this issue and we want to work on it," often you have to, through your experience, get to know that you're seeing something coming up over and over, where there's a big gap somewhere. Certain people aren't at the table when it comes to discussing health concerns. Then you go searching for those people. You get quite good at figuring out your "grapevine," we call it, looking for somebody. There's a lot of us who work with people on the street or close to the street who . . . meet as a network once a month or once every two months. We needed to get together for advocacy and communication.

This nurse also described her initial involvement in a street outreach project with prostitutes. She explained that the issue was brought to the city's attention by a community centre, as there was an aggressive backlash against the prostitutes by some citizens in the neighbourhood. The project was legitimized by linking it to an AIDS prevention program and acknowledging that the women were living in a very under-serviced part of Toronto with very limited access to health services.

Her experiential knowledge in street outreach work, her supportive community network, and her individual relationships with the women were named as critical factors in laying the groundwork for community development. She emphasized that in order to show respect to the women, she needed a legitimate reason to approach them. She approached them with a different mind set and a different role than other community health workers:

**Mary Lou:** I'm working on the project as a mental health nurse. When I go into something like this . . . this is where the community development piece starts. I don't have an agenda, so other people who are sitting on the team have agendas, telling about the health centre, telling about AIDS, handing out condoms. I have a different
I look at AIDS education as almost the hook. But the issues I'm interested in and am working on go far beyond AIDS education. In fact, that piece is being done by someone else. I'm looking more at helping the women first of all, to get to know us.

The high-risk prostitutes, the ones who are not making lots of money, the ones who are doing this for survival and to buy drugs to support a habit, etc., or have a pimp, are not doing it to make money - these women on the street tend not to support each other very much.

Another nurse described the challenges and her innovation in searching out the women for her special pre-natal classes. She made her own flyer, sent it out, and called various community centres to tell them about the classes and to spread the word to other community links. One nurse, in describing how cases come in through pre-natal referral and the Children's Aid Society, described her involvement with a young woman who gave birth to a stillborn baby.

"Starting Where the Women Are": Authentic Use of Self

The phrase “Authentic Use of Self” applies not only to the nurses’ professional and practical versatility, their awareness and respect for their clients, and the problems that these women had to face on a daily basis, but also applies to their efforts to foster a positive and inspired sense of self among their clients. This theme, therefore, embraces many of the strategies that the nurses used to establish and sustain a dialogue with the women to promote personal and community empowerment. Although the nurses believed that community development was a process that enabled the women to look outward in a collective way to change their situation, they emphasized that the process began with hearing what the women were saying and, from there, building trust for mutuality and engagement. The nurses progressed along a continuum in their empowering practice. Their strategies were dynamic, increasing in depth and breadth, from beginning a relationship to nurturing it over time. Multiple narratives featured the nurses' beliefs, roles, and strategies to build their clients' personal capacity and readiness for community empowerment. Broadly stated, the strategies were implicitly and explicitly designed to foster hope and possibility for the women. They consisted of working in an open, creative, and collaborative way, listening in a respectful way that set aside professional jargon, respecting the women's experience, differences, and
capacity to participate in mutual decision-making around their health-related issues, challenging and negotiating complex situations that limited possibilities for the women, and connecting them with both their nurse network in the department, and with their community resource network.

The strategies that illustrate the authenticity in the nurses’ approach with the women clientele have been grouped within five themes: (a) Public Relations Work; (b) Bridging One-to-One and Collective Practice; (c) Being Present, Available, and Giving a Forum to Talk About the Issues; (d) Respecting Difference and Valuing Diversity Through Authentic Caring; and (e) Engaging More Deeply: Working with Uncertain Alliances. These themes are discussed below.

"Public relations work." Public relations work was a term that was used by some nurses explicitly and by others implicitly to encompass the many roles and strategies they employed to initiate a relationship with the women in high-risk environments and to create opportunities for health and social justice. I interpreted this naming as representing, in part, the invitational attitude of the nurses’ practice and their willingness to listen in order to establish relationships. The meaning of their public relations work varied among the nurses and across the work settings; however, there were many similarities, the most common being their willingness to situate themselves in the women’s lives and to listen to what the women were saying and needing:

Kay: Our job is public relations work and getting to know the moms so they will trust us. Then they open up to asking questions and so on. It’s really important, because if we want to get honest feedback from our participants to improve the program and to find out what they would like, they have to like us, trust us, and feel that they could say whatever they want to and not feel threatened by not saying the right thing.

Many different topics given by different people. Many of them are nurses. It could be on breast-feeding, breast health, labour, and delivery. Theses are topics that the participants themselves showed an interest in and wanted. So that basically it is really very much a community development-oriented program because we do listen to the moms.

Kim: They let you into their lives. It’s a privilege. The women share their reality, acknowledge they have problems. They invite you to listen. I encourage follow-up
with them at the centre or in the district. Right now it is gathering people together to increase their knowledge, helping them with how to talk to their doctors and awareness of community resources.

Tracey: Now sometimes it's not the concerns of the women, it's the concern of the counsellors. So you have to be careful because it's really important that it comes from the women, themselves.

The following narratives further delineate what the nurses saw as characteristics of the skillful listening required to facilitate relationship building: treating the women with respect, taking time to listen and showing genuine interest in them, not offering quick solutions but respecting their right to make decisions, being sensitive to the position of privilege they held as nurses and consequently not flaunting their authority through verbal and nonverbal communication (including dress), avoiding criticism of the women's physical environment as long as it remained safe, appreciating the social-cultural context of the women's situations; being there for them and with them, and earning how they themselves saw their needs.

Tracey: Certainly when they see me coming, it's like "the nurse" and that can be scary. I'm a gentle person and try to ease into what do they need. It's not what you think they need. I try to be very careful with my language. "This is one thing we can do, would you be interested?" Giving them a number of options. "I can give you the information if you want to help," or "please come back." So trying to leave the door open. Trying to relate to the person as a human being. Just the respect for the person. Talk to them at their comfort level and make them feel at ease. Just taking them at why they want to see me, whether it's a nosebleed or a rash or a woman's health issue. Then if they come back, we might get into more details just because they're telling me . . . [I try to] make them feel respected and that I am interested in them . . .

If they need to talk, I listen and don't offer solutions because often times they come up with them themselves. I realized in nursing you can help in all sorts of ways. It's not just giving resources, it's listening and supporting. All of that is so important. That is a part that I have incorporated into what I do with the women and I hope it helps. They do come back to me because they recognize, "Okay, so she's all these things but she is listening to me. She is not trying to figure out a solution while I'm
talking, "which people recognize. They can see you doing that.

Mary Lou: *If you take the time to draw out all the experiences and feelings, the person feels like you actually care about what they’re feeling about, and that they’re trying to get an appreciation from the outcome and that you can try and bridge that gap. You have to be really sensitive and ready to spend some time to listen to what the person has to say. I make sure I don’t come across as somebody who is in a different position, because I’m there to be with the client. I’m not there to be somebody else. I’m not there to make them feel bad or point out differences.*

**Bridging between one-to-one and collective practice.** The nurses’ words reflected their situated understanding, their loyalty to the women, and their challenge to bridge the reality between the traditional-individualistic and the societal-collective aspects of their practice. An indicator of the nurses’ tension in bridging the link between their traditional practice and current community development practice was evident in how they described their practice, or referred to the women they worked with as either clients or community members, and how they viewed their standardized programs and expected practice, often going beyond it.

The nurses infrequently used the term client to describe the women they worked with, employing the term only as they referred to the women in a collective way as family client or community-as-client. In their everyday practice, the nurses commonly used the term “participants” (in group program), “people,” “moms,” “tenants,” “senior citizens,” “women,” “students,” “persons,” “parents,” “victims who are trapped,” and “prostitutes.” The term client was used occasionally, and the term patient was never spoken.

The nurses assumed a facilitative and invitational approach to engaging in the women’s lives, exploring strategies, and nurturing the women and their families’ capacities. This positioning also motivated them to go beyond their prescribed practice. They respected a social definition of health that recognized that primary prevention of targeted diseases and injury prevention was not the women’s first priority. Furthermore, they recognized that education in the traditional sense of depositing facts would have little meaning in the context of the women’s high-risk circumstances. The nurses were challenged to decide the relevance of the information for the women, and then to tailor their approaches to develop trust, respect differences, mobilize strengths, and still try to capture the teachable moment.
All the nurses expressed frustration with the city’s narrow definition of community development within which their practice was framed. Most of the nurses in the study professed a philosophical commitment to empowering practice and a resistance to prescribed health programs that did not relate with the women’s realities. This attitude is exemplified in the following excerpts:

**Kristen:** I’m going to do the Ready or Not program but I’m going to go with what the parents needs are. I have 10 parents in a group, and 3 of them have a real concern because they have children with Attention Deficit Disorder. Well that is not part of the program, but I’m going to address it because that is a desperate need for those patients. So that gears away from a standardized program.

Maybe there are problems with the set programs, but I don’t necessarily follow the set program. When I teach Puberty, I use the set program as a basis. I find the set program very dry and like a lecture. I don’t like to work that way. I have added a lot of interactive things to the program that I have done on my own. I’m getting a much better response from teachers and the schools in terms of the program. But the program that will be evaluated when they say, “this Puberty Program is not working, let’s cut it,” is not going to be the program I do.

One nurse clarified that her involvement in the department’s standardized program Nobody’s Perfect fit within the principles of community development as she understood them. She saw herself as a resource, facilitator, and health promoter with the program. She strongly contended that the program promoted personal and group empowerment. Furthermore, she noted that she started where the women were and created a safe setting for sharing in learning. She stressed that the nurses’ sense of integrity was critical to community development work. It was essential to have the freedom to modify prescribed programs to meet the women’s needs.

**Jan:** Maybe it doesn’t fit in community development in terms of how the model [in the city’s’s definition] stands now, but I like to think of theories as flexible and adaptive. If you don’t have the people at the grassroot levels that are willing to try different, innovative, and creative ways of making programs accessible to clients... I see it as being a way of meeting a need. The women who want this group asked for it. It is
something they need to feel good about themselves in their roles as parents. It is [a] small group. The main purpose of Nobody's Perfect is to empower the parents, to empower these women to recognize their strengths as parents and know how to network. They still have [an] avenue to carry on. They may have learned some things in the group, but it's not the be-all and end-all.

I see my role as facilitating. I don't go there with an agenda. I have a plan, but I'm not rigid in how I implement it.

"This is your group" and I sell this group to them. "This is about you." Every group is different. It depends on needs and how comfortable you are sharing. I'm here to create a safe environment for people who want to share so they can learn.

With reference to her one-to-one crisis work at a shelter for abused women, one nurse explained how she moved beyond a traditional view of her practice and assumed roles as an information resource and health promoter, similar to other shelter workers, to help the women take back control of their lives:

Tracey: It is giving people, the clients as a group, the power to work together towards a common goal. We give them information, or work with them to see what they need and to recognize things that can work for them. You look at an issue that they're dealing with, no money, no job. You are trying to create jobs with help from outside or whatever, and empower people to do that for themselves. They were trying to get together a catering business, working with the social workers and the nutritionists. So they were trying to get recipes together of different cultures and different things. The challenges, obviously the women are changing all the time. So you wouldn't have much time to train. Also the women have a lot of other issues to think about. That particular group of women [wanting to start a catering business] sounded very motivated and were empowered, as if to say, "Oh, now we can take back some of our control and power, and we can do something with our lives and not be at the whim of everybody."

The following nurse, who worked with a unique population of women in special pre- and post-natal classes, reflected on the facilitative and invitational relationship that the nurses strove for in their practice, to respect the women's ability to own their experience and build capacity for connections and community responsiveness. The professed and observed structure and process of her sessions indicated a teacher-learner dynamic that strove to be
democratic and women-centred, one which I would describe as a “mid-wife teacher.” She was more concerned with enhancing the women’s self-worth than with imparting only concise content. Her interest in the women as people and her value for their lived reality was obvious in her stories of practice. She iterated that she started with their individual needs and integrated them into the prescribed content on pre-and post-natal care. She noted that she deliberately tried to show respect for them and build personal capacity through her roles as facilitator and enabler. She also attempted to build a network of peer support in order to help the women become a group and feel part of a community of women.

Catherine: We are only there to give them information. They can reach out and take what they want. You can’t direct what another person needs and what they are going to learn. It’s a two-way street. You have to respect that you’re not up here and they’re down there.

She was also conscious of building group cohesiveness and addressing barriers such as unmet physiological needs, illiteracy, and cultural issues. She expressed an intense commitment over time, of skill and energy to establish an open, supportive, and non-threatening environment to promote learning and the building of self-worth and a sense of community. It was important to her to establish a very informal atmosphere in which the women could interrupt at any time and ask questions to meet their needs. She displayed an openness and sensitivity to different learning styles and life circumstances, and used a loose outline of the sessions, seeking the women’s personal input on the outline by asking “what did they want from the class?” She displayed a great deal of literature, pictures, and models in the sessions, invited the women to help set up the room and the snacks and drinks, gave time for them to chat and meet each other, and gave introductions and self-disclosures from her own experiences with pregnancy, as well as encouraged the women to tell stories from their own cultural perspectives. She also made a great number of calls and searched the women out, showing them that they were more than a number, helping them to find what they needed if it could not be found in the class, and asked them to call her when they had their baby. She also worked to find the women labour coaches, and if problems arose with breast-feeding, she worked to find them support through the hospital and the lactation consultant.

Besides the classes related to pre- and post-natal care, this nurse covered topics related to community resources, welfare, housing, and legal matters, and generally helped the
women with future planning. She also assisted these women in making connections to broader community services and other public health nurses. She emphasized how important it was for the women to include breathing and relaxation exercises with every session, and from her perspective, this activity brought the women together and built up self-esteem. She believed it was important for them to have some sense of control over their bodies, because so many of them had such little control over their lives. She invested a great deal of extra work to stay connected and to make connections for the women, and to provide tangible and affirmational support. She did not set herself up as an authority, and expressed trepidation about other nurses doing pre-natal sessions with the women without going beyond the program guidelines for pre-natal classes, or viewing the sessions just as classes to be taught. In fact, distinguishing between “classes” and “sessions” was important to her. “I keep saying classes when I should not say that. That is their [the department] terminology.”

The following narrative described how the nurse was creative in learning as much as she could about the community of women and in helping to strengthen the resource network available to them. The nurse explained that she saw a number of women on a weekly basis and some consistently for up to one year. She took many of the women on as cases, and therefore kept a client record in the district office. She referred the women she could not include in her caseload to other public health nurses, neighbourhood services, or both. She seemed to equate flexibility in her practice with professional autonomy, something that gave her the freedom to be creative in her development work.

Jan: I see the community of women at the centre as a client. Call it case finding. When I saw them at the centre it gave me flexibility in terms of the contacts. I might see them in their homes and see them at the centre. It gave me more flexibility to my practice of nursing. It felt more comfortable having that flexibility. Through that mechanism, I was able to learn more about the community as a whole.

Because we’re always looking for ways to help the women solve their problems, whether it’s a second-hand store selling children’s clothing at a reasonable price or whatever. I would try to bridge gaps and help them access things they needed.

For many nurses, the practice of supportive accompaniment of the women to appointments and helping them make other connections to community resources such as group programs was necessary to help the women make connections and to advocate on their
behalf with agency personnel. This practice was felt to be particularly important for new immigrants, especially for those who were undocumented. In these cases, the nurses took risks, going beyond their bureaucratic and professional boundaries to partner with other professionals in the community, bypassing rigid systems to help the women. If the boundaries had been adhered to, the nurses could not (or should not) have worked in this way with the women. The various strategies that the nurses used to link the women to tangible resources for everyday needs was basic to the practice of all the nurses in this study and was valued as important to their efforts to help the women and build trust and credibility.

Several of the nurses' stories and comments about this situation highlighted the moral dilemmas that the nurses faced due to legal, political, and professional regulations. However, it was obvious that they were motivated to go beyond the boundaries of their practice to do what was best for the women and their unborn child and/or children. Several nurses stated that many of the public health nurses assumed professional risks to hide the truth and do what was needed to protect the women and their children, and to acquire access for the women to health and health care. They also believed supportive accompaniment built trust with the women. The following story accentuates the value of this activity for this nurse, and the women and their children, along with highlighting the complexity of the nurses' practice situation:

**Tracey:** Accompany them down to the appointments just to show them where it is so they can have that connection to health care. Sometimes these women don’t have any immigration status, so sometimes they don’t have health cards. I advocate on their behalf to other agencies. The most important thing is getting them access to the health care system, which is very difficult for a lot of them. A lot of the women come in pregnant, at the end of their pregnancies. They don’t have any hospital. They don’t have anybody to help them through their pregnancy or be there for their labour and delivery. So, we connect them up to services. They may have been abused by their partner or family members.

Often times I tell them that it is a refugee claimant, that it is in process, the health plan is in process. So, we don’t get into the fact that they don’t have a health card. Because we know them so well and I am calling from the shelter, they know that means a lot of questions are not going to be asked at the moment. I say this with the client’s consent so it is confidential with them as well. They can’t divulge that
information. So it is tricky sometimes.

All the nurses identified numerous examples of doing extra things “beyond the call of duty,” to help build their women clients’ self-worth and overall capacity. One nurse explained, for example, that with her pre-natal and post-natal special classes, the Department of Public Health paid for transit tickets, while she paid for food and drinks for the women (and their children, if they came with them). On the last class day, she would have a celebration with a congratulations cake, certificates, and an invitation for the mom and baby for post-natal sessions. She also made phone calls to search the women out if they missed a session, explaining that she wanted them to know they were “more than a number” and to help them find what they needed if the class was not right for them. She asked them to call when they had their babies, and if she did not hear from them, she had all their due dates and called them, herself. If the women were having problems with breast-feeding, she also worked with the hospital and the lactation consultant, to get the mothers labour coaches if they needed them. She explained her actions as part of an effort to “try to show [the women that] they are important . . .”

Catherine: Well it’s trying to show they are important and have something to contribute. And certainly in the evaluation. I have had the women say what they got out of the class was to be able to feel they were important and to speak out, say what they needed, and go and get it. And that seems to be the essence. If they don’t learn anything else, that is what you want them to do.

Being present, available, and giving a forum to talk about the issues. The nurses’ various reflections highlighted the value of being present and available in the community, “hanging in,” collaborating to build a forum in which to dialogue about issues of interest and concern, as evident by the following comment:

Kay: The longer they come, and they start to feel comfortable with each other, and they feel they have opinions, and start to see changes amongst people, like women coming back with their babies . . . gone through some difficult times with breast-feeding and so on, for that mom to be able to share that kind of information with another mom. They start to feel really good about it. They start to value themselves. They realize they have skills and can do lots of things. They know some answers and can help other people. When it’s time to leave the program, it’s a pretty sad time
sometimes, but hopefully we’ve linked them up with other things in the community.

Another nurse noted that public health nursing is accessible to people due to the location of their practice and their interpersonal relationship skills; “people tell things to public health nurses they wouldn’t tell anyone else.” In many instances, the nurses were innovative in going beyond their prescribed responsibilities to establish themselves as a resource in their group work. One nurse spoke about how she co-facilitated a parenting group with her women clients, getting them to talk and engage in the process, enabling them to get as much as they could from the group, negotiating roles for the betterment of the group, and sharing her own parenting stories when she believed it would help the dialogue.

The following interview excerpts further attest to the value of being present, consistent, and willing to put in extra time and immerse oneself as a professional, and as a person in the process of listening and building trust and credibility as a partner:

Penny: I’ve used a program, I’ve used my expertise to build trust. I’ve had moms come to me. I’ve had principals come to me. I’ve experienced this from the kids. I am going to run a couple of programs. Then I talk to the parents, “we have a problem here.” It got bigger and I had a stake in it. I truly believe in what I’m doing and I’m not doing this for the department. Taking them to the point where they can believe in themselves.

Mary Lou: I’m working with people in the community to develop a response to a need they have. You have to be present and consistent if you’re actually doing community development. Work with women and getting them to identify what it is they need, and then start working with them to try to figure out how we can meet that need and start drawing your community in [order] to fulfill that need. It takes a lot of time. You start thinking with them [the community members] about who we can bring on board who would work with us, who has the expertise that is needed to get this goal achieved. Who is going to be able to stay and be involved for the long haul.

This same nurse described how she engaged with the prostitutes in her street outreach project. She explained that these prostitutes were not doing it for the money, but for sheer survival - to buy drugs to support a habit and pay a pimp. She explained that they do not support each other very much; therefore, her role was to extend support to help them with their experiences of violence. Making reference to an example of a prostitute who was beaten
by her “john,” she indicated some of the strategies she used to establish initial dialogue and trust:

Mary Lou: We said to her, “Oh, you’re down here.” “Oh yes, I just needed a break.” So, I thought, hmmm, “needed a break.” Why does she need a break, because we heard through the grapevine she had been beaten? Instead of coming right out and saying, “Have you been beaten?” I started building on [the prostitutes opening statement] “Oh, you needed a break. How have things been lately?” That sort of thing. Eventually, she said she was depressed. Then we got more into the violence and how she was managing. So I give them more of a forum to talk about those issues.

This nurse explained that once she made contact, she worked at building trust so the women felt they had someone to talk to about their situation. She described several critical strategies that she implemented to establish a relationship: using her grapevine to locate the women, showing respect for women as persons with a name, building a connection over time, promoting herself as a resource, using her communication skills, being prepared to take risks, building on past trust relationships with another prostitute, and working with her community resource network. Her reflection on these views is further evident in the following quote:

Mary Lou: It took a long time [one month]. Certainly people were very suspicious of us, the first contact. But as soon as we brought out the condoms . . . because condoms are fairly widely recognized as something that you would be handing out if you were legitimate people. But really, it’s time. Just repeating yourself. Who you are, what you can offer.

If you’ve seen somebody before, acknowledging that you have seen them before, that you recognize them. So they don’t feel like they are just another face. You’ll start to get somewhere in being able to make a connection with them.

Running into her [another prostitute] was a major bonus, because . . . you have somebody who is actually part of the street scene vouching for you. That really opens the door for people to come up to you.

It was evident that extensive groundwork development based on comprehensive practical knowledge and skilful relationship building on the part of the nurse was integral to this developmental work. This groundwork included taking risks to build networks, trust, and
legitimacy; and continuously building trusted peer support, informal networks, and coalitions. She also explained that she and another nurse from the community centre were present in the neighbourhood once a week from 7 p.m. to 9 p.m., where they “hung out . . . so people can watch us.” For safety reasons, because she was not known to the community, she had to learn about the neighbourhood. She commented on the importance of network support for safety and assistance to connect with the women. In this situation, she informed the police of her activity and informed family sex educators, who told prostitutes when they came to the health clinic at the community centre.

All the nurses expressed this notion of “being present and available” in an almost incidental way when they described their practice with their women clients. However, it became obvious that it was a key approach that the nurses used to establish and sustain a relationship with the women, reflected clearly in their language. The nurses often “stayed with [the women] for quite a while,” “. . . stuck with them when they have shown little progress or change . . .” or when they were “nasty.” The nurses designated “being present” as an essential strategy in counselling and self-help, group development, and building trust and partnerships for therapeutic relationship.

The nurses also told stories of unstructured open dialogues on various topics that they initiated, many of which took place during the nurses’ lunch period. These informal discussions took place at their schools, women’s groups, liaison attachments to community centres, and women’s shelters with the women clients and interested staff. For example:

**Jan:** I always would do a group assessment on the women who were interested . . . I did bring people around and introduce them to the environment. I would also help link women with services where they needed them. I would do grief counselling and support around parenting. The lunchtime discussions were very interesting. Informal discussions were often around issues, an open discussion around the table, anybody could participate. The women who worked at the centre would be there, and they’d participate as well as the mothers with their children.

**Respecting difference and valuing diversity through authentic caring.** Many of the nurses, in explaining how they practised in a community development way, named respect for difference and cultural diversity and authentic caring as key elements in building
personal capacity through individual, group, and community interactions. They recognized that differences and contradictions with their women clients/community members existed. However, most of the nurses noted that the differences were not an issue or a problem most of the time. One nurse’s expression captured the view of many of the nurses, that “there are purposeful things that help diverse people to relate to each other” and rise above the apparent contradictions in their lives.

The nurses’ expressions and observations of their practice reflected genuine caring and authenticity, which translated into a skilful use of self in a variety of roles and strategies. It allowed them as nurses to connect with the women and to negotiate their differences, whether they be of colour, language, class, income, or ethno-cultural identity. The following interview excerpts illustrate these views:

**Catherine:** It [the difference] certainly is there I’m sure, because I am the nurse. I am not one of them. I think if you are genuine and don’t flaunt whatever it is you have, and talk about all your great holidays and those kind of things [differences will be made less apparent]. I try to be genuine and they take me the way I am.

This nurse explained that in working around the differences, she valued the women’s experiences and did not set herself up as an authority. She tried to establish a “power-with” atmosphere by having an “equal thing around the table,” whether sharing stories about their culture and old wives tales, using a map of the world to elicit their cultural experience, or being open and self-disclosing as appropriate.

One nurse stated that the socioeconomic and cultural differences between the public health nurses and the women clients were offset most of the time by who they were as people, their nursing expertise, and their ability to facilitate access to needed health resources:

**Mary:** Most of the time. I find that people know that you’re a nurse, but figure that if you’re standing there in front of them offering them help with something, that you must be there because you care. They recognize that you have some access to something they need, or you have skills to help them.

Mary further explained that she entered into relationships with the mind set that the women would accept her, and that she worked for them:

*I go in not being conscious of the differences. If I’m conscious of the differences, they*
will be. I go in assuming they will accept me. And I accept them and admire them, and praise them and help them, and find out what they want from me. I don't make assumptions. I go in with the understanding that I work for you.

The words of the following nurse highlighted the meaning of taking time to be honest, empathetic, and listening attentively:

Mary Lou: If you take the time to draw out all the experiences and the feelings, the person feels like you actually care about what they're feeling about, and that they are trying to get . . . [an appreciation] from the outcome and that you can bridge the gap. You have to be really sensitive and ready to spend sometime to listen to what the person has to say.

I make sure I don't come across as somebody who is in a different position, because I'm there to be with the client. I'm not there to be somebody else. I'm not there to make them feel bad or to point out the differences.

She also stressed that it was important "to look at how your image is coming across," including one's style of dress and attitude, which could create barriers. It was necessary for the nurses to adopt an attitude whereby they didn't "get all worked up about the environment, as long as it is safe."

One nurse described various strategies she used to connect with the women and negotiate the differences between them: easing into the situation, being careful with language, giving a number of options, respecting them as human beings, leaving the door open, valuing their experiences, and being culturally sensitive to their situations:

Tracey: Certainly when they see me coming . . . that can be scary. I'm a gentle person and try to ease into [questioning] what they need. It's not what you think they need. I try to be very careful with my language . . . giving them a number of options . . . trying to leave the door open . . . to relate to the person as a human being. Just the respect for the person. Talk to them at their comfort level and make them feel at ease. Just taking them at why they want to see me, whether it's a nose bleed or a rash or women's health issue. Then if they come back, we might get into more details just because they're telling me. [I try to] make them feel respected and that I am interested in them.

Another nurse used the term "intuitive adventure" to explain how she negotiated and
engaged in her relationships with the women. She explained the process as "light and easy . . . alliance building . . . real authentic . . . therapeutic reciprocity . . . more than a morally correct position, but a nourishing life force." Within this alliance process, she used various approaches to overcome differences such as being perceptive, modelling, and being creative. For example, with the use of a map, she had the women identify where they were from, which initiated conversation and storytelling that improved the group's cohesiveness and understanding. "The stories that people can tell . . . reveal where folks are at, and they explain so very much of peoples' behaviour." She described the basis of this alliance process as her commitment to "not feeling a separateness from the women." Other nurses expressed a similar value-biased approach in their work with these women.

Many nurses described creating more open, non-threatening space as an important strategy for decreasing barriers for women, particularly for those women from nonwhite, racial and ethnic backgrounds. As described in the following excerpts, the nurses used various techniques to accomplish this objective such as building peer support and friendship, and restricting male partners from attending the group sessions:

**Kay:** By just going around and being friendly and chatting with them, maybe encouraging them to meet somebody else. If you notice that two people are coming from the same culture or they share the same language, sometimes just making introductions makes it a little bit easier for them.

**Catherine:** What I found was there were women whose partners would never go to class [pre-natal], especially with some of the various ethnic groups. So I could not exclude them. So we had women with partners. It was a very loose terminology. When I asked them about support for labour, they were not sure whether they were going to have it or not. So I started saying they were to come to class without partners, so that it included a wider range of women.

**Joan:** . . . For example, the community development amongst the Moslem women; I think that we have certainly helped them to connect with each other. One of the ladies from [Healthy Beginnings program], who was not the director but the next down, said that husbands had approved the ladies coming to our group because this was okay for them. Men have a lot to say where the women go. One of the things we did to facilitate this . . . We used to
have men come to the group too. But then we had too many problems with the men because they were not nice guys. These guys were the controlling guys who had to keep their eyes on these gals for the whole session. A lot of them were very disruptive. They used to really stir things up, so we made a decision that we had enough. Some of the women were asking for this. We started getting a lot more Moslem women coming into our group because there were no men there. They could breast-feed safely without men looking or being around.

The women really do enjoy networking with each other. I imagine that they get together with each other in their apartments in the community. That has certainly been my experience with visiting other women who are in the Moslem community. They are coming back [to the Program] for their third, fourth, fifth child. . . . formed friendships. That is what we have tried to do in other groups, too.

Another nurse, referring to her practice with Tamil women, further illustrated that respect for cultural diversity and inclusiveness was a basic step in building trusting relationships, individual self-esteem, and community:

Mary: They come because they want to meet other Tamil women. It's not that we're not trying to integrate them into society, but they will integrate on their own terms. That is community development. With community development you can not say to the client, "we will meet you on your terms with the left hand and then on the right hand you must integrate into Canadian society, and do it on my terms." You need to bring people in where they are comfortable and you find out what they need.

Additionally, she noted that building trust in one-to-one and small groups was basic to community development to offset the barriers for these women:

It is with this room, this project [Growing Together], this staff that they are comfortable to build trust with. They like coming. They have to get used to coming outside of their home, being social in an English setting, coming to a group. These are not cultural norms for them. Either is being autonomous and not having their husbands speak for them; and coming out in the winter and
dressing their babies. Once they have gotten used to that, they then get used to weekly groups and these are the norms. We take them for granted. For these moms, they are incredible hurdles. It can be suggested that they come and have conversational English, or join Community Kitchen, or Playground Babies. Or hear from them that they want to come to something else after. They want to come out weekly. They need to be better integrated and we need to do that better.

Indeed, the public health nurses were aware of the potential problems that may have arisen between themselves and their clients as a result of barriers imposed by social and cultural differences. This recognition provided them with awareness, the first step in overcoming these barriers. By carefully situating themselves in the context of the women’s lives, listening to their stories and approaching the women as individuals, they were often able to surmount these barriers. As their dialogue indicated, these differences could also work to the nurses’ advantage in the development of programs and services. The differences not only provided a starting point for the discussion of various health and community issues, but they also allowed the women to bring their cultural experience into each encounter in a validating and positive manner.

**Engaging more deeply: Working with uncertain alliances.** The nurses gave numerous examples from their practice with women in high-risk environments that accentuated their belief that the distance between the initial contact with these women and the women’s self-motivated social action was significant. The investment over time to engage in building, maintaining, and nurturing trusting relationships, and nurturing and building solidarity between the women were identified as especially difficult as the women had complex health and social issues. Furthermore, the practical and relational knowledge and skills that were needed to outreach and establish a relationship had to be sustained over long periods of time. There was also a constant and demanding process of working through the many contradictions; “being with” the women, listening to them, using careful self-disclosure, supportive accompaniment, knowing when to bring in other resources, keeping connected to the women’s reality while challenging them to see beyond it, making connections in learning from each woman to attain the objectives of establishing solidarity
with the women. One nurse highlighted many of these characteristics as part of her empowering practice and categorized them further into the notions of immersion, giving, and negotiation. It was evident that the depth and breadth of the repertoire of knowledge and skills required of the nurses was complex and demanding, especially since there was a need to be innovative and timely due to the myriad of health and social issues the women and their families were living with. Additionally, the nurses needed and to go beyond expected traditional practice and the boundaries of community development practice normally permitted for public health nurses in the city Department of Public Health.

One nurse described her intense engagement to enable community empowerment for the women as a process of "therapeutic reciprocity," a "two-way kind of dance" with an eventual "magic transformation" when it works. This conceptualization captured the views of most of the nurses and highlighted the fact that timing, authentic engagement, being a reflective practitioner, and having both practical and relational knowing were critical factors that contributed to building alliances with the women. The following reflection illustrates the invitational and sensitive nature of building the relationship for mutuality and engagement:

**Carolyn:** Some of it has to do with a style which is light and easy until somebody says "come" and then once the person lets me know eventually what it is they are wanting, then to do it in alliance. It's a real alliance building. And there is an important part which is real authentic. It's kind of sharing. They call it in the literature "therapeutic reciprocity."

It's a two-way kind of dance. And when one little inch is permitted and a breather happens, and you have a chance to go another, to risk another venture... I feel a little part of the unleashing of potential positive energies from women.

When the glaciers retreated from the land, it rebounded. And this is what we're seeing: when the awful hurts have a chance to be lessened and the person rebounds. What I have seen among the women in this community is the rebound, but it is not a selfish keeping of progress to themselves. It's a giving outwards. It's giving to others. A magic transformation.

Another nurse shared a story from her assignment in the Growing Together project, which highlighted the relationship of the nurses’ investment of time and energy, the client’s readiness or capacity for empowerment, and the complexity of the situation. She prefaced her
discussion by explaining that outreaching at the Growing Together project consisted of individual outreach, either through one-to-one, pre-natal contact or group work at the community drop-in-centre. The outreach activities focussed mainly on birth assessment through contact in the home. She stated that the community development work she engaged in with the woman in the following story, and others like her, spanned several years. She clarified that to understand the woman’s story, it was important to know that the woman was pregnant and had been sexually assaulted as a child, and had not received help with the abuse issue. The nurse reported that she spent one and a half years in frequent, regular visits to the woman’s home for the purpose of building trust, helping her to focus, and building her self-esteem and confidence to attend a supportive-educative peer group program. The nurse also described the helping process as a “dance.” She described the process as including various strategies: frequent careful assessment, active listening, reflection, role modelling, didactic teaching on breast-feeding, baby care and self-care, mobilizing resources such as a homemaker and social worker, and importantly, “staying with her when she was nasty”:

Jennifer: “[I] met the mother at the birth of her second child, the first one born in Canada. It is that outreach of contract assessment. I met her in her home and got her trusting enough that she came to a newborn group. The Filipino population is very private and do not like to come to groups. She got some group skills, some comfort and trust in meeting other mothers. So we’re building readiness. Then she came to a Community Kitchen. At the same time the little girl seemed to be very slow in growing, and there were issues around feeding and development. She came back to the Development Clinic.

After the Community Kitchen, the women proceeded on to being involved with the initiation of the women’s support group and is training as a Community Kitchen leader. Also, four of the women from the women’s group began a catering business, meeting with community consultants, learning business skills and advocacy skills. She is braving it out. This shy, little mom who wasn’t ever going to come out of her home after the birth of this child, did, because she trusted the public health nurse.

An excerpt from another nurse’s narrative further highlighted the importance of establishing authentic alliance with the women clients/community members and reflected the “tapestry” nature of the nurses’ community development work. It also supported the role that
standardized supportive-educative group programs played as stepping stones for social change. This story highlights the nurses' creativity, the relevance of the connectedness of the public health nurses as a community of nurses in facilitating community empowerment, the nurses' sensitivity and reciprocity with the women, and the critical role that organizational support from the nurse manager played. The nurse explained that a group of women had completed the Ready or Not parenting program with another public health nurse and wanted to continue as a group. This particular nurse was asked to meet with the women due to her expertise with a community development program designed for low income women. The nurse prefaced her discussion of the particular program by describing the context of the "lived reality" for this group of women:

**Kristen:** *They were a pocket, a housing project in the middle of an affluent area. They were feeling the scapegoat of the community. Whenever there was a problem in the community, it was "those people from the housing project." They didn't feel comfortable going elsewhere in the community. They didn't feel that Parks and Recreation programs were meeting their needs. It was geared to the middle and higher income people in the community. The times and child care arrangements and all, didn’t fit the low income women. There were women in there wearing fancy fitness outfits and they [the poor women] would feel totally out of place.

Most of them were on social assistance. When you’re involved in those big bureaucratic systems, you begin to feel like you don’t have a voice and the system just takes over, and you have to fit the policies of the system and that sort of thing. So you get a little defeated and stop speaking up. And it takes a little bit of work to get their voices back.

*They just needed some encouragement to speak up.*

When I examined the basis of this last statement in terms of the program and the nurse’s approach, I discovered a rich collection of empowering strategies that the nurse used to engage in the women’s struggles and to advocate with and for them. The essential empowering approach was based on the premise that the group chooses their direction and builds peer support within the group.

**Kristen:** *It’s a concept [the program for low income women] and it’s an idea that there will be life skills and there will be fitness and health information sharing. But*
exactly what will happen is up to the group. They choose. I encourage them to work on how to set goals for the program and then to set goals for after the program. They also buddy-up with a peer in the group, so that they can encourage each other in terms of the goals that they have made for the program. The goal can be whatever they want. I work the program and me to them.

Kristen further described how she practised with the women in an empowering way: valuing their opinions, “going in a gentle way by spending time,” respecting where they were coming from and what they could endure in confronting contradictions in their lives, encouraging and pulling out the strengths in the group, helping to increase their confidence to speak up through group-building activities, providing a “gripe auction and discussion of gripes.” goal setting, and establishing peer support. She explained that along with these approaches, she educated them about community resources. In addition to these strategies, she gave extra of herself in order to build a conducive milieu. She bought and prepared food for the group sessions, borrowed equipment, used her connections to get them an appointment with management for the Parks and Recreation facility, and accompanied them to seek managerial support from Metro Housing.

When I probed more deeply with all the nurses to understand how they engaged with the women to enable growth, many expressions about their beliefs and descriptions of their practice revealed the nurses’ skilfulness in building interpersonal relations through the use of highly developed communication expertise, experiential knowledge, and reflective practice. Although not all nurses demonstrated the same degree of expertise in interpersonal relations across individual, group, and community interactions, some common characteristics existed. The starting point was always the nurses’ ability to tune into the women’s situated reality, to be flexible, and to adopt a democratic facilitative stance in how they engaged. This approach enabled the nurses and the women to mutually solve the problems in a given situation.

Thus, engaging and building partnerships was clearly rooted in getting to know the women, their context, and their strengths, believing in them, and allowing oneself as a nurse to be responsible and authentic in the situation. The following vignette highlights these characteristics.

**Carolyn:** Intensive care doesn’t just happen in ICUs. If you are prepared to be a factor in a family getting over a hump, you can’t sit back and say, “Well now, what is
it you were going to do next?" If you become part of the team, you are part of the team. Because there isn't a bag of tricks or knowledge and skills that has such a range. It's almost like putting a label onto one which is more "high falutin'" than the other. I think engaging is other than nurturing, and being collaborative and consultative. It can be any of these.

Carolyn further explained that her practice was not static. She did not stop her work at 4:30, but moved into different spaces according to her client's needs (individual, family, group, community).

Another nurse described her practice as "inspirational" rather than prescribed, and emphasized that a "free flow" unfolded, because she was responsive to the women and their efforts to build their strengths:

Penny: If you were to see me interact with the women, it isn't like miracles. It isn't that nursing intervention is number one. It isn't a formula, a recipe. It's that I've gotten to know these women and I build on their strengths. It's inspirational. She said to me, "You inspire me, you motivate me, you push me."

They identify with me as a human being. They never see me as Public Health. They know I'm a nurse. I've lost that label in that group. I'm not threatening anymore. I think because they know I believe in this wholeheartedly, they know I have as much at stake as they do, even though I'm not a parent. That's a big contradiction. I know the issues so well that I want to do something about them. Sometimes I'm not getting paid overtime - that has made them believe in me as a core person. Once I commit to something, I'm going to be there. I talk about my life as not the mainstream.

Penny believed that her authentic engagement allowed the women to see beyond their contradictions. She made the connections between their common understanding of their experiences, valued their cultural reality, and was committed to them. It was apparent that her expert knowledge and authentic use of self helped to overcome any potential conflicts between them. The nurse further explained that she put in extra time outside prescribed hours of work and used practical strategies to connect with the women. As a result of all these factors, she believed she was able to risk confronting the women with the apparent contradictions in their lives, and coaching and counselling them into overcoming the
oppressive situations in their world. In doing so, she believed she continually built their self-worth.

A pattern that emerged from some of the nurses' stories of their practice was that as mutually trusting relationships were established with the women and community resource workers, permission was implicitly given to the nurses to move further and to take more risks in challenging and negotiating contradictions, and to assume roles and strategies that would inspire hope for the women. Concurrent with this process, the nurses gained an increased sense of agency, and valued their work as authentic, particularly as they engaged more deeply in the women's lives. As shown in the stories that follow, the nurses were often able to provide more than basic health care, and engage with their women clients on a personal level that transcended social and cultural differences, encouraged respect, and resulted in a two-way flow of information and learning. For these nurses, this deeper relationship represented an authentic practice for a public health nurse.

Tracey: One woman, in particular, I've seen her face about three times [at the shelter]. She brought it up in talking about the cycle of violence. And she felt so bad about leaving [her spouse], about going back and leaving. I said, "You know, there's a cycle, but also as you leave and you come back, you're farther away from that person. The more and more you leave, the farther and farther away you get from that person, so the safer you get." So saying to her that you haven't failed, it just takes time to break the connection. So just give them support, not looking at the negative. When they come back, that is a big achievement. I always say "You're pregnant, you're going to have a baby, and you're in a shelter, you must be very stressed." Acknowledge they are struggling and courageous for even being there and making the decision.

Carolyn: I didn't have a clue how to behave and proceed with the women, other than just taking one little step at a time. What developed was an accumulation of knowledge that was so geared to the population. They were teaching me how to use the ropes to their benefit; to what they were needing, and how to create bridges among very despairing people in like circumstances.

Progress was very slow, but surprisingly accumulative. We didn't know what to do, but we figured it out. Women's needs were acknowledged and carefully
The nurses acknowledged the significance of the nurses’ practical wisdom and communicative expertise in building effective relationships with women in multi-challenged situations. It was evident that the practical knowledge and moral integrity of the public health nurses were critical in building capacity for this population of disadvantaged women. The nurses stated repeatedly that it was essential that they be open, honest, sincere, and nonjudgmental in their interactions with the women. It was also important for the nurse to know when to stay involved and be supportive and when not to, when to refer to other resources for the benefit of the women and when not to, according to what the Department of Public Health allowed.

I asked the nurses how they could be open, honest, and nonjudgmental in connecting with the women’s reality as they challenged the women to see beyond the contradictions in their situations. The nurses explained that the public health nurse continually made judgments, but hoped that they were not being judgmental and critical. Being judgmental and critical would immobilize the women and/or damage the relationship and the nurses’ ability to work effectively with them. The following narratives capture the delicate and skilful interpersonal relations that many nurses employed to negotiate the situation: openness, honesty, and non-judgmental behaviour; respect for the women’s right to make choices; harm reduction, understanding, and being there with them; and building a network of resources around the women and their families. In essence, skilful discernment and therapeutic interaction in any given situation was critical.

**Mary:** It’s semantics. I can be honest and sincere. That doesn’t mean I disclose everything I’m thinking. If I thought it would help you to know, “I had concerns about . . . Made some judgements, some quick assessments, some assumptions in judging her. If I was honest where the concerns were . . . because she had given them to me already, to pretend that they didn’t exist . . . I wasn’t going to be able to help her. I was going to have to call Children’s Aid. So I might as well be up-front with her, and proceeded in a delicate way. You don’t just blurt it out, didn’t do it in a hurtful way, or threatening way. Did it in a very “I’m here to help you, but I want you to know this is what I see, and this is what you’ve told me. I’m here to work with you . . . Let’s look at it together.” She appreciated that it was all on the table and she
had some choice in it. She agreed to come into therapy. These girls normally don't go to therapy. I came back on a regular basis. I would share with her what she was doing well, what concerns I had, within limits. There were lots of concerns and you pick and choose the big ones because it's overwhelming; you'd be there all day shaking your finger at her. We share the biggies, and you find things to praise . . . Support her.

**Kristen:** You're always making personal judgements. But I may be working with a group of clients that I may think something about them, but I'm not going to express that to them. I'm still going to treat them as if it's their right to make their decisions even though I may not agree with the decisions.

There are some people who are going to abuse drugs no matter what. So the least we can do is help reduce the harm, do things to make it safer for those people who are going to do it, anyway.

Women who are in an abusive relationship and aren't ready to leave . . . I've worked with a number of women in that kind of situation. You know that the best thing for them is to leave, and you want to shake them and say "Just get out of this relationship! Wake up!" But that is not where they are. So, it's letting them know that you respect their decision not to get out of that relationship at the moment. I don't say "Listen to me and get out of the relationship or I won't work with you." But still be there for them; encourage them to have a safety plan, help them work that out but still respect their decision to stay where they are. If they get beaten up again and they come to you, not to say, "I told you so" but to say, "I'm here for you. What are you ready to do now?"

Several nurses in the study told stories of their beliefs and practice that went far beyond hearing the women's stories, helping them to have choices, and making connections. These nurses felt their responsibility was "to witness" and take an obvious stand for social justice and structural change. A number of the nurses in this study saw this action as integral to their community development practice with the women they worked with who were marginalized. They felt compassion for the women in their oppressive circumstances such that they were energized to speak out about grave injustices through various strategies such as modelling and advocacy with and for the women. The following excerpt describes the
meaning of witness to one of the nurses:

**Carolyn:** Witnessing, that audience, that group, that whatever it is you are communicating. They don't have the privilege of knowledge that you have for whatever reason. The privilege of gaining that knowledge comes with an obligation. Particularly if one has a core value of social justice. That is really the core value. So society may wish to engage in avoidance coping for nursing - it's called unilateral neglect. The group of people you are trying to reach does not have the capabilities of perceiving or knowing whatever it is . . .

So the privilege of gaining that knowledge through disclosures, confidences, and what we have to see, society forces us to carry we're forced to see like lots of people; the police, ambulance workers, folks who go into homes who are required by society to do that, to be a vessel.

You can just bounce it off or you can just let the whatever it is bounce off you, or you can take it in and hold it, which is not good either. Or you can let it flow a bit and then project it out.

Many excerpts across the nurses' stories explicitly demonstrated the evolving knowledge, skills, and responsibilities that the nurses assumed in nurturing the women's capacity for individual and community empowerment. As time progressed, the nurses' interpersonal, group, and community building skills increased. They acquired increased understanding of the women's lives, became more conscious of and deliberate in their knowledge and skill building for personal and community capacity, and increased their facilitation and leadership expertise, which enabled them to be more authentic. The following vignettes exemplify this reality:

**Penny:** I'm at a point where the content doesn't matter. It is the facilitation process. It is the connecting with . . . I'm very good at that. There is a difference in practice. There is a difference in comfort, in confidence, in the skill.

**Kay:** Beginning, a facilitator in a sense. You are facilitating health issues and social issues and making people feel comfortable, encouraging them to ask questions and making referrals. We still do this, but we do things in more depth. We are more conscious of trying to make people feel comfortable.

**Tracey:** It was really hard to put myself in their shoes. But I've seen a lot of women
and hear some of the stories, and I understand more. I’m not in your situation. I don’t know how you feel. . . I can just imagine it.

Just to give the power because they need the power back. They’ve lost it. The worst possible thing to say is, “I know how you feel,” “when you haven’t been in the situation.

One of the nurses in the Growing Together project discussed how the project matured into a more obvious community development process. Initially, the staff of the centre for children’s mental health were not practising within a community development philosophy. However the roles, leadership expertise, and commitment to community development by the professionals evolved in large part through the public health nurses’ involvement. An alliance between the staff at the centre and the nurses developed such that there was more effective use of the resources of the staff and the public health nurses:

Jennifer: And it has matured, how those staff resources have been used. . . . We started to develop programs in true community development style in terms of what the parents and families were telling us they needed and what we saw they needed. We started developing Life with Baby on a permanent basis there, also utilizing years of experience of what worked and didn’t work. Community Kitchens, . . . implementing them in a pre-natal model, which was starting to be developed in the West End.

Building Connections and Overcoming Barriers to Create Partnership Milieu

The public health nurses in this study continually strived to build connections to inspire a sense of personal empowerment for their women clients/community members by drawing the community to them and getting them into the community and peer support groups. In cases where the women were already involved in group or community programs, the nurses facilitated the capacity of the group or the community to advocate for themselves and for social change. The theme of Building Connections and Overcoming Barriers to Create Partnership Milieu consists of the sub-theme: Building Trusted Networks to Open Doors, which is examined in the following section. This theme consists of several elements: (a) “Working with Multi-disciplines . . . Part of Our Culture”; (b) Creating Coalitions and Other Resources; (c) Consciousness Raising: Educating Other Professionals; and (d) Building Reciprocal Relationships with Community Resources.
Building Trusted Networks to Open Doors

The nurses consistently used the term "we" in describing their practice. In most cases, the term was used in referring to the nurses and their women clients/community members. However, it frequently referred to other public health nurses and the community resource network, which the nurses perceived as part of their definition of community. As Chapter Four describes, a recurring theme was the time and effort the nurses invested to develop trust and credibility with these community resource persons and other public health nurse colleagues to gain legitimacy and earn passage to create, or be invited to participate in community development programs. This same effort was required to develop and sustain a meaningful partnership milieu for their development work in general. The nurses were emphatic that their practice depended on the connections they made in the community over the years, and how, as nurses, they proved their abilities to other professionals, who then referred people to them. This process was described as taking from a few months to several years in some cases. The following example illustrates this process for the nurse working in a high school:

Elaine: *If people know you, they see you every so often or can leave you a message, then they’ll ask you about different things, and that usually takes a good year into a situation for them to ask for help or to say, "What do you do?" Once you’ve worked with them, it opens up a whole number of doors. Aids educators, sexual health educators, STD personnel are able to come in more freely, because I’ve been able to open the door for them.*

*The relationship with the school is very important, because if a nurse has a good relationship she can get many doors opened.*

Elaine noted that although she was the only health and nursing resource in the high school, it took over five years to build a trusting relationship with the school staff that enabled her to be invited to partner with the staff on broad health issues and concerns that affected the student population. Along with her pre- and post-natal program activities, she was involved in the student intake team at the school. Through this mechanism, she provided input on student health issues and built her credibility as a trusted colleague. Additionally, she was a member of the school committee that examined literacy, racism, sexual
harassment, poverty, and disparity among students, and developed related programs with students and staff. She perceived her relations with co-workers to be effective and collaborated with them on various high school and Department of Public Health programs.

One other nurse explained that the women she worked with in the shelter for abused women formed a "family" with other abused women in the shelter over their two-month stay. She perceived her role as making connections with staff and supporting agencies for the women and the shelter:

**Tracey:** *We [the shelter] are making more of a connection with Women's Health and Women's Hands. I am making more of a connection with them for the women and the shelter.*

"**Working with multidisciplines ... part of our culture.**" The image of a "tapestry" or a "puzzle" in which the various parts were essential in forming a complete picture metaphorically portrayed the connectedness of the public health nurses with each other and with other professionals and community resources. They saw their interest and ability to make connections and establish conditions for effective formal and informal networks as integral to the public health nurses' way of practising. They described these competencies as "part of our culture." They believed that these assets emanated from the public health nurses' basic strength as members of a "community of nurses" with a broad repertoire of knowledge and skills. According to one interviewee:

**Joan:** *A number of these women [in the Healthy Beginnings program] will be referred to district nurses to see them one-to-one. So they are coming into the group to see us but are also getting one-to-one support in the community, which can continue for a long time. I have worked with this long enough to see just how much of a positive post-natal experience the women can have when they have connections and support.*

Another nurse described the wealth of knowledge, skills, and energy that public health nurses brought to the community partnership. With reference to the Growing Together project she noted that these resources included experiential knowledge of families and children, skill in performing high-risk assessment, and working within holistic practice models:

**Mary:** *The nurses brought a phenomenal amount of experience in doing physical*
assessments, of working with high-risk populations, with training and doing community kitchens and parenting programs. We had done a range of different parenting groups, and we bring a flexibility. We could put them together in multiple ways. We bring pre-natal teaching. We brought a wide range of skills that we all had. Not only an interest, but great expertise in working with families with children who were from birth to five years.

As a team [of] one of six public health nurses, we were better than one individual [nurse]. We brought together incredible energy. Nurses, especially public health nurses, like and are used to working with multi-disciplines. This is part of our culture.

I think if you asked public health nurses who they were, they would say they were a little bit planner, a little bit policemen, a little bit social worker, and a little bit of this and that, a little bit of a welfare worker. Nurses feel that they bring a lot more than just clinical knowledge to what they do in the community... [They] desire to seek changes outside of the medical model.

Creating coalitions and other resources. One of the nurses provided a poignant example from her practice that highlighted how she and a colleague showed their initiative and commitment over time to a community development way of practising. They developed a coalition to correct an inequitable, health-damaging situation for senior citizens residing in a senior’s metro housing complex, which the public health nurses visited once a week for many years, doing individual-focused case work. The nurse tried to increase their preventive and health promotion activities, with poor response. Consequently, they initiated a meeting of a team of public health nurses who were familiar with the senior’s complex and the neighbourhood, to summarize the issues existing in building and community. The nurses wanted to further assess the situation and to help the residents address the many issues that they as nurses were familiar with: individual safety, limited accessibility to health and social services, fear, isolation, and cutback of support services in the building. They organized a meeting with key residents and another health professional from the local community health centre. Together, they took their concerns and proposal for action to the Long-Term Coalition in their community area, of which the residents and their partnering community
professionals were members. The president of the coalition rejected the proposal; however, some of the member agencies approached them to express their interest in involvement. On that basis, a coalition of residents and community professionals began. The following story illustrates the values and involvement of the public health nurses in giving direction to the coalition:

Tracey: It's really a network of seniors that live in the area, live in the building, and do whatever. It's really setting up the network and letting the tenants take ownership of their building, rather than us going in there spearheading everything.

We just recognized a need - that there was a gap. Connected, communicated with people that recognized the same things, and tried to communicate to a larger group. We've done a lot of network building in terms of the agencies and other community members. There was a readiness to start something. It's been working, subtly working. We just hit at the right time, with the right people.

Why are we all doing different things when we could all work together rather than on different levels of competition? Let's work together as a group.

We started getting together as a multi-agency group, a coalition, working together to meet some of the needs of the tenants. Our underlying thing is that we want to give power to the tenants to run their own thing and step back but always be there as a safety net if they needed help.

Meeting in small groups, setting agendas, trying to get things going, preparing for Long-Term Coalition, and trying to organize the big meetings afterwards. It was quite a bit of investment in the beginning.

We brought these people to the group to talk about Care Watch. So [we] definitely [had] a leadership role, but really a subtle one. The meeting itself had a life of its own . . . It was a deliberate one, but in a subconscious way. I don't think we realized. We just wanted to see what would happen. We weren't expecting a lot in terms of being very rigid about certain things or being very present as a public health thing that we brought there.

It was apparent that the public health nurses did not need to do much ground work to build the coalition, as they had already established a readiness in the community and the capacity for leadership among some of the seniors in the housing complex. They invested a
significant amount of time to establish a structure and process for the meetings, and performed various leadership roles to bring direction to the coalition. These roles included: chairing the meetings; setting the agenda; establishing communication links among agencies and tenants; building a trusted network for the tenants, the agencies, and themselves; using peer support to build empowerment and partnership relationships; and mentoring the residents with the assistance of invited guests, community members, and peers. In the early stages, the nurses saw their roles as facilitators and catalysts for group development and tenant empowerment, but they also valued the experiential knowledge of the tenants.

**Tracey:** As a resource . . . they should try to develop this [coalition], because it would be more valid [as a result]. They are seniors. Us standing up there talking about falls - they're not going to listen to us because we're not their age. The connection wouldn't be the same. [or] be as valid.

The nurses who were involved in coalition building noted that eventually they stepped back and assumed a "background role, a subtle role in terms of leadership," letting the seniors take ownership of the coalition. The following vignette illustrates this point:

**Tracey:** Okay, so we've done this. We're going to step back. I think we should all be chairing the meetings, doing the minutes.

In the background as more groups are breaking off and doing different things, we're stepping back a bit, but our presence is still there.

Our role has changed over time from a leadership role in being out there driving the meetings, setting the agenda, to sitting back and letting go and letting people take ownership. We're relating it [chairing sessions]. We're hoping it's equal. I can't say who is taking the lead, but what I can say is that we're hoping the Tenant Association is going to be off and running. They can come back to us if there are problems and to discuss "what next."

When Tracey was questioned about how she and her public health nurse colleague knew when to let the leadership of the group transfer to the seniors themselves, her sense of practical experience and intuitive knowledge of group dynamics and growth, and the nurses' sensitivity to seniors as a community was reflected:

**Tracey:** I think we just came to a point where we agreed it was time to hand over ownership of the group meetings to the group. Easing back from "this is our baby,"
"no, it's not." It began as that, but it's bigger. It's way bigger. So just recognizing that it [the project] needs to develop and it needs to grow and progress.

At one point someone proposed, "Do we really need to be meeting anymore? No we still need to meet, as there are lots of good things going on. We need to keep this group and eventually we'll get to this."

We're continuing to try to refocus. If the group gets off track, we're trying to refocus it back. We need the tenants to try and take this over and spearhead it, although we'll always be there to help.

The public health nurses believed they were important in this interagency coalition for maintenance of a community development approach and negotiation of the value of the tenants and the coalition. They believed that part of their responsibility included maintaining the coalition and not letting it disband, because they perceived that the group was not solidly formed. They identified roles for themselves as interpreters of the stages of group growth, facilitators for external tenant-peer support, and gatekeepers for keeping the coalition focussed on its purpose, as exemplified in the following passage:

**Tracey:** There have been two times in our history with this group that somebody has brought up, "Well, why do we need to meet anymore? I think that things are okay." This is really important for us to stay involved. It's at a very fragile stage. It could still fall apart. It's not solidified yet. There are a lot of things going on but it's not safe enough yet to leave it. You can just sense it. You look at the indicators. Maybe the Housing Authority thinks that they're doing their job and they don't need anymore input. But that's not right. . . . Supported in terms of "this" staying as a group, an important part of the group. I often wonder what would have happened if we hadn't been there.

Tracey noted that the time commitment to the coalition varied significantly. In the beginning, she and her colleagues invested a great deal of their time, but as the coalition developed a life of its own, their time commitment decreased significantly.

Tracey described similar efforts to collaborate with staff at a shelter for abused women and support agencies affiliated with the shelter, in her attempt to decrease barriers for the women at the shelter and to promote their personal empowerment:

**Tracey:** I'm starting to network for the shelter, on its behalf with different agencies
so the women don't have so many barriers to health care. The counsellors work on certain things and I work on other things and we work together to try and help the women take back their lives. We [the shelter] are making more of a connection [with Women’s Health and Women’s Hands]. I am making more of a connection with them for the women and the shelter.

She continued to explain that she was in the process of building a resource network of doctors for the women, promoting accessibility to essential services, and enabling educational and support programs. One such program was a Department of Public Health program Nobody’s Perfect, which is designed for parents who have children five years and under, receive a low income, are possibly isolated, and may have minimal parenting support. She hoped to build the women’s parenting knowledge and skill through group learning and support. She enlisted the involvement of one of the counsellors at the shelter to take the Department of Public Health’s training course in Nobody’s Perfect so they could co-facilitate the program.

Another nurse talked about her unique skills and the process of building connections to overcome barriers constraining an ethnic community she worked with in her affiliation with the elementary school system. She explained her unique skill as “making connections in the community, convincing other agencies that there’s a need, putting a little team together and doing it.” She explained that she used established Department of Public Health programs, i.e., Ready or Not and Nobody’s Perfect, to open doors and gain entry into the community so she could build links and establish credibility. She recognized that the first step to increase accessibility to health resources for the community was to translate the Department of Public Health programs. Therefore, she initiated a coalition with the school principal, other school staff, the parish priest, and the community developer with the Metropolitan Separate School Board. Together they organized a Parent Forum, starting with the question, “What do you need from us to parent more effectively in the 90s?” With the assistance of her nurse peers and other professionals, she had the English program Ready or Not translated. The parents eventually assumed ownership of the parenting program and developed various resources, such as videos. Over time, they were consulted by other community groups who saw a similar need.

Another nurse illustrated how she worked with junior high and high school students
to establish an intergenerational group for capacity building for both groups of students. She saw her role as motivating the students to see beyond their group, to see themselves as a resource, and to see themselves as role models for disadvantaged grade seven students.

**Consciousness raising: Educating professionals.** Several nurses expressed the view that a significant aspect of their practice was to decrease the stigmatization of their women clients/community members. One way to do this was to educate other health professionals about the problems of discrimination and to increase their awareness of the injustices the women faced. For example:

**Tracey:** I'm just starting out at the shelter, so I'm trying to make connections with agencies so that they are increasing their awareness of the clients who come from the shelter and not stigmatizing them. Making them [the agencies] aware that there are so many issues.

I'm doing more one-to-one counselling with agency people . . . networking. It's a beginning piece. I'm gathering information. Even if I'm not writing down on paper, these are the things that I'm seeing and plans that I'm trying to develop. Networking with the agencies is the biggest thing . . . raising their consciousness, what can they also help the women with? How can we all do this together? Certainly I see raising people's awareness of what it means to come from a shelter like this is important, as people don't know about this shelter. It's new. At some point, I would love to sit down with Women's Health and Women's Hands. If there is a woman who has a problem, we can send her directly to this place or to family medicine, because often when I call the hospital, I have to go through all this red tape in order for them to see the women. It would be nice to take down those barriers for women.

I think there needs to be something set in place at the shelter for the women so that they can automatically go to places and get access to health care without me having to be there to direct them.

Another nurse gave examples in which she challenged the discriminatory language used by professional colleagues in reference to women in high-risk environments:

**Carolyn:** I'm just really troubled by the term "high-risk patient" or "high-risk women." My sense is that the conditions that the family are living in puts
them at risk for many things. It could be abuse. It could be neglect. It could be drug use. But it is not because the women are high-risk, it’s the situation.

There is a more accurate way and also a respectful way of describing people one calls “illegal.” It is more respectful to refer to people without immigration status as “undocumented immigrants.”

**Building reciprocal relationships with community resources.** The nurses described many challenges they faced in their relationships with community resources, including the way in which referrals and projects were presented to them and how they were valued by co-workers. However, foremost they noted that they engaged in reciprocal relationships with many positive outcomes for their collaborative efforts. The nurses attached a high value to their supportive networks, and the interest and support they received from their co-workers in various settings. For the most part, the feedback the nurses received from their professional colleagues was affirming. They felt valued for their knowledge and efforts, relied upon, and acknowledged for making a difference. The coordinator of a pre-/post-natal community development program that one of the study participants was involved with took time to meet with me to comment on the public health nurse’s expertise with the program. She freely commented on how fortunate they were to have this particular nurse due to her commitment, flexibility, and effectiveness in working with the women. She said that it was hard to say just what it is one does in this type of work. “It is going the extra mile without being a doormat.” She saw the public health nurse as a key person in advancing the empowerment of the women and the program through subtle and overt ways. She acknowledged that a lot of public health nurses have been involved in the program, and they could not all work in such a setting. “The work is so transdisciplinary with respectful role negotiation and blurring.”

Some nurses commented that when they worked in traditional one-to-one practice, the affirmation they received from their community colleagues and fellow nurses was often their main evaluative feedback and source of support, particularly as they received little support from their nurse managers. As one nurse stated,

**Tracey:** Sometimes I’m pulled in many directions, but I feel I’m managing it. You know, you are a really good face for public health because the women [staff] trust you. They come to you. They feel comfortable with you. To me that was a big
complement because you don't know how you're doing. Nobody really tells you. So you're looking for a measuring stick or something.

Nurses involved in designating community development program/projects acknowledged receiving many tangible supports, along with affirmational support:

**Jennifer:** *Working in partnership with Growing Together, with the centre staff, I didn't have to spend as much time on one-to-one because I had a partner who did it. This is an advantage of an integrated model.*

Jennifer also spoke of the support she received from various administrative and program coordinators within the Department of Public Health, and the wide array of resources available to assist the program personnel and the women and children participating in the program. Many of the resources were not easily accessible outside of a designated community development project.

However, one of the most challenging relationships the nurses experienced was with the Children's Aid Society, an association that affected the nurses' abilities to establish trust with their women clients. The public health nurses worked closely with the agency, as many of the women living in very high-risk environments were in need of pre- or post-natal care and were initially referred from Children's Aid. Children's Aid was seen by the women as a resource and/or as a threat to losing their children. The relationship with Children's Aid posed a delicate legal and moral dilemma for the public health nurses. One nurse, in discussing this situation, explained that she resolved the dilemma by placing greatest value on the life of the child. Consequently, she accepted and worked within the limitations the relationship presented in her practice. For example:

**Jennifer:** *If they [women clients] have mental health problems, then probably the chances that they’re going to be able to take a child home from the hospital is going to be a problem. You can work with clients and try to prepare them as best you can, but still Children’s Aid is going to be the one that is going to make the final decision from hospital. They certainly may reject you. We can’t fix everything and you just have to accept that. You try the best you can, but I have obligations legally and morally too, that the child is going to be safe.*
Measuring Progress

Through their narratives, the nurses in this study repeatedly reported that their practice was very diverse, with much of it elusive and informed by the practical wisdom of their daily practice experience. It did not fit neatly into a "box." Actually, their stories revealed how they often worked outside the box and made a difference in building individual and community empowerment for women and their families living in high-risk environments. Several of the nurses acknowledged through their descriptions that they did not agree with the Department of Public Health’s standardized measures and identified their own indicators of progress to measure and evaluate their practice. This action was seen implicitly through many nurses’ stories. This phenomenon lends further support to the nurses’ commitment to their empowerment agenda with their women clientele.

All the nurses noted that their identification of outcomes was not valued by the health care culture and their Department of Public Health, which they believed placed greater value on efficiency and standardized measures than on measures of success consistent with a community empowerment process. The following examples poignantly illustrate the nurses’ commitment to an empowerment paradigm in measuring the value of their practice:

**Penny:** Several times they [nurse managers] have asked me to pull out of this network. I said, "I’m the connection here. I’m the birth mother. I’m mobilizing women. If you pull me out, where is the credibility?" In community development, you don’t have to pull out. That’s not success. Community development is when the whole thing is running. You’re always part of the community. Community development is milieu-building. True community development is what nurses have the skill in. That is not documented, it’s not concrete.

**Mary Lou:** What we do a lot isn’t a task. We work with people around a lot of psychological and sociological issues, mental health issues which can be measured, but you have to have a fairly sophisticated tool to measure that sort of thing. When I go in to work with the women, the prostitutes for example, talking to them about violence and depression is going to have an impact on that person’s life and health status. But it’s not something I can just tick off in a box to say I did this. So, it’s hard to measure. I think it is still valuable.

Mary Lou noted that she understood outcome-based measures of practice and worked
toward it, but she did not necessarily use “outcomes” the way the Department of Public Health, the Ministry of Health, or politicians valued them. Furthermore, when she could, she challenged the politicians valuing for economic outcomes as the only marker of success.

Another nurse explained how she saw the public health nurses’ practice threatened by the current “outcomes movement” in health care research and the persistent adherence in the department to an epidemiological approach as the only measurement:

**Kristen:** *If it comes to cutting, probably what will stay is the stuff that can be proved epidemiologically, like communicable disease control. We will always have communicable disease control, but what we do is more complex. Epidemiology is just a piece of the whole person and their life and their community.*

When the nurses were asked to identify the measures of progress outcome in their community development work, they recounted many examples, which included personal capacity building, small group development, and community capacity building. Personal capacity building and starting within the women’s lived context and building their self-worth were consistently defined as the beginning of an enabling process and a main benefit associated with their involvement. They believed their focus here had many tangible outcomes: allowing the nurse to continue to work with the women and their families, helping them to make social connections to getting them involved with other resources, improving their access and that of their family members to health resources and health care services, and over time, inspiring them to know their own power as women and to act independently from the nurse in such a way as to give outwardly to others, starting to live more independently in the community.

The following excerpts from the nurses’ stories elaborate on these outcome measurements. One nurse who worked with women in pre- and post-natal group sessions indicated that she was more concerned with the women’s sense of self-worth and in nurturing their capacity to find their voice rather than with the program content she was expected to transmit:

**Catherine:** *Well it’s trying to show that they are important and they have something to contribute, and certainly in the evaluation, I have had the women say what they got out of the class was to be able to feel they were important and to speak out, say what they needed, and go and get it. That seems to be the essence. If they don’t learn*
anything else, that is what you want them to do.

She believed that the women’s increased sense of self-worth allowed them to become open to make social connections within and outside the group, and build individual and family support. The women exchanged phone numbers, joined other supportive-educative women’s groups, and some called the nurse when they delivered their babies.

Another nurse told a similar story. She explained that as the women in her pre-/post-natal nutrition and support group program started to value themselves, they shared information and helped others, some linked to other programs at the end of their pre-/post-natal program, some returned to the program as a volunteer, some joined committees, and some talked to other groups about the program.

Kay: The longer they come and [the more] they start to feel comfortable with each other, and they feel they have opinions and start to see changes amongst people. Women coming back with their babies . . . gone through some difficult times with breast-feeding and so on. For that mom to be able to share that fund of information with another mom, they start to really feel good about it. They start to value themselves. They realize they have skills and can do lots of things. They know some answers and can help other people. When it’s time to leave the program, it’s a pretty sad time sometimes. but hopefully we’ve linked them up with others in the community.

The following passage describes the nurse’s goals of building the woman’s self-esteem while keeping her grounded through therapy. This example provides another illustration of how the nurses’ practice was fundamentally rooted in valuing women and building their personal capacity in their lived reality to enable them to begin to look and move outward. In the example, the complexity of the situation and the nurse’s repertoire of skill in attainment of these goals is evident. The nurse declared that it took three to four years of regular nursing contact, along with involvement of other professional services with this woman and her family to see positive changes.

Mary: Let’s look at it together. She appreciated that it was all on the table and she had some choice in it. She agreed to come into therapy. I came back on a regular basis. I would share with her what she was doing well, what concerns I had, within limits. There were lots of concerns, and you pick and choose the big ones because it’s overwhelming. You would be there all day shaking your finger at her. We share the
biggies and you find things to praise. Support her. She got into therapy for probably eight or nine months a year. She got really messed up again, made bad judgements. Then I got her involved with Growing Together.

For some of these high-risk clients, us pulling out, although it seemed like duplication and monitoring, has a halo effect. That keeps them in therapy. It keeps them grounded and keeps their self-esteem high because sometimes it has a negative effect you never anticipated. They don't see it as duplication of services.

Another nurse gave an example of her understanding of outcome-based practice in her community development work with high-risk populations. She perceived the outcomes set by the Ontario Ministry of Health as working against high-risk, vulnerable people and more appropriate for middle class groups. To put a face on her one-to-one practice and to demonstrate how her interventions fostered empowerment for the individual and, over time for the community, she provided an example of a woman with mental health problems who lived in a rooming house.

**Mary Lou:** It's easy to measure outcomes. There are outcomes that happen, positive outcomes that happen with work with high-risk populations, but you have to know how to measure that. And there actually are outcomes that fit the outcome-based practice that they're [Ontario Ministry of Health] talking about. But it takes longer.

To give an example... I'm working with a woman that lives in a rooming house in this area. She has mental health problems, but she doesn't want to seek help in the psychiatric system. For the most part, she can make it on a day-to-day basis without medication. Although if she was living in a traditional setting, like a regular apartment, probably her neighbours would be really angry and wanting her to be evicted. She lives in what I call and what the city considers, one of the most high-risk rooming houses. A place that has actually had its license suspended for a while a couple of years ago and is still considered on a high-risk list for keeping its license. She's able to blend into that place because a lot of the neighbours are in the same boat. So she doesn't stand out as much there. She can have a much broader range of behaviours in this place than she could in a much more rigid place. But even in that type of setting, the landlord was getting very fed up with her, and the [health] inspector had been in and told him she was going to have to clean up her room,
because she hoards and it was becoming unmanageable. He really wasn't sure that he could pass the place.

The landlord basically said he just wanted to evict her. I heard about her through the inspector and through a worker I know at a drop-in. They asked me if I could do anything about this. So I went to see her. It was typical. First the door didn't open. And then the next visit the door opened an inch, and stayed there a while. And then we're starting the community breakfast [program] . . . and so I get her starting coming, because food was the hook for her. Most people don't have enough money to make it through the month . . .

I was able to work with her to help her stabilize . . . to get to the point, through spending some time with her she was able to trust me and saw I was consistent and I wasn't going to turn her in or call the police or something like that.

The wish of the landlord was that I would have her certified and put in the hospital. But she wasn't certifiable. I could see even if we put her in the hospital, she was going to do like she's done the last times, which is throw her prescription out on her way out the door, go home and forget about it. So there was no percentage in that.

We've been able to help her stabilize. She comes out every week for the breakfast [program]. She eats there, she's dressed properly for it. She's not harassing the neighbours. She's not banging on doors. And the landlord has actually said that she's doing much better and he's not interested in evicting her any more. So there's a measurable outcome.

This woman would have been homeless . . . Instead of paying for her own living accommodation and looking after her own food and going to food banks and so on, she would be living off the public purse. So if these politicians want to look at it to that degree . . . look at things in terms of money, there was a significant outcome. So it shows you can make a difference. But you can't do it in one visit. I had to make a few. But the outcome at the end, in my opinion, was worth it. She's living independently in the community. She isn't in the hospital and is not in a shelter or the street, where she'd be really at risk of being harmed.

This excerpt is a salient illustration of Mary Lou's commitment to empowering
practice, with the objective of helping the woman discover awareness of her strengths and build relationships with others. All the nurses verbalized that a reciprocal relationship is needed to build authentic partnership for individual and community empowerment. This reciprocal relationship is described metaphorically in the following nurse's narrative:

**Carolyn:** It's a two-way kind of dance . . . when one little inch is permitted and a breather happens, and you have a chance to go another, to risk another venture.

I feel a little part of the unleashing of potential positive energy from women. When the glaciers retreated from the land, it rebounded. And this is what we're seeing. When the awful hurts have a chance to be lessened and the person rebounds. What I have seen among women in this community is the rebound, but it's not a selfish keeping of progress to themselves. It's a giving outwards. It's a giving to others.

This same nurse described a strong marker of progress toward individual and community empowerment as the women's ability to teach her how to help them and be a community guide:

**Carolyn:** I didn't have a clue how to behave and proceed with the women, other than just taking one little step at a time. What developed was an accumulation of knowledge that was so geared to the population. They were teaching me how to use the ropes to their benefit, to what they were needing . . . [Also], how to create bridges among very despairing people in like circumstances.

**Facilitating the Community's Capacity for Self-Advocacy**

The nurses gave many examples that described how the women individually and collectively moved along the spiral of learning toward self-definition and advocacy, and found their voice to speak out against injustice and optimize their health. The nurses' roles evolved. In the beginning they were more directive and catalytic. Over time the nurses adopted to a great degree, the roles of background resource, enabler, consultant, interpreter, collaborator, and advocate for political action. Two of the nurses working in the Growing Together project described some “monumental inroads” made over the three years since the inception of the project. Of note, these empowerment indicators of progress were not elicited by the Growing Together research team. The nurses noted that over time, many of the
women, with specific reference to the Tamil women, came out of their apartments, trusted each other, attended group programs, and shared responsibilities. The programs Life with Baby and Community Kitchen were established on a permanent basis, while many of the women went further along the empowerment continuum, for example:

**Jennifer:** *We're at action now with some activities. Some of the women went on from Community Kitchens to form a women's group. After the Community Kitchen, the women proceeded on to being involved with the initiation of the women's support group and some trained as Community Kitchen leaders. Also, four of the women from the group began a catering business, meeting with community consultants, learning business skills and advocacy skills. [One mom] is braving this out. This shy, little mom who wasn't ever going to come out of her home after the birth of this child did, because she trusted her public health nurse. They've identified safety issues. They're getting a Walking-School Bus going. It's not at City Council level, but there is a safety committee.*

Jennifer also described the Walking-School Bus; a co-operative project in which the women took turns as a lead mom, picking up at least four to five children and taking them to school safely.

The nurse involved in developing a coalition with tenants from a Metropolitan Housing Authority senior citizen's complex and community agencies described several markers of progress toward self-advocacy, one year after the inception of the coalition. The key indicator was described as the coalition doing "a lot of things as a group. We work together." She also noted that the coalition continued to meet, and membership, group ownership, and a number of activities increased. A security audit of the building, a Fall Safety Committee, exercise classes, and ESL classes were established.

Two other nurses described their social action markers of success for the women they worked with as: the establishment of other women's groups, implementation of train-the-trainer programs, incorporation of their low income women's group, the women writing proposals for funding, and the women obtaining media coverage on their community activities. One of the nurses, who was instrumental in initiating a group program with low income women in the municipality, described the ongoing process for women involved with the "Community Link" program as a marker of success. The Community Link program was a
coalition of eight agencies in the municipality that received federal money under the program “Growing Up Healthy Downtown,” a program for low income women. The nurse acted as a consultant to the group and facilitated its building of resources and networks.

Kristen: They are developing the Community Link, which are women who had been participants in the group who are being trained in leadership. That's what I'm helping out with. So they are doing a group, and when they run into a problem and they are stuck with something, they have a resource to come to. As a group of women, they're looking at how they're going to be able to keep funding it. They're looking at things like what does incorporation mean. They're writing proposals.

Kristen began her relationship with many of these women through one-to-one contact and small group work, and fostered their evolution as a “community of women” committed toward self-advocacy and political action.

Another nurse provided examples of how she partnered with the women in an ethnic community and other community agencies to nurture leadership and social action through the development, implementation, and evaluation of a parent’s and children’s program in their own language. Initially in her school health assignment, she identified that the community needed help with parenting. She organized a forum on parenting issues and strategies in collaboration with the school principal, the parish priest, and the community developer with the Metropolitan Separate School Board. From here, she was instrumental in introducing the Ready or Not program on a community basis. One hundred and seventy-five people came out to the first forum, and from there it mushroomed into a coalition. She also facilitated the translation of the Ready or Not texts into the ethnic community’s language. The program eventually was managed by parents and the wider community. A video and other resources were also developed, and the women were invited as consultants to speak across Ontario. The translated program was the only ethnic Ready or Not program in Ontario at the time. The public health nurse described how her roles evolved in the project over time:

Penny: Trouble-shooting with proposal writing. I translate the internal jargon to them to be able to put it in writing. But that's as much as I do. I'm giving them tricks of the trade to run and manage.

She described numerous measures of success for the women: getting on TV, going into boardrooms, starting other chapters of parents, implementing train-the-trainer activity with
the Ready or Not program, and, most importantly, seeing the women evolve as persons: "She [they] now know[s] her own power as a woman, as a parent. She [they] is [are] doing things independent of me. I've gotten her from doing just her work into doing community work."

Discussion of Findings

The nurses understand and practice community development as a multidimensional concept firmly rooted in a philosophy and process of empowerment for social justice and health. They believe that public health nursing is framed in a community development way of practising, a “way of being” in the community. This approach is based on the democratic belief that women in high-risk environments can participate in decisions affecting their health and change their situation. Community is defined primarily in a relational and political way and the women clients valued as a “community of women” having an affinity of interest as a result of their extreme vulnerability and impoverished circumstances. Community development means building authentic partnership with the women by being committed to the women in their everyday realities: “starting where they are,” building on their strengths, and building their social connections to each other and to the broader community, for individual and collective capacity and integration. Although pre-natal classes have a finiteness to them, the act of attending creates some sense of community. A pregnant Somalian woman who speaks very little English gets help and words of caring and support from the other women. This builds self-esteem that potentiates further personal growth and possibility. A major motivational factor is the nurses’ passionate commitment to working with the women and helping to correct their inequitable circumstances, and promoting social justice, and the women’s health. Hence, their notion of partnership includes a creation and communion with the women that generates mutual energy and growth.

Personal and community capacity building through self-help processes with the women and helping them to look outward to social change is integral to the nurses’ model of community development. The nurses believe that the basic values and way that they practice, whether in individual, group, or community associations, are more similar than different. Community development is not envisioned in a linear way, but as a complex and interactive change process that is described as a puzzle or tapestry that moves backward, forward, up and down, toward individual and community empowerment. Although they respect coalition
building, political action, and women speaking for themselves as the ultimate of community development, they firmly believe that it takes many steps and building trusting relationships and connectedness to get there for the marginalized women in their practice.

In the public health nurses' scope of practice, this social change process is seen as starting mainly at the individual level with practical and health issues. The community development process in their practice progresses in most instances from individual empowerment to a group of women, a group of women, to a community of women. However, the women also enter into the relationships at different points along the continuum, from individual or group associations to broader community associations such as coalitions. The nurses' practice is consistent with Sadan and Churchman's (1997) definition of a process-focused community planner who is a critical player in fostering an empowerment process that values an egalitarian partnership. The nurses value their practice as a unique and essential beginning step in the community development continuum, believing they make a special contribution to the empowerment process with this disadvantaged population through their presence in the early trust-building phase of relating to the women in all their vulnerabilities. They believe that their practice gives them special status, skills, and access to this population. They outreach to marginalized populations through several avenues: home, school, women's centres, senior's residences, and on the street. As nurses, they are generally given initial trust and credibility by community members. Additionally, they possess an extensive network of trusted relationships with public health peers, other professionals, and community resources; and could offer a wide variety of Department of Public Health programs.

A philosophy and practice committed to what John McKnight (1987) terms as "being in community" is clearly operational in the nurses' stories of their practice and foundational to the meaning of their empowering practice. This relational and ontological conceptualization of community and commitment to building individual and community empowerment emerges as the overarching theme and framework in which the nurses' practice is embodied. It is consistent with the views of several scholars (Freire, 1994; Jackson et al., 1989; Labonte & Little, 1992; Minkler, 1991; Sadan & Churchman, 1997; Wallerstein & Bernstein, 1994). The nurses value themselves as active in a complex of relationships, authentically committed to engaging women in high-risk environments in building
community for health. They create and/or are already part of, to the extent they can be, what McKnight defines as a “community of association.” This is viewed as a collective consciousness committed to shared responsibility that shapes itself to each individual through authentic relations; relations that are not managed and that aspire to authentic partnerships and capacity building of the community. It is also obvious through the nurses’ stories that there is another sense of community and community development that is less formal than a designated community development program: the community of nurses linking up with the women and the many formal and informal community associations, to create and maintain safety nets, or a buffer zone to permit possibilities for the women. Nurses also identify elements of their practice that they consider community development but that were not credited as such by nursing management.

Several of the nurses in my study indicate a greater psychological identification with “being in community” than with being an employee of a large organization. McKnight, with reference to his notion of community of association, refers to this position as “people in the gap” (personal communication, April 28, 1999) because professional community workers, as part of a formal system, cannot by definition be members of the citizens’ community of association. He acknowledges that professionals are challenged by their position between two worlds: the community and the institutional system of their employment. Therefore, to be effective in fostering individual and community empowerment, professionals need to be committed to authentic partnerships and integrate with the informal community of association to the greatest extent possible. In this study, some of the nurses held such a deep identity with their “community of women” and practice setting that a threat of actual separation from the community(ies) posed significant emotional consequences.

The practical context of their work with women in high-risk environments demands a level of praxis, versatility, and innovation of the public health nurses. This results in a community development process and practice that moves far beyond the basic concerns of disease prevention in high-risk communities. Correcting inequitable, health-damaging conditions is integral to the nurses’ practice, as they perceive these conditions as major factors in promoting the women’s marginalization and placing them at great risk for ill health. They identify health as a resource for daily living and based in social justice and conditioned by many prerequisite conditions. However, this perspective causes some tension
for the nurses. They live with the tension between their traditional practice of prescribed programs and services and adopting a community development approach that means starting with the women, tailoring services to their needs, and fostering partnership in decision making on their health. All the nurses describe their practice as holistic, yet the interpretation of this concept varies among the nurses. The context and circumstances of the practice situation affect the roles and strategies they adopt.

Significantly, a unique aspect of the nurses' view of holistic practice within a community development perspective is conditioned by their responsiveness and commitment to address the women's immediate health concerns and crisis situations. Crisis work is a term frequently used by the nurses to explain the acute, extensive, and continuous nature of their work with these women, who are profoundly compromised by their socioeconomic circumstances. Most of the women are single, either on social assistance or are the working poor. Browne et al. (1995), in their study of the shared clientele between public health nursing and General Welfare Assistance and Family Benefits Programs in an urban centre in Southern Ontario, concluded that these clients had greater health and social problems than did public health clients who were not receiving assistance. They also reported that they consumed more ambulatory health and social services.

The realities of the nurses' community development work occurs in a web of relationships and processes. This web consists of multiple interconnections and of independent and interdependent activities of the nurses working as a team. Team work is advanced with each other and with community resources through individual, family, group, and community associations to enable the women to build capacity for transformation. Numerous scenarios of this web of relationships are evident in the nurses stories' of their complex practice. One scenario includes the nurse working with women on a one-to-one basis, then progressing to a group situation, which the nurse facilitates alone or with another public health nurse and/or other disciplines. In many of the situations, the nurse continues to see the women individually, while working with them in informal group associations or formal group programs. From here, the nurses or their nurse colleagues might take the group of women further along the continuum, guiding them to represent themselves on their journey toward social action and social change, with less reliance on the nurse. Furthermore, as the nurse works with the women one-to-one or in a formal group program, she also refers
and links them with other community resources. In another scenario, the nurses start with an established community of women and guides them on an issue as a consultant. Team work and putting the puzzle together in a collaborative working relationship is basic to their practice.

As illustrated in Figure 5, I conceptualize this web of relationships and processes in their community development work in a multidimensional spiral of learning. This spiral represents the building of awareness, capacity, and integration that needs to occur for the nurse and the women they work with on the journey to social action and social change. The spiral is open, dynamic, and widening, representing the nurses' network of multiple interconnections and relationships. It is possible to move forward while frequently circling back among individual, group, and community associations. It is anything but a linear and solitary process for the women clients/community members or the nurses, because it represents a complex change process of individual, group, and community strategies. This construction of a spiral of learning that is based on continual reflection and action toward transformation is comparable to Purdey, Adhikari, Robinson, and Cox's (1994) spiral model of community empowerment, and Sartre's (cited in Bloom, 1996) progressive-repressive life spiral of integration. Sartre asserts that a person's life develops in spirals in which individuals can challenge, resist, learn from, and go beyond hegemonic conditioning by engaging in a process of progressive and repressive movements along the spiral. The progressive or forward movement represents experiences as a journey of becoming and possibilities, while the repressive or backward movement is a reflection of past experiences. This integration process can also be symbolized as a labyrinth—a state of chaos and confusion in which it is possible to move forward while frequently circling back from both positive and negative experiences. The nurses in this study and their women clients/community members were at varying points in this individual and community empowerment process.
Enacting Community Development Over Time

![Diagram showing the Spiral Path of Building Awareness and Capacity for Transformation]  

Facilitating the Community's Capacity for Self Advocacy

Building Connections and Overcoming Barriers to Create a Partnership Milieu

Building Trusting Relationships for Mutuality and Engagement

Measuring Progress

**Figure 5.** Schematic representation of **Spiral Path of Building Awareness and Capacity for Transformation**
Building trusting relationships, building connections to overcome barriers, and measuring progress were core processes in all the public health nurses' practice situations and levels of focus: individual, family, group associations, or community associations of agencies and community members. Some nurses in the study engaged at a more advanced level in community development work, participating more obviously in facilitating community capacity for self-advocacy. The stories of their practice support a profile of their community of women in which the women developed sufficient political skills to represent themselves in moving to social action and change without dependence on the nurse. The nurses' sense of agency, repertoire of roles and strategies, and the level of readiness or capacity that the women achieved in personal and community empowerment account for the difference between the various practice situations and stages of community development that were achieved.

Critical reflection for transformed consciousness and social action requires that the professional and the community members have sophisticated skills to work through the conflict generated by challenging power differentials: a process necessary for social change to be achieved (Eng & Parker, 1994). Indeed, the challenge of moving the women forward along the spiral was a daunting one in many instances, both for the nurses and the women, themselves. It represents an uncertain partnership and a significant transition for the women, as they are taking in new learning and simultaneously dealing with the ordeal of their high-risk environments, separating from their familiar world into the unknown, and accepting help. The nurses understand that the women need to accomplish particular tasks for personal and collective growth at different steps along the spiral to enable them to continue to progress. A profound barrier to overcome is meeting the women's multiple crisis needs, while simultaneously building trusting relationships and partnerships. Furthermore, this challenge is complicated by the need to guide the women to make connections and to participate as active members in groups. The nurses need to discern and be creative as to when and how best to act with the women to facilitate the process. The greatest barrier is building individual and community empowerment for the women and their families within the reality of the women's often chaotic and multiple socioeconomic, linguistic, and cultural circumstances. Consequently, community development work is viewed as intense, time-consuming, and uncertain. It is a long-term process that demands a heavy investment of time.
and emotional energy on the part of the women and the nurses. Equally important, having time means having the power to engage more fully in community development work. The nurses felt that the department did not give them the necessary time and freedom to engage as they would like in a more comprehensive community development process. Further, the nurses perceive that much of their community development practice, whether in individual, family, small group, or community coalitions, is often not valued by the Department of Public Health.

The complexity and uncertainty of their practice in a community development process to move the women along the spiral demands an extensive repertoire of roles and strategies from the nurses. Complex, contextual knowledge and relational skills that include negotiating multiple tensions, political relations, and working through ethical dilemmas, the nuances of the diverse situations, and the importance of timing is very much part of their community development work. Indeed, there are themes that are sometimes difficult to pinpoint, but which saturate the data and are expressed through multiple themes. Two such themes in the present study are building trust and the nurses' ways of knowing, particularly personal, sociopolitical, and ethical knowing that permit them to be responsive to the impossibilities and possibilities for the women and their families. The skills to get everything to work while reflecting the values held by the nurses are essential attributes of practice.

Building trusting relationships and mutuality are regarded as a basic and essential process in nursing and empowerment practice. This process is especially significant in community health work, as it enables the public health nurse to gain and maintain access, credibility, and partnership with community members (de la Cuesta, 1993; Smith Battle, Drake, & Diekemper, 1997). The public health nurses describe themselves as playing a key role in laying the groundwork for establishment of trusting relationships for individual and community empowerment with women in high-risk environments. The nurses describe various strategies to establish trust. Outreaching to connect with the women is a preliminary step, as the women tend to be very socially isolated and disconnected by their multichallenged situations. The nurses believe that most of the women only make connections to community resources as a result of the public health nurses reaching out to them. The nurses seek out the women in high-risk environments through their traditional roles as public health nurses, in various ways such as offering programs like Healthiest
Babies Possible. They also use creative ways to search for women who were hard to reach and who were at high risk for health problems: people with mental health concerns; women and children with low socioeconomic status, especially new immigrants and women who are pre-natal/post-natal, and/or with young children; and people living on the street. The nurses firmly believe that most of these women are not ready to participate in a formed group and certainly not a community program for social change.

In outreaching and their interactions with the women, they employ many diverse roles and strategies that I describe within the theme of “authentic use of self.” Through this therapeutic process, the nurses work with the women to develop increased personal capacity by acquiring relevant knowledge and confidence to extend themselves further. In so doing, the nurses anticipate that the women acquire awareness and capacity for ongoing change of consciousness, from individual to group readiness, for informal and formal associations with other women, on to broader community readiness, and then toward social action and social change. The roles and strategies that the nurses practised increase in depth and breadth from the initial establishing of trusting relationships to nurturing and sustaining the women’s capacity over time. The nurses’ stories indicate that comprehensive practical knowledge and sophisticated relationship building skills are critical to weaving through the complexities of the women’s everyday situations. The initial connection with the women to lay the groundwork for an empowering process and community development to occur is termed “public relations work.” This work is associated with situating themselves in the women’s lives, listening to them, and starting to build trust, credibility, and a safe milieu for sharing and learning. Additionally, skilful, nonjudgmental listening, and promoting therapeutic and critical dialogue are valued as essential ways to engage more deeply and partner with the women over time. Specific strategies within this process include: working in an open, collaborative manner; being present and giving time to listen in a respectful way while not giving quick solutions; and being willing to put in extra time. In addition, the nurses stress that it is important to feel a connectedness with the women and to respect their diversity; be aware of their privileged positions as public health nurses and the effect of how they speak, dress, and acknowledge their physical environment; be consistent, honest but nonjudgmental; and prepared to take risks.

However, maintaining and nurturing trusting relationships and working with
uncertain partnership with the women demands a great depth and repertoire of communication and political skills for the intense engagement needed to accomplish individual and group transformation for social change. It is aptly described by one of the nurses as requiring extensive immersion, giving, and negotiating on the part of the nurses and the women. At this stage of development, the women need help to work through many of their contradictions, and more sophisticated skills were required of the nurses. This confrontational process is depicted in many of the nurses’ stories as a delicate balance of intuition, timing, and authentic caring on the part of the nurse, based on a mutually trusting relationship. It is apparent from the nurses narratives that as the relationships develop, implicit permission is given to go further in challenging the contradictions and foster capacity building.

In addition to the strategies previously described, the nurses profess they need to be skilled at discerning which issues to confront as the women generally are overwhelmed with a lot of concerns; so “pick the biggies . . . and give support.” They also identify other significant strategies: using careful self-disclosure, keeping connected to the women’s reality while challenging them to go beyond, knowing when and how to connect them with other resources, and making connections among the women in learning to build their confidence and eventual solidarity. Some nurses used the terms “therapeutic reciprocity” and a “two-way kind of dance” to describe the empowerment process. One nurse described a “magic transformation when it works” to explain the outcome of a success.

The public health nurses’ descriptions of their engagement process with the women and their relational skills resonate with Newman’s (1999) conceptualization of the rhythm of relating in a paradigm of wholeness. Newman posits that because nurses often meet people in times of uncertainty associated with disruptive health events, they need a view of partnership that includes a tolerance for disorganization and living with ambiguity. She uses the rhythmic movement and metaphor of the dance to highlight the importance of nurses “joining in partnership with clients and dance their dance, even though it appears arrhythmic, until order begins to emerge out of chaos” (p. 228). The nurses’ behaviour is consistent with ethical caring practice and the concept of personal knowing that values integrity in the personal encounter, democracy, freedom, situational and relational caring, responsibility, existential advocacy, and empowerment (Benner, 1985, 1991; Benner & Wruble, 1989; Carper, 1978;
These attributes are professed in the “new” public health and are fundamental to effective community development practice.

It is well documented that the effectiveness of public health nursing interventions relies significantly on the nurses’ understanding of the daily struggles of individuals and families and an awareness of the larger social, economic, and political context (Deal, 1993; Stevens & Hall, 1992; Zerwekh, 1993). Most of the public health nurses’ activities focus on the level of individual, group, and family-centred care with pre-natal, post-natal, and parenting care. Recent studies and meta-analysis of research on the effectiveness of public health nursing home visiting identified the most positive outcomes for maternal-infant and child health, and mental health development with women in high-risk environments (Ciliska et al., 1996; Oda & Boyd, 1988; Olds, Henderson, Chamberlin, & Tatelbaum, 1988; Olds, Henderson, Kitzman, & Cole, 1995).

Recent interpretive research on the everyday practice of public health nurses describes findings that are similar to those in the nurses’ practice in this study, related to the practical wisdom of community health nurses who work with vulnerable and marginalized peoples (Smith Battle et al., 1997; Diekemper, Battle, & Drake, 1999a, 1999b). These researchers concluded from their examination of the narratives of 25 nurses working across a variety of settings and individual, family, and population foci that the nurses’ situated and relational skills of responsiveness were essential to developing partnerships between the nurses and people considered as “outsiders” and marginalized by their situations. They term this process “responsive use of self.” Regardless of the setting or the client focus, the nurses’ responsiveness enabled them to acquire situated understanding, establish connectedness for their clients to meet basic needs, sustain self-worth and identity, and ensure hope to become an engaged community member.

The nurses in this study also demonstrate their commitment to an empowering practice and disadvantaged women in how they bridge between a one-to-one and collective perspective in their actions. The terms the nurses use for the women reflect a respectful partnership approach. The nurses rarely refer to them as clients, except as family client or community-as-client. Rather, they chose terms such as participants, people, moms, tenants, women, and parents. In this sense, the nurses’ language coincides with popular usage of the
term in community nursing literature and practice, which is to designate an aggregate or population-focused approach with the notion of “client.” Over the last number of years, the term client has been subject to criticism and redefinition in community health circles with the emergence of the paradigm shift to a socioenvironmental conceptualization of health, broad-based health promotion, and a prevailing community interpretation of the concept of client. Other terminology such as community member, citizen, or participant are considered to be more consistent with the philosophy and principles inherent in the socioenvironmental paradigm. This alteration of the language of the nurses can be seen as a reflection of the nurse’s evolving community development consciousness. It highlights the tensions created within competing discourses; between a predominately individual, service-oriented, and power-over approach to change, and a collective and community empowerment perspective based on collaborative and egalitarian partnership for change. It also symbolizes the conflict between the public health nurses’ position as employees of an official public health agency with its traditional approach to health problems and work, and the nurses’ evolving practice within new conceptualizations of community, health, health promotion, and public health.

The nurses adopt an invitational stance in their relationships with the women. They frequently use the department’s prescribed programs as a “hook,” and an entry point, to start a relationship and build credibility. The nurses believe that education in the traditional sense of depositing facts would have little meaning in the context of the women’s high-risk circumstances. Therefore, they strive to implement a democratic and women-centred milieu to build the women’s personal empowerment, and to develop group cohesiveness in their teaching opportunities and their small group work. The nurses commonly go beyond the prescribed programs and rigidly structured approach and tailor them to the women’s needs and link them to health and social services the women required. Their willingness to defy traditional boundaries helps to develop a rapport and trust with women in high-risk circumstances, and helps the women access health care and services they need to overcome their situations.

The nurses sometimes take professional risks. They face legal, political, professional, and ethical dilemmas at times to protect the women and their children, and to acquire access to health and social services for them. This is especially so when working with undocumented immigrants who do not have legal access to health care and are ineligible for
public housing. Immigrant women, including undocumented immigrants, who need pre-natal, post-natal, and/or parenting support, account for a large part of the nurses' practice. According to Messias (1996), undocumented immigrant status has multiple social, economic, political, and public health implications. Discrimination, marginalization, invisibility, and exploitation are profound consequences. These individuals also face significant barriers to access and utilization of health care due to fear of being reported, inability to speak English, and lack of information and knowledge. Messias notes that women are especially vulnerable to exploitation. Further, she asserts that it is well documented that lack of pre-natal care is significantly correlated with low birth weight and other pre-natal and neonatal problems. The public health nurses in this study go beyond the boundaries of their practice to break the women's isolation and invisibility and to help them access health care that most often concerns pre-and post-natal services.

The nurses also go beyond their prescribed duties by paying for food for the women who attended classes, and by using their unpaid personal time to follow-up as a result of their compassion for the women and their unborn child or children. The nurses also describe many ways they make themselves present in the community to build a sense of trust with the women. They risk their own personal safety at times, when they establish themselves in high-risk areas. One nurse, when working with prostitutes, conducted visits one night a week in a neighbourhood where the prostitutes worked. Since she was not known in the area, the police, family sex educators, and the prostitutes were told about her activity for safety reasons.

The strategies the public health nurses use to help the women cope with deficiencies in the health and social systems are described as a major part of public health nursing work (de la Cuesta, 1993). De la Cuesta describes these activities as "fringe work" that includes "relief work" and "novel work." The work is considered covert because the nurse is not supposed to do it, but does freely in order to compensate for deficiencies in the health and social safety net. Fringe work is designed to mobilize resources and develop new ones; often to rectify inequalities and alleviate poverty. De la Cuesta asserts that often the work is also undertaken to build reciprocity and solidarity between the nurse and the community members. However, she cautions that fringe work frequently generates overload and dissatisfaction for the nurse because it is invisible in the documentary practices of the health
agency and is very time consuming. Indeed, linking the women to tangible resources for everyday needs, participating in unconventional activities such as supportive accompaniment to appointments, and developing new resources are basic to all the nurses’ practices in this study. This work is seen as integral to their efforts to help the women and build trust and credibility. Additionally, several nurses believe that their responsibility in working with marginalized women is to go beyond hearing the women’s stories, helping them to have choices, and making connections, to bear “witness” in a more obvious way about the women’s grave injustices. They do so by modelling and advocating for structural change with and for the women. Witnessing speaks to the view that the ultimate of social justice or critical consciousness is “witnessing” and giving testimony, in being a social activist against things that are so horrible or so unjust and discriminating that one becomes committed to changing the socially unjust situation (Freire, 1994; McKnight, 1995).

Building connections with community resources to create a partnership milieu evolves with, and builds on, the creation of trust and integrity. The process also helps the nurses gain legitimacy and participation in broader multidisciplinary community development programs. The nurses emphasize that it takes months to years to build trusted community networks, to be grounded in the community, and to establish credibility. According to Sadan and Churchman (1997), for the process-oriented nurse, the process of building connections in community planning work is critical as one prepares the groundwork, whereas for the product-oriented practitioner who is mainly interested in outcomes, this process is less important. The nurses were committed to building connections to overcome barriers with their community of nurses, and the internal and external community networks, using the Department of Public Health as the boundary. These connections are designed to build personal empowerment and self-esteem among the women and for the nurses, themselves, and to pave the road for community empowerment. The process is composed of several components: educating other professionals, including their nurse peers, to reduce the stigma that the women faced; establishing the credibility of the nurses’ own work with their colleagues and other health professionals; and engaging in respectful role negotiation. The nurses consider the process of building these community networks as a fundamental aspect of their public health nursing culture. They believe that this attribute helps them to weave connections and networks with other community workers, create coalitions and other
collaborations within the community, and to strive for and maintain a reciprocal relationship with community resources.

However, this partnership building poses some delicate moral and legal dilemmas for the nurses. This is particularly the case in their necessary relationship with the Children's Aid Society and their involvement with undocumented immigrants. According to Hall et al., (1994) undocumented immigrants may use secrecy and hide personal information for self-protection and survival, which affects their relationship with the nurse. The public health nurses report that immigrant women face incredible hurdles that are monumental for the undocumented immigrant women. Thus, in order to facilitate their partnerships with immigrant women and women involved with Children's Aid, it is essential that the public health nurses nurture positive and sustainable relationships with their wider community of formal and informal associations.

The public health nurses' practice can not be easily measured by the prevailing definitions and epidemiological measures of the Department of Public Health. The nurses' views on the importance of community development and their insistence that its success depends upon the maintenance of a collaborative process means that much of the nurse's work, and perhaps their greatest successes, happen in "in-between spaces," in a diverse and elusive sociopolitical and ethical context that often escapes being credited.

There are resounding calls for public health nurses to provide evidence as to the effectiveness of their community empowering practice (Clarke, 1995; Drevdahl, 1995; Hayward et al., 1993; Oda & Boyd, 1988; Ploeg et al., 1995; Strohschein, Schaffer & Lia-Hoagberg, 1999). Because community development is understood as encompassing change across individual, family, group, community, and organizational levels, it follows that measuring public health nurses' empowerment practice should occur across these domains (Deal, 1993; Drevdahl, 1995; Israel et al., 1994). Moreover, the complexity of public health problems and of public health nursing demands an understanding and focus on individuals and families in their lived reality (Olds, Henderson, Kitzman, & Cole, 1995; Zerwekh, 1992a, 1993), coupled with attention to population-based approaches (Deal, 1993; Drevdahl, 1995). Evaluating outcomes in public health nursing is not an easy task, given the magnitude of complex methodological and sociopolitical issues and constraints (Baum, 1995; Clarke, 1995; Hayward et al., 1993). It is even more challenging to measure community development
work (Ploeg et al., 1995).

According to Sadan and Churchman (1997), measurement of public health nurses’ practice is dependent on the public health department’s preferred approach to community planning and evaluation. It can be either product-focussed or process-focussed, with the product-focussed or rational planning process being the classical approach. Sadan and Churchman argue that the process or empowerment-focussed practitioner sees an ongoing change process and will ask a very different set of questions that should focus on the degree of empowerment that was facilitated and occurred. While the product or efficiency-focussed practitioner will consider pre-established standardized measures, ideally there should be a valuing for a combination of the empowerment and efficiency-focussed measurement (Baum, 1995). Therefore, the nurses’ attitudes and perception of their role in process-focussed or empowerment practice, and their skill at working within the tension between product and process, is critical in the empowerment discourse and its measurement. Indeed, a valid starting point in this conundrum is hearing the public health nurses, themselves, and their perceptions of evaluation issues and measurement of progress in their practice.

Indeed, measuring progress is an ongoing process through the public health nurses’ practice. The markers of progress are generally established by the nurses, as there are limited, empowerment criteria identified by the department to evaluate community development practice outside an officially designated community development project. However, the nurses acknowledge that complexity of their practice makes it difficult to evaluate. The public health department’s approach to measurement is primarily product-focussed and standardized, while the public health nurses’ approach is process-focussed and based on the situated reality of the women they worked with. All the nurses state that their identification of outcomes is not generally valued by the health care culture and their public health organization. The nurses create their own indicators to evaluate their practice. They cite many indicators of success, ranging from personal capacity building to small group development and community capacity building. The women’s increased sense of self-worth is named consistently as the first indicator of success because it allows the women to become group-ready and then to connect socially within and outside groups, and to move forward with social action and social change activities.

The public health nurses’ community development process can be compared and
contrasted with Sadan and Churchman’s (1997) seven-stage community empowerment process model. The nurses’ community development framework has many similarities to the first four stages of this model. These stages include: Discovery, Partnership and Togetherness; Self-Definition; and Self-Representation. According to Sadan and Churchman, Stage One, Discovery, is an individual development stage that takes place within the group when participants discover that they are not alone and begin to become aware of their own strengths and abilities and those of the group members. Stage Two, Partnership and Togetherness, focuses on relating to the common characteristics of group members as a basis for engagement and the beginning of critical consciousness development. In Stage Three, Self-Definition, participants become less dependent on the assigned “expert” and begin to define the situation on their own. Stage Four, Self-Representation, is associated with community empowerment.

Sadan and Churchman (1997) define these stages solely from the perspective of group involvement. In contrast, I argue that the public health nurses apply these stages in one-to-one and group situations with women in high-risk circumstances. The nurses act as catalysts in promoting these tasks in their one-to-one relationships with the women, and through informal interactions of two or more women, who they bring together around a common purpose. Although the nurses strongly support the view that these empowering processes are more achievable through formally guided group associations, they recognize that this carefully graduated relationship-building is a necessary prerequisite for many of the women who are isolated by multiple problem circumstances. The process of facilitating community capacity for self-advocacy compares with the fourth stage of community empowerment, self-representation.

The multiple roles and strategies that the nurses employ to enact community development that coincide with the first four stages of Sadan and Churchman’s community empowerment model are explicated in the three processes Building Trusting Relationships for Mutuality and Engagement, Building Connections and Overcoming Barriers to Create a Partnership Milieu, and Facilitating the Community’s Capacity for Self-Advocacy.
CHAPTER SIX
THE CONTESTED TERRAIN:
SOCIAL CONSTRUCTION OF PUBLIC HEALTH NURSING

*Human beings are constituted in conversations; and hence what gets internalized in the mature subject is not the reaction to the other, but the whole conversation, with the internalization of its voices.* (Taylor, 1991, p. 314)

**Introduction**

In Chapter Four, I discuss the nature of the public health nurses’ practice with respect to the fundamental context of their practice, profiles of the public health nurses, and profiles of their women clients/community members. In Chapter Five, I examine the meaning of community development for the nurses and the process in which they engage with the women in a context of *Being in Community*. Within the discussion in this chapter the values, anxieties, ambiguities, and strategies of the nurses in this study are analysed to portray the character of the public health nurses’ work. Smith (1987) categorizes this characterization process as the first step of analysis, which is necessary to uncover complex relations from the standpoint of particular individuals and to make their everyday world visible. The second step in this layered analysis is to explore how the nurses’ practices are embedded in the social relations of the larger social, economic, and political contexts. This step is valued as an essential component of feminist research in which the situation is reconstructed and deconstructed. This second level analysis is presented here in Chapter Six. The power relations of the macro cultural-political context is examined from the perspective of the public health nurses, as it poses constraints and contradictions for the nurses.

*The Contested Terrain: Social Construction of Public Health Nursing* emerges as a consistent and dominant theme, crystallizing as a major force over the life of the study, as municipal and provincial political backdrops rapidly and constantly shifted. The social organization of these processes exercises a significant impact on the public health nurses’ professional autonomy and their community development practice, affecting some, however, more than others. Examination of this theme also illustrates the contradictions and resistance within the nurses, themselves. Yet, more significantly, the contested terrain represents the nurses’ struggle for a voice to attain and/or maintain professional integrity and autonomy to experience individual and community empowerment for themselves. In so doing, they could
be allowed the freedom to help their women clientele move toward individual and community empowerment, a professed policy directive of the Department of Public Health in which they were employed. I propose that the underlying basis of this effort was the nurses' conscious and unconscious desires to challenge the social construction of how they and the women they served were defined and excluded in policy development that directly affected them.

My study is a snapshot of the practice life of the participants in the study. Therefore, there may be a tendency to consider their stories as only reflecting the multiple changes occurring within the health care environment and broader community. However, as the narratives, my professional experiences, and the academic literature attest, this situation is not only affected by the changing public and professional landscape, it also has a deeply-rooted historical basis and is embedded in diverse discourses. The myriad of changes stemming from the larger social, economic, and political environments serves only to intensify the struggle and, positively or negatively, bring it to the surface for closer examination and for a reaction by those involved: practitioners, researchers, politicians, administrators, and the public.

The following discussion represents my construction of the "stories on the ground"; the public health nurses' perceptions of the ideological processes and practices they struggled with in their everyday practice. As noted above, the heart of this contested terrain consists of nurses' struggle against the social construction of public health nursing and their community development practice. This situation is influenced by historical, social, political, economic, professional, and personal factors that pose constraints and contradictions. Several themes emerge from this study that reflect how the larger organizational processes and the nurses' everyday work environment constrains the nurses' ability to enable an empowering community development practice with the marginalized women they serve. Any thematic representation gives the impression that the social and political relations are easy to dissect, though this is far from the case, as the nurses' situation consists of a complex web of relationships and a multitude of roles and strategies. Three broad themes are discussed here: (a) The Larger Social, Economic, and Political Agenda; (b) The Nurses' Everyday Work Environment: Autonomy Versus Control; and (c) The Invisible Community: Ethical Conflict, Moral Distress, and Job Dissatisfaction. The themes, The Larger Social, Economic, and Political Agenda and The Nurses' Everyday Work Environment: Autonomy Versus Control,
represent the contradictions and constraints that the nurses struggled with in the contested terrain. The theme, The Invisible Community: Ethical Conflict, Moral Distress, and Job Dissatisfaction, describes the consequences for the nurses in this struggle. These themes and their sub themes are discussed in the following section and depicted in Figure 6.

**The Larger Social, Economic, and Political Agenda**

The macro sociopolitical context is an appropriate place to begin this discussion, as historically it has controlled the professional autonomy of public health nurses, the health agenda, and community capacity. The following comment by one of the public health nurses exemplifies this reality:

*Kristen:* Things are getting tighter, and it all has to do with the political climate, too, because the Public Health Department is part of the political body. When you value community development, and helping to advocate, and helping people with what they see as their needs, and if those needs conflict with the politics of the time, you are really constrained and [you] worry about offending the politicians who oversee the Department of Public Health, like City Council, the Board of Health, the Management Board, and all that sort of thing.

Three sub themes explicate the tensions, ambiguities, and constraints derived from the macro sociopolitical organization of the nurse’s practice: (a) Hierarchical Male-Medical Dominance; (b) “People Just Don’t Ever Know What We Do”; and (c) Divergence with Community Partners; Strained Partnerships.

It is relevant to first describe the larger contextual changes that were affecting the nurses’ practice, because this description provides a background with which to understand the nurses’ perception of evolving barriers in their community development practice and consequences for them and their partnership relationships within and outside the department. Included are some of the changes that occurred prior to the data collection phase, during the data collection phase, and those changes that were anticipated by the nurses. This description is not exhaustive, since there were more changes than I have indicated, but this sketch represents my understanding of some of the important changes that the nurses shared with me and that I observed through the media. The changes will be referred to more contextually throughout the discussion in this chapter.
Figure 6. Schematic representation of *The Contested Terrain: Social Construction of Public Health Nursing* - Narrative Themes
I first envisioned the changes as a rippling effect, but I came to see them more appropriately as a tidal wave. These changes emanated from the Ontario Provincial Government legislative and policy mandates to the various provincial ministries, to the Municipal Government, to the municipal Board of Health, to the Department of Public Health and the nursing division, and ultimately to the public health nurses and their practice with an extremely vulnerable population of women. Indeed, the changes in the sociopolitical backdrop, which developed into a crescendo through the study period, presented significant challenges for me as a researcher engaged in a reflexive process with the participants. While trying to focus on understanding the nature and the “how to” of their community development practice, I was also discerning the role the sociopolitical context played in the nurses’ everyday practice. The changes did not affect all the nurses similarly but did have a major impact on all of them. My challenge to “make the familiar strange and the strange familiar” became even more important in order to gain a deeper understanding of how they engaged in a community development practice within their over-arching sociopolitical context.

As mentioned in Chapter Four, just prior to my data collection the nursing division in the Department of Public Health restructured, changing from a program-focused, service delivery model to a district nursing model of delivery, commonly referred to as generalist practice or “neighbourhood nursing.” Almost concurrent with this return to district nursing, the other Department of Public Health (nursing division) initiated a policy whereby public health nurses who had been in a district office in the municipality for 14 years or more were transferred to another district office in the city. The public health nurses had little choice in deciding which office to transfer to, or in resisting the policy directive. Three of the nurses in the study had relocated within a few months of participating in my study. One of the nurses, however, requested the transfer. Another nurse relocated through the study period. These two changes were unsettling, for various reasons, for all the nurses.

During the data collection phase, other changes that emanated from the provincial and municipal government level had far-reaching effects for the public health nurses and also for the Ontario health care environment. In the early stages of a new provincial Conservative government moving into office, they professed that their “common sense” platform was based on deficit reduction, guided by an efficiency/business model. This model generated major reductions for the health care, education, and community services budgets. The
funding cut-backs became acutely evident, with increasing emphasis placed on privatization and provincial government control.

Several newspaper articles appeared in local and national papers professing a critique of the cutbacks and their implications for the vulnerable populations, and more specifically women and children. One such article by Laurie Monsebratten (Toronto Star, October, 1995), "Tory Cutbacks: Women and Children Fall Victim to Cutbacks, Advocates Say" makes reference to Sunera Thobani, president of the National Action Committee On the Status of Women:

Since the election, Premier Mike Harris and his government have launched what can be called a war on women and children. Cuts to day care, welfare, non-profit housing, legal aid, employment equity and pay equity are all hitting women who are already economically disadvantaged . . . the most glaring of these anti-women cuts came this week when Community and Social Services Minister David Tsubouchi cut $2.6 million in counselling services to women trying to escape violent spouses.

Additionally, the provincial government announced changes to the financial arrangements between municipalities and the province. Financial responsibilities in several sectors were down loaded to the municipalities. Although the cost-sharing arrangements between the province and the municipalities varied, the common feature was the expectation that public health programs would be covered 100% by the municipality as of January, 1998. Although provincial funds were transferred to community-based programs such as home care and community health centres, public health departments did not receive new funding. Hospitals received funding for some new programming, which was seen by the public health nurses as the traditional domain of the public health system, i.e., post-natal programming.

Reflecting the provincial government's ideology, the Ministry of Health instituted several policy changes that were based on a shift in ideology and direction-away from broad-based health promotion and a special emphasis on the disadvantaged and vulnerable populations. The ministry shifted to an emphasis on a "population health" focus. This shift in focus targeted disease and injury protection and prevention (i.e., breast and cervical cancer were added, while substance abuse and seniors' health promotion were removed). Increased emphasis was given to standardized programs and evaluative measures. Further, there was a decreased focus on health promotion and community development activities, increased expectations for health education group activities, and diminished emphasis on one-to-one case work. Coinciding with the ministry's new directions, revised Mandatory Health
Programs and Services Guidelines were anticipated and eventually released in November, 1997. It was generally understood by the public health nurses that the guidelines were designed to retain control through regulation of public health standards. The nurses noted that the new guidelines were significantly altered from 1989: “rather than allowing for multiple strategies for health promotion, appropriate for the local context, special activities are mandated.”

After January, 1998, the municipal government, which employed the study participants, announced that $8.5 million would be cut from the budget, with an 8.5% to 10% budget cut expected in the department. At the same time, further restructuring of the department was announced; upper management positions were cut by almost 50%, and nursing directors were not retained in the restructuring. Upper management also found themselves reapplying for their current jobs and/or new ones. In addition, talk began on the provincial government’s proposal to merge municipalities on January 1, 1998, which would also mean a merger of several unions and the potential for further strife and instability.

Concurrent with this process, other changes were occurring; the CUPE contract for the public health nurses in the study was ending, and it was rumoured that a “Centralized Intake” would be implemented over time across the “new” city to enhance efficiency. Intake services for referral would no longer be available at each district office. All referrals would be processed through a centralized intake phone line. Concern was expressed widely that this change in securing client referrals and program requests would remove the public health nurse and the district office staff as the first contact by telephone or face-to-face with the people in the local community, especially with the disadvantaged, who often came directly to the district office. As one nurse commented, “The human face of public health is disappearing.”

In general, the impact of the changes spread broadly across interpersonal relations, community programs, and public discourses. The collective changes were described by the nurses and other department staff as continuous, confusing, disruptive, and monumental with an overall destabilizing effect, which generated much uncertainty, personal and professional turmoil, and stimulus overload related to too much change happening too quickly. It signified major organizational, program, and individual change. One nurse interpreted the changes as follows: “They’re moving very quickly, in Ontario anyway, to try to get rid of everybody they can.” Another nurse used the phrase “the new flavour of the month” to indicate the constancy of the changes and the flip-flopping of the provincial government and the Ministry of Health
in policy positions. The accelerated change created much disruption for the public health nurses. More than 30 years ago, Donald Schon (1971) made a statement that has relevance today in interpreting the impact of the changes in the Ontario's health care environment. Schon described accelerated change as precipitating a chaotic state and negatively affecting community health: "... While technological change has been continuing exponentially for the last 200 years, it has now reached a level of pervasiveness and frequency uniquely threatening to the stable state." (p. 27)

Hierarchical Male-Medical Dominance

Several of the nurses articulately linked their day-to-day contradictions, their devaluation as nurses and women, and the invisibility of their health promotion practice with marginalized women with the larger sociopolitical agenda. They blamed the situation largely on the hierarchical, male-dominated medical system in which their practice had been historically embedded. The following quote poignantly reflects this view:

Mary Lou: I think that it's a sort of chauvinistic power base. The ones who make the decisions tend to be men, or women who have clawed their way to the top and have learned to act like men when they are there. Stuff was going from the Medical Officer of Health, who is a man, to our nurses' managers. As soon as we try to break out of a passive role and not accept whatever they happen to fling our way, then they start threatening us with our jobs. Give you the idea that at anytime we could get rid of you if you don't smarten up and stop this. I saw it work here and in the hospital. That is what has kept us [nurses] from being really political. There is always somebody above us in the hierarchy.

The nurses stated that the budget cutbacks drastically changed the health agenda in the province and increased the shift toward re-medicalization and privatization. They perceived this situation as strengthening the medical control over the health care system and nursing. Some public health nurses argued that the medical discourse directed what happened in the health care environment, because physicians were losing potential patients to health promotion and prevention activities and incurring loss of target income.

Mary Lou: The only way I look at it, if that means you get rid of a whole group of people who are doing the work that's eating into your income, then you get rid of them whatever way you can. That's what I mean by medicalization.
All the nurses in the study believed that what public health nurses were doing in community development did not receive the value it should partly due to the dominance of the medical discourse. The physicians, in the role of municipal and provincial medical officers of health, were definitely not viewed as a supportive peer group by the nurses. The nurses shared a common perception that physicians and other upper management personnel viewed public health nurses as "handmaidens" to the system. All the nurses believed that the government was sending a clear message that high-risk populations are an economic burden and therefore not valued. The nurses perceived the government's ideology as also diminishing the value of public health nursing and public health, traditionally associated with high-risk populations. This devaluing was believed to be strengthened by the Ministry of Health under the direction of the Chief Medical Officer of Health, the municipal Medical Officer of Health, and other administrative personnel in the public health system hierarchy who implemented the Ministry of Health's policies and programs. The following reflection by one of the nurses highlights the oppressive environment she and many of the nurses perceived to exist:

Mary Lou: *If you deal with the real hardened neo-conservative politicians, the way they look at this [high-risk populations]... well would it make any difference anyway, those people are so far gone, why would we even bother spending any money on them if they're going to end up where they are going to end up regardless. They are beyond any kind of intervention. The city is trying to back away from working with high-risk people. There's some pressure from the ministry to step away from high-risk populations who the ministry, incorrectly I think, feels take a lot of time and are very expensive to work with, that you really don't have a worthwhile outcome, which is a very negative and paternalistic attitude.*

Further to this response, Mary Lou provided a concrete example of the Ministry of Health's philosophical shift toward privatization and devaluing of public health and high-risk populations. She linked the Ministry of Health's policy directive on community mental health and drop-in centres, to the government's ideology of familism, volunteerism, re-medicalization of public health, and devaluing of high-risk populations. She explained that funding for the centres had changed, so that it would be based on statistics of people seen with psychiatric diagnoses, rather than statistics gathered on anyone who comes through the door, as used previously. She believed that this policy created two levels of marginalized people: the marginalized with a (psychiatric) diagnosis and the marginalized without a
diagnosis. She perceived the policy as promoting volunteerism and charity works and as an attack on women in the workplace.

**Mary Lou:** It's almost a way of creating two levels of marginalized people, the marginalized with a diagnosis, which are okay. Then, the marginalized without a diagnosis, and they are going to be in major trouble because in five years they aren't going to have access to a drop-in centre unless it is run by a church or volunteers or whatever, that nobody is paying for. That goes back to the volunteerism the premier is promoting when we all get out there like June Cleaver, from *Leave it to Beaver*. That model when she would go off and do her charity work. It's always the women who will be doing the volunteer work and looking after everybody that nobody else wants to look after. The men will be with the jobs and bringing the money back. That's straight out of the '50s. He wants us to go back to that. That is very much an attack on women in the workplace, because we can't be volunteering and doing all this stuff for free if we're also at work.

"What is Sacred?"

The constant change that was occurring, combined with the underlying negative perceptions of high-risk populations and public health nurses, and the flip-flopping policies of the Ministry of Health, the medical officers of health and the Department of Public Health management on what counted in priorities and expectations, was seen by most nurses in the study as exercising significant control over the public health nurses' everyday practice. The following nurse's account captures the uncertainty and lack of professional control the nurses generally expressed in relation to these hierarchical forces:

**Mary:** Every year or two years or three years, you are told to undergo a complete philosophical shift. We're to not have anything to do with people on the street, and then times change and we're to do all kinds of youth work with people on the street. We're to take on communicable diseases and then to give it all up. We're to protect home visiting and then you have to let some of it go. The provincial Medical Officer of Health will say you're to do all population health and group programming. What is sacred here? How many times can you flip-flop? Nurses can't mobilize, because nobody has an idea.

Mary explained that she and other nurses in the city and surrounding municipalities
formed a nursing coalition to build support amidst the changing context of their practice. However, she and her colleagues were confused and overwhelmed by all the changes and different messages about what counted. She stressed that this instability affected their enthusiasm and ability to collaborate in creating possibility for themselves.

The nurses also stated that a major barrier to their community development work was the change in direction from broad-based health promotion and community development to an understanding of population health based in a medical model. They did not believe that the prevailing interpretation of population health had a basis in social justice aimed at the elimination or modification of socioenvironmental, health-damaging conditions or structures that negatively affected the health of all populations, especially the vulnerable. The nurses argued that the ministry’s approach ignored the situated realities of high-risk populations by re-medicalizing health and public health to mean simply the absence of disease. In this perspective, the public health nurses’ case development work with individuals and families, especially those with multiple challenges, was not valued. The nurses acknowledged that population health was rooted in health determinants, however, as it was understood by the Ministry of Health, it was directed to the mainstream population and primarily focussed on targeted illnesses and disease prevention. To illustrate in the nurses’ words:

Jennifer: That’s clearly the medical model, the epidemiological-based model. There’s more than one way of defining a population. The provincial minister of health recently admitted there’s more than one way to define a population. The populations are such that to get them engaged in a process to move on, which is what I think we’re doing, there is a role for that in high-risk populations stuff he’s talking about. Now, he’s talking about specific high-risk populations.

Mary Lou: Hearing from the ministry that they want groups and broader-based work, rather than one-to-one work. Sometimes I don’t agree with that, because some of the people that I work with can’t be reached in a group and have to be reached one-on-one. He [medical officer of health] has worked very hard to discredit home visiting as a program. He’s always talking about having hard data to justify the work you’re doing. But his attitudes aren’t supported. There is no research to say that home visiting is worthless, but he’s saying that’s worthless anyway. So when you don’t use hard data, you’re using attitudes and values, and where is that coming from? He’s been against public health nursing, and public health nursing doing
anything beyond communicable disease follow-up or TB follow-up, which is very specific and doctor-ordered.

Mary Lou emphasized that the devaluing of public health nursing and home visiting started with the provincial government in the Chief Medical Officer of Health's office.

All the nurses were in agreement that the standardized measurements of success set by the Ministry of Health for their program activities did not coincide with community development and empowerment practice with high-risk populations. They expressed frustration with the fact that no one in the Ministry of Health or the department seemed to be looking at outcomes of community development with this population in a comprehensive, empowering way. They posited that with the change in ideology within the ministry, health promotion and community development were viewed as even less important. The Mandatory Health Programs and Services Guidelines (1989) served to reinforce this ideology with its emphasis on standardized programs and measurements:

Kristen: The messages are coming down; you have to prove outcomes. You have to prove what you are doing. That is coming from the level above them [nurse managers] who are not out there in the field, who don’t see the clients, who only see the numbers, and don’t really understand exactly what we do . . . programs have to be standardized. Putting a lot of value in bureaucracies and statistics rather than in people and their lives. This is the mandatory core program stuff, people have to fit to the mould. But everybody is an individual. We don’t fit moulds. I struggle with that often.

Several of the nurses explained that the cutbacks to hospital budgets and community agencies, the loss of funding to public health, and the redirecting of new monies to hospitals for outreach programs had significant repercussions. These factors fragmented services, accounted for the loss of many hospitalized, high-risk women to follow-up, increased competition among community services, and eventually threatened further the credibility and visibility of public health nurses. The following nurse’s story illustrates her perception of the impact of these budget cuts on public health nursing’s role in hospital health service. She believed that the loss of public health nursing in hospital health service occurred because the unique knowledge of public health nursing, hospital nursing, and women’s health was not valued by the provincial government or the Medical Officers of Health.

Mary: I don’t get to determine [if an emergency visit is needed and whether public
health or home care is appropriate], the floor nurses do. They are very skilled in hospital nursing, but their understanding of community nursing and what happens to the client in their home situation, the limitations of going home and the stresses of going home, and the realities of going into the community, and how difficult it is to co-ordinate care, I think it’s poorly understood within public health and within the hospital. To give the nurses credit, that’s not what their training is. They weren’t trained in community nursing. They really don’t understand the difficulties.

Mary witnessed a substantial loss of time and commitment in hospital health services: loss of roles, activities, and relationships with new mothers and other professionals. She believed that the damaging ramification of this change was greatly underestimated. As result, the outreaching into the community to advocate and make connections for marginalized women was being lost. She noted that before the cutbacks occurred, she worked full-time in hospital health service. Her time was then reduced to 3 hours per week, and she received one or two referrals in a morning as compared to the four or six referrals received each morning when she was full-time. In the past, she could refer and work with other hospital services, do breast-feeding assessment, teach, and make very specific community referrals, based on first-hand knowledge of mothers, and their medical and home situations. At the same time that this change was occurring, she explained that hospitals were receiving money to contract out “24-hour early discharge of new mothers and babies.” The nurses commented that although the Ministry of Health espoused a move to an increased emphasis on community-based health, in reality the move represented increased money to home care and hospital-based medical control through ambulatory services and other hospital outreach programs. The hospital silo as compared to the community silo was still perceived as the most powerful one. The public health nurses perceived the funding arrangements as a significant blow to public health and representing a “stomping of public health nursing.” The nurses were left questioning their destiny as a professional group:

Mary: The new flavour of the month right now is to hire contract agencies [employing nurses] to do home visits or follow-up assessments of new moms. Like 24-hour discharge. Stomping of public health nursing. The mandates of the silos is changing constantly, and the expectations are changing within the ministry. It’s a very confusing time . . . looking at a different model of health care. So where will we be in this change?
"People Just Don't Ever Know What We Do!"

As noted previously, inside and outside the department and the Ministry of Health, the public health nurses and their scope of practice was poorly understood by the public and alarmingly misunderstood by professional colleagues, department, the Ministry of Health staff, and the Medical Officers of Health. This misunderstanding presented significant contradictions and constraints for the nurses and their practice. Of note, the nurses emphasized that the negative perception of public health nurses was generally not a barrier with their women clientele.

This section uses two sub themes to describe why the public health nurses' practice was not well understood: (a) Circulating Discourses in Public Places, and (b) Uphill Battle Against Medical Science.

Circulating Discourses in Public Places

The image of a public health nurse portrayed in popular culture was seen by the nurses as a very damaging factor. They believed that society's stereotypical view of a nurse, their status as an employee of a government-funded health agency, and their status as an all-female workforce negatively affected their image and credibility. To preface this discussion, I have included an excerpt from the popular press that poignantly addresses this issue. The passage is from an article written by Michael Valpy (The Globe and Mail, December 19, 1995), "Must Our Serious TV Dramas be Freakishly Glum?" In the article, he criticizes the national television industry for its failure to portray real-life human journeys that could contribute to a national consciousness, that reflect "the social environment in which we live, enlighten us as to the workings of our institutions or our prevailing mythologies." He states:

I'd like to see a well-researched drama about a public health nurse in a large Canadian city. I know what those nurses experience in their work. They see all of us at our most exposed and vulnerable. Perhaps more than anyone else in Canadian society other than police officers and teachers, they live with, confront and deal with the true drama of ordinary people's lives.

Their work ranges from the funny - a head lice epidemic in a ritzy public school (and confronting a mink-coated mother with the evidence that it's her child who is responsible) - to the tragic: the terrified, isolated immigrants, the dipso/maniacal wealthy wife-batterers, the teen-age mother sliding towards child-abuse, the cauldron of life in a public-housing complex.

They are the first to see the effects of changes in government social-welfare policy. The stresses of their work undoubtedly have an impact on their marriages, their family life.
"Oh but you're just this big institution..." The nurses expressed a common belief that a stereotypical view existed in society of a nurse. To some, she is someone in a white uniform who does "needles and stuff." They argued that because public health nursing was not easy to identify by concrete tasks, it was not generally understood. The following nurse's comment, with reference to confusion between public health nursing and St. Elizabeth's visiting nurses, indicates how she understood this perception to affect professional relationships. She felt that the following explanation to her seniors' group was warranted. A St. Elizabeth visiting nurse who was doing home care treatment in the senior's complex where the public health nurse also practised did a presentation at the senior's coalition meeting in the complex and described her roles as similar to the public health nurse, only with the addition of treatment.

**Tracey:** They have no idea what we do. "Oh, you do needles and stuff." Well, those were immunization nurses. This is what we do. We're always telling people what we do. They have no idea, because we don't really have a high profile. I guess that's always been that way. Actually we do a lot of different things from St. Elizabeth [nurses]. I stated that very clearly in the group, so at the beginning that made the lines clear.

Another nurse felt that the title of public health nurse contributed to the problem. She contended that different expectations are held, depending on how the title is perceived by both the nurse and others.

**Carolyn:** Public nurse can either be a snooper or the one you can access when you don't have anybody else. Or it can be the one they have to listen to, that is, the other bureaucrats. The health nurse can be the health policy, the teacher-preacher or can be the one who isn't concentrating on the other problems. People relate to you differently according to those perceptions.

However, she viewed the title of public health nurse in a very different way - as one who could represent social justice and liberation through one's access to power sources. "Public health nurse means what you can liberate from this bureaucratic process for the grassroots."

All the nurses agreed that their employment in a government agency and the persona of public health nurse that went with it, which was associated with conventional public health practices, was a significant handicap for them in their current community partnerships,
and in forming new partnerships and succeeding in them. They believed they were somehow seen in partnerships as an "institutional nurse," a "bureaucrat," and an "official city representative." Thus, they were not seen by professional colleagues as working in the community, but as bureaucrats who work in an office making phone calls and moving paper. Some nurses also believed that some community agencies wanted to avoid them because they were viewed in this narrow and official way. Certainly, all the public health nurses in this study saw the negative images as a significant contradiction to the reality of their practice. The following comment captures the contradiction and frustration of the nurses in seeing themselves symbolized paradoxically as a big institution, yet somehow invisible:

Mary: We only spend a small fraction of our day in an office. We were in the community doing programs, doing visiting in schools, everywhere so we never saw ourselves as being an institution where people came to us. We came to the people, and we developed programs they wanted. But the perception was, I think because we were also a large entity, that we were an institution and we weren't really part of the community. We weren't a community resource reference or a community agency. We were something else. It's the same today. "Oh, but you're just this big institution." So it's almost like trying to forget the elephant is there. We shake our heads thinking "why aren't we included [by hospitals]?" Like why don't people get it?

It's only "women's work." It was implicitly and explicitly evident through the nurses' narratives that they perceived that many professionals and the public in general took their practice for granted as "women's work." Several nurses believed that this perception significantly conditioned the value of their practice in public discourse. All the public health nurses expressed concern with the devaluing of public health nursing within the Ministry of Health, particularly by the Medical Officer of Health, who publically stated that public health nursing is women's work, and public health nurses could be easily replaced in pre-/post-natal and parenting activities by community mothers, or that their work could be eliminated. Some nurses expressed feelings of hurt, frustration, and confusion in being misunderstood and did not make a connection to the larger political agenda. However, several nurses articulated the connection of their work to the larger sociol-political, economic agenda. One of the nurses challenged the public and professional perception of public health nursing work as insignificant and of little value, with criticism of public health nurses themselves and nursing
in general, for not doing enough to dispel this distorted image. She qualified her comments as reflecting how nursing’s practice was controlled within the relations of power of the hierarchical, male-medical system:

Mary Lou: As public health nurses, we haven’t been smart politically in the past, because people still perceive us as [doing] women’s work. As long as times were good, you could afford to pay for women’s work and it’s all right. They can go off and do that because they are seeing people that the rest of us really don’t want to deal with anyway. But, when money gets short, it’s perceived . . . . that any old person can come along and do what we do straight off the street. It goes back to what I was saying earlier - [physicians wanting] less and less education at the bedside and less and less education in the community. It’s only women’s work, and it’s just sitting around drinking tea and eating cookies with people and chit-chatting. They don’t actually have an appreciation of the work. I can’t remember the last time I sat over a cup of tea with somebody.

In a few instances, nurses credited public health nursing’s lack of visibility in health promotion/community development with nursing education, claiming nurses are socialized to be passive, to keep a professional distance, and to conform to a white middle class image of “nice ladies.” It was believed by many of the nurses in this study that the health care bureaucracy and society maintained this image, which many public health nurses struggled against. The following excerpt highlights this point:

Penny: I don’t think we’re comfortable enough. Some of us are not comfortable enough to say, “Hey, this is tooting my horn.” This is a passivity instilled in us, like the dogma you get through school, the caring and the nurturing and that’s great, and to work in a system and to co-operate in a system. What about to be a leader, to be an advocate? If you have the personality to bust the barriers, if that is what you’re good at, let’s foster that.

Uphill Battle Against Medical Science

All nurses felt that they were continually fighting an uphill battle against the Department of Public Health’s traditional, medically-oriented, epidemiological policies and practices to have their community development perspectives and practices understood. They perceived this conflict between traditional and epidemiological science and the new health
promotion/community development discourse as one of the most significant constraints. The following quotation illustrates this point:

**Kristen:** An incident in which I was involved concerned communicable disease. The Communicable Disease Control [Division] was involved but it was treated epidemiologically without an understanding of the emotional support of the community. And it [the matter should have been approached] would be more within a community development perspective. I think it's her role [nurse manager] in educating the rest of the department about what we do as nurses in terms of community development in support of the community in a crisis as opposed to what they do from a surveillance and follow-up approach. You can't do one without the other.

The public health nurses in The Growing Together project (described in Chapter Four) were initially enthused about participating in research activities and opportunities to learn and to see their work validated. However, over time they developed growing concern that their activities and health promotion/community development outcomes were not being measured. It became evident that evaluation of community development outcomes was not a part of the research agenda; only clinical, epidemiological, and behavioral outcomes were evaluated. The nurses noted that the pre-established "outcomes" of the research project did not capture the effectiveness of the public health nursing in community development work. Instead, they were designed to test the effectiveness of the clinical and behavioural interventions performed by the psychologists and other professionals with the project partner, the centre for children's mental health. The public health nurses' practice was included in shared records but not assessed in research evidence. Expressions of frustration were directed to their nursing management and the advisory team of the centre for children's mental health for allowing this omission to occur. As they spent more time in the project, they questioned their community partners about their status as equal partners and challenged the misrepresentation of public health nursing by the medical and epidemiological research.

To illustrate:

**Mary:** "Research they were doing was not nursing research." Sara kept saying, "but it involves nursing. The end result is what benefits you." And my point was it's going to be difficult to sort out who was involved with this client and was it nursing work that did it or program work? I think we're evaluating the program.
There is no way we're evaluating any of the work that nurses are doing. And, the problems that they are posing, the research problems, are based on their questions and theories, not nursing theories.

The nurses believed that the omission of research outcomes that included the public health nurses' health promotion and community development work could ultimately be traced back to the medical officers of health and their positive valuing of medical science relative to nursing. Furthermore, the nurses stated that the department culture did not support research on public health nursing and community development practice. They believed that the lack of research emphasis and allocation of resources emanated from the Chief Medical Officer of Health for Ontario and his devaluing of public health nursing and qualitative research. The nurses strongly professed the belief that qualitative research has an important value in the examination of their complex practice. The following comment exemplifies this point:

Mary: Nurses basically say qualitative is really what we need and should borrow those models from social sciences, not from the medical model and challenge the system. I think we could move it [research] along. "[The medical officer of health] I will not accept qualitative data research." He just stopped it. No one would take him on.

Divergence with Community Partners: Strained Partnerships

Despite the many effective partnerships that the nurses engaged in, as have been previously recounted in Chapter 5, there were many stories of strained partnerships. Constraints and resistance imposed by some community partners, limited the nurses' full participation as credible partners and their establishment of an empowering practice with individuals, groups, or communities. It was apparent in situations where authentic partnerships did not develop, or where they were strained, that a precipitating factor was a distorted perception of public health nursing. A number of themes that represent the situation emerged from the nurses' narratives as follows in their terms: (a) Conflicting Perspectives; An Outsider: "A Partnership of Sorts;" and (b) Competitive Atmosphere: "As the Pond Starts to Shrink, the Services, the Animals Around it Become Uglier."
Conflicting Perspectives

Nurses shared examples that illustrated tensions they experienced when their definition of health and health promotion conflicted with their community partners’ medical and/or behaviouristic perspective. Conflicts of values had implications for the quality of partnerships that evolved, the valuing of the public health nurses’ practice, referrals they received, the portrayal of their roles and responsibilities to potential clients, and as previously mentioned, the professing of their effectiveness through research evidence.

The following excerpts from the nurses working in the Growing Together project with psychologists, social workers, and psychotherapists from the centre for children’s mental health illustrate the conflict they experienced and their perception of the implications:

Jennifer: Some of the workers can be really involved in early intervention, the therapeutic stuff and forget that we do more health promotion. But it’s equal. It’s just that we need to be reminded that there are other viewpoints that are of value. The program will get described as primary prevention and early intervention. They forget that we’ve always wanted health promotion as part of that description. There are times when they’re not even doing health. They’re not even doing primary prevention. We’re talking secondary and tertiary stuff!

When I asked the nurses how the roles differed and how they worked out their differences in actual practice, they presented different examples. The contradiction of models became evident:

Jennifer: Child Abuse Prevention Day - 350 parents and families attended. We thought we would be going in a certain direction after that in development programs or having parents work together to make it a safer community in terms of child sexual abuse. What came out of it was interest in how to talk to your kids about sex. There is an excellent, well-established program done through our Family Planning workers here that was prepared for day care providers and parents. This is a known entity and is proven. One of the workers suggested we could ask so and so from this network across metro whose mandate is treatment of child sexual abuse. I said, “Well, you can find out what they have but, maybe there is something to add to the public health program.” Why reinvent the wheel, when something works and we know is health promotion and that’s what parents are looking for.

The nurses emphasized that staff of the centre for children’s mental health struggled
to learn a community development approach to their practice. The public health nurses educated the staff on a community development approach and continually asserted this perspective, along with the resource repertoire that they and the department could offer. In contrast to the everyday working realities, this community project was lauded, both inside and outside the department, as a major community development partnership program. Generally, the nurses described the partnership arrangement as an effective one where they felt affirmed and respected for their credibility. They firmly believed that they were equal partners who were essential to the success of the program.

An Outsider: "A Partnership of Sorts"

Gaining acceptance by staff as a trusted and equal partner was a persistent issue for all nurses. Although being an "outsider" with their community partners was not the reality for the majority of nurses, some of the nurses’ stories implicitly and explicitly portrayed the public health nurses as outsiders who lacked or were perceived as lacking credibility with their community partners. These nurses described general feelings of frustration and alienation, and remarked on the significant investment of time and creative strategies they used to gain trust, establish credibility, and gain acceptance to dispel their community partners’ negative image of their capabilities.

Several of the nurses believed that the department’s lack of support in promoting a positive image of public health nursing detracted from their partnership status. This lack of support became increasingly problematic during the escalating fiscal conservation of the provincial government and subsequent cutbacks in public health services and programs. To emphasize this point, one nurse stated that she was told that public health nursing was being seen by school principals as a joke because their activities in the schools had been cut back so drastically. The nurse was dismayed by this view because she had worked hard to build positive relationships in the school community. Additionally, diverse programs were disappearing that she had been instrumental in developing.

Characteristics that illustrated strained partnerships included: poor or no communication on major program planning and decision making; not being informed until the last minute on day-to-day program changes, or change of location of the centre where they liaised; not having a mechanism to document their activities with the women other than on their public health record in the district office; feeling they were doing effective work but
not getting credit and affirmation; and lack of understanding of their professional expertise. These nurses, who felt positioned as outsiders by some community partners, did not experience their desired reciprocity in communication, respect, and inclusion in major program planning. It seemed that the community partners viewed the nurses as deliverers of specific public health programs. The following vignettes elaborate on the nurses' outsider status:

**Tracey:** *I deal with their health issues, and the shelter is asking me not to counsel them in terms of their abuse issues because that is what they do.*

**Kim:** *They [centre staff] see themselves as respecting individual differences in people and we don’t? . . . Hands off prostitutes and drug users who have been on the street.*

**Mary Lou:** *They [social activists] say, “You have no right working with that person because you don’t work as a prostitute. You have a job. How can you possibly understand where they’re coming from?”*

Tracey commented, “I don’t even know if they know I do charting. That it is part of what I do.” She stated that she did not document her planning activities and overall plan at the agency. Documentation on a specific client was kept in a record in the district office. The centre did not expect her to record, but rather to share her work with and for the women verbally. She was also not allowed access to any client files. Her work, for the most part, was invisible to her colleagues, other than through responses the women shared and visible outcomes for the women. In the reflection that follows, the public health nurse noted that she was welcomed by the women and children who came to the centre, yet she did not sense a partnership with her community partner, although the centre staff would describe it as a partnership. She describes it as a “partnership of sorts.”

**Jan:** *They always referred to me and other public health nurses they had connections with as their community partners. I felt there was a partnership of sorts, but it wasn’t what I would call a really strong partnership. Gaining acceptance by staff as a trusted and equal partner was a persistent issue, and it never resolved over my four-year assignment. They had agendas of their own. They worked out disagreements among each other behind closed doors. I was never privy to “behind closed door discussions.”*

She iterated that the community partners in the centre viewed the public health nurse as an “official city representative” useful for delivering department programs for women and
children that the centre wanted (i.e., the Nobody’s Perfect program). She also did not have a mechanism at the centre to record her activities. The following story further illustrates the resistance and the lack of reciprocity and professional respect Jan received from the staff. She explained that the centre notified her one week before the Nobody’s Perfect program started, which she was co-facilitating with one of their staff, of its move to a new location outside of the nurses’ district boundaries. This lack of communication resulted in Jan having to obtain her nurse manager’s permission to remain in the liaison assignment at the centre and scrambling at the last minute to recruit and retain potential participants.

**Jan:** ... Feeling a bit frustrated, as one of the closures that they made directly impacted on one of the programs I was ready to start. It was a week before I was supposed to start the series. They didn’t even tell me in advance that this was going to happen. They knew I was committed to ensure that the service that they provide to this vulnerable group of women continue. In the years that I was liaison there, I had contacted managers and gotten letters written to support their funding efforts, and helped them with mailing letters off and various sorts of things. It was frustrating because then I had no access to the women I was ready to recruit.

This next story is similar, in that the nurse was excluded from major program planning and decision making. This nurse also implied that public health nurses did not receive the respect they deserved for their work and contributions to the community health centre’s programming. She was offended by the devaluing. In contrast to Jan, their public health nurse viewed the community associate as an unequivocal partner. In this particular community health centre, a community health officer, the Healthy Beginnings program co-ordinator, and the public health nurse’s manager participated on the centre’s program planning committee. The nurse described herself and the dietician as the front-line workers. Although she had been part of the community program for several years, she had not attended program committee meetings; her nurse manager had. The nurse saw the program as better than most community programs, with a co-ordinator who was a very reasonable person. Although she was upset by the poor communication and exclusion from important program development, she minimized the situation as “an oversight.”

**Kay:** We were rather upset the first time we went, because they were talking about changing all these goals and objectives and so on. They had a game plan, and we were thinking, “we’re the workers in this program. We should have been consulted
earlier. So we were pretty upset about it. Plus we had set down the original. We were wanting to make changes, but somehow we felt we weren’t part of it.

It was advantageous for us to be there, but we should have been there the meeting before, not after they came up with all of these things. Hurt by it, that they would start changing things around the program when they’re not involved with the program. I think it was just timing. We should have been there sooner. We still have to respect each other for our purpose of being involved. I think it was an oversight.

Competitive Atmosphere: “As the Pond Starts to Shrink, the Services, the Animals Around It Become Uglier”

Some nurses believed that the distorted perceptions of the public health nurse were enhanced by the provincial government’s cutbacks in funding to community agencies, particularly non-mainstream agencies and women’s programs. Additionally, funding cutbacks to hospitals and new funds to hospitals for programs, which the nurses perceived to conflict with public health’s mandate, generally added to the creation of a stressful working environment. These elements instilled a competitive atmosphere and hostility among some agencies and personnel, with increased competition for clients among nurses and between nursing and non-nursing community workers. In several instances, the evolving outcome was the destruction of community networks and the loss of support and community for each other and for community members. One nurse gave the following illustration to explain how the competitive atmosphere was affecting her coalition work:

Tracey: There have been a few tensions in terms of agencies and competition things with clients. It’s more of a supportive group in working together, but these still are clashes. We have had a few clashes with the nurse practitioner and [defining] what we do and what she does . . . a lot of politics.

One nurse who found doing community work with disenfranchised populations in this environment less rewarding metaphorically portrayed this destructive atmosphere as antithetical to community development practice, comparing it to animals viciously trying to get water from a shrinking pond:

Mary Lou: Community development and working with disenfranchised populations is less rewarding. As the pond starts to shrink, the services, the animals around it become uglier and more vicious with each other, tear each other down rather than
building each other up. They are in a position where anybody who is in the mainstream who ends up unemployed or in a lower class status, it's almost like some kind of victory. It won't be too long before you'll be just like us, down in the trenches. You have to be interested in work for reasons other than your own personal style, because those rewards aren't there.

She also commented that many nurses were feeling a sense of needing to prove themselves due to the greater expectations placed on them by the department and community partners and the devaluation and criticism of public health nursing. Additionally, some public health nurses expressed concern that work they traditionally had done was either being dropped and/or assumed by other professionals or nonpaid community workers. They were uncertain that this change of service was necessarily better for the women they served and for the community's well-being. This concern is captured in the narrative of a nurse who shared her experience in the hospital health service assignment in which public health nursing involvement was decreased:

**Mary:** The work we've been doing as hospital health service nurses had been advocated for and why our positions should be retained and maintained, and why it's important. The difficulties moms have post partum, whether it is breast-feeding, or whatever... Floor duty [nursing] is being cut [as well] and they're [hospitals] getting funding to do some of our work, some community-based work. But, it's somebody else who is getting the work, not the floor nurses. The work is going to contract people, new people being hired to do follow-up, and pre- and post-natal assessments, clinics are coming into being. The new flavour of the month right now is to hire contract agencies to do home visits or follow-up visits to moms... 24-hour discharges.

**The Nurses' Everyday Work Environment:**

**Autonomy Versus Control**

This section deals with the policies and practices within the nurse's immediate Department of Public Health work environment that exercised control over their autonomy, credibility, and visibility in community development practice with women in high-risk environments. Included here for examination are relevant department policies, practices, and structures that posed constraints and contradictions for the public health nurses. The theme,
The Nurses' Everyday Work Environment: Autonomy Versus Control, best captures the nurses' struggle. Within this theme, two sub themes are discussed, (a) The Ruling Apparatus: "The Wheels Keep Turning...It Will Only Change to its Design's Ability...", and (b) Nurse Managers: The Gate Keepers.

Smith (1987, p. 3) uses the term "ruling apparatus," also referred to as "relations of ruling," to represent "a complex of organized practices...as well as discourses in texts that im-penetrate the multiple sites of power" and invisibly co-ordinate and control people's everyday lives." Although nurse managers are included in the ruling apparatus, I examine their participation in the process separately due to their proximity to the nurses' work, and because the nurses tended to speak of them differently than other management and administrative personnel at higher levels in the department organizational structure.

Ruling Apparatus: "The Wheels Keep Turning...It Will Only Change to its Design's Ability"

The examination of the ruling apparatus represents my partial knowledge and does not fully represent the multiple sites of power that played a part in constructing the nurses' everyday practice. Several key factors that influenced the nurses' community development practice and were part of the ruling apparatus merit examination here: the Mandatory Health Programs and Services Guidelines (1989), divergent definitions and expectations on community development and public health nursing, documentation mechanisms, day-to-day work load management, and management and administrative practices in general. An account by one of the nurses comparing the organization of the department's work environment to the metaphor of a machine effectively captures the views expressed by all the nurses with reference to how their work was controlled and valued and the lack of organizational change to accommodate their community development practice.

Kristen: The wheels keep turning. You might change the driver, add some bells and whistles, take different drivers, change the paint job, but the engine and guts are still the same. It will only change to its design's ability, and this I see in the public health department.

The many actors and processes within the ruling apparatus that influenced the nurses' community development practice have been examined under this theme through six sub themes: (a) "Trying to Put a Round Peg in a Square Hole," (b) Not Valued as a
Professional. (c) “The Priorities . . . Stay in a Low Corral,” (d) “We’ve Always had to Fight for Our Place,” and (e) The Department’s Ambiguous Commitment to Social Change for Women in High-Risk Environments.

"Trying to Put a Round Peg in a Square Hole"

Chapter Five addresses to some extent the contradictions that the nurses’ experienced with the department’s policy statement on what defines community development activity. In the discussion here, I elaborate on the tensions and contradictions related to the divergence of expectations and possibilities professed in policy documents and the ruling apparatus in general with the realities of the nurses’ everyday practice. Most of the nurses proposed that the department’s policy statement on “Community Development and Advocacy” was designed to serve some individuals’ political interests and define who was valued and who was not valued. The policy was not deemed to be reflective of the nurses’ community development practice, but rather as a mechanism to repress their professional autonomy and practice. For example:

**Penny:** But community development is nursing. Just because they coin the word community development it’s no one’s domain. Some have tried to do a discipline out of it, community developers or whatever. We’ve been doing it all along. We do it everyday. . . . We are not letting go of our projects [now], but we are watching them bloom.

The nurses saw community development as part of a health promotion process, in which outreaching to individuals in one-to-one practice was an integral step in community development practice with women in multichallenged situations. They asserted that a significant gap existed between management’s understanding of the concept and the realities of their practice with high-risk populations, with the effect of devaluing women in high-risk circumstances and public health nursing expertise. This gap is illustrated in the following reflection:

**Mary:** People follow more the models or the perceptions of the models put out [from department] where community development is at zero point. Well we say no, we’re at one. They [management] don’t see that. So we work from different models. This community development just drives me absolutely bananas, because we’ve been putting too much emphasis on that and not on health promotion. Even in something
that came from our own department [nursing]. Models . . . it had healthy promotion as a square, and then it had community development as a square. They are part of the same thing. We give community development equal weight to healthy promotion. Management cannot understand that we’re part of the process. They don’t get it. They cannot see that these are two things going on at the same time, that community development is part of health promotion. They can’t see that the one-to-one is still part of community development. You’re not going to get them into groups . . . not the high-risk ones, not the ones you’re really worried about. You’re not going to get the new immigrants, those at risk. You have to do the marketing first. We have to promote ourselves.

The nurses generally felt that the contradiction between management’s and nursing’s understanding of community development created a significant gap between theory and practice. They believed that the outcome of this misperception represented a devaluing of the nurses’ practice because management saw community development primarily as coalition building and community organizing. One-to-one and family case management and small group work in department programs such as Nobody’s Perfect, Ready or Not, and Healthy Beginnings pre-/post-natal nutrition and support programs were not validated as part of a community development process. The nurses asserted that because their meaning of community development and practice was not understood and valued, supportive resources or opportunities such as increased time, affirmation, sufficient staff, role flexibility, and acceptance of the public health nurses’ meaning of their practice were not forthcoming:

Jennifer: The language that was being used was very devaluing of public health nurses. The directors said, “But we know that has to happen.” They knew it, but the public relations staff, the language was not valuing it. We all have equally significant and valuable roles. It [the city’s definition of community development] created a lot of feelings with public health nurses. Feelings that their work wasn’t being recognized and valued. Senior management verbalized being stunned with this . . . would have said “but it’s all important. We couldn’t do one part of the work if the nurses weren’t doing what they’re doing.” But because the sexy stuff was coalition building and the city was saying that’s the only place its starts, if you’re not doing it then you’re not doing community development.

Some nurses contrasted how they were legitimized in community development
practice compared to how community health officers were valued. They believed that the community health officers had more freedom and resources to do community organization. However, they did not see them as working at a grassroots level with the population. They felt that the department and nurse managers valued the community health officers, not the public health nurses, as the community developers. Consequently, the nurses believed that they were not given the freedom to do community development as they understood it to be. The nurses saw themselves as possessing a broader range of competencies and interpersonal relation skills with marginalized populations, and a broader vision of the situation than a community health officer possessed. They explained that the public health nurses’ community development practice was being increasingly curtailed by the current financial cutbacks and regressive Ministry of Health philosophies and policies.

As mentioned previously, one of the changes that occurred during my data collection period was the transfer of three of the study participants to new district offices. The decision precipitated significant personal and professional anxiety for the nurses involved. One nurse identified her major challenge as finding the time needed to build networks and get knowledge of the new community and district office so she could become versatile. The nurses saw unrequested transfers to new offices as a contradiction by nursing management to a community development way of working, which necessitates a long period of time to build trusting relationships. It also signalled to the nurses the failure of the community development philosophy to penetrate the organizational hierarchical processes and practices of the department. One of the nurses observed that it “shows a real lack of administrative support, management support for community development that they would do something quite so arbitrary.”

Not Valued as a Professional: “Autonomy on a Day-to-Day Level... Stifled at Higher Levels”

Some nurses spoke explicitly about the conflict between their definition of being a professional who was committed to social justice in a caring practice and the Department of Public Health’s definition of being a professional nurse working within a government-funded public health agency. They firmly believed that they were “invisible to their own...” in the department and that the community knew their practice better than their own system. Many nurses noted that the department did not seem to understand that as professional nurses, they
are guided by a professional code of ethics, regulatory practices through the Ontario College of Nurses, and academic and experiential knowledge. Indeed, they believed that public health nurses integrated all of these facets in their practice. In the following example, the nurse describes the conflict she recognizes that many public health nurses experience related to or resulting from the professional distancing and bounded practice that management prescribed for the public health nurse.

**Mary:** One of the things I learned with this Growing Together project and working with a psychologist; they have a different model than we do, their relationship with their client is different than nursing. We've always been trained, especially in public health, keep your distance. You don't give out your home number, you don't go out after 4:00. A lot of us would love to do that but that old trust with management comes back a; “if something went wrong, would they really support us.” The fear is they might not.

One nurse described directives from nurse managers that created an ethical dilemma for nurses concerning their involvement in a breast-feeding research project. The public health nurses were expected to be research assistants and practitioners at the same time. They were told not to interfere with the research process by engaging in nurse therapeutics. “Do the researching first and then the nursing intervention.” In addition, several other contextual factors accentuated the ethical stress for the nurses: the interaction was done over the phone; the mothers had delivered babies and went home without planned public health nursing follow-up arranged; some nurses performed this work along with assuming duties with the new, 24-hour early discharge of mothers and babies’ contracting program; and the nurses were expected to assume this research activity along with their other assignments. Additionally, the nurses were pressured to obtain more women as research participants because the study was not meeting its quotas.

Some nurses explained that they felt professionally and ethically compromised, and made to look “stupid” with other professionals because the department “is yanking us around as pawns in the system.” Indeed, the nurses noted that they were generally expected to respond quickly to new program requests.

The following nurse’s commentary and use of the metaphor “we're the bottom feeders in the system,” captured the feelings and views of several nurses in the study who felt undervalued as professionals, as nurses, and as women; felt devalued in their community
development practice with women in high-risk environments. These nurses also believed there was a lack of valuing of women in high-risk circumstances and the effect that their lived reality had on their health. This vignette describes the relations of power and the oppressive circumstances I heard echoed across several of the nurses’ stories. The account also exemplifies the nurses’ resistance to the restrictive social construction of who she is as a public health nurse.

Penny: It [her returned transcript] validates for me where I’m at in my struggle and not fitting into the nurse role the administration wants. It’s concrete now. I’ll do what I have to do to keep my job, but it’s capturing what I’m actually about. The work is not recognized. My interview with you is capturing my thinking and my practice. I was just reading it, and I was thinking it was almost like a fight within the system for me to do what I do to develop as a professional. I’m doing it on my own with some support from the system, but not a lot. It’s not fostered in all of us, unless you have an inherent need to do community development. I want to keep my integrity as a nurse. Some of the [community development] projects were started by nurses and then given over to community health officers. And that’s it. We’re all nursing [some community health officers are nurses]. How come we don’t shine? How come we don’t have power in this institution? Because we bow out. I’m not going to re-label myself. I find in the community there are no rules for me. I’ve had to make my own rapport. I’ve had to prove myself professionally and they [the community] take it, they’ve embraced it and they’ve given back to me . . . and we create.

Here, there is so much red tape. To spend my energy to change a system that is so medicalized . . . and public health is the most political beast, reactive to politicians. The tragedy is I look at all the work the nurses have done, and others have captured it in their writings, but not for our benefit. They had an agenda to keep community health officers alive as their own identity and profession . . . not everyone can do community development! A territorial thing! I’m going to keep my label as a nurse, and I’m going to do nice projects. I’m going to get our name on them. Our managers don’t open up to take risks and to allow us to nurture and to be risk-takers.

Away from this building, away from here, we can work amazingly in the community. There is a sense of respect as nurses. We are given the respect which drives us even further to do more, for some of us because it fuels us. When we come
in here, there is a sense of: "Well, what is your job?" This is a sense that we're the bottom feeders in the system. Some of us are not valued. Some nurses have expressed being devalued in the system as a professional. And that comes from our leadership. It comes from the hierarchy where we fit. It comes from these mandatory programs that dismisses what you are doing. It's not important. So what, you've helped women go to university, get out of an abusing relationship? "That's not important." That is what is important!

"The Priorities . . . Stay in Your Low Corral"

The Mandatory Health Programs and Services Guidelines (1989) were termed by many of the nurses as "the priorities" and considered essential tools of the Ministry of Health to exercise control and ensure commitment by the Ontario public health system to the ideology of the day. The nurses viewed them as exercising significant control over their everyday practice. Through discussion with public health nursing management and nurses in the study, and review of the revised guidelines (November, 1997), it was apparent that an emphasis on health promotion and on a community development philosophy and approach to public health practice had been deleted from the guidelines. A focus on seniors' health was also eliminated. A medical model approach with an emphasis on disease prevention, injury prevention, children and youth, and greater emphasis on communicable disease control emerged. In speaking about the mandatory guidelines, it is appropriate to discuss them in conjunction with the Public Health Nursing and Education Services Program Activity Reporting System (PARS), as the two were generally spoken of together by the nurses. PARS was the department's statistical coding system and was computed every six weeks. The document defined activity codes such as advocacy, community development, case management, consultation, and education groups; subject codes, such as "Healthy Beginnings," "Heart Health," etc. It also described codes such as multicultural, research, etc. Most nurses did not describe the relationship of PARS to how decisions that affected their practice were made at the management level, but they expressed concern about what was included and excluded and its possible meaning. The nurses generally felt that the department's "fixation" with mandatory core programs, standardization of their practice, and trying to fit the nurses' practice into "boxes" [PARS] indicated their unresponsiveness to the nurses' work with communities.
Tracey: So the priorities were being set down, because we were all going into a
generalized role, there wasn't going to be as much time for us to do things like this
[community development project] because at that point we were still in our focus
groups.

One nurse used the metaphor of a "low corral" to depict the effect of "the priorities"
as subtle control over the nurses' community development practice:

Penny: When I look back at my experience at university and having to conform, and
then coming to this institution, there is the same subtle control. We're supposed to do
what we're supposed to do. The priorities are made up. You stay in a low corral and
do your little thing, and if you stray away to some creativity they will allow that. But,
then when you go beyond that, they'll say, "well you know, you're taking time away
from the priorities." I've been given that on and on! Everyone has their different
priorities. I think we're a dying species and they want to contain us.

All the nurses emphasized that working within the pre-set mandatory guidelines, and
trying to fit their complex practice into statistical coding boxes and pre-set standardized
measures did not allow them freedom in doing community development work. It also did not
accurately reflect the work they did. Indeed, they perceived the guidelines and the
documenting mechanisms as fragmenting what they did. The following reflections depict the
nurses' problems in documenting their practice on PARS:

Tracey: Some public health nurses work by the book. Some are doing the work they
want to do. They're making it their own. They're trying to fit things in. Because you
see the need. I mean you are out there and you see the need. And then you are not
allowed to address it because of this stuff [PARS]!

Jan: On the weeks we had to do PARS, the statistical coding system for the city, and I
was at the centre, I would put it as a community location. How many units of time I
spent doing what I often found there would be a 50/50 split between one-to-one and
community development activities. For the activity code, that was difficult to choose,
if I was specifically mental health I would put mental health. But a lot of the time it
was parenting, sometimes it was pre-natal. One of the activity codes is community
development and I put it down. If I was there for two hours, and I spent one hour in
one-to-one with four or five clients, I would put that under the individual contacts,
and four units of time, which is an hour, and one unit stood for 15 minutes of time
doing community development. It's very subjective how we do that [fill in PARS].

Mary Lou: What we do a lot isn't a task. We work with people around a lot of psychological and sociological issues, mental health issues, which can be measured, but you have to have a fairly sophisticated tool to measure that sort of thing. When I go to work with the women, the prostitutes, for example, talking to them about violence and depression is going to have an impact on that person's life and health status. But it's not something I can just tick off one box to say I did this and that, so it's hard to measure. I think it is still valuable.

It was important how the nurses recorded their work. If the public health nurses did not know what was valued by management as community development and did not document a particular way, they could be seen as not doing community development. However, the nurses were generally shrewd and creative in naming their practice on PARS, yet I believe the nurses each completed PARS somewhat differently because they had varying perceptions of the concept of community development and how to complete the tool.

"We've Always Had to Fight for Our Place"

The nurses described being misunderstood within and outside the department as a significant barrier to public health nursing. Furthermore, this limitation was described as endemic to the department and a major factor in fostering invisibility and undervaluing of public health nursing in the department and in the community. Reflected here are the nurses' views on how they perceived the department's inadequate promotion of public health nursing.

Mary: Since I've been here we can't get communications, and it's been endemic not to publicize our programs or write them up for journals or for newspapers to let them know what we're doing. We've got this wonderful Life of Baby program. Why are we letting the hospitals write on their list of community needs survey, which look at where they want funding, and write it up and send it to the hospital silo and get funding for parenting programs?

To give that work to hospitals without seeing that work was being done by somebody, but was always kept very low key. We never had the PR and the visibility. It's always the feeling that if you spoke up and identified who you were, somebody might want to cut you. And now, rather than saying, "Well, we're here. We're doing
"it," somebody is saying, "Well, see it's a gap in services and we're going to give it to this group."

Another nurse explained that other public health professionals within the Department were better understood as a result of legislation that legitimated their work. As such, these public health workers were seen as important, with more exact and legitimate functions, i.e., those who worked in environmental health and community disease control. Several nurses stated that when public health nurses wanted to publicize what they did, their nurse managers or directors told them that they had to promote all divisions. The following reflection highlights this view:

**Kristen:** I was clearly told that we can not promote public health nursing without promoting the rest of the department. You also have to promote communicable disease control, health inspectors, and dental. We have to promote everything. You're not allowed to promote just nursing, yet I don't see the other areas of the department given the same message. You can't promote nursing by itself.

One nurse explained that a recent pamphlet, which was designed to promote public health nursing, was stopped by the new director, who replaced two nursing directors who lost their positions when the department moved into program management. This situation occurred despite the fact that the research had been done, money had been approved, and the pamphlet was ready to be printed. The nurses commented that preventing the promotion of public health nursing in this way had been repeated many times in the department. The following nurse labelled the situation as historical injustice and related it to the domination of nursing by the Medical Officer of Health and the non-nursing directors.

**Tracey:** Well we sure had to fight tooth and nail to be seen. We're not being respected or heard. Definitely the restructuring [toward more program definition] has had an impact on it. But historically, this has always happened. We've always had to fight for our place. I don't know why it is. It's been a huge power struggle. I think they [provincial government] is just trying to disassemble nursing and get cheap labour, with the "volunteer" idea. It's frustrating... this invisibility! And volunteers, which is unbelievable. Who are these volunteer people? The people out of work. So they are not being paid for their labour, and a lot of them are women.

One nurse associated the invisibility within the department with the general lack of documentation of the nurses' work with the nurse managers and some nurses themselves.
Penny: There is a fear between the managers and the director being a male. The comfort is not there. But we're invisible to even our own, because a lot of our work is not documented, a lot of our fine stuff, whether you call it community development or nursing activities or whatever. I wish it was all documented like a report after you do a big thing, you do a log. I do every year an activity log for my manager, the completion, my contacts, progress stuff. It's like a business report. It's hard core. It's documented. A lot of people don't do that. Indeed several nurses agreed that they need to describe in writing their involvement in community developing projects, however, they felt limited by time and the complexity of their practice situation.

Jennifer: We really need to write this up. When you're already juggling so many things, it really is hard to remove yourself away from the grassroots thing to do that. It's an availability or an access issue.

Kay: Part of it [getting an article published] is we're all so darn busy we can't even think.

The Department’s Ambiguous Commitment to Social Change for Women in High-Risk Environments

There appeared to be an incongruity between the professed commitment within the department to community development with women in high-risk environments and mechanisms to foster communication across women’s programs that would enhance advocacy for social action and social change. This incongruity was apparent particularly with pre-/post-natal nutrition and support programs for women who were disadvantaged for multiple reasons. In most cases, the nurse managers attended the program co-ordinating meetings, not the public health nurses. All the nurses who were involved in the programs saw this situation as an issue, but they did not elaborate on it in our interviews, even with prompting. One nurse, who had been involved in the pre-/post-natal program for several years, made the following statement in support of greater involvement of the public health nurses as front-line workers in policy planning meetings:

Kay: It will be interesting if we ever get together as a group, from all the variety of parental supplemental programs, what will happen. I did say to [the nurse manager] that I don't think there is any point in the co-ordinators being there, because things
are not going to come out. They didn't come out. I think the nurses have to be there collectively and then maybe work from there.

There also seemed to be more communication within a program than between the programs. The public health nurses appeared to be working in fragmented ways, building solidarity across the department on marginalized women's issues. Furthermore, the communication to validate, legitimize, and enhance these programs as a collective was not evident. The nurses did not clarify why the nurse manager went to the meetings instead the public health nurse. This factor seemed to be important in terms of affecting the public health nurses' status, credibility, and partnership building.

A few nurses explained that some of their own public health nurse peers and other department staff posed barriers for them and community development work with women in high-risk environments. Prejudice toward the women, lack of knowledge and experience of community development, and a lack of knowledge of "what it means to be the background person and be the support rather than the person actually doing it" and "helping the women to take control" were cited as hindrances and characteristics of a "subculture within the department" that could not do community development work with the women due to their de-valuing. One nurse noted that she had seen active scapegoating and use of the terms "those people" or "you people." Another nurse explained that:

Carolyn: I pick up things from some colleagues that are definitely narrow class attitudes. I could see how the people that I might be working with could also be aware of it because I am aware of it, as well.

**Nurse Managers: The Gatekeepers**

The nurses held a common perception that the nurse managers had significant power as gatekeepers to allow or disallow the public health nurses' community development and advocacy practice, and to promote or not promote their credibility and visibility. To quote one nurse:

Jennifer: You may be at a point of community organizing or coalition building, and the population is such that needs to happen at a point where the department's staff needs overtime and it [the project] may get stopped. This is where a manager can have a vital role in supporting or stopping something.

It was apparent that some of the programs the nurses described received appropriate
resources, while other programs that seemed greater in need did not, and therefore, could not go no further in community development because of the nurse manager. Two sub themes are discussed that elaborate on the nurse managers’ gatekeeper role, (a) Conflicted Support: “Management is Keeping an Eye on Us More,” and (b) Caught in the Relations of Power: “How Much Power Do They Have to Support it?”

Conflicted Support: “Management is Keeping an Eye on Us More”

Across the nurses’ stories, there was recurring reference to both positive and negative support received from their nurse managers. The nurses who were involved in officially sanctioned community development projects reported that they received affirmation and were reinforced by an extended consultant network, release time, and status. However, the predominant message from all the nurses was that there was generally incongruence between the nurses’ view of community development and public health nursing and the view of their nurse managers. Most nurses in the study stated that although they were encouraged to initiate new community development projects, sufficient and appropriate support was not forthcoming. The nurses noted that in many instances, there was a contradiction between the community development policy of starting where the community is and doing more inter-sectoral and partnership work, and the work their nurse managers allowed. Several stories revealed that the managers gave their support only after much strategizing and experimentation on the part of the nurses. The nurses generally interpreted this resistance with several factors: the nurse manager’s personality, her lack of experiential knowledge in community development, her power position within the organization, her sense of responsibility to have traditional programs covered, her knowledge and vision of public health nursing and community health nursing, her valuing of women in high-risk circumstances, and her abilities to manage. The following nurse’s comment is reflective of many of the nurses’ view that the nurse manager’s experiential knowledge in community development work was a major factor in whether or not the staff nurses received support in doing community development work.

Kristen: If they haven’t experienced something that was community development that was a successful link, they may not really understand how they can even empower. Putting a lot of value in bureaucracies and statistics rather than in people and their lives.
Allowing the nurses time to do community development work, moving away from and/or being flexible with, traditional programs and mandatory program guidelines were seen by the nurses as methods of control exercised by the nurse managers.

As Chapter Five explains, several nurses identified the lack of officially legitimized time as a major limitation in their community development efforts and ability to work toward social change, a project that took much time and effort with marginalized people. One nurse illustrated this lack of opportunity by comparing it to the amount of time a community health officer is allotted for community development work.

**Jan:** When you are working with a community to affect change, you can’t expect change to happen overnight. And that was the other limitation to my role there and why I thought that at least if there was a community health officer there . . . I’m assuming their role is legitimized over a longer period of time, or at least get to a certain level where it’s agreeable with both the community developer and the organization.

Many nurses described discussions with their nurse managers to get permission to free up time for the community development work they believed was needed. To illustrate:

**Tracey:** . . . Time allotments and how things are changing, and do we really have time to waste having people going in when nothing is happening. Nobody is coming to see us. Do we have more time to be attending meetings, huge meetings and things?

In this case, Tracey received permission to embark on a community development program, but it was added on to her already heavy work load. The nurses repeatedly described the fullness of their workload and the fact that they were so busy dealing with the micro picture and their day-to-day traditional practice expectations that they did not have time or were not given the opportunity to see the big picture. As one nurse stated, “How can you push to the next stage?!’” [without these resources].

The nurses generally believed that the nurse managers did not value their expert knowledge and were reluctant to allow them to move away from traditional roles and to be creative in individual and community empowerment practice with marginalized populations. From this standpoint, the nurse managers were perceived as promoting a negative image and invisibility of public health nurses. To illustrate:

**Penny:** She said let go of it [the community development project] because it’s time consuming. You have to bring the community health officer in on this. It’s getting big.
It's too time consuming and it's going beyond your scope. I think it was time management, time allocating her staff. She wasn't negative. It was more of a "The community health officer should help you with this." I couldn't tell them how much time I was putting into this because her message to me was, "There are other things you need to do." Those things are important but this is much bigger. This will be sustaining. If we do this part, this other part is going to really work because the children will benefit from it. Her saying let it go, I held on even tighter. I thought, just because in your description of the public health nurse, community development is not entertained as well. It's not supported . . . I don't have to be re-labelled as a community health officer. You can repackage me, but I'm still a nurse. The priorities for the manager were not consistent for me. I was aware that I had to do parent groups, the in-class stuff for sex education . . . the priorities. I thought, I'm doing this class to get to know the kids, to get to know the parents. I'm looking at this as a stepping stone to where I'm at right now [in community development].

Penny also proposed that some of the nurse managers did not necessarily know how to manage and sell themselves and a more creative public health nursing. She used the metaphor of a tribe engaged in fighting a war to make her point. She believed that the manager was expected to nurture and promote diversity among her nursing staff by valuing their individual uniqueness.

**Penny:** I'm mixed in types of leaders we have; they are not real managers. They don't know how to manage people, some of them. They don't have a vision. They are easy at throwing talent aside. They don't know how to sell themselves or sell our service as well as they should.

Nursing, it's like a tribe we have, we fight wars. And we have the hunters. We have the warriors and we have the nurturers that stay in the village and cook. And our chiefs have to send out the warriors with weapons, and allow us to take risks, and be hunters. They cannot make us scared of the system. They have to empower us. Go out there and multiply. Sometimes that is not nurtured and the message isn't given out. There are those who fight for us, and that it's okay to fight. It's part of our instinct. Within nursing, we haven't been able to do a good fight. I am fighting.

Some nurses acknowledged the inconsistency among the nurse managers in validating and promoting the nurses' community development work through documented
evidence and professing their work within the department. To illustrate, the nurses who were involved in community development projects, which were sanctioned as such by the department, were asked to complete an evaluation tool. Some nurses completed it and some did not. The nurses involved explained this response by noting that each district office worked differently. In some cases, the nurse manager approached only certain public health nurses to complete it, while in other situations, the nurses themselves said they were too busy. When I probed this latter point with one of the nurses who did not complete the tool, she commented that the community development documentation was not valued by the nurse manager but seen as “extra stuff.” She was not given release time in her schedule to do it; it would have been an add on. Other nurses acknowledged that it was the nurses’ responsibility to keep the nurse manager informed of their practice and to advocate verbally and in writing for their credibility in community development practice.

As the changes escalated in the department, more and more the nurses had to justify their practice to their nurse managers, explain their involvement in community development work with women in high-risk environments, and advocate for the promotion of health for marginalized people; “Now we have a hard time doing work [community development] even if there is a need for it. It basically comes down to whatever the manager wants or will allow.” All the nurses exclaimed that their time was being restricted with marginalized populations, their flexibility and freedom to develop community partnerships and to exercise a holistic practice were being sharply curtailed, and there was increased surveillance of their practice. The following example poignantly illustrates these points. The nurse is talking with reference to the nurse manager, asking her to decrease her time on a community development project.

**Mary Lou:** It’s not very good for the kind of work that I would like to see done [with high-risk women]. It’s going to take me three times longer probably, because you have to be present and consistent if you actually are going to do a community development piece. Work with the women [prostitutes] and get them to identify what it is they need and then start working with them to try to figure out how we can meet that need and start drawing your community in to fulfill that need. Takes a lot of time. If I get to the point where the women were asking for a drop-in centre or a support group, I might be able to spend more time on the project. Talk her [nurse manager] into letting me have more time. Because then I would be developing a very specific,
identifiable, concrete Ministry of Health response to the issue. I'm working with people in the community to develop and respond to a need that they have. I find management is keeping an eye on us more, in terms of "How much time are you spending there, remember, we're not there to deal with all the issues." We are asked to go in and deal with this issue, and that's all we should be doing there.

Increasingly, they were being told to refer their community development activities to community health officers. Some nurses stated that they felt they had less support in the destabilizing atmosphere of their district offices and were demoralized by the power dynamics of their nurse managers. Some nurses perceived that unless they "toed the party line," they were overlooked for new project work within the department and were not given affirmational support. A few nurses commented that when they spoke out, they were belittled by their nurse managers and silenced in their team meetings on important issues.

Caught in the Relations of Power: “How Much Power Do They Have to Support It?”

Several nurses acknowledged that although they were confused and frustrated by their nurse managers' mixed messages of support and of resistance to their vision and expectations for community development practice, they recognized the nurse managers as a primarily positive resource. Generally, they perceived them to be compromised by "their power position within the organization . . . the power struggles" and in a similar situation to them, only on a higher rung on the hierarchical ladder. Some nurses believed that because the nurse managers were not heard by and were invisible to upper management, they participated in the unresponsiveness of the system to public health nursing and community development with marginalized populations. It was also noted that the role of the nurse manager was changing significantly as the public health system changed to program management. There was serious concern that under program management, nurse managers could be replaced by a nonnurse. This change was seen as having an even more negative effect on public health nurses' identity, standards of practice, and skill development.

Carolyn: Where then do the nurses get clinical consultation? Maybe the supervisory, monitoring, and evaluation component of the nurse manager? But what is retained for standards of practice, nursing identity, and skill development?

Some nurses saw the nurse manager as complicit in increasing bureaucratic control in line with new policy directives from the provincial minister of health, who imposed
programs on the community rather than worked with the community to elicit their urgent needs. The following examples illustrate the contradiction between the department's community development and advocacy policy and goals of the Mandatory Health Programs and Services Guidelines (1989), and the action of the nurse manager.

Jennifer: They [department] sent some letters to teachers, "These are the health promotion topics that the public health nurse people could be available to consult with you, work in your classroom - do whatever." And our work is supposed to be generated from that. This is the provincial minister of health coming down from the top stuff.

Joan: The managers have decided that the programs are being offered to grades five and six only. It's substance abuse prevention, puberty, heart health, and cancer prevention.

With the escalating organizational change that was occurring within health care and the public health system, it was uncertain where power and authority resided. Some nurses saw the nurse manager as being at the mercy of the organizational changes, and therefore, somewhat compromised and powerless to support the public health nurses and their community development work. The following nurses' comments illustrate the general understanding held by most nurses that the nurse manager's behaviour was a consequence of the same oppressive power they too were caught up in.

Jennifer: It's more than nurse managers. We certainly get verbal support. There is support on paper. But with all of the organizational changes that have been going on . . . we don't have a single CEO of public health anymore. We have four directors. It's not known how it's understood. No one knows how much power or authority there is at certain levels. This has only been since November [1996]. They are looking for outcomes. When you do something like community development, measurable outcomes are much more long-term than short-term. [The outcomes] haven't been defined exactly. There is anticipation we need to show what it is we're doing. You don't know how far the support is going to go. I don't think they [nurse managers] know how far they can give it. There are a lot of unknowns.

Maybe that [invisibility] is part of the problem. Part of the gap is not what the managers understand, what they are advocating for, but in being heard. There is a sense of powerlessness at that point between them and the next level, and then to the
top level. It's not enough that they understand and support what we're doing because how much power do they have to support it.

Kristen: I think people understand that community development is important but at the same time, everybody is struggling with loss of so many resources. How are we going to stretch it? What are we going to do and what are we not going to do? I feel like they [administration] can't decide really what we're going to do because that depends on what the group or the power or the community that you're working with, what they need.

Mary: They will always feel as part of the nursing culture. I know they're all being caught one way or the other. In this climate, the guillotine is on its way down again all the time. The people that were our largest supporters even three or four years ago are very quiet now, so careful. They don't want to do anything that could be misconstrued as siding. They've cut nurses before they'll cut another discipline. They don't want to be seen as being from nursing.

Tracey: Management is trying to work to keep the lines of communication open in terms of hearing rumours. So this [dropping of the senior's programs] isn't going to happen. We really don't know what is going to happen with the "new" city. They are trying to think of different things to keep it going rather than to have it just cut back to bare bones.

The Invisible Community: Ethical Conflict, Moral Distress, and Job Dissatisfaction

The many contradictions and barriers to the nurses' community development practice had major consequences for the nurses, both personally and professionally. The impact of these factors are captured in the theme, The Invisible Community: Ethical Conflict, Moral Distress, and Job Dissatisfaction. Based on the nurses' stories and my observations of their practice, the contradictions and the constraints in the nurses' everyday practice and the effect on their integrity seemed invisible to colleagues and management within and outside Department of Public Health. Ethical conflict, moral distress, and job dissatisfaction were common consequences for the public health nurses as a result of the many contradictions between the social organization of their practice and their sense of integrity and agency as public health nurses. Their moral distress and invisibility in community development work increased over the research process as the ideology of fiscal conservatism was implemented
through the public health system: from the Ministry of Health to the municipal Board of
Health to the Department of Public Health, to the nursing division, and into the wider
community. The nurses felt more and more as outsiders to their own Department of Public
Health. The situations that provoked ethical conflicts, moral compromise, and distress are
been aptly described earlier in this chapter. In this section, I want to portray the unsettling
feelings and concerns that accompanied this situation.

Constant change related primarily to economic factors was seen as a prime enemy of
community development practice and an instigator of the escalating disempowering practice
environment for the public health nurses, high-risk populations, community partnerships, and
community health. As the social, economic, and political climates changed, the nurses’
expressions of uncertainty, powerlessness, frustration, loss, grieving, anger, paranoia,
intimidation, fearfulness, and worry increased. One nurse commented, "[I am] coming
unravelled because of all the change and projected change." Many nurses expressed a sense
of increasing powerlessness in the fight to maintain their commitment to community
development practice and their marginalized clientele and to resist what they perceived as the
 eventual demise of public health nursing. One nurse observed that there were different
reactions to the changes between recently recruited and more experienced public health
nurses. The more experienced nurses seemed greatly demoralized by the changes and the
constant need to resist the bureaucratic control, while recently employed nurses seemed to
have more energy and optimism.

The following nurse's reflection accentuates the power the nurses believed the public
health system held over public health nurses and their practice, and the pending doom they
associated with the changing sociopolitical domain:

Kristen: Things are getting tighter and it all has to do with the political climate, too,
because the public health department is part of a political body. When you value
community development and helping advocate and helping people with what they see
as their needs, and if those needs conflict with the politics of the time, you are really
constrained and worry about offending the politicians who oversee the department,
like City Council, the Board of Health, the management board, and all that sort of
thing.

Although the nurses saw nurse managers, directors, and themselves as working
together in the struggle against the imposed sociopolitical changes, they were deeply
concerned that the situation was creating a widening gap between their nurse managers and themselves as front-line workers. They indicated that they suffered reduced and/or poor communication with the nurse managers. As the following nurse explains, the managers did not ask the nurses for their opinions on issues any more:

Kristen: The managers don’t really come to the public health nurses and ask what they think any more. It used to happen more. Part of the issue now is that changes are happening so fast that things are to be done so fast. And to even a community development approach, which takes time. The directors who are trying to save the department and nursing as a profession in the department feel like they have to work very quickly and don’t have the time for consideration and feedback and input. They have to make decisions and go with it that day.

Another nurse’s comments reflected her frustration and disbelief in the nurse managers’ complicity in promoting the invisibility and what she perceived as the eventual extinction of public health nursing. The immediate implication for her was the feeling that she could not count on the nurse manager for support, as the nurse manager’s loyalty seemed to reside with the bureaucracy and not with public health nursing.

Mary Lou: You feel at odds because you see a certain decision is made, like not to get involved with a certain committee in the community or not to go into high-risk to a certain type of client . . . and that decision is made up above. For those of us that see this could hurt us in the long run and isolate us in the community and make us not as obviously valuable to people in the community, it is going to be very difficult to work with that. It is going to be very difficult to work with managers who are trying to get you to do things that you know in the long run is going to get rid of your job.

It’s hard to understand why they go along with it. If I can see it and I’m working on the front-lines, somebody in management should be able to see that. Why aren’t they rebelling a certain amount?

Another nurse explained that because the nurse managers were caught in the oppressive relations of power and “seduced by the efficiency paradigm, administration, and sentiment,” they were the gatekeepers of maintaining the status quo, which she viewed as contrary to the department’s professed health promotion/community development mandate. In the following excerpt she explains her rationale for the nurses managers’ actions.

Kristen: And those groups [nurse managers] can feel that they have to work together
as opposed to being able to challenge each other, to move ahead. "We [nurse managers] can’t defend this group because we’re here. And we can’t defend this group." So everybody has to keep the status quo rather than anybody being able to challenge it.

The following nurses’ comments reflect feelings of frustration and powerlessness created by the lack of freedom to practice as they believed. They felt compromised trying to meet the expectations of traditional and community development practice demands.

_Kristen_: [Management is] putting a lot of value in bureaucracies and statistics rather than in people and their lives. I have been very frustrated. This is the mandatory core program stuff, people have to fit to the mould. But everybody is an individual. We don’t fit moulds. I struggle with that often.

_Jan_: In my position [as a public health nurse], I didn’t feel I had the power to do that as a community developer, whereas the community health officer had through his position. He could get them help at a higher level. Sometimes these things are very unspoken, but you know they’re there. If you test the waters, there will be consequences.

_Tracey_: We’re going to be more general, but we are still expected or we expect ourselves to specialize and do that intensive work that we did in the summer and before. So it’s hard!

Tracey was referring above to the change of delivery of nursing services from program focus to neighbourhood nursing and feeling caught in trying to meet all practice expectations for both types of nursing.

Several nurses stated that as a result of resistance from management, it was a continuous challenge to practice in a community development way with the multichallenged women and families they served. Some nurses responded to the contradictions in their work environment by going "underground" in particular situations and/or at varying times. The nurses who described this action mistrusted the ruling apparatus to do otherwise. They saw this move as a viable community health practice to fulfil their commitment to their vision of practice. Regrettably, going underground and not documenting or professing their values or actions could have the negative effect of reinforcing the invisibility of the nurses’ practice.

All the nurses expressed uncertainty of some degree about the future of public health nursing and questioned how public health nursing and themselves as public health nurses
would fit into the health care restructuring that they were a part of. The following excerpt highlights this concern:

**Kristen:** We're almost thinking does public health nursing have a different vision? Has it changed with the times? It has to change, but where do we go now? Where are we going? [We] A feeling of powerlessness that decisions are being made without any seemingly sense to them. Everybody is fighting to stay employed and worried about how they are going to take care of families. Fighting to try to prove what we do. The whole picture is pretty overwhelming, and on top of not knowing what is going to happen [with the merging of municipalities].

Some nurses stated that the nurses were not working as a team, as a consequence of not feeling valued in the organization and being too busy. This situation was viewed as contributing further to feelings of frustration and powerlessness.

**Penny:** The team: meeting and giving out cases - no one wants to take the cases . . . . Everyone says they're too busy. They call it a team but we're not a team. We are a group. We don't work together. We have to work very independently. That frustrates people because we don't work as a team. It's not a team in here.

One nurse stated that she needed a new purpose in her work, as she was so disheartened by the conflicts with community partners. The nurses saw the increasing fragmentation of services, loss of roles, and changing priorities of the Ministry of Health as having significant consequences for the image and power of the nurses as a professional body. For example, one of the nurses commented, “Nurses can't mobilize, can't mobilize in solidarity. What is sacred here? How many times can you do this flip-flop? Nurses can’t mobilize because nobody has an idea.”

All the nurses noted that trust with clients and other professionals was also significantly affected by the Ministry of Health’s change in policy direction. The Ministry of Health’s new policies ignored realities of people’s lives and the need to respect issues of safety, confidentiality, and trust-building as critical with disenfranchised people who are difficult to reach. For several nurses, public health nursing’s future was seen as integrally related to how vulnerable populations were valued by society, the provincial government, the Ministry of Health, and the Department of Public Health. They feared that the devaluing of high-risk populations and leaving them behind would precipitate the removal of public health nursing from direct service and preparation for public health nursing’s eventual extinction.
Two nurses suggested that working with disenfranchised women positioned public health nurses as also disenfranchised. Therefore, public health nursing was deemed somehow powerless and invisible in the eyes of department management and other policy makers. The following account articulates the views and tensions that were reflected in several nurses’ stories:

**Mary Lou:** My big fear, high-risk women, who tend to be more hidden perhaps than men, will get left behind, and we will be more constricted in our roles. The population-based approach and what the provincial medical officer of health is buying into – homogenization, so they are playing to the mainstream and ignoring the disenfranchised. They justify it by saying we were taking a population-based approach and looking at the broader collective. Then people who public health nurses work with predominantly, get pushed to the side.

It has been too much of getting us away from the front-line work, away from the [high-risk] populations into higher class education; getting us away from doing hard core nursing. It’s obvious to the public that we need to be there. Having us do higher level education that most of the disenfranchised wouldn’t even come to [gets the public health nurse away from high-risk populations].

It’s easier for the taxpayers to look at that education stuff and say, “Well, that is all very nice when times are good and we can afford that, but right now we don’t have enough beds in the hospital. We can’t afford all this airy, fairy education stuff.” So getting us away from all that work with high-risk has only set us up. It has made it easy to get us to a point where they could get rid of us quickly. Who is going to say anything?

They’re moving very quickly in Ontario anyway, to try and get rid of everybody they can. I don’t know what I can do about it. I think that really I am being somewhat paranoid, but I think we’ve [public health nurses] been set up for this for a long time.

Mary Lou stated that she was unsure what she could do to change the situation, as she did not see herself as an activist to resist and fight the macro level politics. She identified research as important, but she did not believe that evidence would be available soon enough, or that even if it existed it would be listened to by policy makers. Furthermore, she did not see the medical officer of health as a supportive peer, but one who would easily dismiss
public health nurses because the nurses' professional autonomy posed a threat to him/her.

Mary Lou: Nursing that doesn't need the relationship where you need a doctor involved, doesn't seem to be alright. They're not valuing what nurses are doing. It's the medical model or nothing.

Some nurses stated that because public health nurses accounted for the largest number of public health professionals, their work was not easy to define, and because they were not protected by legislation they were an easy target for losing their jobs. To illustrate:

Kristen: If it comes to cutting, probably what will stay is the stuff that can be proved epidemiologically, like communicable disease control. We'll always have communicable disease control, but what we do is more complex. Epidemiology is just a piece of the whole person and their life and their community.

One of the nurses used the metaphor of the abuse victim to portray the ultimate consequence of the sociopolitical climate for public health nurses, including staff nurses and managers, if they did not resist and stand for what they believed in. She perceived the biggest challenge as avoiding becoming an “abuse victim” in the increasingly oppressive public health environment:

Mary: This recent development [merger of municipalities] has taken a lot of energy from people in terms of professional survival, interpersonal survival. People can only cope with so much. Some of the managers are so afraid of saying the wrong thing because they won't have a job, and so you do nothing. If you come to terms with the fact that this isn't the be-all and the end-all, . . . there is an integrity there. If you're not held ransom then integrity is allowed to stay and stand.

Like the abuse victim. Who do you kick? Do you kick the one who is screaming or the one who is quiet? You're going to kick the one who is quiet. Many nurses have become very quiet, and they won't come out to meetings. And they are becoming more and more quiet because they are afraid that if they associate, they will be targeted.

Discussion of Findings

According to the annual Public Trust Index (Pollara, 1996), nurses are the most trusted professionals, listed at 97%. Building trust in client relationships is fundamental to
nursing's code of ethics and nurses' integrity as professionals (Canadian Nurses Association, 1997). In fact, integrity is the core value that underlies ethical nursing practice and the moral agency of the health professional (Yeo & Ford, 1996). Maintaining integrity, which consists of moral autonomy (the freedom to direct your own moral code); fidelity to promise (being counted on); steadfastness (speaking up for what is right); and wholeness (consistency, and continuation across one's professional and personal life), is a profound challenge for nurses in today's health care environment. This challenge is largely associated with nursing's historically subordinate position in the health care system, its struggle for autonomy, and the restructuring of health care within a market-based model. The challenge also originates in the nurses' multiple obligations to personal consciousness, client autonomy, institutional policies, colleagues, and the wider community (Yeo & Ford). There are major issues for nurses that often result in ethical dilemmas and moral distress; knowing the right thing to do but being compromised by others in positions of greater power (Yeo & Ford). These issues include: balancing the multiple obligations; remaining true to the professional code of ethics; contending with social, political, and economic forms that are not consistent with the nurses' professional values; and the need for personal empowerment.

Ethical conflict, moral distress, and job dissatisfaction are consequences of practice for the public health nurses in my study. These conditions developed primarily as a result of growing organizational contradictions and constraints within their work environment in the Department of Public Health. This situation challenged their integrity and autonomy in community development work. The nurses' distress escalated over the length of the study as a result of the continuous and monumental changes that were occurring in the restructuring of public health and public health nursing. The many changes, the accelerated pace of the changes, and the increasing devaluation of public health nursing and their community development work with high-risk populations had a destabilizing effect that created psychological turmoil. In general, the nurses expressed frustration, anger, hurt, helplessness, and powerlessness. They felt like outsiders, marginalized in their own department. They expressed concern for the continuity of service to vulnerable populations, uncertainty about their personal and professional future and the future of public health nursing in general. Uncertainty on a personal basis was related to security of employment, long-term personal planning, and family well-being. They believed that the department increasingly did not know or care what they did. Further, they perceived their value as public health nurses and
their involvement in community development practice as becoming invisible to their colleagues in the nursing profession, other professionals who were internal and external to the department, and to politicians and the general public.

Some nurses in my study were at a reflective level in describing their feelings, behaviours, ambiguities, and the challenges to their beliefs and their professional practice. However, most of the nurses possessed sociopolitical insight and were able to critically reflect on their situation and the interdependence of their everyday practice and the larger social, economic, and political context. These nurses were able to explain what the experience meant to them and their community development work, relate their understanding to the existing sociopolitical climate, and explain the difference that the understanding had for them. Some nurses also elaborated on the implications, for themselves, their women clientele, and public health nursing, if action was not taken to resist the devaluing of their practice with high-risk populations and to ameliorate the rate of change effects.

The findings reported in this chapter are consistent with the literature. Indeed, the deteriorating quality of nurses' work life and its consequences for nurses is a growing area of concern and study in the nursing community in Canada (Canadian Nurses Association, 1998; Donner et al., 1994; Irvine & Evans, 1992; O'Brien-Pallas, Baumann, & Villeneuve, 1994), and in the United States (Mohr & Mahon, 1996; Shindul-Rothschild, 1996). In 1998, the Canadian Nurses Association released a document, *The Quiet Crisis in Health Care*, as a submission to the House of Commons Standing Committee on Finance and the Minister of Finance. The purpose of the document is to draw attention to the “quiet crisis” that has gone largely unrecognized by government and the public; the severe shortage of qualified nurses to meet future health care needs of Canadians. To amplify the seriousness of the issue, the document refers to comments by the Minister of Health, the Honourable Allan Rock in an address on June 15, 1998:

> *No professional group has borne the brunt of health care restructuring more than Canadian nurses . . . with widespread layoffs, . . . increased workloads, . . . loss of job security, . . . diminished job satisfaction, . . . becomes harder and harder to feel like a valued member of the team when your work does not seem valued and when the teams have been disbanded.* (p. 2)

This sinister phenomenon has not escaped community health nursing, as evidenced in the literature reviewed in Chapter Two. Community health nurses across Canada are expressing deep concern and frustration as they try to implement the “new” public health
practice (Beddome et al., 1993; Chalmers & Bramadat, 1996; Chalmers et al., 1998; City of Toronto Nursing Practice Committee Report, 1995; Craig, 1991; Hayward et al., 1993; Leipert, 1996; Ploeg et al., 1995; Rafael, 1997; Reutter & Ford, 1996, 1998; Wong, 1993). They are concerned about: their loss of traditional practice with individual and family health, and lack of valuing for direct service and home visiting; the devaluing of high-risk populations; loss of professional autonomy; increased complexity of client situations and related work load; reduction in resources to meet the increasing demand; and the devaluing of public health nursing.

Although the Canadian health care system is lauded as among the best in the world, major inequities exist between groups and the health status of poorer people is worsening (CPHA, 1997). Fiscal, trade, and demographic pressures; increased reliance on technology; increased consumerism; diminished resources; and high rates of unemployment and family poverty all contribute to impoverishing the least capable (Canadian Council on Social Development, 1997). These forces are also increasing the emphasis on prevention and treatment of disease rather than on health and health promotion, ignoring the relationship of health and illness and socioeconomic status, and incurring human costs for health practitioners and Canadian citizens who suffer declining standards of care. Some argue that this situation is happening because Canadian society is caught in a tension between conflicting values in its health care restructuring efforts (Dickinson, 1996; Storch, 1996; Vail, 1997). The value conflict is seen as tension between ethics and economics, between a humanistic, healing commitment and a business approach to health care planning (Storch). Dickinson refers to it as a conflict between the health promotion framework with emphasis on social justice and health for all, and a market-based health care delivery model. In fact, Rachlis and Kushner (1994) argue that some of the contradictions in the public health infrastructure are developing because the changes in policy and practice toward a new public health are occurring in the midst of deficit reduction, with the result that the commitment to the new public health discourse is not exercised in real terms through the allocation of additional money or resources to the public health sector. The economic, social, and social justice aspects of the nurses' work that nurses have taken-for-granted (Campbell, 1992) and issues of justice and ethics in the allocation of health care resources are becoming significantly more important aspects of nurses' practice (Yeo, Moorehouse, & Donner, 1996).
It is apparent that the many contradictions and barriers to the community development practice of the public health nurses in my study are precipitated by the larger social, economic, and political agenda that is reflective of fiscal and social conservatism, which is turning its back on social justice. As the public health nurses were attempting to enact their expected community development practice, the social and political sand in Ontario was rapidly shifting. The new was becoming suddenly old. The social, economic, and political transformation generated significant change at the organizational, program, and individual nurse level. An emphasis on primary health care and health promotion that is rooted in social justice and equality was being quickly overshadowed by the ideology of the provincial government’s fiscal conservatism and affinity for market-based health care. This ideology was translated into the Ontario Ministry of Health policies. The nurses found their vision and practice of community development compromised between several competing discourses: medical, health promotion, population health, and the provincial government’s efficiency/business paradigm.

Reflecting the provincial government’s ideology, provincial and municipal funds were cut and increasing emphasis placed on privatization and provincial government control. There was a shift away from broad-based health promotion among vulnerable populations, specifically women. Increased attention was given to a new population health agenda that was based in an economic and epidemiological framework with a major emphasis placed on standardized programs and evaluation measures, and new ways to enhance efficiency in public health. The predominating medical discourse and the imbalance of power relations were seen by the public health nurses as significant barriers to their professional autonomy and scope of practice.

It is helpful to interpret the public health nurse’s contradictions and conflict within their everyday work environment, with reference to factors that are identified as important in influencing the quality of the work environment. It is generally understood that the quality of the work environment and work life of the employee is complex, multidimensional, and consisting of several factors (Kanter, 1977; O’Brien-Pallas, Baumann, & Villeneuve, 1994). O’Brien-Pallas et al. acknowledge that although a definition of quality of work life is still emerging, several factors have been identified from numerous studies to characterize quality work environments that influence both nurse and client outcomes. These factors include: individual factors; socioenvironmental, contextual factors; operational factors; administrative
factors; client demands on the system; health care policy; and the labour market. O'Brien-Pallas et al. contend that a general view on quality of worklife "is that a satisfied employee will give better quality care as well as maintain a higher quality work environment" (p. 395).

In fact, a significant antecedent to quality of work life and an empowering practice, which by nature is politicized and advocacy-oriented, is that the professional has self-empowerment (Haugh & Laschinger, 1996; Labonte, 1990; Sadan & Churchman, 1997). This process is conditioned by the professionals' ability to critically analyse the social distribution of power and be committed to critical consciousness for themselves and the lay persons in the process (Labonte; Sadan & Churchman). However, the organization also has a significant role to play. It is responsible to assess its capacity to enable an empowering practice, because it is unreasonable to expect the professional to promote empowerment of individuals and communities if the professional is denied empowerment. It is argued that often the organization professes the rhetoric of community empowerment while disempowering its community of professionals (Labonte; Stevens & Hall, 1992). Stevens and Hall contend that many public health nurses try to engage in authentic health promotion and community development practice, yet are stifled by the embedded philosophy of the public health infrastructure that does not endorse individual and community empowerment practice.

Situational and relational moral decision making is foundational to the nurses' ethic of care. Yet, employing institutions often disregard nurses' professional status and autonomy, do not include them in policy decision making and expect them to act outside their ethical standards (Donner et al., 1994; Rodney & Starzomski, 1993; Yeo et al., 1996). There is agreement across a significant body of literature that situational constraints associated with structural and interpersonal factors in the nurses' workplace constrain ethical and moral reasoning and make it difficult for the nurse to be faithful to ethical standards (Rodney & Starzomski). These constraints are associated with development of stress, burnout, and job dissatisfaction (Irvine & Evans, 1992; O'Brien-Pallas et al., 1994; Rodney & Starzomski). Irvine and Evans conclude from an extensive meta analysis of the literature that professional autonomy correlates consistently with nurse satisfaction. Yeo and Ford (1996) argue that, "the ethical problem has not so much to do with deciding what is morally right, but rather with doing it in a constrained environment that is not conducive to the realization of professional values" (p. 278). According to Yarling and McElmurry (1986), moral distress is regarded as a serious issue for nursing, as it can pose a major threat to
professional identity and freedom to act as a self-determining moral agent. Indeed, Mohr and Mahon (1996) claim that the shift to commodification of health care in the American health care system has created deviant environments, shaken the moral foundation of the health care system and placed many nurses in a morally compromised position of having "dirty hands." This position is defined as a violation of moral autonomy and selfhood as nurses are forced to participate in an immoral act; "the moral quandary of working within the externally imposed parameters that directly counter the provision of high quality patient care and the principle of beneficence" (p. 33). Through their research with hospital staff nurses, Mohr and Mahon identify that nurses find themselves working in situations that pose many ethical contradictions for them. They experience feelings of guilt, grief, anger, and anxiety in the morally compromising situations. Regrettably as these situations persisted, nurses in their study described avoidance behaviour for self-protection. These authors associate this behaviour with Lifton’s concept of "psychological doubling" (as cited in Mohr & Mahon, 1996, p. 33). This behaviour is described "as a conscious or unconscious division of self into two functioning wholes in such a way that each part functions as an entire self." In addition, Mohr and Mahon, with reference to Karl Marx, note that loss of autonomy and integrity can result in alienation:

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Marx observed that workers' loss of autonomous decision making, discretion, and creativity within the work processes has the potential to result in a pervasive source of alienation. Deskilling and alienation are the underside of what appears on the surface to be rationalized managerial control over the work process. (p. 35)
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One of the nurses in my study described the loss of autonomy that the public health nurses are experiencing by reference to the metaphor of "abuse victim." She noted that the biggest challenge for staff public health nurses and nurse managers is to avoid becoming an abuse victim in the increasingly oppressive public health environment.

Not unlike the nurses in Mohr and Mahon's (1996) study, public health nurses in my study and other Canadian and American studies express concern and conflict over the increasing contradictions and constraints they are experiencing in their work environments (Chalmers et al., 1998; Duncan, 1992; Rafael, 1997; Reutter & Ford, 1996; Zerwekh, 1991a). As the socioenvironmental conditions worsen for vulnerable peoples and the social, economic, and political context of the public health nurses' practice becomes more complex and restrictive, they face increasing ethical challenges. As well, they feel less support from
their agencies and more isolated in their struggles. Zerwekh concludes from her qualitative study of 30 public health nurses who practised with high-risk maternal/child families that as the public health nurses are expected to work with more disturbed and disturbing families due to deteriorating societal conditions, they do so “at the expense of their souls.” She identifies “nurse preserving” as a major competency for public health nurses. Specific competencies inherent in nurse preserving include: struggling with diversity, confronting the threat of violence to themselves and learning to recognize danger, and preserving nurse well-being. The nurses in her study found it harder to make a difference with the multichallenged families they worked with. Further, the growing uncertainty about whether they made a difference was especially difficult for the seasoned nurses. Indeed, the nurses in my study worked with a population of women in high-risk environments and extreme vulnerability similar to the nurses in Zerwekh’s study. Struggling with diversity and preserving their well-being or integrity were major issues for these public health nurses.

Although it is acknowledged that community health nurses face major ethical challenges in working with vulnerable populations, little research is forthcoming in this area. One study by Duncan (1992) examined the ethical dilemmas faced by Canadian public health nurses. Duncan studied 30 community health nurses who worked with increasingly high-risk populations in urban and rural public health units in British Columbia. The nurses stated that the most difficult decisions concerning client rights occurred with: adults with mental health concerns, the frail elderly, adolescents who did not want their families involved, and high-risk parents. The nurses identified several ethical dilemmas related to health care system interactions: inadequate community health resources for the complex nurse-client interactions, breaches of client confidentiality by other members of the health team, and the pull between old and new programs. They identified conflict between acting within professional ethical standards and their employee contract, demands of increasingly high-risk caseloads, and limited resources as dilemmas related to their rights as professional nurses.

In addition to the ethical challenges confronting public health nurses providing nursing care to vulnerable individuals and families, they are presented with even greater ethical contradictions in community development work. Community development is considered one of the most ethically problematic areas for practitioners (Minkler & Pies, 1997). Minkler and Pies acknowledge that one of the most ethically challenging situations for the health professional is choosing and staying committed to, “starting where the people
are.” Building trust in the community and “true” participation, while being expected to comply with the agency’s prescribed agenda. Minkler and Pies contend that making links between these often two disparate agendas requires risk taking and a wide repertoire of sophisticated listening and political skills. Indeed, finding a balance between these competing obligations was a significant issue for the public health nurses in my study, especially as the expectations surrounding mandated programs increased and supportive resources decreased.

Inequitable, gender-related, hierarchical structures of power in society and the health care environment are also considered to be critical factors associated with the quality of nurses’ work life. These factors can explain much of what is happening in the public health work environment that creates a disempowering environment, which excludes public health nurses in a meaningful way from the decision making process, and keeps their community development work misunderstood and often invisible (Fee & Korstad, 1992; Donner et al., 1994; MacMillan, 1994; Stevens & Hall, 1992; Rafael, 1997). Public health nurses have a long history of being controlled by local, provincial, and larger social, economic, and political forces, particularly the medical dominance of the health care system, due to their status as employees in government agencies and their status as women (Donner et al.; Rafael; Stevens & Hall). Nursing’s work is generally positioned as marginalized with respect to medicine and the curing of illness whether it be in the hospital or the community setting. The practice of the public health nurses in my study was marginalized with respect to three dominant discourses: medicine, health promotion, and population health.

The public health nurses of this study described the image of public health nursing that existed in the popular culture, nursing’s complicity in perpetuating a distorted identity, and the power of the medical discourse as key factors in producing and reinforcing a negative perception of public health nurses. The distorted image contradicted their practice reality and presented many barriers. Of significance, all the nurses stated that their position as employees of a government-funded public health agency was a major barrier in forming and strengthening their partnerships with professional colleagues. Additionally, several nurses contended that their practice as public health nurses was devalued as “women’s work” by some community partners, public health management, and policy makers.

The public health nurses of my study engaged in many effective partnerships with professional colleagues, yet they also experienced strained partnerships that limited their full
participation in community development activities. These strained partnerships were precipitated by several factors. In some cases, the meaning of partnership varied between the nurses and their community partners. Often the community partners had narrowly preconceived views of the scope of knowledge and practice of the public health nurse. Some community partners were committed to medical and behaviouristic science with limited knowledge of, or value for, the health promotion/community development paradigm. Although some professionals viewed the public health nurse as useful for their program and research purposes, they did not value them as a partner in their community development work. Community agencies whose funding and position in the community were less stable and defined saw the public health nurse in a privileged position and/or a barrier to their evolving practice. Also, the public health nurses’ relationships with community partners became more strained in some instances as a result of the fiscal reduction policies of the provincial government and consequential competitive environment created among health and community workers. The public health nurses noted that in such situations, community networks were destroyed and support and solidarity were lost for the professionals and community members. It is not surprising, therefore, that the public health nurses felt like outsiders and invisible to their own and other professional groups when one considers the contested terrain in which they practised and struggled to obtain power for themselves among the many competing discourses.

The nurses’ everyday work environment in the Department of Public Health posed the most profound ethical contradictions and conflicts for the nurses. Positioning themselves within the “new” public health or health promotion and community development discourse called for in professional and government policy papers was a major challenge. The nurses tried to move from a beneficence model of expert (thinking we know what is best) to a primary health care and social justice model that is based on citizen participation, equality in decision making, and a collective perspective on practice with the community as partner. The new federal, provincial, and professional policy directives on health promotion and community development also expected the public health practitioner to be more flexible and to work within less defined parameters. As discussed in Chapter Five, nurses in this study are in agreement with public health nurses across Canada and celebrate the new policy directives, because they concur with how the nurses understand and try to enact their community health nursing practice. The see this social change as a window of opportunity
for public health nursing to recapture its true nature. However, the public health nurses in
Southern Ontario (including the nurses in my study) repeatedly note that although all
documents profess a commitment to community development and advocacy, they felt
compromised by the Mandatory Health Programs and Services Guidelines (1989), which
prescribe core programs they need to implement (Craig, 1991; Rafael, 1997; Wong, 1993). In
my study, the management of the Department of Public Health did not appear to explicitly
value and support the realities of the public health nurses’ model of community development
with women in high-risk environments. Therefore, supportive resources such as time,
affirmational support, sufficient staff, and role flexibility were not available as the nurses
expected.

Additionally, as the organizational changes escalated, management in the department
became less responsive to the public health nurses and their community development
activities. This situation posed further constraints to the nurses’ professional autonomy and
their community development work. The public health nurses acknowledged that they
experienced professional autonomy on a day-to-day level in their community work, but felt
stifled by the social organization of their work environment. The psychological dissonance
and ethical conflict that resulted was influenced generally by several organizational factors:
increased institutional devaluing of high-risk populations, especially women; devaluing of
the public health nurse’s professional autonomy; limiting their input into policies that
controlled their everyday practice; institutional promotion of medical discourse rather than a
broad-based health promotion perspective; the highly hierarchical management structure of
the department; insufficient supportive resources for the public health nurses to embark on
and/or maintain comprehensive community development practice; limiting the nurses’ voices
in community development activities through research; and increasing restrictions and
surveillance of public health nursing practice.

Recurring comments of frustration were made by the nurses in reference to the
hypocrisy of the public health leadership in relation to community development and
advocacy work, and especially as it pertained to public health nursing. The consequence of
the contradiction between the traditional, epidemiological approach to public health and the
community development approach was described by some nurses as a way for bureaucracy
to maintain the status quo. This inertia was enforced through several mechanisms of control,
such as the Mandatory Health Programs and Services Guidelines (1989), documentation of
their practice in "boxes" (their statistical reporting system), and standardized evaluation measures, and limited promotion of public health nursing work by the department. The various forms of overt and covert control challenged the nurses in their commitment to a community development process: practising holistically, being true to their word, speaking up for their marginalized clientele, and balancing their personal and professional beliefs with the actualities of their work environment.

Strained partnerships between the public health nurses and community partners seemed to be instigated and maintained in some cases by organizational practices, as frontline public health nurses were not generally members of the community health promotion/community development program advisory committees. Therefore, the credibility and value of public health nurses was placed under scrutiny at some level with unequal status and reciprocity in the partnership. The nurses stated that although policy rhetoric espoused that they become more politically active, their involvement in visible political action was discouraged by management due to the perceived conflict of interest created by their positions as employees of a government agency. Some nurses described this policy as a contradiction and tension for them that affected their commitment to their women clientele and social justice and their solidarity with their community partners. While some nurses expressed their participation in consciousness-raising events in less public ways, through campaigns on their own time as citizens, on their lunch hours or vacation days, others decided not to get involved at that political level. The nurses in this study supported both macro and micro, global and local, population-based and individual perspectives of their community health practice. However, the department generally defined a bounded and traditional practice for the nurses that did not provide the supports the nurses needed to engage in community organization and macro level political advocacy. Their participation in research and decision making that affected their practice was limited. Their practice seemed destined to be bounded in traditional and bureaucratic ways.

The nurses reported that the nurse managers exercise significant power as gatekeepers of their community development practice. Generally, the nurses describe conflicted support from their nurse managers in terms of positive and negative support. This conflicted support was related to the organizational changes that were occurring. As the changes unfolded, the question of how health promotion and community development were understood within the department and by the nurse managers was becoming less clear to the
nurses. The nurses explain that the rhetoric is on paper and is professed verbally, but is not followed through with concrete resources. An increasing lack of respect for vulnerable people and a move away from health promotion activities in general was perceived. As the organizational changes escalated, the public health nurses felt less support and devalued in their community development practice by their nurse managers, and less support for their involvement with people in high-risk environments. There was an increasing pull of the nurses away from the community development practice with high-risk women that included being responsive to the priorities of community partnering and intersectoral co-operation. Increasingly, they were told to refer their work to community health officers. Furthermore, they found that the gap widened between how the public health nurses and the nurse managers understood the nurses’ practice. As the nurses struggled to be heard, they felt more and more invisible to their nurse managers and the Department of Public Health.

Major tension occurred for the nurses with the increasing restrictions and surveillance of their practice and the need to justify and explain their involvement in community development work with high-risk women, along with their challenge to ensure that this population was not left out. Several nurses explained their nurse manager’s nonsupportive behaviour as a consequence of them being caught up in the same power relations as themselves, only at a higher level. The nurses believed that the vision the department held for the future for public health nursing was a return to “expert” practice and imposition of programs on the community, elimination of programs, and moving away from community development practice.

Kanter’s (1977) structural theory of power, which evolved from her qualitative study of the work environment of a large American corporation, is relevant to this analysis. Kanter’s theory looks at how factors in the work environment can affect work effectiveness and therefore contribute or distract from one’s power and sense of empowerment. Power, according to Kanter, is derived primarily from structural conditions and is the ability to get things done in the organization. According to Laschinger (1996), “Kanter believes that organizational designs or one’s position in the organization contributes more to the empowerment of the individual than personality traits or predispositions” (p. 43). Therefore, work behaviours are seen as a direct response to work conditions and situations. Kanter posits that power arises from two sources: formal power, which is found in jobs that are visible and central to the purpose of the organization, and informal power, which is derived
from alliances in the organization (Laschinger). Further, Kanter's theory describes three organizational structures that influence work effectiveness: power, opportunity, and proportions. Structure of opportunity, which is viewed as a key factor in affecting employee job satisfaction and productivity, relates to job conditions and the chances to advance in the organization. The structure of power pertains to access to information, support, and resources to do the job. "Positive feedback from superiors and important others in the organization, as well as the opportunities to exercise discretion in one's job are important components of this source of power" (Laschinger, p. 26). Disempowering work environments that limit employees' structures of power or opportunity are seen as the major reason for employees' sense of powerlessness and loss of meaning. In fact, nurse managers are seen as playing a critical role in creating work structures to enhance job-related empowerment and high quality nursing work environments (Kanter; Laschinger). O'Brien-Pallas et al. (1994), with reference to an extensive review of the literature, also argue that the nurse manager plays an important and unique role in creating quality work environments.

The role of the nurse manager in affecting a positive work environment for community health nurses and enhancing the nurses' sense of empowerment and job satisfaction is supported in the literature (Haugh & Laschinger, 1996; Stewart & Arklie, 1994). Haugh and Laschinger employed Kanter's structural theory of power to examine the empowerment structures in public health nurse work environments. They studied 46 public health nurses and 10 nurse managers from three health units in Ontario. They were motivated to conduct this research due to the mixed reaction by public health nurses to the Mandatory Health Programs and Services Guidelines (1989) and the change in practice to a population-based focus. They examined how the workplace prepared the nurses for self-empowerment to engage in the expected empowerment and community development practice. The results indicate that although neither the staff nurse or the nurse manager had high empowerment scores, staff nurses felt less empowered than the managers felt them to be; staff nurses' own power was significantly related to their perception of their managers' ability to get things done in the organization; managers perceived themselves to be more powerful in the organization than staff nurses perceived them to be; and managers had significantly higher empowerment scores. These authors conclude that the nurse manager is vital in promoting the public health nurses' sense of empowerment, job effectiveness, and quality care. Further, feedback and reinforcements from the manager and access to resources are essential features
to quality of work life.

Similarly, Stewart and Arklie (1994) conclude from their survey of 101 public health nurses in Nova Scotia that support from the nurse manager is a key factor in the quality of the work setting and the nurses’ job satisfaction. These researchers found that work support was received mainly from co-workers and spouses, not the nurses’ supervisors. Although the nurses enjoyed their jobs and their independent practice and felt that they made a difference, they identified several sources of stress, strain, and burnout. Stress was associated with: insufficient time for care, poor work environment, difficult client situations, perceived lack of support from supervisors, and heavy workload. Strain and burnout related to little room for advancement, their work not being understood, the number of rules and regulations, and fatigue.

Foucault’s interpretation of the concept of surveillance provides some insight into the interpretation of the public health nurses’ situation in my study. Surveillance is described as a technique of disciplinary power and domination (Foucault, 1980). According to Foucault (1983), disciplinary power is spread through production of certain knowledge and disciplinary techniques such as surveillance, reward, punishment, and regulatory power. Through these mechanisms, individuals are constituted and managed by institutions. Further, disciplines arrange and classify knowledge and situate some voices as authoritative and worthy of respect and attention, and push to the margins anything that they cannot assimilate. These voices then become silenced. In fact, one of the characteristics of marginalization is the silencing of voices different from the dominant discourse. To accomplish this control, subtle disciplinary measures that are located in institutions are applied at the micro level in local sites of everyday activities and habits of individuals and play a role in normalization and social control (Sawicki, 1991). Sawicki, with reference to Foucault’s theory of power/knowledge, explains that:

... Disciplinary practices represent the body as a machine... render the individual more powerful, productive, useful, and docile... secure their hold by creating desires, attaching individuals to specific identities, and establish norms against which individuals and their behaviours and bodies are judged and against which they police themselves. (p. 68)

Power and knowledge construction are central to the social organization of the nurses’ practice in the Department of Public Health and are embedded in ideological processes and practices of dominant discourses that govern the department and constitute the
nurses' identity and cultural meaning (Foucault, 1980; Smith, 1987; Weedon, 1997). The public health department is an apparatus of surveillance, and public health nurses are part of a unique myriad of power relations and disciplinary practices within this context. Hence, public health nurses may carry out various practices within the system, but choices are mediated by the public health system that decides the nurses' practice through mechanisms of social control that can render them docile. Campbell (1992) argues that by nurses participating in completing documentaries of their work in prescribed and concrete ways (such as statistical accounts and technical nursing records) that do not capture the complexity of the work, they become complicit in their undoing. She holds that there are two kinds of work: doing it and accounting for it. Accounting for it has special organizational functions, such as making decisions about adequacy of service provision and managing the nursing work force. In addition, Hagey and MacKay (cited in Craig, 1991) argue that the control over professional practice, which is dictated by government policy and organizational management techniques, is borrowed from the corporate sector as a method of establishing a systematic "class" differentiation to community worker relations. This type of control could, therefore, provide opportunities for ambitious practitioners while possibly deprofessionalizing others, such as public health nurses, whose knowledge of health becomes less important than the managerial process.

Shaull (1994), in his prologue to the revised edition of Freire's "Pedagogy of the Oppressed", presents a salient cautionary comment on the cause and effect of oppressive environments that I believe is pertinent to the situation of the public health nurses in my study: "our advanced technologies [e.g., efficiency models] are . . . subtly programming us into conformity to the logic of the system. To the degree that this happens, we are also becoming submerged in a new culture of silence" (p.16). However, public health nursing and community development do not lend themselves to business-based, efficiency-technological models as they are based in caring and social justice frameworks. With the increasingly individualistic and dehumanizing ethos of North American society, scholars and social scientists such as Etzioni (1993) and McKnight (1995) are calling for a renewal of community and a shift to an ethos of caring and idealism.
CHAPTER SEVEN
CREATING SPACE FOR POSSIBILITY

Introduction

"Man's [wo] ontological vocation is to be a subject who acts upon and transforms his [her] world, and in so doing moves toward ever new possibilities of freer and richer life individually and collectively." (Freire, 1994, p. 14)

The previous chapter gives voice to the public health nurses in expressing their concerns about the constraints and contradictions of their community development practice and the consequences for the nurses and their practice. It is admittedly a rather pessimistic chapter. In contrast, the meta theme of Creating Space for Possibility that is explored in this chapter is about freedom and the public health nurses’ struggle to reclaim their autonomy and identity. In doing so, they create possibility for themselves and their community development practice. The nurses’ integrity, practical knowledge, and sense of agency are integral factors in promoting their own empowerment, an antecedent to fostering an empowerment process in others. According to Freire’s (1994) concept of critical consciousness, people can only know and change their world to the extent that they can problematize the natural, cultural, and historical reality in which they are immersed, and respect difference while simultaneously establishing common characteristics between diverse peoples. In this study, community development happened to the extent that the nurses valued the women’s realities; critically reflected on their own position as women and public health nurses in the health care system, and their beliefs about health; and the public health departmental structures allowed possibilities for the nurses.

Recall that an aim of this study was to examine instances in the nurses’ work that constitute notions of community development and partnership with women in high-risk environments. During the interviews, issues were pursued that reveal the importance of the nurses working through some of the contradictions they encounter, both as women and as public health nurses. I posed questions of particular interest: How can public health nurses work in difficult situations with women in high-risk environments if they have not come to terms with their own identity and value as women and public health nurses? How do they negotiate the problems they most likely experience with the women through differences of class, colour, religion, linguistic, and/or ethno-cultural identity?
In Chapter Five, I explored the diverse roles and strategies that the nurses employed to promote the personal and community empowerment of the women they worked with in high-risk environments. This chapter takes a different approach. My focus is on the nurses themselves. I examine the theme of Creating Space for Possibility from two perspectives. In Part I, I explore the evolving nature and commitment of the nurses to a community development practice. In accepting that community development is a complex social process of change, it follows that the professionals’ understanding and evolving commitment to such a multifaceted process is also complex. My intention is to identify the understandings and processes that nurses in the study name as critical influences in the evolution of their thinking and practice. In Part II, I explore the strategies the nurses use to sustain meaning and negotiate the constraints and contradictions in their practice. The emergent data is categorized in two core themes: (a) Part I-Evolving Commitment to Community Development Practice: I Know What I Do and Do What I Know; and (b) Part II-Mapping New Terrain to Resist and Create Space for Possibility.

Part I- Evolving Commitment to Community Development Practice:

I Know What I Do and Do What I Know

There are several factors and processes that evolve from the nurses’ narratives as significant in influencing their developing knowledge and commitment to an empowering process and community development practice: (a) Formal Education, (b) Philosophical and Theoretical Knowledge, (c) Complementary Work Experiences, (d) Feeling Affinity with the Women, (e) Personal Knowing; (f) Evolution of Identity and Credibility, (g) Initial Community Development Experience as “An Eye Opener,” and (h) Reciprocity: “A Nourishing Life Force.” I explore various questions in discussing these factors: the differences that their practical experience as public health nurses made for them over time; how their work and life experiences affirmed or unsettled prior assumptions, beliefs, ideas, skills, and experience; and how their ways of valuing and thinking about themselves both as women and public health nurses affected their day-to-day work. Also woven into the discussion is a description of strategies the nurses use to resist constraints on their commitment to community development nursing, and to sustain their commitment.
**Formal Education**

All the nurses identified educational opportunities through the Department of Public Health as a good source of knowledge on the concepts and strategies for empowering practice. These opportunities included educational workshops on community development and public health nursing and population health. Formal baccalaureate education in nursing was identified by two nurses as important in introducing them to current knowledge on health promotion, community development, and population health. Some nurses identified theoretical knowledge that they acquired in workshops and research endeavours on community development and empowerment practice through the Department of Public Health as a key factor in enhancing their basic awareness of the concepts. One nurse identified her Master's preparation in community health nursing as a significant factor. According to those nurses' interviewed, theoretical knowledge of community development and health informed their responsiveness and interaction with their clients. In effect, the nurses' narratives revealed that formal education creates a space, both personal and professional, in which the nurses are able to link practical experience with the ideas and knowledge required to move beyond simple physical care and into the realm of empowerment.

**Philosophical and Theoretical Knowledge**

Some nurses articulated the philosophical and theoretical positions that informed their way of “being in community” and interest in working with marginalized populations, particularly women. One nurse, in noting that public health nursing allows her the freedom to be innovative and exercise professional autonomy in her practice, described herself as a deontologist in her ethics. She explained that within this ethical orientation, her first responsibility is the promotion of individual self-determination. She acknowledged that she experienced ethical conflict as a result of the contradiction of her beliefs as a deontologist with the primary focus of the public health department on groups and population health. She described her constant challenge as balancing the values of individualism and collectivism in her practice and explained her position in the following manner:

**Jan:** Every individual has a right to be self-determining. Certainly we are in an ethical situation where you have to look at allocation of resources to
groups. I wouldn’t ignore that at all. But I still think of individuals more highly as humans. I try to promote equity, justice, and fairness in my practice. You get to know how things work in the neighbourhood and the community. In working with a specific community, there are opportunities to look at the environment and how people are recognizing their health needs and lending that expertise to help them explore options that will help them achieve a better level of health.

Another nurse described her commitment to the “core value - social justice.” She explained that her commitment to social justice and women was influenced by Rogerian theory that embraces the concepts of co-creation, unfolding, the unpredictability of things, and evolving consciousness. She noted that theory, related to a health worker’s sense of coherence in the community, further informed her philosophy and practice:

**Carolyn:** A worker’s sense of coherence in community has been linked with the worker’s sense of danger or comfort level in the face of what some would identify as danger and other people don’t identify as danger.

Two other nurses articulated how the concept of “therapeutic use of self” guided their practice. One nurses stated that:

**Penny:** . . . “Therapeutic use of self means using your life energy to enrich someone else’s. And I use that. Interactional analysis is the only thing I embrace and I bring it to my work with me.”

The notion of “therapeutic use of self” is also evident in varying ways in all the nurses’ stories of their practice. The nurses who explicitly described the philosophical or theoretical understanding of community development work also explained how it enhanced their commitment to social justice, women in high-risk environments, and effective community development practice.

**Complementary Work Experiences**

One nurse stated that she came to public health with a community development perspective because she did community development work before becoming a public health nurse. Other nurses explained through their interviews that the dominance of the health care system by the medical model motivated them to try public health nursing, which they
understood to have a broader perspective on health and nursing. These nurses believed that public health nursing could give them freedom to be innovative and experience greater professional autonomy. Previous experiences in nursing were also described by the nurses as opportunities that prepared them for their community development practice. These experiences included: psychiatric and mental health nursing, maternal-child care and care of sick children, experience in other departments of public health, experience as a community health nursing educator, work as a Family Services camp nurse, and experience as a Mission care worker. One nurse described her past experience in neighbourhood nursing as "a wonderful training ground for public health nursing/community development practice in the city."

Feeling an Affinity with the Women

Respect for women and the correction of the injustices in their lived realities are significant motivational factors that fostered the nurses' empowerment practice. All the nurses expressed a strong commitment to engage with these marginalized women to help them address their health and social issues. They actively sought women out in their practice. To illustrate:

Mary Lou: I work with a very high-risk, marginalized group of people who I found, through my experience, don't always feel comfortable coming forward and saying "We have this issue and we want to work on it." Often you have to, through your experience, get to know that you're seeing something coming up over and over, where there's a big gap somewhere. Or certain people aren't at the table when it comes to discussing health concerns. Then you go searching for these people.

People don't realize just how close they are to being in the same position as someone on welfare. They don't have an appreciation. Part of it is fear and part of it is arrogance that they are beyond. It's very easy to stereotype the welfare bums and the whores on the corner. It makes people in society feel that this is not part of their reality. They would never have gotten into that.

It wasn't until I started working with people on the street literally that the blinders come off and you realize these people aren't here because they want to be
One nurse commented that "the core of injustice that motivates [her] is 'women, women in society, women in oppression.'" She further commented that her commitment to women and children's health grew when she began with the Department of Public Health as a public health nurse in district nursing. In this capacity, she was involved in doing pre-natal case management, birth registration follow-up, breast-feeding counselling, and in-school work. To illustrate:

**Penny:** I started working more with schools thinking every child has a guardian, a parent. Then we went into focus [nursing]. I went into 5-19 [years] focus with primary schools and I started my groundwork with women. Major issues: poor parenting, women not having time to parent effectively, language as a barrier to education. Because of the economic need women were pushing themselves, using sub standard daycare and not realizing the importance of stimulation for infant and child. [The women were not able] to give to themselves, not feeling worthy to give to themselves anytime. The priorities are muddled. Also, the children weren't visible in the schools and lagged behind.

Penny believed that often the school was not connecting with children's ethnic and working class culture. As a result of her understanding of the reality for the women/mothers in a particular ethnic community, she could not blame them for their circumstances. She also described her commitment to children's health as another major motivator for her:

*My thing is also children. I look at women as the major caregivers. And if they don't heal themselves, they are no use to that child. And I've seen a lot of bad parenting, abuse of the kids. If I can help one woman feel 60% sound, she's going to be a lot better mom, a better woman, a better person and more active and that child will benefit from the healthier woman. It comes down to the child.*

Other nurses expressed their valuing for marginalized women in various ways. For example, one nurse declared:

**Catherine:** I'm trying to show that they [the women] are important and have something to contribute, to speak out, say what they need and go get it... [that's] the
essence.

When one nurse was asked if she saw herself as an insider or outsider with the women clientele and the staff in her community program, she stated that it was both. She noted the significance of the context, as exemplified in the following comment:

**Carolyn:** [I was] involved in putting on an anti-racism workshop. At certain points in the workshop, I was an outsider. I wasn’t a person who lived the struggles of a woman of colour, and so I was an outsider. In contrast - most of the women in this advisory panel [from the community development project] are women of colour and...

... there are some inside moments. It’s both. The context of the moment answers the question.

Several nurses highlighted the importance of life experience as vital in helping them to confront contradictions, both as a woman and as a public health nurse, and to strengthen their commitment to social justice and their empowering practice. They cited the following as key influences: their experiences as mothers; as students; growing up in particular family and community dynamics; their personality characteristics, such as patience, motivation, humour, and energy; their personal valuing of life-long learning; their creativity; their desire for autonomy; and their appreciation and value for their women clientele. Several nurses stated that the socioeconomic differences between the nurses and the women were not an issue. They identified with the women through their own personal life experiences and struggles as women, and in some cases, through their own experiences of marginalization. These nurses asserted that any cultural divergence with the women was minimal and far less significant than might appear to an outside observer. Indeed, all of the nurses believed that through their empathy with the women, their acceptance by the women was made easier. The following excerpts illustrate these points:

**Carolyn:** The overlap and shared struggle of single-parenting certainly offered one whole bank of knowledge experience, both feeling- and practical-wise. I lived that. I know it [their struggles].

**Joan:** It was a lot to do with your own personality and how you engage with an individual; being nonjudgmental, being supportive. I really like working with women. I’ve learned a lot through my own experiences and have found that I have a great deal of patience in working with individuals, too, which is essential for this work. It
has really helped me because I've stuck with them when they have shown little progress or change.

Kristen: [It makes a difference] having a life experience, understanding where the people that I'm working with are coming from, and being able to empathize in a real way rather than guessing what it must be like. The sum total of all your life experiences and how they interplay into who you are and how you interact in the world; I've been there and am there.

Kristen explained that she had a similar background to many of the woman and always felt an attitude of acceptance and nonjudgment from the women. Furthermore, she held a positive, personal identification and understanding with the women that enhanced her ability to work with them. For another nurse, knowledge of a particular ethnic community and a strong personal identification with the community were fundamental to her way of practising.

**Personal Knowing**

Having a "good sense of self" and being a "reflective practitioner," open to developing critical awareness of one's role in the community is explicitly and implicitly named by the nurses as the first stage in an ongoing process of developing an empowering practice. One nurse stated that an important motivator for her, before and during her public health nursing experiences, is that she "likes to do a lot of group and community stuff, a lot of community advocacy, helping groups in the community, particularly women and mothers."

I asked how they resolve the contradictions between their world and that of the women in high-risk environments. One nurse explained that one enables clients on a deeper level as one grows in her practice and life experience, reflects, and develops more confidence and sense of self. She identified personal empowerment, through reflection and openness to challenge, as what is needed to be effective. She stated that in her early years as a public health nurse, she knew a great deal of theory. As she matured in life and on the job, she obtained the experiential knowledge to accompany the theory. She believed this practical knowledge was key to grounding her theory and allowing her to work through contradictions and be therapeutic in her relationships. She realized the significant growth she achieved through her roles as a parent, a nursing supervisor, as someone having experienced sexism in
her job as a new nurse, and through other life experiences. She commented that as she looked back to her role as a new nursing supervisor, she acknowledged that she used theories from nursing, interpersonal theories, and education theories, but she had no practical experience to ground them. Over time she related better with women as a result of personal and professional experiences and learned “to draw things from her experiences.” Reflecting on this, she affirmed her respect for diversity in ways of practising, noting that she worked from one model, while other colleagues practice with other models:

**Mary:** *We all practice in a number of ways when we are new nurses. We practice as a novice, more on a theoretical, practical level. They told us if it’s X, I do Y. If they tell you, you have a disenfranchised group, you refer them, you help them, you might accompany them... do more concrete things. As you mature, and part of that is life experience and reflectivity, you can use that to help empower your clients on a deeper level, as you are empowered yourself. I just had nothing to ground theory in as a new public health nurse. I can’t reflect because I don’t know. When you reflect it against something to make sense of it you can put it back into some kind of new order.*

*Being in a system where you’re not understood, and not having doctors advocate for you; I can relate to all of that. That makes me a better nurse; my ability to empower grows. I have a different system... I draw things out of my experiences.*

Another nurse commented that one needs to be a “*really anchored realist*” to work with very disenfranchised people. To be a “*really anchored realist,*” it is important for the nurse to have a good situated knowledge of the meaning and content of people’s lives, an ability to let go of ideal goals for herself and the clients, starting with what they can handle, being patient and compassionate, allowing time for change, being prepared to challenge politicians and their unrealistic policies for high-risk populations, and above all else, not compromising one’s integrity. It is obvious through her narrative that the expression “I know what I do and do what I know” is a living theme in her practice. The following account further illustrates this point:

**Mary Lou:** *You have to be the sort of person that can put off motivators like you don’t get that everyday. It starts to come over time. Learn to put off goals or resolves for a bit longer than you normally do. Look at the person or group within the context*
from which they come, so you're not looking at huge goals. Getting someone to talk to you for 10 minutes on the street and tell you something about themselves and that's going to put someone on the next level in working on their issues.

You have to be a really anchored realist, or else the people aren't going to come forth. Don't get so influenced by the politicians. Be willing to challenge them on their time lines if they want to see something happen in a week with high-risk populations.

The stories of several nurses, which are provided below, lend further support to the view that personal knowing and an integration of who one is as a person and professional allow the nurses to take greater risks and do so with greater confidence:

**Penny:** How do you separate [it]? How is it humanly possible to divide, to put that professional barrier or whatever it is up? Are you effective when you put that up? Do people respond to you differently? I have a permeated wall. I don't carry a different person. People sense the falseness, or that you're just a public health nurse, or you're just a doctor . . . I don't carry that. These are the skills; this is how I make a living. This is me.

When I work with grassroots [people], I bring a lot of me; I bring a lot of my life experiences. I am teaching what I've learned. I am using what I've learned in life and applying it in a positive way.

I've always danced to my own tune with boundaries with social rules, with not being anti-social but living in context. I've always followed my gut. There is some passivity in me but not much. That is my style. It's my life experience. Like the rising of the phoenix from the ashes. What is there to lose, besides dying? I mean, don't be scared of being tangible.

I'm at a point where the content doesn't matter. It's the facilitation, the process. It's the connecting with; I'm very good at that. There is a difference of practice. There's a difference in comfort, in the confidence of the skill.

**Carolyn:** I can't separate myself into all these little pieces. The little pieces seem like waves and sustenance happened for me in ways that aren't little boxes in a 9:30-5:30 piece of time and place. I do what I call expand energy, parts of the wave patterns are occurring, synchrony and integration.
It takes me a while to figure out what would help me conserve energy or do what I call "expand energy." To what would give me a chance to float and rest. These are not things that in my mind happen from 9:30-5:30, or in this district work. Some of it might. Certainly a part of those parameters or parts of the wave patterns that are all occurring, synchrony and integration. Integration involves those waves, in fact, not being dissonant. Although there are times when they are dissonant.

One nurse, who had only practised public health nursing for two years at the time of the study, explained that "it was a transition over time, to enabling women more effectively." She emphasized that community development started with the nurse’s sense of professional and personal identity and feeling empowered. She explained that in the beginning of her practice as a public health nurse, she was nervous and tried to find solutions for the people she worked with. However, once she had more insight into her behaviour and listened to the women she worked with, her practice changed:

Tracey: Once I calmed down, I realized that in nursing you can help in all sorts of ways. It’s not just giving resources, it’s listening and supporting. All of that is so important, and that is a part that I have incorporated into what I do with the women, and I hope it helps. They do come back to me because they recognize, “Okay, so she’s all these things but she is listening to me. She is not trying to figure out a solution while I’m talking,” which people recognize. They can see you doing that. If they just need to talk, I listen and don’t offer any solutions because often times they come up with them themselves.

The reflective insights gained from her experiences and her sense of confidence helped her to move beyond a mainly one-to-one practice, to seeking out group activities to help the women build their capacity. She also acknowledged the challenges she faced in trying to understand the incongruence of her world with that of the disenfranchised women she worked with:

Tracey: It was very hard to put myself in their shoes, but I’ve seen a lot of women and hear the stories. You understand more. “I’m not in your situation I don’t know how you feel...” I can just imagine it! Just to give the power because they need that power back. They’ve lost it. The worst possible thing to say is, “I know how you feel,” when you’ve not been in the situation.

Most of the nurses also expressed the view that the public health nurse, in knowing
herself, challenges her abilities and boundaries by continually proving her self, being self-directive, outreaching, and networking. To illustrate:

**Mary Lou:** *You can’t be afraid or you couldn’t do this work. You have to feel secure within yourself. You also have to be able to look at things from somebody else’s perspective. How did they end up on the street as a prostitute? It then becomes more of a personal history issue and an economic one, almost a victim/trapped issue, particularly the women who work right on the sidelines. If you look at it from their perspective, rather than society’s perspective, or your own, you get beyond [the situation when the “john” comes along]. So it isn’t an issue anymore.*

*You have to prove yourself with the community that you actually know what you are doing. You just can’t take your caseload that you get in the office, go out, do your one-to-one work, come back, chart your stuff, and sit at your desk. You have to be out getting to know your community and being aggressive. I’ve had to learn to run up and down and beat bushes through my course of experience in public health.*

Other nurses’ comments concur with the view that it is essential to know oneself and one’s limitations, and know how to negotiate boundaries and work collaboratively. For example, one nurse explained why she did not assume more extensive community development roles and responsibilities as other workers were already assuming them.

**Jan:** *They [the Women’s Centre] do coalition building. They were doing that before I came there. I recognize that as being important. I didn’t see a need to really get too involved with that.*

*There was an overall development, especially when they were planning the march on Queen’s Park and some other protest activities. All of them would do this en masse. So there were other higher levels of community development that was going on.*

According to another nurse, who was involved with the Growing Together project, negotiating and working collaboratively are important skills in community work:

**Jennifer:** *With diminished resources very few people can do it all. You need to be able to know who can do what and how you can work together.*
Evolution of Identity and Credibility

Strong identity as a professional nurse also surfaced as a key factor in determining the public health nurse’s commitment to a community development practice. The nurses described how their unique nursing experiences informed their practice in a different way to other public health workers involved in community development work. The nurses’ expertise in interpersonal communications and relations with these women in times of intimate crises was described as “a gift.” This “gift” is acknowledged as integral to the nurses’ unique contribution to community development:

Penny: We bring in content from our nursing background and issues from grassroots. I bring in my experiences in mental health crises, pain, family, death and dying, bedside care. We bring in all these human feelings. Our practice is so intimate. It’s not even one-to-one, we pass beyond. We see them physically intimate, emotional, and in crisis, in milestones and crisis. I don’t think very many practitioners get that. Maybe it’s a gift of having a 12-hour shift, when all the other professionals go home. If you ask a patient when they leave hospital who’s there to hold your hand, to really feel that human bond, even with a stranger, it’s that nurse.

Carolyn: There is a quietness that nurses bring to intimate, assistive kinds of moments where you do something that you know is needed and it will lead somewhere but it’s not a big deal. If you string a lot of those moments together in a public health nursing kind of role, maybe something big will come up, maybe healing, maybe growth. There is something very core that is nursing. It isn’t medicine. It isn’t zoom in, cut, medicate, or whatever it may be. It’s a different kind of moment.

In explaining their commitment and involvement in community development work, several nurses also described it as a “natural evolution.” However, on probing deeper it became clear that for the nurses in this study, it is essentially a created evolution. Their stories illustrate the intense work and time invested by the nurses to gain credibility to be “asked to join things.” Buried within this intense work is a synergistic process of creating opportunities. The nurses integrate their sense of identity, the organizational context of their work, their valuing for women and women’s health, and their networking. As the nurses’ knowledge and skills grew in community development work, doors opened for them and
invitations to join various community development projects were extended. One nurse described how her networks and background experience in street outreach work helped pave the way for her participation in community development projects, because she built a reputation as a client advocate.

Mary Lou: I stood out more because I was standing up for client rights, or a population or a group's rights. Working one-to-one with people I had a lot of skills as an advocate . . . [I was] starting to get a reputation as an advocate . . . [I would] get to know various players . . . then was asked to join things within hospitals, committees within day cares, etc. I stood out more because I was standing up for client rights . . .

. . . [I] worked closely with other colleagues in public health who were doing the same kind of work. We supported each other, and then we started to be seen as a little unit, core group of nurses doing a certain kind of work. People working with homeless issues or high-risk issues, tend to be looking for people to work with them. Not everybody wants to do that work.

There are a lot of us who work with people on the street or close to the street and we meet as a network once a month or come every two months. We needed to get together for advocacy and communication.

Another nurse's words illuminate the important role of the public health nurses' peer supports and mentors, in building the nurses' knowledge and confidence in community development practice. This resource is consistently named as a major factor that contributed to the nurses' experiential knowledge and credibility in community development work. For example:

Tracey: In the last two years of nursing, there was a lot of group work and facilitating, like teaching in front of groups and getting them moving. The schools set the stage for that. But definitely it's a learning experience because there's so much politics. I watched her [her mentor] to see what she was doing. You learn from watching and from doing as well - what worked, what didn't.
**Initial Community Development Experience: “An Eye Opener”**

Some nurses described the experience of working in a community development program or project sanctioned by the Department of Public Health as a community development one as an “eye opener.” These nurses described how the experience changed their attitudes, knowledge and skills, and enhanced their community development consciousness with women. As the theory became more “real” for them, they could name their actions in a more meaningful way. Further, they felt affirmed and empowered from the knowledge and skills they acquired in their practice:

**Tracey:** Well, at first we didn’t know. We have been taught about community development but we didn’t know what that meant. To be able to apply it practically, and to use the community development evaluation tool to identify what we are doing, because we would not have found it easy to identify what we are doing without using the tool, really opened our eyes to what our role has been. It has changed over time, from a leadership role, in terms of being out there driving the meeting and setting the agenda, to sitting back a bit and letting go and letting people take ownership. Just watching the public health nurse with Care Watch and seeing what she has done is amazing. It just tells you how you can mature in this role. Nobody understands it, though, until you actually do it.

**Jennifer:** Until I got involved in the [community development project], I hadn’t had grassroots, real practical experiences beyond the early stages; things that went the full cycle of community development. I always felt like I shouldn’t be there. I haven’t done this. I knew clearly what I did and how what I did fit. This had been quite affirming for me to have this experience, as well. The experiential stuff really tempered the theory, that the theory wasn’t as far off as I thought.

   For me where the switch came was in actually working with [the project] and realizing what a relief it was. I have the ability to do that [coalition building, etc.] and then realizing I don’t have the time to do that.

When I asked why some public health nurses do not practice with a community development approach, a variety of reasons were provided. One nurse stated that possibly
some nurses never had the opportunity to follow the community development process through to the social action stage. Other nurses commented: that possibly their peers did not engage in community development practice because they did not know how, or community development was new to them, or the politics were intimidating, or they had not been exposed to recent philosophies, or that they had been in public health nursing for a number of years and were “just stuck,” or some combination of these factors. As one nurse stated, “Some people are just beaten down themselves in terms of their experiences in nursing, with the department, with life.”

The following excerpts describe Jan’s experiential learning about community development through her liaison attachment to a women’s health centre. The example highlights the value of experiential knowledge in helping the nurses understand and grow in their community development practice. Jan described how her personal knowing increased as a result of the experience. She increased her skills in political astuteness, increased her consciousness in seeing women as a community, realized how she could better help the women, respected her own knowledge as a woman and parent, and improved her skills as a group facilitator:

Jan: There are a lot of practical things you learn on a day to day basis. I became more astute about political issues and how best to support women in these situations. You can get wrapped up in the one-to-one issues and advocacy, personal care issues, and the families. But looking at community as a whole, of women with an identity and a purpose, and women’s health, and how mechanisms work at different levels. I became much more aware of issues affecting women, women’s health, and how mechanisms work at different levels.

She began to see beyond the one-to-one to appreciate the collective. More importantly, she became comfortable living with the tensions of individual and collective consciousness. She grew to see them not as opposing forces, but as a dialectical relationship that was a part of the nature of her practice. Furthermore, she learned to stay focussed on the participatory roles suited to empowering work:

A lot of time, I was not conscious of separating out the one-to-one versus larger issues I was helping to address. I always felt I stayed focussed on my roles as facilitator, educator and resource, and as a woman and a woman
who has children. I integrate my own self-concept into how I deliver my service. I came out a little bit wiser. I learned the dynamics of working with collectives and knowing more about how boards function. I see the community of women at the centre was a client. Although I never really formed a diagnosis for them.

Reciprocity: "A Nourishing Life Force"

Reciprocity between the public health nurses and the women is described as “a nourishing life force” that motivates the nurses in their community development work. Their stories highlight their emotional connection with the women, and how grounding their practice in the women’s reality energizes and sustains them. Some nurses described how this reciprocal relationship is influential in nurturing capacity in the women over time. According to one of the nurses:

Jan: Even though I was providing or offering health service, personally, I was always taking something out of this experience. It kept me down to earth. Because sometimes if we are from more privileged backgrounds or we have more [privilege] than people we’re helping or offering service to, our perception of reality can be distorted. I have a better grasp then of where people are coming from in their lives.

Another nurse reflected this same view in describing her work with reference to the “in-between spaces” she experienced with the women.

Carolyn: I think there are values; particular values that I came in with them . . . [to public health nursing]. They got stronger. Each day has anecdotes. There are also many things within the system. The most touching are the ones in the in-between spaces where no one else knows about it. You just help it.

In stating this, Carolyn gave examples of touching moments in the in-between spaces, that are more elusive, such as the positive relationship she had with her nurse manager, her ability to push the edges of her skills and experiences with the women she worked with, and the external networks in the community. She emphasized that the accumulative effect of making a difference in the women’s lives, even in small ways, energized her:

Carolyn: Watching women help women. It’s a cascade effect. To know that one can work in this endangered professional work and can make such a
difference. The perks occur in an unpredictable fashion, both larger and smaller. It's an enrichment that is phenomenal. It could be a jar of pickled relish or being invited to be a godmother.

Another nurse described her relationship with an indigenous leader in a coalition project and the reciprocal support she received through the process: “Before we became involved, this tenant was really doing a lot with the residents. The tenant needed pats on the back. I think we gave support. We gave each other support.”

Other reflections exemplify the strength of the reciprocal relationship in nurturing capacity over time, both for the nurses and the women, by validating, affirming, and building support networks. For example, one nurse described her work and the relationships which developed through it in a group program for low income women:

**Kristen:** We made a poster for each person, put what were their special things they liked about that person. I actually still have mine on my bedroom wall. When I’m feeling down, I can look up. All these people in this group said these were things they liked about me. So it helps. I hope they have been able to use the posters in the same way. They still wanted to be a group. I passed it on [she left the district shortly after the group finished].

In a similar way, another nurse spoke about her community development project with seniors in a metro housing complex, emphasizing the way in which the project became empowering, both for the nurses and the residents.

**Tracey:** Bringing something to the group like that, which really none of the agencies had done, was unique. We [she and another public health nurse] felt good about bringing that to the group. It planted a seed. It validated what we were doing with the group. We were doing our own Care Watch, so it gave us a few more ideas . . . our own way of doing it.

Having a tenant, a community member coming to the group and talking to the tenants gives them some power. It’s not just the agency groups doing all the talking, it's one of their own, a community member. That empowered the tenant association because they are off and running now.

One nurse had very tangible memories about her public health experiences. She kept a scrapbook with a description of each pre-natal series, including anecdotes about the women
and pictures she had taken or that the women sent her. She noted that often the women called after several months or years had passed:

Catherine: Sometimes they would come to class. I’ve seen them come years later. drop in, find me. I would move locations about three or four times; they found me.

Part II- Mapping New Terrain to Resist and Create Space for Possibility

Introduction

In this section, Part II, I examine the strategies the public health nurses use to respond to the increasing contradictions and barriers posed by the larger social, economic, and political context of their practice. The nurses believed that multiple strategies are necessary to negotiate and sustain meaning in the dissonant discourse in which their practice is immersed. Through various strategies, they sought to experience personal and community empowerment for themselves and their women clientele. The nurses’ responses in this discussion flowed freely from specific questions that I posed in reflection to the increasing constraints on their practice: What sustains you in your community development practice amidst the restrictive organizational factors? How easy is it to maintain your energy? How will you feel if and when the bureaucracy doesn’t value and resource your practice with marginalized women? What strategies will you use to survive? How as a nurse do you get a sense of autonomy and empowerment in the midst of increasingly oppressive circumstances and multiple challenges to your professional integrity?

Mills (1997), citing reference to Michael Pecheux’s 1982 work on discourse, explains that discourse is always viewed as a site of contested meaning where individuals can resist dis-identification and oppression by “mapping new terrains” and taking up different “subject positions” to construct a reality that is humanizing, one in which their autonomy and identity are reclaimed. Within this discursive framework, power is understood in a relational context as something one participates in, resists, and creates (Foucault, 1980).

In my reconstruction of the strategies the public health nurses describe, I acknowledge their multiple realities and also recognize that they are bound by organizational policies, job descriptions, and many similar practice experiences. The nurses are generally flexible in repositioning themselves in different subject positions so they can ultimately make a difference for the women they work with. They exercise a repertoire of roles and strategies
across a continuum to resist and negotiate their value as public health nurses. I discuss these roles and strategies in two emergent patterns or themes that represent how the nurses strive to map a new terrain for themselves: (a) Expand Personal Energy and Resiliency: “I Want to Keep My Identity as a Nurse”; and (b) Expand Collective Energy: “Keep Talking to Each Other.” All nurses use some or all of the strategies to varying degrees. These themes and subthemes are discussed below and illustrated in Figure 7.

**Expand Personal Energy and Resiliency: “I Want to Keep my Integrity as a Nurse”**

As noted previously in this chapter, personal knowing, being a critically reflective practitioner, standing up for professional identity, and having a meaningful reciprocal relationship with women in high-risk environments are fundamental factors that influenced the public health nurses’ community development practice. These factors energized and sustained the nurses in the midst of escalating constraints on their practice. These characteristics also helped them feel integrated as nurses and individuals and avoid fragmentation. Indeed, the continuous challenge was to maintain professional and personal wholeness in the midst of their multiple obligations and the increasing dissonance between the everyday reality and social organization of their practice. The following are specific approaches the nurses use to expand their personal energy and maintain their integrity and autonomy: (a) Create a Safety Zone; (b) Speak Yourself into Your World; (c) Go With the Grain, but Push the Boundaries; and (d) Go Underground.

**Create a Safety Zone**

Many examples are evident across the nurses’ stories that attest to the importance of taking time to critically reflect, to value, to know, to protect, to expand their energy, and remain integrated. Narratives affirming themselves as individuals and public health nursing as a discipline are repeated across all the nurses’ stories and are exemplified in the following accounts:

**Penny:** I have a lot of energy. I become crispy. I take a month off to re-energize. I think of all my successes. I think about who I’ve touched in my life through my work. I look at concrete stuff I’ve been able to do.
Mapping New Terrain to Resist and Create Space for Possibility

Figure 7. Schematic representation of Mapping New Terrain to Resist and Create Space for Possibility
- Narrative Themes
You're vital, you are needed. You're integral. You're part of the team. You know the
birth, you know how this thing was put together.

Mary Lou: The public health nurse is accessible to people because of location of
practice and interpersonal relationship skills. People tell things to public health
nurses they wouldn't tell anyone else . . . Community saw as a major need, working
with hostels and rooming houses, working with a population that public health was
later not working with.
If you go back to the beginnings of public health, that's where we started.

Jennifer: It certainly is important that there always be a public health nursing
presence to help clarify how it works for the nurses, and have their interpretation
there.

Several nurses emphasized the importance of knowing yourself personally and professionally
and setting limits to maintain energy and integration to avoid burnout, which they identified
as one of the major dangers and challenges in working with high-risk populations. One nurse
states:

Catherine: I could not take that person's problems home with me. I would not be
able to be in any state to help. Do what you can do and help them to learn to look
after themselves. To find out what they really want because you can't change the
world.

Another nurse's comment captures the perception of some of the nurses who saw the
reflection of similarities between their increasingly compromised positions as public health
nurses and the disadvantaged women they worked with as a catalyst for them. This
realization motivated them to be deliberate in struggling against fragmentation and
marginalization:

Mary: We're exactly the same. I never thought of myself this way. I thought I was the
empowerer. I thought I was the advocate and I think that's how nurses see themselves. They
don't see that part of them might be that way. But as a person, they are behaving this way. So
I thought, "No way." How are you then going to mobilize your way out of it?

Other nurses verbalized that there would be a price to pay for resisting and fighting
for wholeness and professional integrity. One nurse, who defined herself as working more on
the edges of public health nursing practice than most of her colleagues, accepted that she was
marginalized politically within the Department of Public Health. She regarded being vigilant as an important strategy to help her resist and to be politically astute in negotiating her value so she could feel empowered. Further, judicious discernment, political astuteness, and being grounded in her front-line practice were described as prerequisites for her energy expansion.

Carolyn: I work on the edges. I am conscious of it. I have my supports mostly outside the department. I have to keep a vigilance and an ability to look at a suggestion [from management] from many kinds of points of view which could be having to do with diffusing of power [hers], it could have to do with I'm making too many waves elsewhere. Or it could be that this is an opportunity, a flowering opportunity, a time for nursing here.

Speak Yourself into Your World

Several of the nurses were cognizant of the power of language and were deliberate and assertive in how they defined their practice according to what it meant for them and/or how it coincided with the language of the day. It was apparent that how the public health nurses discussed their practice was relevant to whether or not they were permitted to exercise a community development practice as they wished.

As Chapter Five notes, the Department of Public Health’s definition of community development that focused primarily on coalition building and political action is perceived as a major contradiction and constraint for the nurses. The public health nurses generally perceived the language of community development as it was sanctioned by the department as a mechanism to devalue them. They stressed that although the department’s management professed that they valued the nurses’ work, the allocation of resources and awards did not match the rhetoric. To resist this reality, the nurses generally did not talk about community development in explicit ways or use the department’s terminology in their everyday work: "There was some shutting down. People just didn’t want to talk about community development because they weren’t being valued." This was perceived by some nurses as a powerful resistive strategy, as eventually there was more acceptance of the nurses’ model of community development by some of their managers. Generally, all nurses in the study talked about their community development practice using their own language according to their tradition. One nurse explained this collective response with reference to herself:
Jennifer: *I use my own language. It's something like the way nurses work with community development. We don't use the language. We use whatever fits for the families and the women. They don't know the term social action.*

The following vignette exemplifies the eventual success the public health nurses had in changing the accepted community development rhetoric in the Department of Public Health. Some nurses explained that through a convergence of factors, the definition of community development was modified to also respect the public health nurses' definition of their community development practice. The dissonance of the community development discourse for the nurses, combined with the nurses greater awareness and articulation of their practice, was described as significantly influencing a change in the definition of community development in the department. To cite one of the nurses:

Jennifer: *Everything worked together. There was this crisis point of change here. It was that the understanding of what was being done and how it was being done [had to change]. The other thing, there are a lot of people here that have a real wall of resistance to looking at things more analytically and conceptually. They're very capable of doing it and they do it, but they're afraid to do it, to practice doing it. Because they're afraid they don't have the language. Even that dissonance caused people to start articulating their practice better. It wasn't that they changed what they were doing. It was just how they talked about it.*

After those workshops, at least two or three nurse managers/directors said, "*I think maybe we need to be doing community development work within our own staff operations.*" They didn't hear each other say it.

Other efforts that contributed to the convergence were: workshops for public health nurses on community development and public health nursing, increased awareness over time by the directors in the department of the dissonance caused by the city's community development definition, an increased involvement of public health nurses in community development projects, and lobbying by the nurses for pre- and post-natal home visiting for women in high-risk circumstances.

Indeed, it is evident that over time, the nurses blended their own understanding with the department's policy description of community development to build their case with nursing management to continue their community development projects and/or to initiate
new ones. The following comment by one nurse captures the view expressed by several nurses who re-labelled their work:

**Penny:** You choose what you are going to highlight and you choose what you're not going to highlight. It's very much in terms of how you identify. Have your work fit the language. Know the language of the hour and use it to your advantage.

Similarly, the following nurse revealed her commitment to women in high-risk circumstances and her innovation and political astuteness in using the “language that people are using” to be faithful to her clientele and community development work. She rewrote her role description and defined her work in new language:

**Mary Lou:** I actually had to write a role description for my manager and show her how working with this population fit the expected criteria for the job. You also learn how to define things using the language that people are using. “Oh, so you want population-based. There’s this population over here, and this is how we’re going to meet their basic measurable health needs. You end up defining things differently.

Having your work fit the language of the time and the roles and whatever. It is that happens to be within the realm of the work from management’s perspective. To lobby and advocate for why mental health nurses fit in new way of defining our work. So you make sure that populations don’t get left behind just because somebody’s happening to change their political language, or the Ministry of Health for Ontario decides to change its focus.

Some nurses cited examples of how they used reports, videos, and talking about their successes to resist and construct a new terrain and social construction of public health nurses and their clientele. To illustrate:

**Penny:** There is invisibility because no one talks about their successes. I think they feel it's like a sense of bragging. I think of it as my job, as a success, so I'm going to talk about it. We're not giving ourselves permission to do that. A lot of our work is not documented, a lot of our fine stuff, whether you call it community development or nursing activities or whatever. I wish it was all documented like a report after you do a big thing, you do a log. I do every year an activity log for my manager, the completion, my contacts, my progress. It's like a business report. It's hard core. It's documented. A lot of people don't do that. I wrote a report to the director on the Body
Image project I did. I like to toot my own horn. I like to document. So I wrote this report. We don't document our projects. We talk about it, but it's not concrete. We didn't do it the business way.

For me, making things concrete, sending this up to him [the director], inviting him to whatever he wants so that he gets a feel for what we do. My openness in that way, my ability to do that has made even my manager see me differently and appreciate my skill set. That leadership, that public relations piece from public health nursing is not strong. I don't think we're comfortable enough. Some of us are not comfortable enough as nurses to say, "Hey, this is tooting my own horn."

A few nurses expressed difficulty with the common understanding and language associated with the concept of caring. Although they regard the concept as including political action, connectedness, and genuineness, they stated that they modify their language for their audience and purpose. Therefore, they changed the discourse to open possibilities. From this perspective, the following public health nurse asserted that health needs to be discussed as a business and spoken of as such to open doors and create possibility.

Penny: I have difficulty because we as nurses are nurturing, caring and those are not valued words in the business world. Those are not the words I ever use in that context. I view health as a business. I use the words that get me in. Those words in a system, and what we do . . . even though it's great, we do much more than the caring. I think it's the words we use for our work that are not operative words to alert the system of what we're doing or help get us respect. This is why I talk about the "therapeutic use of self." I'm able to connect, a genuineness, which is caring, the nurturing stuff. That is in me. But, I also have a layer that is like an enzyme that fits into the system when it needs to be fitted. And when it's in, the caring comes out. That is very business-oriented.

Those words [caring, nurturing] are very female. That has no power in the system. Reports have power, documentation, bar graphs. So you play with those. If I need support, it's the reports and community development is the word that is trendy. It's a community development piece. I'm doing community development, okay. I'm re-labelling some of my work. It's community development. It's nursing. But those words — nurturing, caring, etc., — for some of the males who hold the power, it reminds them
of their mothers breast-feeding them.

Many nurses noted other strategies that had a business orientation or rational planning perspective to give voice to their community development work: "Work smarter"; "Pick your issues"; "Don't be a whiner or destructive, but be smart"; "Choose your timing of when to talk and to whom"; "Know how to use your resources, particularly your nurse manager"; "Interested in understanding community development and women's needs through reading pertinent articles, attending seminars, sitting on panels and advisory boards," and "Get on committees to get knowledge."

One nurse gave an account of how she confronted her colleagues' use of discriminating language to increase awareness of how they were complicit in perpetuating injustice through the language they used:

Carolyn: I'm just really bothered by use of the term "high-risk parent" or "high-risk women." My sense is the conditions that the family are living in puts them at risk for many things. It could be abuse, it could be neglect, it could be drug use. But it's not the women who are high-risk, it's the situation. You know there is a more accurate way and also respectful way of describing people, they call "illegals." It's more respectful to refer to people without immigration status as "undocumented immigrants."

Go with the Grain, but Push the Boundaries

Going with the Grain, but Pushing the Boundaries is a strategy that several of the nurses used to resist and create space for how they viewed their professional practice. They stated that they needed to stay in the Department of Public Health to use the resources the system provided for work they wanted to do with women in high-risk environments. The following comment captures this view:

Penny: Yes, I don't go with the status quo, but I've gone with the grain. I wouldn't be in the system. I wouldn't survive in the system if I didn't know the system. I challenge the boundaries.

What is apparent across all the nurses' narratives is the many ways in which they exercised their creativity and political astuteness in "making room" and "taking risks" for their community development way of practising. Some of the descriptions of their innovative
manoeuvring have been previously mentioned under the theme of *Speak Yourself into Your World*. As the constraints and contradictions to their practices escalated, the nurses became more committed “to fight” for what they believed. Some were masterful at repositioning themselves to resist and create power for themselves. The nurses described several factors that gave them the courage to resist and push the boundaries of their practice: “*experiential knowledge.*” not “*just a gut feeling*”; being a gambler, “*artsy,*” aggressive, assertive, a risk taker, a non-conformist; knowing the system; remaining true to your vision; not feeling victimized; going the extra distance; giving yourself permission; helping the nurse manager push boundaries; reframing how public health nursing practice is viewed in the Department of Public Health; knowing yourself; remaining faithful to the women in high-risk environments; and ensuring that as nurses they have external support.

Several nurses noted that despite the constraints on their practice, they respect the nature of their public health nursing practice as allowing them the flexibility to push the boundaries from their community development way of practising. They view their practice as a public health nurse as diverse, with the potential and flexibility to make it what they wanted. One significant way to do this was described as taking risks and giving themselves the freedom to learn new skills and move into various roles that enhanced their autonomy and identity, and allowed them to practice according to their beliefs. The following nurse’s excerpt captures the feelings and views that several of the nurses expressed in this regard:

**Penny:** *I always believe that there is always room, and I’ve always made room, whether it’s been spoken room or unspoken room. I make room. I make my jobs fulfilling. We are our own oppressors. The only way I’ll survive in nursing is being in the community. I can never go into management. I can never go in without creativity and without room. Some of the barriers of following criteria that make no sense, or duties that make literally no sense. They make people freak. Taking a bureaucratic perspective on who you are as a professional, with these rules and regulations and boundaries, for me, I see that intertwining. We move out of different roles. I move away from being a business person, selling a program, into holding someone’s hand when they’re crying. And I move into being and artsy and creating . . . I move into being a counsellor with a student. I move into being an educator. . . . Part of it is taking a risk, part of it is being a salesperson.*
A few nurses explicitly stated that they know how to be political and to use various power sources to position themselves for new ventures. This knowledge and skill is respected as a critical way to be creative in sustaining them in the midst of the political chaos. And standing up for themselves as nurses and professionals and not allowing themselves to be "re-labelled" was critical to the nurses negotiating their value in the Department of Public Health and in the external professional community. This strategy enabled them to keep their work visible, gain respect, and to continue their community development practice. To illustrate:

**Elaine:** *We have to be assertive and stand up and say, "This is what we can do, and this is what we're doing."*

**Penny:** . . . *It's almost like a fight within the system for me to do what I do to develop as a professional. I'm doing it on my own with some support from the system, but not a lot. Community development is not fostered in us unless you have an inherent need to do this. I don't want to be re-packaged as a community health officer. I want to keep my integrity as a nurse. Some of the projects were started by nurses and then given to community health officers. . . . I'm not going to re-label myself!*

*The tragedy is I look at all the work the nurses have done and others have captured in their writings, but not for our benefit. They [Department of Public Health] had an agenda to keep community health officers alive as their own identity and professionalism. . . . (implying) not everyone can do community development! A territorial thing.*

*I'm going to keep my label as a nurse and I'm going to do nice projects. I'm going to get my name on them.*

Along with a commitment to their professional identity, wanting to overcome their increasingly restricted situation and being faithful to the vulnerable women they worked with were significant motivators for several nurses in creating possibility and taking action. There was a strong commitment to witness, to show compassion and to fight injustice. To illustrate:

**Kristen:** *I work really hard to do all the mandatory programs and put in a lot of extra effort. Time left over to do the other stuff too. I'm not typical but I'm not the only one. There are other nurses who are similar but not everyone.*
Mary Lou: One of the things that keeps me going is I don't see a decreased need for the type of work we're doing. I see an increased need. I feel that as long as somebody is still doing this work and bringing these issues to the table, to the politicians, then they can't be swept completely under the rug. If it ever gets to the point where nobody is around doing this kind of work at any level then it will be easy to sweep under the rug. I look at it as being a responsibility to bring these things to the table.

Giving permission to themselves to decide for themselves is another important strategy that most of the nurses used to resist and circumvent the rules and the Mandatory Health Programs and Services Guidelines (1989), to feel empowered, and to create a growing edge in their practice. Coincidently, several nurses who were skilled at pushing the boundaries did not seem to need much support to challenge the system. The following excerpts exemplify these views:

Carolyn: I have felt, number one, permission to be and permission to act. Not that I asked for it, but it wasn't obstructed, and so, if it is not obstructed, I read it as permission. I have gone for support to nurse managers. I can't say I've felt unsupported. I don't need a lot of support, so that's another difference maybe. I'm giving her [the nurse manager] the opportunity to push the system just a little further. It's like the growing edge. You never know where the growing edge is because it's always changing.

Penny: I'm a brainstormer. "Well, we have to groom you," and I never understood that... I'm very artsy and aggressive at times. I jump ship, yet carrying political baggage and political astuteness. She [the nurse manager] knew I took a lot of leaps and jumps, and then afterwards. I would say, "This is the leap I took." I would never go prior to. I took a gamble. I'm not very good at asking permission.

Although Going with the Grain but Pushing Boundaries is the preferred strategy the nurses used, there are many stories (discussed in Chapter Five) that describe the nurses going against the grain, particularly with respect to teaching standardized, mandated programs they believed did not appreciate the women's realities. The nurses were uncertain about the consequences of their actions, but saw it as more important to adhere to their beliefs, the women, and an interactive, empowering learning approach:

Carolyn: My own experiences as a single parent told me that the largest issues for
women trying to get by are not issues of learning. They are issues of support, of healing, of community development . . . issues of learning will come later. Parenting support has to do with supporting the women as real women in their own rights . . . when women feel better about themselves and cared about, then that will flow naturally to their children.

Kristen: I’m going to do the “Ready or Not” program but I’m going to go with what the parents needs are . . . So that gears away from a standardised program . . . I don’t necessarily follow the set programs.

Go Underground

Going underground is not the most common strategy that was described by the nurses. However, as the restrictions increased on the nurses’ practice, the nurses described examples of going underground more readily. The nurses went “underground” in different ways and in certain circumstances to resist and fulfil their commitment to their vulnerable clientele and their community development work. All the nurses stated that as changes escalated in their everyday work situation, it was increasingly necessary to keep some of their activities hidden from their nurse managers. Under-reporting time the nurses invested in aspects of their practice and filtering reports of their practices that were discouraged by their nurse managers are strategies that several nurses felt driven to employ. Indeed, one nurse was given advice from a trusted colleague in nursing management that she should “not be too upfront if you want to survive.” The following excerpts illustrate the nurses’ perceptions:

Jennifer: Going underground . . . specific to . . . some changes in policies. They have taken away things from nurses that the nurses wanted to do, so they were continuing to do. I have given back to the project on my time because it wasn’t worth asking for overtime but I needed to support the other workers. I’m doing that underground.

Penny: I couldn’t tell her [nurse manager] how much time I was putting into this [project] because her message to me was, “There are other things you need to do.” Those things are important but this is much bigger. This will be self-sustaining. If we do this part, this other part is going to really work because the children will benefit from it.
Tracey: Sometimes people don't say anything and just go ahead and do what they need to do. Some public health nurses work by the book. Some are doing the work they want to do. They're making it their own. They're trying to fit things in. Because you see the need. I mean you are out there and you see the need, and then you're not allowed to address it because of this stuff [statistical coding records].

Some nurses acknowledged that overcoming opposition in this secret manner was not sustaining their integrity as employees of the Department of Public Health; however, they saw it as a necessary way to survive, to remain faithful to their beliefs about empowering practice, and to feel personal and professional integrity.

Expand Collective Energy: “Keep Talking to Each Other”

Building and expanding collective energy is a major strategy that each nurse identified they use to achieve empowerment as individuals and as a professional nursing group. This collective energy was critical for enabling them to take risks to do community development work, and to modify or limit the traumatic turmoil created with the escalating sociopolitical change in their health care environment. Dialogue with each other and building informal peer networks, whether with nurses, colleagues, or other professionals was valued by the nurses as a fundamental way to expand collective energy. The nurses commonly spoke in a collective voice and referred to their nurse colleagues, or community partners when describing actions they would take to challenge perceived barriers, advocate for their vulnerable populations, and claim their value as public health nurses. The following excerpts highlight this view:

Mary Lou: There's a lot of us who work with people on the street or close to the street that we meet as a network once a month or once every two months. We needed to get together for advocacy and communication.

Joan: I think home visiting and one-to-one practice is absolutely essential. It should never be done away with. Most of my colleagues feel the same. We certainly will fight to try to maintain it.

Carolyn: . . . a king of subculture of people [nurses in her district office] really breaking their necks, working hard . . . more aligning themselves with the issues of
Some nurses strongly valued political action as integral to their nursing practice even at the simplest level. One nurse poignantly articulated how as public health nurses, they start with personal motivation and critical reflection and become political in developing collective energy and sharing to advance public health nursing and client issues. Furthermore, she accentuated the power of the group in this advocacy work:

Mary: Work through the irony. Keep talking to each other. Go for it. What have you got to lose now? That is part of being political within the workplace . . . have to be on a broader base . . . linking up with other people. I'm not a political animal, but I know there are public health nurses who are better at that. You make use of the contacts you get when you get them.

The power of the group. The group is always bigger than each part of the group. And you look at this informal mass of people that you have been really connected with. Put yourself in a position with people that you trust, who inspire you. And maybe that is mostly what we can do. I'm not someone who keeps my head in the sand. You have to want to make it better, or have to at least want to support each other, and somehow find a collective energy . . . to have the leadership. I certainly don't have the magic answer, There is so much happening there isn't one magic answer, there has to be collective energy to move us along.

As a collective energy, we want to have some research compiled. We made a big noise about it through the peer group. Then went on to get funding to get the quality of life project and one of the seeds. We have to collect the research, collate it and find out how nursing is validated. What is there that proves that public health nursing and home visiting is useful . . .

I've come to terms with what is the minimum I need. How would we [family] survive? I don't know that I have all the answers, but certainly all of us are putting a lot of energy into that [municipalities merging]. It has taken a lot of energy from people in terms of professional and interpersonal survival. People can only cope with so much.

Moreover, some nurses emphasized that public health nurses need to be more obvious in supporting research on public health nursing, being political at the grassroots level with
colleagues, and always building networks and coalitions. Several of the nurses described other political strategies that they felt were important and that they participated in to obtain visibility and affect policy directives: participating in union work, using nursing coalition meetings as a political forum, bringing in speakers, supporting sympathetic politicians, writing letters, working with their professional associations, getting involved in focus groups that define their practice, and lobbying with other professionals to initiate task forces on significant practice issues.

Some nurses described how the networks they established that were external to their public health department provided a sense of safety, security, and tangible and affirmational support to take risks and push the boundaries. To illustrate:

**Penny:** I know that if it's seen as a risk and if they're very concrete thinkers themselves [nurse managers], and they do work ethics thumping, "the rules of the game," I take risks. I look to the community. I make sure that I'm covered in the community politically. I'm very connected with the larger systems in some of my projects. I've earned my stripes in the community so I take risks, knowing that if anything was to happen in my system, my supports would be right there with letters, with recommendations. So I feel safe that way.

One nurse described the establishment of these external networks as a "generic strategy":

**Carolyn:** A generic strategy, whereby one establishes a network which is also external to the system that can help to put pressure on the system that can help,...acknowledge and project you capabilities, mobilize you a little bit more, expand you energy.

I came upon those thoughts about three to four years after working with the department. And then I was consciously aware of doing it. I have told that to people in many different places. You need to somehow reach out and get external supports, contacts, and networks. It's probably just going to arrive, like opportunity by opportunity. Take the ones that you can... it will pay off in ways that you can not predict.

**Discussion of Findings**

*Creating Space for Possibility* refers to the influences that affect the nurses’ evolving
consciousness and the strategies the nurses use to sustain meaning and negotiate the contradictions and constraints on their practice. A vital component of the nurses’ community development work centres around the issue of creating possibility to have freedom and autonomy in their practice. Space for possibility is created through personal and professional development and is fundamental to their conception of community development and their ability to facilitate individual and community empowerment for women in high-risk environments.

Part I of this chapter examines factors that influence the nurses’ evolving community development consciousness to a level of praxis of “I know what I do and do what I know.” It is evident that these public health nurses create space for themselves through several ways. Educational opportunities, their awareness and internalization of theories about nursing and community development, and diverse work experiences prior to becoming a public health nurse are important factors that the nurses identify. However, experiential knowledge is identified as the most significant influence on their growing community development consciousness and practice. Indeed, experiential knowledge, through learning by doing, being a part of the community, and feeling grounded in the women’s realities are described as essential to this evolution. The nurses’ perspective on experiential knowledge reminds me of a comment by Freire in his dialogue with Myles Horton (Bell, Gaventa, & Peters, 1990, pp. 6, 7), “We make the road by walking . . . It’s a natural way of doing it. It’s what grows out of what you do. Everything comes out of the past and goes beyond.”

Common themes emerge from the nurses’ stories to characterize the nurses’ experiential knowledge. It is evident in their stories that personal knowing and their development as reflective practitioners are important influences on their evolving community development consciousness and their subsequent efforts toward empowerment for themselves and women in high-risk environments. Personal knowing is relations to others and with oneself, as self is formed in interaction with other and neither is possible without the other (Carper, 1978; Phenix, 1964). It is also arrived at through critical reflection, and is contingent on the nurses’ degree of engagement in the experience. The nurses’ narratives demonstrate the compassion and affinity the nurses hold for women living with extreme vulnerability and significantly marginalized by multiple oppressive circumstances. The nurses were passionate in their commitment to correct the injustices that the women lived
with and to engage in the women’s struggle though strategies of courage, creativity, immersion, negotiation, and giving of themselves. Several nurses empathized with the women as a result of their own life experiences and struggles to confront contradictions and personal and professional marginalization.

Reciprocity between the nurses and the women was a life-giving energizer that was described by one nurse as a “nourishing life force,” which is consistent with Marck’s (1990) definition of therapeutic reciprocity in professional nursing. She defines therapeutic reciprocity as a mutually, empowering exchange of thoughts and feelings between the nurse and the client for benefit of all participants involved. In this study, the nurses’ emotional connection with the women and grounding their practice in the women’s realities sustained the nurses and nurtured capacity for the nurses and the women over time. The nurses shared several stories of reciprocity and the accumulative effect of reciprocal acts making a difference in the women’s lives even in small ways. The nurses firmly believed that the differences between themselves and the women due to class, race, and ethnic identity were offset by their sincere commitment to respecting the women in their realities and going beyond empathy, and exchanging purposeful things and situations. All the nurses shared accounts of validating, affirming, and building networks to nurture capacity for themselves and the women in individual, group, and broader community experiences. According to Benner (1991), at the heart of ethical and authentic caring practice is personal knowing that can only be learned experientially. Further, it is situational and relational knowledge that is based in mutual and reciprocal relationships (Benner & Wruble, 1989; Gadow, 1990; Gilligan, 1982; Watson, 1988). The nurses’ practice with the women they worked with in such impoverished and health-damaging circumstances is a profound testament to ethical, authentic practice.

The nurses identified being a reflective practitioner, knowing who you are and your limitations, and feeling personal empowerment as critical to doing community development work, especially with disadvantaged populations. They told stories of their personal development as reflective practitioners. Integration of who you are as a person and a professional and not being fragmented were described as inherent in this personal knowing. Having this knowledge allowed the nurses to challenge their abilities, boundaries, and to work collaboratively. The expression by one nurse of being a “really anchored realist”
embraces several attributes the nurses’ associate with having a good sense of self and working in an empowering way: situated knowledge of people’s lives, being patient and allowing time for change, being compassionate, not compromising one’s integrity, and putting off personal motivators and seeing the world from the women’s viewpoint. The nurses’ identity as professional nurses with expertise in interpersonal communication and relations with the women in times of intimate crises was valued as a unique asset in their community development practice. In addition, awareness and exploration of the power relations that they, themselves, occupied and resisted, and respect and understanding for empowerment of women in high-risk environments was fundamental to their community development practice. These factors combined to gave the nurses a mature sense of themselves as public health nurses and women.

The nurses also carved out possibilities through the diligent cultivation of their credibility as nurses, in the traditional sense, and through their experience and connections with their clients and other health professionals and community resources. In fact, in most cases the nurses created their opportunities by investing intense work and time to gain credibility to be asked to join community development projects and networks. The empowerment milieu that developed around and through the ideas and programs of community development the nurses engaged in also provided several of these nurses with the capacity necessary to overcome the limitations imposed by traditional definitions of public health nursing, and by structural or administrative constraints on their practice. The public health nurses awareness of this “space for possibility” - their sense of self and their professional integrity that they brought to their work in the community - fostered a sense of possibility, of mutual respect, and learning. Importantly, however, it also involved an awareness of, and respect for, the oppressive situations occupied by the women clients, themselves.

In Part II, the nurses describe several strategies to negotiate and sustain a sense of agency and empowerment for themselves and the marginalized women they worked with in the midst of an increasingly oppressive work environment. According to Foucault (1980), one needs to know the relations of power to resist, weave through them, work with them, and work around them. A relational, resisting, and productive model of power as theorized by Foucault (1980) is helpful in looking at ways that public health nurses position themselves as
active agents in their practice. Power is also described in the model as local, particular, embedded in a complex web of discursive relations, and at the site of subjectivities and intersubjectivities (Foucault; Sawicki, 1991; Weedon, 1997). The public health nurses exercised their sense of agency by adopting various subject positions to resist and negotiate larger social, economic, and political influences on their practice. Intentionality, agency, self-reflexivity, and autonomy are integral to these subject positions (Butler, 1990).

Expanding their personal energy and resiliency to keep their integrity as a nurse was described as a key strategy to map their new terrain for empowerment. Resiliency is defined as “the capability of individuals and systems (families, groups, and communities) to cope successfully in the face of significant adversity or risk” (Mangham, 1995, p. 3). It is commonly identified as a combination of protective factors that provide a positive focus, but do not offer complete protection against severe stress, hardship, hopelessness, or lack of opportunity (Mangham, McGrath, Reid, & Stewart, 1994).

Creating a safety zone through critical reflection, affirming themselves as individuals and public health nursing as a discipline, setting limits to avoid burnout, and being grounded in front-line work were several strategies identified to protect themselves, fight fragmentation and marginalization, and maintain wholeness. Nurses also used the power of language in deliberate ways to resist devaluing of their community development practice. Language is described in various ways: the medium for constructing, not discovering, meaning (Freire, 1994), the basic element of discursive frameworks, which are always in dialogue and ideological struggles (Mills, 1997); a powerful means of excluding people from power positions; and the opportunity to transform the way power is exercised and experienced. Smith (1987), in reference to Rowbotham’s identification of the “diverse between home talking and educated language” (p. 57), submits that for women there has not been a “home talking” to contrast with “educated language.” Rothbotham’s conceptualization of home talking versus educated language evolved from study of the British working class in Britain who found they were silenced by their language, embarrassed by their dialect, and experienced the “otherness” of their culture (Smith, p. 57). In more recent times, groups of women have used their experience as a starting point and developed symbols and concepts to acquire knowledge and have expression and power in discursive frameworks (Smith).

The nurses had some success with their resistance through language. They were
assertive in defining their practice in their way, and not generally using the department’s terminology. They did, however, blend their own understanding with the department’s policy descriptions on community development when needed to convince management to allow them continue their community development efforts or to start new ones. Some nurses astutely defined their work in the language of the day as need be, used reports, talked about successes, and used rational planning strategies. A few nurses confronted peers for using discriminatory language toward clients.

Going with the grain but pushing the boundaries was a major strategy used by all the nurses. They did so to fight for what they believed in: their community development practice, being faithful to vulnerable populations, and their professional identity and integrity. The nurses considered going with the grain as the best way for them to access the resources the department could provide for the women. In the words of one nurse, “I work with it to survive, but I make room.” The nurses’ expertise at pushing the boundaries varied with some nurse being masterful and politically astute at repositioning themselves to resist and create power for themselves. The impetus for this arose from a combination of factors: their sense of self, being a risk taker, experiential knowledge, knowing the system and having sociopolitical knowing, giving themselves freedom to learn and do, and standing up for themselves as nurses and professionals. The strategy of going with the grain but pushing the boundaries is comparable to what Rafael (1998) terms judicious circumvention, which means not challenging an issue openly or directly but going around it. The public health nurses in her study used this strategy to resist when they were ordered to care and did not agree. Many nurses in my study went against the grain by modifying mandated programs, but they interpreted this action as pushing the boundaries. Some nurses challenged social injustice more publically on their own time outside the Department of Public Health.

As the nurse’ work environment became more oppressive, all the nurses saw it as important to go underground to some extent and keep some of their activities hidden from their nurse managers to survive and remain faithful to their community development practice with women in high-risk environments. The practice of circumventing the system imposed practice limitations and allowed them to remain committed to empowering practice, but it also carried negative consequences. It could reinforce the invisibility of their practice, encourage the nurses to over-extend themselves and suffer burn out, and cause stress for the nurses when they were found out and reprimanded.
Expanding collective energy by forming networks with each other and other professionals was seen as fundamental to who they are as public health nurses. Some nurses stressed the importance of supports external to the department to garner safety and security, and support in taking risks and pushing the department boundaries, while other nurses emphasized the value of research on public health nursing practice and various collective approaches to build solidarity on issues and their group identity as public health nurses.
CHAPTER EIGHT
FINAL REFLECTIONS

. . . the experience of what happens when human beings encounter one another. You learn each other’s names and begin to hear each other’s stories. This is the reach of mercy and within it the desire for justice is borne. . . To remain life size in a time of moral diminishment: this is the challenge for all of us today. (Leddy, 1997, p. 5)

Synopsis

These final reflections begin with a synopsis of my study. Key findings are highlighted as they pertain to the three meta themes that emerged from the data. Implications for nursing practice, education, and research are then discussed. I conclude in an epilogue with a discussion of the implications of this thesis journey for me.

My goals in this research have been to understand the complexity of the community development practice of 13 public health nurses working with women in high-risk environments, and to represent their voices. As I write this final reflection I return to my research questions. I wanted to examine how public health nurses engage in partnerships with their women clients for community development within the larger social, economic, and political structures and processes of the health care environment, and specifically, under the aegis of a large, urban Department of Public Health. This examination also included analysis of how the nurses valued the women’s lived experiences, of the impact of the women’s social, economic, and political realities on their health, and of how the nurses nurtured and sustained capacity for these women over time. I also wanted to examine how the nurses negotiated the contradictions and constraints in their work, generated through employment by a public health agency, to allow possibility for themselves and their women clientele.

Through a feminist inquiry using an ethnographic approach, I illuminated a deeper understanding of the everyday community development practice of public health nurses employed with a government-funded Department of Public Health in Southern Ontario. This qualitative research study, which extended over a 14- month period, allowed me the opportunity to examine the richness of the nurses’ cultural work and the connections between their everyday realities and the larger sociopolitical context of their practice. It also allowed me to examine the nurses’ contributions to health promotion and community development and to the lives of women clientele living in high-risk environments.
Purposive sampling and the use of snowballing technique, in which peers recommended their nurse colleagues for the study due to their perceived expertise in community development work, provided a select group of public health nurse participants. These nurses worked across a variety of district offices, diverse populations, programs and projects, and individual, group, and community foci. They had an average of 13 years of experience, all had a baccalaureate degree in nursing, and two held a Master of Nursing degree. Thematic analysis was used to reconstruct the nurses' individual stories into a collective story; an abstraction that incorporates each nurses' narratives. A constant challenge for me through this process was portraying the narratives in a credible way that gives a sense of the whole while remaining true to each nurses' practice realities. To ensure that I was hearing and representing the nurses' voices accurately, I read and re-read the transcripts and notes, and carefully critiqued my thematic analysis and interpretations. I also included as much of the nurses' accounts as possible to demonstrate the complexity and richness of the nurses' practice and to give them greater voice.

I do not hold to a unitary categorization of public health nursing practice and I respect differentiation related to the nurses' multiple realities and relations of power and resistance. There are however, general expectations in the scope of practice for public health nurses in a government-funded health agency. Further, the nurses who volunteered to participate in the study represented particular expertise in community development work. Therefore, it is reasonable to find a high degree of similarity in the nurses' understandings and practice of community development. Such was the case in this study. The similarities are captured in the identified themes, with variations highlighted through the nurses' quotes and my analysis. I submit that the views of the nurses in this study may differ from those of other public health nurses in the Department, other public health nurses in general, public health management, and from the women clients they worked with. As the inquiry unfolded, I became more conscious of my partial knowledge of the situation, my privileged position as the writer of the story and of my ethical conflicts.

The findings in this study are consistent with research that acknowledges that public health nurses have specialized knowledge and skills in addressing broad inequities in health and building capacity with people who are disadvantaged and/or marginalized by life circumstances; especially women. However, most of the studies deal with individuals and families as the target of practice. This inquiry adds to nursing knowledge by explicating the
nature of the nurses' community development work with individual, group, and community levels of practice. The study also describes the multiple roles and strategies the public health nurses used to catalyze improved prerequisites for health and to promote culturally sensitive health care for their women clientele. It also reveals the importance of the nurses' reflective practice and of their personal, ethical, and sociopolitical knowing in challenging institutional practices that perpetuate social injustice and inequity for women in high risk environments and for themselves as professional nurses.

Some of the nurses were at a reflective level in describing their feelings, behaviours, ambiguities, and the challenges to their beliefs and their professional practice. Most of the nurses possessed advanced sociopolitical knowledge and were able to critically reflect on their situation and the interdependence of their everyday practice and the larger social, economic, and political context. These nurses showed insights into what their experience meant to them and their community development work, relate their understandings to the existing political climate, and explain how this understanding affected them. Some of these nurses also elaborated on the implications for themselves, their women clients, and public health nursing in general, if action were not taken to resist the devaluing of their practice with high-risk populations and to ameliorate the rate of change and its effects.

As this research demonstrated through the discussion of three meta themes: Being in Community, The Contested Terrain; Social Construction of Public Health Nursing; Creating Space for Possibility, public health nurses' practice makes a significant contribution to the lives of women in high-risk environments in a large urban centre and to the health of the broader community. Indeed the study illuminates the public health nurses' unique expertise and commitment to their work with women who live on the fringes of society and who are marginalised as outsiders and "other." The women with whom the nurses worked were mostly low income, single, and either on social assistance or representative of the working poor. They faced a myriad of socioeconomic and cultural conditions that were even more restrictive for visible minorities, including recent and undocumented immigrants. Adding to their chaotic lives, all the women had health-affecting problems. Most health concerns were associated with pregnancy, parenting issues, substance abuse, and/or mental health problems. The women required distinctive nursing and health care that transcended boundaries set by traditional, medical definitions of health.
**Being in Community**

District nursing was supported as an important practice-delivery model for public health nurses as it allowed them to associate with "community" in a meaningful way. The nurses immersed themselves in the women's lives through a generalist practice within assigned and innovative activities across individual, group, and community foci. This practice was framed by a philosophy of *Being in Community*. The nurses used an extensive range of roles, strategies, and complex contextual and relational skills to promote individual and community empowerment for the women. Building a level of therapeutic trust and respect between the women and the nurses to establish partnerships was germaine to the public health nurses' perspectives and practice. However, establishing a partnership was understood by the nurses as a significant and continual challenge with women in high-risk conditions.

As evident in the literature and the nurses' narratives, community development is a highly complex and political concept both theoretically and operationally, and as asserted is not a new concept to public health and public health nursing. The public health nurses' views on community development both contradict and support the literature. There is a school of thought that envisages public health nurses as practising various forms of nursing in the context of community health, but uninvolved in community development-a field better left to specialists. However, it is obvious that the public health nurses in this study worked in and contributed to community development in important ways.

There were more similarities than variations evident among the nurses in their understandings and contradictions associated with community development. The greatest variation existed between the nurses' impressions and those of other community resources and department policies. We have seen in this inquiry that public health nurses' community development practice needs to be understood as the intertwining of the public health nurses' sense of agency, their relationship with their women clientele and with their community network, the social organization of their practice, and the women's readiness for personal and community empowerment. All factors co-mingled to allow possibilities or pose constraints in the nurses' practice. Although the nurses identified community development as integral to their practice, there was some tension between individual and community focus. This was manifested in how they referred to the women, how they described their practice, and how they viewed standardized programs and their tendency to go beyond them.
Primarily this tension was precipitated by the contradictory policies of the Department of Public Health with respect to public health nursing practice. The study findings support the view that the prevailing tendency through overt and covert processes in the Department of Public Health was to maintain a traditional, bureaucratically-bound and controlled public health nursing.

The nurses understood and practised community development as a multidimensional concept, firmly rooted in a philosophy and process of empowerment for social justice and health, within the principles of primary health care. Their model of community development was motivated by their passionate commitment to work with women in high-risk circumstances to correct inequitable situations and promote social justice and health. Despite the setting or client focus of individual, group, or community, the nurses’ values and way of practising in building individual and community capacity, emerged as more similar than different. Consistent with the literature, the concepts of community and community development were viewed relationally and politically, “starting where the women are” in building relationships, building on their strengths, and fostering their social connections to each other and to the broader community to enable individual and community capacity-development and integration. Further, the nurses’ preference for self-help and social action models of community development in working with disadvantaged women concurs with the literature. The findings also support nursing research that regards one-to-one practice and reaching out to people in their home as an essential beginning piece of public health nurses’ community development work with this population. From this point the nurses worked at connecting the women to informal and formal groups and as possible, to community organizing activities.

Indeed the nurses’ community development work was entrenched in a web of relationships and processes that I conceptualize as a spiral of learning that is based in a process of continual reflection and action on the part of the nurses, to enable individual and community development for their women clientele. Building trusting relationships, building community connections with community partners, and measuring progress were core variables in the nurses’ community development model, with some nurses achieving an advanced level of community development and participating more obviously in facilitating the community’s capacity for self-advocacy. The challenge of moving the women toward individual and community change was a daunting one for the nurses and the women. It
The study revealed that the nurses varied in their ability to engage more deeply with the women to build alliances and promote social action. The process was conditioned by the nurses’ responsiveness and commitment to address the women’s immediate health concerns and crisis situations; the nurses’ varying commitment of time, energy, critical consciousness, and emancipatory goals; the sophistication of the nurses’ communication skills across individual, group, organizational, and community affiliations; and their personal knowing that includes experiential, interpersonal, and intuitive knowledge. Personal knowing emerged as fundamental to the meaningfulness of the nurses’ ethical and caring practice, connectedness to community and a social justice basis of community development practice. Although community development was viewed as time consuming, intense, and uncertain, it was also considered energizing and fulfilling by the nurses.

The Contested Terrain: Social Construction of Public Health Nursing

Through this theme the macro-cultural and political context was examined from the perspective of the nurses. This study demonstrated that the public health nurses’ unique and vital contribution to the community development process for disadvantaged women was not always understood by their nurse managers, public health administration, community partners, policy makers, and politicians. The larger social, economic, and political processes and the nurses’ everyday work environment posed major contradictions and constraints for the nurses’ empowerment work with these women and empowerment for themselves. Indeed, these factors had a significant impact on the nurses’ autonomy and community development work, affecting some nurses more than others. A predominant concern was the contradiction between the Department policies on community development practice and verbal support by nurse managers, and in reality, the lack of resources and valuing of the public health nurses’ community development practice.

At the time that I began this study, community development and advocacy work were sanctioned as major mandates of the Department of Public Health where these nurses worked. As the study unfolded, there was a significant shifting of ideologies and priorities of the provincial Ministry of Health and the Department of Public Health, with a move away from health promotion, community development, and special attention to people in high-risk environments. This shift presented increasingly contradictory directives for the nurses and
consequent uncertainty, loss, and confusion. Over the life of the study, as a result of mounting changes, an accelerated pace of change, and devaluing of the nurses’ work with women in high-risk environments, the nurses experienced more ethical conflict, moral distress, and job dissatisfaction that culminated with them feeling increasingly like an invisible community of nurses.

The concerns of the nurses in this study resonate with the research on the quality of worklife of public health nurses across Canada. Public health nurses report many barriers to their primary health care and community development practice and increasingly stressful work environments associated primarily with organizational constraints in their everyday practice that are prompted by budget cutbacks. The nurses’ stories include a pervading sense of uncertainty, job dissatisfaction, frustration and confusion. Work overload and role conflict, loss of autonomy, and lack of understanding and visibility of public health nursing are resounding concerns in nurses’ stories.

Creating Space for Possibility

This theme refers to the influences that affected the nurses’ evolving community development consciousness and strategies the nurses used to assert their personal agency, to sustain meaning, and to negotiate constraints. The nurses’ evolving community development expertise was influenced by several factors. Importantly, we have seen through this study that community development happened to the extent that the nurses valued the women’s lived realities, critically reflected on their positions as women and public health nurses, their beliefs about health, and how the structures in the Department of Public Health allowed possibility for the nurses. Additionally, experiential knowledge, being part of the community, feeling grounded in the women’s realities, and cultivation of their credibility and identity as professional nurses, were significant influences on the nurses’ evolving community development consciousness.

The nurses’ narratives identified several ways in which they asserted their personal agency in negotiating multiple constraints and allowing empowerment for themselves in the midst of their increasingly restrictive work environment. In varying degrees, the nurses successfully asserted control and affected change in their professional life and gave more value to their knowledge, self esteem, public health nursing, and their practice with women in high-risk environments. Expansion of personal energy and resiliency to keep their
integrity as a nurse, and expansion of collective energy, emerged as key strategies.

Indeed, the stories of the public health nurses in this study tell of their compassion and soulful work of hope, courage, and witnessing by "being in community" to give the vulnerable women and children they worked with the tools to elevate themselves from the depths of their impoverished lives and to build community around themselves. It has been proposed that the root cause of the crisis of increasing social injustice, inequity, and isolation in our society, is the diminishment of our richest energy source, our potential for a spirituality of compassion (Fox, 1979; Miller, 1993; Purple, 1988). Fox posits that compassion, which he defines as to suffer with, to undergo with, to share solidarity with, and to celebrate with, is our greatest hope and our greatest creative energy resource for ensuring survival of the global village. He acknowledges that the role of critical consciousness development, which is inherent in this definition, is an essential part of the commitment that is needed for social change. Unless we make the journey from dualism to a dialectic consciousness of both letting be and letting go, and adopting a critical consciousness that is whole and globally-oriented, we are incapable of compassion and social justice (Fox).

Of note, immediately following the completion of the data collection phase of this study, the municipality in which this study took place amalgamated with several adjoining municipalities. This organizational restructuring represented monumental changes for the public health nurses' practice, the impact of which is still being felt and worked through today. Many changes were instituted: program management with loss of generalist practice and a broad community focus; realigning of districts and managers; new management and practice structures, processes, and policies; more standardized programs; centralized intake for referrals; and loss of an emphasis on community development and particular populations, such as the elderly and mentally ill, to name but a few of the changes as I understand them. Seven of the nurses in my study have left their practice with women in urban high-risk environments, either leaving front-line practice completely or relocating to assignments in programs and communities that are not so demanding. Some nurses noted they did this to survive, as the contradictions and constraints became untenable. They stressed that they could not work in the fragmented ways they were being asked to practice.
Considerations for Nursing Practice, Education, and Research

Practice

The experiences of the nurses in this study support the view that public health nurses' unique community development practice with women living in high-risk environments in urban settings needs to be recognized and validated for the contribution it makes to health promotion, community development, primary health care, and women's health and health promotion.

Further, public health nursing practice needs to continue to be firmly planted in the principles of primary health care: accessibility, promotion and prevention, inter-sectoral collaboration, public participation, and appropriate technology. This represents a significant challenge as Canadian society progresses more quickly toward market-based health care and a right-wing agenda, and away from a caring and community consciousness, primary health care, and broad-based health promotion frameworks. Seemingly, awareness of the relationship between health, illness, and socioeconomic status is being denied by policy makers and health management. Nurses and the Canadian public are being more and more compromised by the increased complexity of clients' health situations, declining standards of care, devaluing of women's caring work, and growing emphasis on definitions of self-care and self-reliance that separate the personal from the complexity of the social, cultural, and structural factors and relations of power/knowledge. Statistically there is increasing inequities between groups and deteriorating health of poorer people, especially women and children. Raphael (2000) cautions that in Ontario the health promotion efforts and the "Healthy Cities" movement with a focus on equity, participation, social justice, and social activism, are being over shadowed by a neo-liberal ideology and backlash that is sweeping Canada. Consequently, large, urban centres such as the City of Toronto, which includes a very diverse multicultural population, is in crisis in terms of deteriorating health and socioeconomic status.

In general, the deteriorating quality of nurses' worklife and lack of attention to vulnerable populations are growing areas of concern in the entire Canadian nursing community. Specifically, public health nurses need to become more creative and persevering in resisting the silencing of their practice by dominant discourses, and remain faithful to their nursing identity and expertise in building individual and community capacity with women in high-risk environments. An emphasis on feminist and critical perspectives to build solidarity
and agency for the nurses and the people they serve are necessary to meet this challenge. In so doing, public health nurses can push the boundaries of their practice and maintain the caring and compassionate nature of their nursing work.

Public health nurses also need to ensure that they receive support in their work environments from their managers and public health administrators through structures of power and opportunity that provide an empowering milieu for effective community development practice and evaluation.

**Education**

Nursing education has a critical role to play in preparing nurses for population-focused community health nursing, promoting the visibility and importance of public health nursing, and enhancing the health of vulnerable populations. A significant motivator for this study was my desire to bridge the gap between the realities of public health nurses’ community development practice and the community health nursing curriculum in university nursing programs. In fact, it became obvious in this study that implementing the concepts of community development, authentic partnerships, empowerment, and critical consciousness within the realities of the social organization of the public health nurses’ practice and the realities of women in high-risk environments is highly complex.

As nurse educators we need to develop more creative and effective ways to strengthen content and skill development in community health nursing courses related to primary health care, health promotion, community development, culturally sensitive health care with diverse populations, and the realities of public health nursing practice. A major way to do this is to collaborate with employers and public health nurses to reduce the gap between practice and theory. Importantly, public health nursing’s unique contribution needs to be recognized and acknowledged in the health promotion dialogue. As educators, we also need to continue to increase our knowledge, skill and understanding of the strategies that are necessary for primary health care, such as the contextual, personal, ethical, and sociopolitical knowledge across individual, group, and community client foci. We need to emphasize critical reflective practice, foster innovative strategies that include social activism, and develop learning experiences where students can obtain the needed knowledge and skills in community development with diverse and vulnerable populations.

To accomplish this goal, holistic-emancipatory curricula are necessary to allow for
an openness to the diverse needs and ways of knowing of our nurse-learners, to understand the increasing complexities of client situations, and to allow the transformed practice that is needed to challenge the growing trend to market-based health care and efficiency paradigms. To do so, we need to humanize the education process and position the learner and ourselves as educators in the broader social, cultural, and political context of education. We also need to challenge ourselves and the learners to develop a critical consciousness about experience and the intersection of race, class, gender, ethnicity, culture, age, and sexuality. Moreover, the developing of critical consciousness needs to include a critique of public health nursing with respect to the dominant health discourses of medicine, health promotion, and population health. The various clinical specialties within the rubric of community health nursing also need to be differentiated to give credibility to each of the specialized areas of knowledge, particularly public health nursing and its synthesis of public health and nursing knowledge within the mandate of promoting individual and population health.

**Research**

Community health nursing is the subject of limited systematic study. Therefore, there are many directions one can pursue. Indeed, an important gap is the examination of the relationship of public health nursing and community development with populations in high-risk environments, particularly disadvantaged women. This knowledge is absent from the dominant health promotion discourse and has only minimal attention in nursing research. There is also a paucity of research that considers the nurses’ voices and their contextual and relational knowledge within the social, economic, and political environment that significantly influences their practice. This study makes an important contribution in this regard. It represents a mere beginning. However, it provides a unique perspective as a result of the feminist, ethnographic approach that guided this study.

Further study of public health nursing is needed through more in-depth and longitudinal inquiries. These inquiries ought to employ critical, feminist, and participatory action research methodologies; multiple methods, such as ethnography and discourse analysis; and multiple data sources, such as public health nurses, their women clientele, and community partners, to compare and contrast assumptions, values, and realities within the social, economic, and political context of the practice. Thus, the relations of power/knowledge that inhere in the individual, group, and social change processes can be
more fully and critically examined.

Evidence is also needed on the effectiveness of public health nurses' practice across urban and rural settings, diverse populations, and various models of practice. Based on the literature, the findings in this study, and my professional experiences, public health nursing faces many research challenges as we advance into the 21st century. These challenges are evident in the form of government political parties, all of whom have swung to the right, and funding mechanisms that devalue the social, economic, and cultural realities of peoples' lives; the devaluing of public health nurses' autonomy and practice that makes a significant contribution to individual and community capacity building with diverse populations; increasing budget cuts to preventive and health promotion activities; a growing need for public health nurses to demonstrate the cost effectiveness of their practice, particularly with vulnerable populations; and the increasing incongruence between the professed ideals of public health nursing, health promotion, and community development and the realities of the practice setting.

**Epilogue**

One of the basic principles of critical, feminist methodologies is that of social action that is transformative in nature. To that end I will present some of the actions I have undertaken in an attempt to bring about change. During, and since this thesis experience, I have embarked on several initiatives in my capacity as a university nurse educator, researcher, and member of the academic community. I assumed a three-year term as chair of the School of Nursing Appointments Committee to introduce Employment Systems Review or equity screening of our appointment policies and procedures (this was the pilot review for the university). I joined the Public Health Association of Nova Scotia as a way to advocate for public health and social justice. As well as continuing to teach community health/public health nursing at the baccalaureate and master's level, I developed a new course to fourth-year nursing students on "Social Justice and the Health Care System".

I am currently conducting collaborative research with nursing colleagues from McMaster University and the University of Alberta to examine “Baccalaureate Nursing Students’ Attitudes and Beliefs about Poverty and Health.” I have made presentations of aspects of the doctoral research at an international and a Canadian community health nursing conference, as well as at the Canadian Public Health Association meetings, October, 2000.
On April 30 and May 1, 2001, I presented my research to public health nurses and managers of Toronto Public Health on the theme “Public Health Nurses’ Community Development Practice: Working with Women in High-Risk Environments”. Recently I became a member of a national committee to develop standards for community health nursing in Canada.

In conclusion, this research experience and my reciprocal and reflexive relationships with the nurses have inspired me on my journey along the spiral of life. Hearing and feeling the stories of social injustice and inequality of the women and families the nurses worked with, and feeling the nurses’ angst as they struggled for autonomy and respect in their practice, motivated me in many ways. At times I was overwhelmed by my own emotions of frustration, sadness, and anger in hearing many of the stories as I identified as a public health nurse, despite the fact that my personal practice as a public health nurse ended almost 20 years ago.

This experience moved me to critically reflect on who I am as a woman, a nurse, and a university nurse educator. It also influenced me to reflect on my role in the university community. Most importantly, I reflected on my attitudes toward individuals oppressed by social, economic, and political circumstances. The energy and commitment to social justice that I obtained from my connection to the nurses’ practice world sustained me through my thesis journey and motivated me to act differently in my world. I also became more committed to tell the nurses’ stories, to create new knowledge, and to challenge some of the misunderstandings and invisibility of public health nurses’ work with disadvantaged women, and to speak out more strongly against social injustice and inequity for women.

Bateson (1990) in her book, “Composing a Life”, describes life as an improvisatory art, an openness to possibilities and the capacity to put them together. She contends that discontinuity may be a more realistic descriptor to apply to our lives today than continuity. Moreover, “we must invest time and passion in specific goals and yet, at the same time acknowledge that these are mutable” (p. 9). This step on my journey of becoming through my doctoral research, that at times seemed uncertain and disconnected with other parts of my life, has allowed me the opportunity to replenish as an educator, researcher, and person.


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Appendix A

Letter of Introduction to the Public Health Nurses

Introduction

My name is Donna Meagher-Stewart. I am a registered nurse and nurse educator with public health nursing experience, and am a doctoral student at the Ontario Institute for Studies in Education/University of Toronto. I invite you to take part in this research study. This study is in partial fulfilment of the degree of Doctor of Philosophy in Education.

The study is described below and information is provided on the purpose, procedures, risks and benefits.

Purpose of the Study

The problem this study addresses is the invisibility of public health nurse's work in community development, and their contribution to primary health care and the goal of “Health for All by the Year 2000.” The purpose of this qualitative study is to make the public health nurse's work more visible by documenting the work process and the issues which define how that work is done in terms of the assumptions public health nurses hold, ambiguities they see, and anxieties they experience in relation to their work. Additionally, I want to explore how the economic and social structures of the health care and community setting influence your practice.

Who Can Participate In This Study?

You are being asked to participate in this study because you are a public health nurse with the Department of Public Health. I am interested in talking with public health nurses who are working with adult women in high-risks environments and involved in community development/capacity building with these women in a formed community group or an evolving community development process.

Taking Part in This Study

In-depth, repeat interviews (lasting 90 minutes in length) will be conducted with all participants. Issues to be covered in the interviews have been outlined and will be elaborated and verified for relevancy as I meet with the public health nurse participants. An open and flexible approach, using directive and non-directive questioning will be followed. Two public health nurses will be identified during the interview process who agree to allow me to observe their practice in community development activities and/or project. These two participants will be asked to keep a reflective journal during the community development activities. I will seek permission from the public health nurses to review their official recording of these activities.

The interviews will be audiotaped, as well as interactions with the public health nurses, as
they engage in community development activities. Tape recording is a way of preserving the meaning of your views and allowing me to attend fully to your words. There may be times of informal and impromptu conversation and activity in which the taping may not be possible. Field notes will therefore be made. Each participant will receive a written copy of their interviews and conversations to read, to validate and to discuss the themes emerging. The interview tapes will only be heard by the investigator and kept in a locked file. After each tape is transcribed it will be destroyed. No specific findings will be made available to anyone in your department. The participants will also receive a draft of the final thesis report for their validation. A final report will be given to the study participants and as a presentation, if so desired.

**Risks and Benefits**

There are no anticipated risks involved in your participation in this study. If you choose at any time to withdraw from this study your job will not be jeopardized. Your participation in this interpretive and reflective process may benefit you by validating your practice. It will demonstrate the contributions of the public health nurse to the health promotion/community development movement and specifically their work with adult women in high-risk environments. Furthermore, the information would inform education of nursing students and further the theoretical development of nursing science.

**Confidentiality**

You will not be identified as a study participant in any publication or presentations of this research. Pseudonyms will be used through the research process and in publication and identifying features will also be altered.

**Questions or Problems**

If you have any questions concerning the research study, please contact me collect at 1-902-425-6170.

Thank you.
Appendix B

Letter of Consent

By signing this consent form, you acknowledge that the guidelines for participating in this research study have been fully explained to you by the investigator and you have read the Letter of Introduction to the Public Health Nurse. You have been informed that you are free to ask any questions in the future and your identity will remain confidential. You will be given a copy of this consent form to keep.

I have read the description of the research study and I have had all my questions answered to my complete satisfaction.

I agree to participate in this research study and know that I am free to withdraw at any time without jeopardizing my job.

Participant ___________________________  ___________________________
                     Name                             Date

Investigator ___________________________  ___________________________
                     Name                             Date
Appendix C

Research Issues and Questions

1. What is the nature of the public health nurses' community development practice?
   - What are the public health nurses' guiding perspectives, assumptions, and beliefs on community development?

2. What is the practical context in which this practice happens with women living in high-risk environments?
   - What are instances in the nurses' work that constitute notions of community development and partnership with women in high-risk environments?
   - How do the nurses value the women's lived experiences and the meaning that their social, political, and economic realities have on their health?
   - How are issues of status, reciprocity, and responsibility evident in dialogue and actions with the women?
   - How do they make the connection of the women and the nurses' experiences and their multiple realities?
   - How do they work with the women to eliminate or decrease possible barriers to the women's participation?
   - How do they nurture capacity building and social action overtime with these women?
   - How do they sustain these meanings in their practice?

3. What is the social, political, and economic context in which the practice occurs?
   - How do they work with the community to establish networks, alliances, and coalitions?
   - How does the culture of the employing agency support or hinder effective community development practice?
   - How is the women's health as a "community of interest and need" prioritized by the public health nurse and by the Department of Public Health?
   - How does the social, economic, and political context of the health care environment and community influence the nurses' community development practice?

4. How do the nurses negotiate constraints on their community development practice?
   - How do the nurses respond to the contradictions in the larger system?
   - How do the nurses negotiate their value?
   - How are these meaning systems sustained in their practice?
Appendix D

Reflective Practice Guideline

Concrete Personal Experience

Describe your experience in the situation:
 meaningful
 impact (+ or -)
 an “aha” experience (insight)
 a specific activity, or concept, or essence of a whole experience What really happened? Why was it significant?

Reflective Observation

Examination, analysis, identification of key factors, feelings, roles, and patterns:
 My feelings/behaviours/leadership

How I saw/see others in this experience?

How do I perceive that others see themselves?

What are the tensions in me/others/the situation?

How does this experience affirm my prior assumptions/ideas/skills/experiences/knowledge?

How does this experience unsettle and challenge my prior assumptions/beliefs/experience/skills/knowledge?

How did my actions match my beliefs?

What are the contradictions?

What factors made me act in incongruent ways?

What does this experience remind me of? (Use a metaphor, image)

Generalizations/Conceptualizations of Your Understanding of the Situation

What is my interpretation of the whole situation and the interdependence of the various aspects? In other words, what does/did this experience mean/say to me about public health nursing and community development and working with women in high-risk environments in this way?
. How can I ground this understanding/insight/awareness with existing knowledge or create new knowledge?

. What contradiction(s) is apparent from me between what others say or value about community development and public health nursing and what I value about my practice?

. What do I know now that I may not have known at the time of the experience reflected on here?

. What difference does this understanding have for me?

**How can I act?**

. How did I or can I test this understanding/insight/awareness?

. What blocks or supports are there for action?

. What alternative strategies are there for action?

. What would be the consequences of alternative actions for me/others/the women?

. What are the implications for me/others/the women in not taking action?

. How has this experience changed my knowledge/skill?

. What values/knowledge/skills do I need to acquire/develop?