THE COMMUNITY HEALTH NURSE'S ROLE IN HEALTH PROMOTION POLICY: AN INTERDISCIPLINARY FEMINIST RESEARCH PARADIGM

BY

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A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

DOCTOR OF PHILOSOPHY

Interdisciplinary Graduate Program
University of Manitoba
Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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ABSTRACT

The literature reports the need for nurses to develop and implement health policy. The extent to which community health nurses are involved in the development and implementation of health promotion policy is addressed by this doctoral research. The interdisciplinary perspective of Women's Studies provided the theoretical framework and methodology to investigate the following research questions: What is the role of the community health nurse in the development and implementation of health promotion policy? What systematic changes to the existing mechanisms of policy development and implementation are required to establish health promotion policy which is congruent with the WHO's definition of "health promotion"?

Community health nurses (n=31), working in two public health nursing service delivery agencies in an urban setting were recruited through a letter of invitation. Data were collected using a semi-structured interview schedule which explored health policy, work environment, health promotion needs, and the opportunity for women's voices to be heard. Transcribed data from tape recorded interviews were analyzed verbatim using qualitative methods in the form of content analysis. All elements of the method, which is naturalistic inquiry, and more specifically women-centered interviewing, were shaped by the tenets of feminist science. The feminist lens was chosen because of the hierarchical nature of organizational structures, the need to make the invisible, visible and, the need to hear the voices of these nurses. By using feminist theory and feminist methodology, themes, categories, concepts, and their relationships emerged from the data.

Fourteen themes were identified pertaining to the "work world" of community health nurses; their alienation from policy development and implementation, their frustration and resistance; and, their desire for equity in terms of gender, programming, and professional status. This study reveals the lack of community health nurses' involvement in policy development and implementation and the consequences of not involving nurses in policy making. Alienation and marginalization come at a cost. The price is high and ultimately everyone pays; the government/ agencies, colleagues, and the public.

Findings are discussed within the context of health care reform and the work of the community health nurse. Beyond the implications for nursing practice, education, research, and management, the findings have meaning for health policy development and implementation at all levels of the existing health care system. One example is the need of a feminist model for policy development and implementation. A model was developed by bringing into focus each recommendation generated by the study within the framework of structure, process, and outcome. Feminist analysis reveals theoretical and practical links between nurses' lack of involvement in policy development and caring values offered by community health nurses who endeavour to contribute to health promotion policy.

ACKNOWLEDGEMENTS

No landscape is ever painted without the insights and wisdom gained from others. Upon the completion of this dissertation work, my first debt of gratitude is to the community health nurses who volunteered to participate in this study. You helped me to know the nature of the health policy landscape as you experienced it. Your voices are a constant reminder of the intelligence and passion you bring to your work.

To Dr. Janice Dodd, who Chaired my dissertation committee, I am grateful for the privilege of learning from you. You guided me with science and with art. You helped me to find my focus and to be true to my feminist learnings. Through your gifts of wisdom, support, and inspiration, I was able to complete this work.

I am grateful to Dr. Keith Louise Fulton who gave me the feminist lens through which to view the world and to conceptualize this study. You taught me the power of language and the strength in women's writing. Thank you for teaching me how to be a good feminist scholar which has changed my life.

To Dr. Parvin Ghorayshi, I am grateful for your research expertise in studying women and work. I appreciated your commitment to feminist scholarship. Your insights into qualitative approaches to research, feminist research, and your support were invaluable to my work.

I am indebted to Dr. Elizabeth Ready. Your enthusiasm and passion for research was a source of continuous energy and inspiration. Your encouragement, support, and wise suggestions contributed to my ability to question, to challenge, and to learn.

To Dame June Clark, I am grateful for your willingness to serve in the capacity of external examiner of my dissertation. Thank you for bringing your exemplary scholarship and international reputation in nursing to the review of my work.

I am fortunate to have had an exceptional colleague, Dr. David Gregory, with whom to share this research journey. With the "stroke of a brush" you were able to show how a research landscape could be made vibrant. I am grateful for your treasured gifts of knowledge, caring and colleagueship.

My gratitude is extended to Ms. Sherry Ripak who transcribed the research interviews and provided computer expertise. Thank you for your compassion, support, and encouragement as I learned how to paint this research picture.

I am grateful to Dr. Ken Hughes who provided me with the direction to initiate doctoral work and envision the pathway. Thank you for your support and for affording me the opportunity to study in the Interdisciplinary Graduate Program.

I wish to acknowledge the Social Sciences and Humanities Research Council of Canada (SSHRC) who awarded me a Doctoral Fellowship in support of this research.

DEDICATION

To all my teachers,
past and present,
and their gifts of learning

For Rebeccah
and those
who love unconditionally

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"Let's hear it for love"

(Shields, 1992, p. 362)

INTRODUCTION

Statement of the Problem

The need for nurses to develop and implement health policy is substantiated in the literature (Andreoli, Musser, & Otto, 1987; Backer, 1991; Bushy & Smith, 1990; Chambers, 1989; Dick, Harris, Lehman, & Savage, 1986; Glass & Hicks, 1995; Hinshaw, 1988; Kuss, Proulx-Girouard, Lovitt, Katz, & Kennelly, 1997; Lefort, 1993; Milio, 1984; Murphy, 1993; Rains & Hahn, 1995; Williams, 1993; Wood & Ransom, 1994). For example, Gilliss (1991) encourages nurses to evaluate clinical work and research data with respect to policy implications. In a publication of the Canadian Public Health Association (CPHA, 1990), entitled Community Health – Public Health Nursing in Canada: Preparation and Practice, the role for the community health nurse as policy formulator is identified. There is also agreement in the literature that the community health nurse should engage in health promotion. Health promotion is defined by the World Health Organization (WHO, 1984) as a process of enabling people to increase control over, and to improve, their health. Thus, community health nurses are expected to be involved in the development and implementation of health promotion policy, which is the focus of this dissertation work.

Community health nurses, by virtue of their practice, are acutely aware of the health promotion needs of their communities. Community health nurses therefore, are

individuals who should be involved in the formulation of health promotion policy; yet, historically, this has not been the case. The reasons for this situation are many and include: invisible care values (Kelly-Gadol, 1987; Watson, 1990); lack of according importance or value to "caring" and "love" in human affairs (Lanara, 1996; Roach, 1991); absence of "professional lineage" (Raymond, 1986); non-caring bureaucratic health care system (Watson, 1991); silencing and devaluing of women's voices (Harding, 1987); patriarchal health care system (Sherwin, 1992); and, lack of a feminist model for health policy making (Sherwin, 1992).

Only recently have researchers within and outside the discipline of nursing used a feminist perspective to gain insights about the caring imperative and love, and their relationship to health policy and health promotion. Connections between feminist perspectives and caring are now beginning to appear in nursing scholarship. Nursing, women, and children are perhaps the paradigm cases for "invisible" care values and help us understand why caring values are not core for health policy and practice (Watson, 1990). That is, caring values among nurses, women, and children are not recognized by policy makers as legitimate or of value. Beyond care values and love, it is the conviction of historian Joan Kelly-Gadol (1987) that women do form a distinctive social group and that the invisibility of this group in traditional history is not to be ascribed to female nature. She further argues that these two notions arise out of a feminist consciousness.

In this dissertation the words "caring" and "love" are used. Sister Simone Roach (1991) argues that "the world in which we live is crying out for compassion, meaning, tenderness, and love" (p. 7). Nursing as a profession embellishes a tradition

of caring and love. Roach conceptualizes caring as the human mode of being. It is her argument that "nursing is no more and no less than the professionalization of the human capacity to care through the acquisition and application of the knowledge, attitudes, and skills appropriate to nursing's prescribed roles" (p. 9). Included in the multiform expression of caring, Roach argues, are compassion, competence, confidence, conscience and commitment. She identifies a paradox about caring in that it is often more obvious by its absence than by its presence in human affairs. The "health world" is not exempt from this paradox.

The meaning of love as an emotion, an experience--its political, social and theoretical implications for feminism is the central question that feminist theory needs to discuss (Douglas, 1990). Simone de Beauvoir (as cited in Douglas) argues that love now diminishes and enslaves women, but this is not an inherent or necessary part of love. Lanara (1996) argues that the word nursing has become synonymous with the word love. "Nursing has its roots in nourish, nurture, and the Greek word for the nurse, adelphe, means brotherly love" (p. 160). Lanara further argues that love arises from the Greek "agape" which means devoted to the welfare of the other. It does not mean personal liking or a sentimental affection.

Raymond (1986) writes about female friendship. She argues that female friendship has given us the experience of each other and it has given us the gift of Self. The ways in which women have put each other first are many. One example she offers is "professional lineage" (p. 36) where women scientists at women's colleges in the United States have mentored and supported the careers of their female protégées. Raymond further argues that "thinking" is a necessary condition of female friendship.

This thinking is best described by "thoughtfulness." This term is characterized both by ability to reason and by considerateness and caring. "Many women may be brilliant thinkers, but that thinking has to be accompanied by a genuine attentiveness and respect for other women if female friendship is to flourish" (p. 221).

In summary, and for clarity of meaning in this dissertation, when the terms caring and love are used, the intended meaning is as follows. "Caring" is defined as the human mode of being (Roach, 1991). "Love" or agape means devoted to the welfare of the other (Lanara, 1996). These concepts are relevant to this dissertation work because they are fundamental to nursing in general and health policy development in particular. The relevancy of these concepts to policy formulation and implementation is established throughout the course of this study.

As defined by Stanley and Wise (1983), "feminism is not only a set of beliefs but also a set of theoretical constructions about the nature of women's oppression, and the part that this oppression plays within social reality more generally" (p. 55). These authors argue that feminism directly confronts the idea that one person or set of people have the right to impose definitions of reality on others (Stanley & Wise, 1991). Jean Watson (1991) states that "caring and the feminist lens that nursing can use to uncover, examine, reclaim, and restore itself is the antidote now called for in the non-caring bureaucratic health care system" (p. x). Feminism is central to understanding the "work world" of community health nurses, their experiences and their degree of involvement with health policy, as well as the oppressive forces they (may) encounter.

Susan Sherwin (1992) argues that a health care system model is needed that can change traditional understanding about who has relevant knowledge to make decisions about health and health policy. She suggests a feminist model that resists hierarchial structures and proclaims a commitment to egalitarian alternatives. In her view, representatives of all groups are included in the decision-making structures. Sandra Harding (1987) states that "only partial and distorted understandings of ourselves and the world around us can be produced in a culture which systematically silences and devalues the voices of women" (p. 7). A feminist model has the potential to promote better health care for those now oppressed in society and give voice to those who are silenced.

A cautionary word is presented by Marsden and Omery (1992) who argue that nurses must not deny their female heritage. These authors cite the work of Adrienne Rich who writes,

> For if in trying to join the common world of men, the professions molded by a primarily masculine consciousness, we split ourselves off from the common life of women and deny our female heritage and identity in our work, we lose touch with our real powers and with it the essential condition for all realized work: community. (p. 488)

The literature review of health promotion policy, as documented in Chapter One, supports the need for closer communication among researchers of health promotion and the community health care groups advocating for populations they represent. A feminist model, substantiated by a literature review of feminist research methodology in Chapter Two, "include[s] many different voices in defining the central questions and exploring the promising paths to answers in the field" (Sherwin, 1992, p. 240).

To date, there have been some preliminary studies exploring the nurse's involvement in health policy (Barriball & Mackenzie, 1993; Batra, 1992; Clarke, Beddome, & Whyte, 1993; Counts & Boyle, 1987; Rains & Hahn, 1995; Thomas & Shelton, 1994). With respect to community health nurses and policy development there is an apparent lack of research efforts (Clarke, Beddome, & Whyte, 1993; Rains & Hahn, 1995). Therefore, the need to examine the role of community health nurses with respect to policy development and implementation is warranted. Furthermore, the need to examine this problem through a feminist research lens is justified (Anderson, Blue, Holbrook, & Ng, 1993; Chinn & Wheeler, 1985; Emden, 1995; Keddy, 1992; Mason, Backer, & Georges, 1991; Wuest, 1997).

Through the use of a feminist research perspective, the objectives of the proposed research include the extent to which community health nurses are engaged in the development and implementation of health promotion policy, and to suggest strategies by which their involvement could be enhanced. The interdisciplinary perspective of Women's Studies provides the theoretical framework and methodology to respond to the following research questions:

1. What is the role of the community health nurse in the development and implementation of health promotion policy?
2. What systematic changes to the existing mechanisms of policy development and implementation are required to establish health promotion policy which is congruent with the World Health Organization's definition of "health promotion"?

These two central questions are based on the following four premises:

1. Community health nurses have implemented health promotion policy with communities, but the majority do not participate in health promotion policy development.
2. Feminist approaches have not been brought to bear on the development of health promotion policy.
3. Although individual community health nurses may use a feminist approach to the implementation of health promotion policy, they may not identify the approach as feminist.
4. Feminist approaches for the development and implementation of health promotion policy would constitute a major and positive change to currently existing practice and policy in the health care system.

Language plays an important part in research. The four key terms used in this study are defined as follows:

1. Health promotion is defined as a process of enabling people to increase control over, and to improve, their health. Health is defined as a resource for everyday life, not the object of living (WHO, 1984).
2. Policy development is viewed as a process which establishes long-term, continuously used, standing decisions by which more specific proposals are judged for acceptability (Blum, 1981).
3. Policy implementation is a process whereby policy decisions are put into action thereby achieving solutions to problems (Siler-Wells, 1987).

4. Community health nurse[s] refers to nurse[s] working in the community outside of institutional settings who promote and preserve the health of communities, groups, families and individuals across their lifespan in a continuous rather than episodic process (CPHA, 1990).

In professional associations such as the Canadian Public Health Association (CPHA), the Canadian Nurses Association (CNA), the American Public Health Association (APHA) and the American Nurses Association (ANA), the distinction between the terms community health nursing (CHN) and public health nursing (PHN) continues to be debated. In some jurisdictions in Canada the terms are considered synonymous while in others, community health nurse refers to a complete range of nurses working in the community, of which the public health nurse is a part (CPHA, 1990).

Kuss, Proulx-Girouard, Lovitt, Katz, and Kennelly (1997) argue from the point of view of the American nursing experience, for a distinction between the two terms because of "the uniqueness of the primary setting for PHN practice, the focus on population-based interventions, the educational preparation, and the specialized PHN roles and practices" (p. 82). White (1982) argues that the PHN philosophy is ultimately committed to the larger population, i.e., where interventions provide the greatest good for the greatest number. Kuss et al. (1997) cite the work of Rothman who identifies the setting in which PHNs work to be primarily in official health agencies, or tax-supported agencies with legal mandates. With respect to the nurses in my study, this was indeed the case.

When the term public health nurse appears in this text, the meaning is considered to be synonymous with community health nurse. For the purposes of this study, the terms community health nurse, community health nursing, are used to denote nursing care (practiced with four levels of client--individual, family, aggregate and community) that is complex and continuous (illness care, illness prevention, and health promotion) and has as its goal the promotion of the community's health (Laffrey & Craig, 1995).

With the advent of primary health care (WHO, 1978), community health nurses are challenged in their practice of community nursing, more than ever, to include aggregates and the total community. For this reason McKnight and Van Dover (1994) argue for baccalaureate education to emphasize "definitions of health and community, community assessment, community development, citizen participation and mobilization" (p. 14). Scruby and McKay (1991) argue for more practice experience in the community for baccalaureate nursing students "to enable students to acquire the necessary skills in community based assessment and program development" (p. 266). These authors also advocate for "a greater student exposure to the theory and practice of community development work" (p. 266).

The term "community" is seen as an organized group of persons bound together by ties of social, cultural or occupational origin or geographic location. According to CPHA (1990) it may be as simple as a number of families and significant others, organized for purposes of survival, or as complex as the World community with its highly organized institutions. Laffrey and Craig (1995) argue for a concept of community as the "target of practice" and cite the work of Sills and Goeppinger. In

this definition the goal of care is to achieve a healthier community, regardless of where nursing care is provided (setting) or to whom (individual, family, group, or society).

In 1986 Anderson and McFarlane introduced the idea of community as the "client." The term "client", I argue, gives the impression of a passive recipient of services rather than an active participant. There is an implied power relationship where the client is the recipient of care, having less power and authority than the provider of care. Kuss et al. (1997) argue that the term "client" is not empowering. Currently, the term "partner", which conveys the idea of a shared relationship, is more appropriate. Anderson and McFarlane (1996) more recently have adopted the term "community as partner" reflecting their shift in thinking. In this study when the term "client" is used, I am aware of the controversy; however, it is awkward at times in scholarly work to write about community "partners" meaning the whole community when in fact the meaning may be taken to be other agencies, for example. I have chosen to use the term "client" for lack of a better one and for clarity. When the term "partner" adds meaning and clarity to an argument I have chosen this term as an exemplar to describe the relationship between the community health nurse and the community within the context of primary health care.

Nurses play a key role at the interface of communities and the health care system. Much of health promotion requires their work of implementation. Mahler (1985) envisioned an active role for nurses in the "health for all" movement: In an article for World Health, he predicted more nurses will move from the hospital to the everyday life of the community, where they are urgently needed; that nurses will

become resources to people rather than to physicians and will become more active in educating people for health. He contended that nurses will become increasingly active in program planning and evaluation, and in interprofessional and intersectoral teams for health development; he foresaw greater responsibility being taken by nurses within health care teams, with more of them becoming leaders and managers of primary health care teams. Finally, he identified four factors supporting a changing role for nurses. These were: "new attitudes and values; re-orientation of educational programs; better resource allocation; well defined policies and plans for the development of nursing personnel" (p. 1).

Similarly, Maglacas (1988) argues that health promotion is nursing's primary focus and goes beyond responsibility for delivering medical or health care services. She proposes that nurses should be running health services, not illness services. New skills and specializations will need to be developed by nursing and these include:

> Enabling and empowering people for self-care, self-help, and environmental improvement; promoting positive health behaviour and appropriate coping abilities of people to maintain health; disseminating information; communicating; developing mobilization strategies when creating contexts within which community participation and intersectoral action for health are fostered; advocating and mediating for the shaping and building of healthy public policy; and creating health care environments that sustain and promote healthy living. (p. 71)

Further inquiry is needed to explain the contradiction between what is being proposed in the literature in theory and what is actually taking place in the practice of community health nurses. The role of the community health nurse in health promotion policy is a paradox. The literature explicitly identifies their role in policy development; however, in practice this is not a reality for most community health nurses. My research develops and makes the argument that understanding this

dilemma and suggesting action for change are found in an interdisciplinary feminist research paradigm.

Context of the Study

In Canada, health is the purview and legal responsibility of the provincial and territorial governments. This was a result of the British North America Act (1867) which set constitutional limits on federal power by assigning responsibility for health and welfare to the provinces and municipalities (Pinder, 1994). The Act made no provision for resources but gave the federal government significant powers with respect to taxation. Several tensions have resulted. For example, the federal government can develop health policy which may or may not be adopted by the provincial/territorial governments. When the principles of medicare are violated by the provinces, the federal government can withhold the transfer payment related to medicare expenses. Pinder argues that federal-provincial cooperation is hard won, and sometimes despite a variety of mechanisms, it is not won at all.

The World Health Organization's International Conference on Primary Health Care held in Alma-Ata, Kazakh (former U.S.S.R.) in 1978, established a world-wide commitment to primary health care. In the Declaration of Alma-Ata, primary health care was identified as the means to achieving the universal objective of "health for all by the year 2000" (WHO, 1978). The concept of primary health care was defined as essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation, and at a cost the community and country can afford. This concept would influence the development

and implementation of health policy on a global scale. Canada participated in the conference and signed the Declaration.

In 1986 the Canadian strategy for achieving "health for all" was identified as health promotion. This was announced by Jake Epp, the federal Minister for Health and Welfare Canada. In the Canadian document entitled Achieving Health For All: A Framework For Health Promotion, health was envisioned to be a resource for everyday life, not the object of living (WHO, 1984). Health, defined as a resource, gives people the ability to manage and even to change their surroundings (Epp, 1986). This view of health, according to the Canadian Public Health Association (1990), "emphasizes the role of the community, family, and the individual in defining what health means to them and in planning and implementing health-enhancing public policy" (p. 4). Health promotion represents a mediating strategy between people and their environments, synthesizing personal choice and social responsibility to create a healthier future (Epp, 1986). Kickbusch (1986) argues that the organization of the health care system as a whole needs to be rethought and moved from a curative focus to one of health promotion.

Within the framework for health promotion are echoed many primary health care concepts (Epp, 1986). Three of these concepts are central to primary health care: equity, which is fundamental to health for all; intersectoral collaboration, which is necessary because the factors that affect health go beyond the domain of Health Departments; and public participation, which is the empowerment of individuals and communities to participate in decisions that affect their health. All three suggest changes for the nursing role: an emphasis on nurse's involvement in reducing the

inequalities in health among their own communities; an emphasis on the enablement of clients; the promotion of individual and community client involvement; and a collegial relationship between professionals in health and other fields, and the public itself. Florence Nightingale (1894) wrote that, "The laws of health can only be efficiently applied when there is cordial co-operation between those who govern and those who are governed. But this cordial co-operation is really exactly the same as self-government" (p. 1). Her thoughts on health and government continue to be significant for nurses and health promotion policy makers in the 1990s.

The First International Conference on Health Promotion was held in Ottawa, Canada in 1986. In the resulting Ottawa Charter for Health Promotion (WHO, 1986), health promotion action was determined. In part, building healthy public policy was identified as one of the means to health promotion action. The phrase "healthy public policy" was coined by Hancock (1982) to emphasize the contribution public policy can make to fostering or hindering the health of the public. Hancock (1994) argues that healthy public policy demonstrates the link between health promotion, politics and power and refers to the WHO (1988) characteristics of healthy public policy as "an explicit concern for health and equity in all areas of policy and by an accountability for health impact" (p. 351). Glass and Hicks (1995) argue that healthy public policy differs from public health policy by being multisectoral (recognizes the contributions made by ministries in addition to health); and, healthy public policy is based on public participation in policy formulation and implementation. Health promotion, because it goes beyond health care, puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions

and to accept their responsibilities for health. It is stated in the Ottawa Charter for Health Promotion that,

> Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments. (p. 1).

The Second International Conference on Health Promotion, entitled Healthy Public Policy, was held in Adelaide, Australia in 1988. It built upon the previous international conferences in support of new public health for all countries of the world. Healthy public policy was characterized and areas of priority were established. Supporting the health of women was one of four key areas identified as priority for healthy public policy. The other three areas identified were food and nutrition, tobacco and alcohol, and creating supportive environments (WHO, 1988).

The Adelaide Conference recommendations recognized that, world wide, women are the primary health promoters and most of their work is performed without pay or for a minimal wage. Women's networks and organizations were identified as models for the process of health promotion organization, planning and implementation. In fact, policy makers and established institutions were advised to give more recognition and support to women's networks. For their effective participation in health promotion, women require access to information, networks and funds. "All women, especially those from ethnic, indigenous, and minority groups, have the right to self-determination of their health, and should be full partners in the formulation of healthy public policy to ensure its cultural relevance" (WHO, 1988, p. 184).

It is the argument of Labonté (1994) that health promotion exists between two perils: co-opting or neutralizing social struggle (conflict) within the conservatizing ethos of institutions and denying its bureaucratic parentage and proclaiming the community as the solution to all socio-political and economic health concerns. He further argues that these risks can be mitigated and the question fundamental to the "new" health promotion practice is: "How can professionals working under its rubric engage in specific actions that are empowering, that ameliorate inequitable social relationships?" (p. 88).

The Canada Health Act (1984) enshrined the five principles of medicare; universality, accessibility, comprehensiveness, portability, and public administration. Nursing leaders lobbied for increased accessibility to health care and more efficient use of nurses as a point of entry (Rodger & Gallagher, 1995). Their unrelenting efforts were successful (CNA, 1984a; 1984b).

In 1997 a National Forum on Health was held in Canada. To provide advice on the development of national policies, four key areas served as the focus: values; striking a balance; determinants of health; and, evidence-based decision making. The final report (National Forum on Health, 1997) was based on members deliberations, consultations and research. Inherent in this report is the need for government policies to shift from the initial focus on lifestyle choices (Lalonde, 1974) to the societal level (societal and economic factors that contribute to better health). Recognition is given in the report for the important role "communities play in building social capital and positively influencing health" (p. 25). An argument is made for a renewed partnership between communities, governments and the private sector.

Current government initiatives in provincial health care reform have proposed an expanded role for the nurse in a restructured health care system. A major thrust of health care reform in Manitoba is a heightened emphasis on health promotion (Manitoba Health, 1989). The nurse's role in primary health care is identified in the document, Primary Health Care Review (Manitoba Health, 1994b). Several documents recently have been developed by Manitoba Health in support of a restructured health care system (Manitoba Health, 1997a, 1997b, 1997c, 1997d). Professional associations such as the CNA (1980; 1988), the Manitoba Association of Registered Nurses (MARN) (1993a, 1993b) and the Registered Nurses Association of British Columbia (RNABC) (1990; 1998) support nurses influencing change within the context of health care reform by advancing the principles of primary health care.

In summary, at the macro level there is extensive rhetoric about the nurse's involvement in health promotion, however, at the micro level (level of nursing practice) nurses continue to be alienated and marginalized from being active contributors to the formulation of health promotion policy. A new paradigm is needed whereby community health nurses, the majority of whom are women, can "establish" their involvement in the development of health promotion policy.

In search of support for this conviction, I reviewed the literature to explore the boundaries of knowledge on health promotion policy. This review of literature is the basis of Chapter One. Included in this chapter is a section which locates my research within the debate about paradigm considerations and controversies. In Chapter Two, I review the literature on feminist research methodology and add a section in which I locate myself within the context of feminist research. A comprehensive discussion

about my research design is found in Chapter Three, Methodology. A case is made for my study design which is feminist naturalistic inquiry, specifically women-centered interviewing. Research findings are presented in Chapter Four. Finally, a comprehensive discussion of the findings including Women's Work, the Context of Women's Work, and Women and Policy Development are located in Chapter Five. Moreover, a feminist model for policy development and implementation based on the findings of this study is offered in the same chapter.

CHAPTER ONE: HEALTH PROMOTION POLICY LITERATURE REVIEW

Introduction

In the literature on health promotion policy a boundary emerges between the research aspect of health promotion policy and the program aspect. Within the research area, paradigm considerations and controversies include both conceptual/ theoretical and methodological aspects. While there is general agreement in the health promotion research literature that a re-thinking of the research paradigms is necessary, there is no consensus for a new paradigm. Within the program area of the health promotion policy literature, various programs are described. Again, there is no consensus for a research paradigm that leads to good health policy. There is agreement in the health promotion policy literature that boundaries between health promotion researchers, practitioners and policy makers need to be bridged. This chapter is organized thematically as follows: Health Promotion Policy: Research; Health Promotion Policy: Programs; and, Locating My Research in the Debate.

Health Promotion Policy: Research

Discussed in this section are the following themes: Epistemology, Methodology, Method; Feminist Research; Interdisciplinary Research; and, Empowerment. Also several sub-themes emerging from the literature are presented (see Table 1).

Table 1

Outline of Chapter One

Introduction
Health Promotion Policy: Research
1. Epistemology, Methodology, Method
    a. Naturalistic Inquiry
    b. Ethnography
    c. Healthy Public Policy
    d. Evaluation
    e. How Much Data?
    f. Social Systems Level
2. Feminist Research
    a. Gender
3. Interdisciplinary Research
    a. Political and Social Theory
    b. Concept of Health
    c. Research Teams
4. Empowerment
    a. Communities

Health Promotion Policy: Programs
1. Interdisciplinary
2. Education
3. Community
4. Concept of Health
5. Informed Public Policy

Locating My Research in the Debate
Conclusion

Epistemology, Methodology, Method

Much of the literature, having a health promotion policy research focus, has something to inform the reader about epistemology, methodology and method. This theme will be discussed according to sub-themes (see Table 1).

Naturalistic Inquiry

In a literature search for evidence of paradigmatic controversy, Lincoln (1992) explored the disciplines of nursing, occupational therapy, family medicine, and health promotion, and found that the evidence was plentiful. She concluded that there was a growing lack of consensus in the health disciplines for appropriate and legitimate methods for carrying out research. One of the contributing factors proposed is the fact that the health services and allied professions are in the process of redefining health. This author envisions no turning back to the medical model as the sole model for practice, research, evaluation or education. In fact, she identifies an overlap in disciplined inquiry in both the areas of health sciences and social sciences. She also sees a trend towards a more constructivist model of inquiry.

Yvonna Lincoln (1992) identifies and clarifies the controversies in the paradigm debate. The conventional, scientific, or positivist, paradigm is being examined and questioned for its continued use as the dominant model. Some involved in the debate argue that this paradigm is useful so long as we add the texture and richness of qualitative methods. Others argue that the conventional paradigm heavily reflects the socially-constructed and politically-mediated nature of knowledge production. Scholars such as Bleier are criticizing the fact that research tends to be controlled by white, middle-class, middle-aged males; and as a cultural activity, science tends to be dominated by their class, social, political and cultural concerns (as cited in Lincoln, 1992).

Lincoln (1992) supports the naturalistic or constructivist paradigm, and acknowledges that the central problem with the on-going debate is that "ultimately,

what is at issue is who gets research contracts, whose work is treated as respectable and worthy of publication and who is accorded legitimacy in the public policy arena" (p. S7). Characteristics of the naturalist, qualitative and constructivist paradigm include the following: it has a relativist ontology which asserts that there are multiple, socially-constructed "realities"; it has a monistic, subjectivist epistemology that engages the inquirer and participant in trading roles of teacher and learner; it has hermeneutic methodology which includes context as part of the thing to be known; it has quality criteria of both trustworthiness and authenticity, i.e., it meets the quality criteria in the positivist paradigm of internal and external validity, reliability and objectivity. In the constructivist paradigm, these characteristics are called credibility, transferability, dependability and confirmability. The new paradigm answers the questions fundamental to any paradigm for knowing: "What is the nature of reality and what can be known; what is or should be, my relationship to that which can be known; and, how can I come to know" (p. S7).

The perspective of community development is brought to the health promotion research discourse by community development researcher, Elayne Harris (1992). Her argument agrees with other researchers in the field that health promotion has outgrown the notion of health as found in the traditional medical model. The naturalist paradigm for both health promotion and community development research, according to this author is an imperative, not an option. This is primarily because there is congruence in both health promotion and community development of the assumptions in the naturalist paradigm and the assumptions in progressive practice. Harris cites the work of Hall who argues that one of the key features of the paradigm is that the

community must not only gain from the results of research but from the process itself. Harris identifies three implications of the naturalist paradigm for research. Firstly, naturalistic inquiry is not the establishment's choice. The author raises the issue of competing for funding in an environment where certain levels of knowledge creation are awarded different status. Secondly, there are limitations to all research approaches for some questions. The author questions whether the research process itself is powerful enough to handle the degree of complexity in health promotion and community development practice. Thirdly, naturalistic inquiry has an unpredictable character. The researcher does not have control over bringing the research to a predictable conclusion. Among other things this adds to the difficulty in obtaining funding. Since feminist research projects originate in women's experiences in political struggles, they query how certain conditions can change.

Lewis (1996) also argues in support of the constructivist paradigm for health promotion. The extended engagement aspect of the new public health, i.e., community empowerment, community partnership, and community participation, requires a dialogue of scientist and practitioner with community members. This nurse believes that the health profession's schools (including public health nursing) focus on methods rather than epistemology and methodology. Thus, the paradigm is set up for rejection by the unknowing. The author recommends that courses introduce several research traditions; for example, feminist theory, ethnography, grounded theory, etc. Lewis is not advocating replacement of the realist or empiricist tradition but argues that "if we are to be at 'the table' of the community, the constructivist paradigm is essential to success" (p. 451).

Ethnography

Elizabeth Townsend (1992) uses the analytic approach of "institutional ethnography" to make explicit the social organization of knowledge. Townsend argues that if we want to support client empowerment in health-promoting practices, research is needed to examine the social organization of health professional practices. This is an important issue for paradigm consideration, not only from the perspective of community empowerment but also from the perspective of community health nurse empowerment. The author recognizes that important reasoning and contextual features of actual practice are obliterated when research uses the categories of discourse common to professional, bureaucratic and managerial practices. According to Townsend, institutional ethnography "explores questions of disjuncture between what we know of our everyday actions and what becomes known through the discourse used to discuss or document facts about these actions" (p. S59). Data collection, in her research on organization of occupational therapy mental health day programs, included participant observation and interviewing by the researcher (documenting actions, dialogue and material conditions of occupational therapy work). In addition, she collected policy and record keeping documents on the organization, and on provincial and federal mental health services. The Ethnograph computer program provided assistance in coding and grouping data. In her analysis she identified contradictions in client responses to her questions.

Healthy Public Policy

O'Neill and Pederson (1992) found problems in searching the policy literature for insights into appropriate methods for conducting research on healthy public policy.

They identified positivistic epistemological frameworks that tended to produce generalizable, replicable, transferable knowledge. As previously discussed, it is only now that the foundations of positivism are being questioned and consideration given to variety of epistemological premises for approaching public policy study. The range of research techniques, based on a review of the literature by O'Neill and Pederson, included a mix of semi-structured, key informant interviews with content analysis of historical documents (especially media materials), supplemented by some participant observation or non-participant observation. Data analysis, they suggest, should integrate the various types of data by a hermeneutical and triangulative approach with a major emphasis on understanding. This approach places a major emphasis, for example, on looking at the meaning of things and involving the researcher's subjectivity to do so.

O'Neill and Pederson (1992) identified strong links to the social sciences and with positivism by academic policy analysts. The applied policy analysts have a range of epistemological positions, seeking substance and methods from several disciplines to produce information for policy that is relevant to political settings. Summarized by Bobrow and Dryzek (as cited in O'Neill & Pederson), this approach includes positivism, piecemeal social engineering, relativism and reasoned consensus.

In identifying a methods bridge between public policy analysis and healthy public policy, O'Neill and Pederson (1992) explore the question of how to conduct healthy public policy research. The work of Labonte is cited in defining public policy, as extending beyond whatever a government chooses to do or not to do, to include the overarching set of ideas that form the basis of action (or inaction) and underlie

decision making. O'Neill and Pederson cite the argument of Milio to support public policy as a means to improve health. Milio (1986) urges governments to be responsible and set the conditions that enable people to make healthy choices in their lives. She says these should be the easiest choices and ones that contribute to a healthy environment. The concept of "healthy public policy" was formulated after a decade of World Health Organization (WHO) activities in health promotion, and characterized at the Adelaide Conference on Health Promotion in 1988. The concept development also includes the work of leaders in the field. Healthy public policy is best described as having an intersectoral approach (WHO, 1986). This view is fundamentally ecological and includes in the process people and organizations that are typically excluded.

O'Neill and Pederson (1992), writing about the epistemology of healthy public policy, note that there are only four papers in existence that address the issue of research, and they all favour implication (in which the researcher aims to understand change in a subjective and intimate way) over distancing (where the researcher aims to explain things in an objective and removed fashion). They cite the work of Milio who advises that new types of policy-relevant information are needed for policy makers, interested groups and the media. Such information would help advocates of healthy public policy to find ways of involving themselves in policy making, find sources of support and develop strategies to ensure the success of health promotion policy. The researcher, according to Milio, needs to become involved and personally to enter the research experience, and talk to people at all levels of policy making, both inside and outside government bureaucracy. O'Neill and Pederson garner additional support from the works of De Leeuw and Ziglio. De Leeuw quotes Ziglio who suggests that when

analyzing healthy public policy, the researcher needs to consider "the meaning, values, aspirations, and motivations that the participants themselves attach to the project being investigated" (p. S27).

Milio identifies two questions that healthy public policy research methodology should aim to address. First, "What policy options will make healthy choices easier for society to make in the continuous creation of goods, services and environments" and, second, "how can options for healthy public policy be made easier for policy makers and their supporters to choose" (as cited in O'Neill & Pederson, 1992, p. S27). The best research approach, according to Milio, is a qualitative approach to data collection and supplement that with quantitative information when necessary. Pederson, Edwards, Kelner, Allison, and Marshall, and De Leeuw (as cited in O'Neill & Pederson, 1992) argue for qualitative approaches to be given more recognition in public health. They encourage a mix of qualitative and quantitative approaches to data collection and analysis with "triangulation" (a method of confirming information by cross-checking it from various sources) as a key tool to insure the validity and reliability of the findings.

O'Neill and Pederson (1992) urge all researchers in the policy field to examine their own epistemological stance and their research methodology choices. They find that borrowing in a "one-way" direction from the policy literature to conduct research in healthy public policy is problematic.

Stachenko (1994) argues that although the health promotion field is new and has contributed to the development of conceptual and theoretical frameworks, it remains filled with many questions. These questions include: "What is empowerment; how do

we know when public policy becomes healthy public policy; and, what is the relation between objective and subjective health" (p. 109).

A series of workshops and an extensive literature review sponsored by the federal government produced the identification of the following issues for health promotion research. As reported by Stachenko (1994) these issues are: methodological developments in indicators of positive health and in research designs; the network of health promotion researchers need to expand to include urban planners, social scientists, etc.; and, effective communication links between researchers and practitioners should be established.

It is Stachenko's (1994) argument that next to policy, community environment (empowerment, community development, community participation, coalition building) is the most important channel to achieve sustaining change. She further argues that the WHO (1984) definition of health necessitates this change in the strategies which enable people to take control over their health.

Evaluation

Program evaluation is an important method in health promotion research for building bridges between researchers on one hand and practitioners and policy makers on the other. Several evaluation paradigms are put forward by policy and program analyst, Joy Thompson (1992). She refers to four main paradigms, detailed by Smith and Glass, with respect to description; how they differ in their conceptions as to what evaluation is; what the relationship with the primary client and other stakeholders should be; who should be making the relevant value judgements regarding the program; and, the criteria for judging the evaluation study itself.

Evaluation as synonymous with applied research is the perspective of the first paradigm. Research methods used in this paradigm are: comparative studies; true field experiments; randomized clinical trials; and, quasi-experiments. The evaluation is mostly summative, comparative, quantitative and targeted at one primary official policy maker.

The second paradigm is evaluation research to aid managers in the administration of the program being evaluated. The research methods tend to include: surveys of decision makers; client satisfaction surveys; surveys of educational achievement or use of goal attainment scaling procedures; and, cost analysis and monitoring of program processes. This formative evaluation is of interest to managers as part of systems management and in particular discrepancies between the stated objectives and performance.

The professional judgement paradigm relies on those identified as most expert to make judgements about the quality of a program. Methods used are: direct observation; checklists; and, interviews of clients by experts. This evaluation is usually targeted to program administrators or the profession in general. An example is the accreditation model.

The fourth paradigm adopts the perspective that evaluation and politics are inextricably mixed. Thompson (1992) names this the evaluation-as-politics paradigm which she argues characterizes Cronbach's approach to program evaluation. These research studies, as described by Smith and Glass and cited by Thompson, take into consideration all major stakeholders (i.e., researchers, practitioners, policy makers). The role they play may be one of maintaining, modifying or eliminating the program.

Although identifying who they are varies with perspective, evaluation research studies are not directed only to one all-powerful decision maker. The results of the evaluation are directed to all stakeholders.

Thompson (1992) raises the issue of dissatisfaction of many evaluators with the little impact that their evaluation research has on the decisions of policy makers. Is this because of poor research design or methods or is it because the underlying assumption that program managers and decision makers are rational and will make the best decision once the results are available is often not met?

The health promotion concept, itself poses difficulties for the evaluation research process. As health promotion moved from the "lifestyle modification" focus to the more socio-ecological concept "achieving health for all", responsibility shifted from a primarily individual to a combined responsibility of the individual (behaviour change approaches), social and political (policy approaches) and environmental interventions for health. It is the argument of Thompson (1992) that health promotion evaluation research requires multiple strategies (interdisciplinary) that combine individual development with environmental intervention, policy development and effective public participation. Evaluation questions that need to be included in evaluation research of health promotion are: Is it responding to the people's needs; will it reduce inequities or will it assist only the middle class; and, does it include living and working conditions or is it focused on lifestyle. The author recommends that the researcher become a participant in the political arena along with other stakeholder groups. For example, the evaluator can take a lead role in program development research or

mediate between different stakeholder groups which Thompson argues is a far cry from the neutral, scientific observer evaluator role.

Higgins and Green (1994) applied the American Public Health Association (APHA) criteria for development of health promotion programs to four healthy community projects in British Columbia (B.C.), Canada. Healthy communities, a Canadian initiative encouraged local municipal action around broadly defined health problems. The authors found that the healthy communities experience accorded best with the APHA criteria in the following three areas: intersectoral (collaborative, balanced power, core committee shared vision, networks of multiple sectors of the community); involvement (local citizens with a voice in municipal planning and decision-making); and, interest (public and politicians committed to the concept of healthy communities and working together toward a common vision by mobilizing local resources).

The B.C. experience of healthy communities and the APHA criteria differed on the following points: specificity of risk factor targets; measurability and modifiability of the targets; specificity of the interventions in relation to risk factor targets; and, evaluation of process and results (Higgins & Green, 1994). They cite Hancock and Hendler who suggest that the healthy communities concept can be deemed a success solely on the amount of critical thinking and dialogue it generated.

Fincham (1992) reviewed several health promotion/ disease prevention programs that were community-based. This author argues that there is a wealth of material published on the mechanics and theory of community-based health promotion programs. The limitation, according to Fincham, is the lack of evidence linking

theory, practice, and outcome. An argument is made that in order to further our understanding of community programs, more basic research is needed to investigate the relations between the process of change, the target of change, and both short and long term outcomes. So far, the levels of success of community programs reported are modest.

Hayward et al. (1996) present several perspectives on the barriers to the production and dissemination of outcomes data. They argue that a conceptual shift has occurred and the impact of health care is now being measured by health outcomes and no longer by elements of structure and process. They explore the idea of precursors to research-based practice and policy in terms of education and funding, and access to implementation. They argue that the pool of public health graduates in Canada remains small, limiting the pool of practitioners prepared to do research. They identify the need for committed funding for community-based studies. They present the fact that the gap between the information "haves" and "have nots" is widening because of the growing dependence on information technology which is rapidly developing. These authors make several comments about the experimental method in public health nursing. Their argument raises questions about the appropriateness of randomized controlled trial which is adapted from clinical research; especially, when assessing levels of evidence, the realities of community-based practice, the social role of public health, and its philosophical roots need to be considered. It is important to keep in mind that outcomes occur at different levels (individual to community). Methodological issues arise at the different levels of interventions. They argue that public health not only encourages but shapes social change and this is a complex and

least measurable effect of public health activity. The difficulty of randomizing in public health, according to these authors, is because there are no clear lines between research, clinical activity, and public policy. The protection of subjects is open and the variation wide. Considering community-wide strategies, client empowerment, and community development, the attribution of specific outcomes to specific interventions is going to be more difficult. As public health practitioners argue that the paradigm of the natural sciences, including randomized controlled trials (RCTs), can not measure the outcomes of their work, alternative paradigms are being developed which include social sciences and health promotion concepts, feminist theory, and anthropology. Included in the scientific debate should be the political and social debate (what is valued as an outcome, how it should be measured, and by whom).

Barriball and Mackenzie (1993), within the context of the British National Health Service (NHS) which is responsible for the delivery of health care services and securing consumer health gains, reviewed the literature on measuring the impact of nursing interventions in the community. These authors found that not a lot of progress has been made in measuring the impact of their work. They argue that it is not enough for nurses practicing in the community to act only as sources of information. They need to analyze the information they collect and use the results to guide their own practice and to demonstrate to others the effectiveness of services. They cite the work of Clark who argues that measuring the effectiveness of care for an activity as interactive as nursing is complicated. Clark further argues that for the discovery of an outcome to be beneficial one needs to know what factors are necessary for it to happen (structure) and how it was achieved (process). The work of Donabedian is

cited whereby the framework structure, process, and outcome has been a valuable approach to measuring the impact of nursing interventions. Again, the relationship of structure, process, and outcome is arguably complicated. The significance of one to the other is often unclear.

Barriball and Mackenzie (1993) argue for further research to test the usefulness of structure, process, and outcome to nurses measuring the impact of their interventions. They argue for nurses in the community measuring the impact of preventive care, health education, and health promotion. They acknowledge that the long term results of these types of interventions plus the influence of social or environmental factors on health status being beyond the control of health care professionals--present problems for measuring impact. They refer to the work of Clark who has discussed value conflict in terms of "dimensions of value."She discusses that a purchaser may link effectiveness with cost, a provider with the outcome of treatment and a consumer with comfort and convenience. A reduction in cost may reduce the quality of care. By maximizing convenience for the consumer, the effectiveness of treatment may be reduced. The different interests need to be acknowledged. Barriball and Mackenzie conclude, after reviewing the literature including user surveys and consumer satisfaction studies, that research is needed to test reliable and valid methods of outcome measurement.

How Much Data?

In a discussion about nutrition and health policy in the United States (U.S.), Elizabeth Barrett-Connor (1987) identifies a peculiarity of nutrition policy in that it is directly proportional to the amount of data; the larger the data base, the greater the

controversy. The question of when are the data sufficient for policy is raised by this author. To answer the question one needs to determine only whether the data can ever be totally satisfactory or satisfying--is conclusive evidence of benefit possible? The author concludes that in relation to nutrition and health in the near future, it is unlikely that any clear-cut experimental evidence, desired by all, will be produced. The epidemiology approach is supported, for example, to determine whether proposed diet changes improve health and longevity in populations. Utilizing case, cohort, and geographical studies, this author believes is the best approach to establish effective guidelines for population goals and public policy for health promotion. The author strongly suggests that junior and senior scientists (epidemiologists) need more training in the application of data to health policy recommendations. "The goal of nutrition policy should be a public educated to choose wisely, or at least as wisely as we know how" (p. 11).

Social Systems Level

It is the argument of McKinlay (1992) that there is no right or wrong methodological approach in health promotion research; appropriateness to the purposes must be the central concern. The author advocates the need for health promotion work to move from the individual to the level of the social system (government, organizations, and providers). When the focus is on the individual and voluntary lifestyle changes, for example, quantitative methods generally work best but when the emphasis shifts to the social system level, they are not always useful or adaptable. Process evaluation in health promotion research is cited as an example where qualitative approaches are more appropriate than quantitative methods. When

monitoring program implementation, if no effect is observed, the following questions can be answered: Is there no effect because the program was not properly implemented; is there no effect because the program could not be fully implemented for some subjects; and, is there no effect because of barriers to program access. When a beneficial effect is observed, process evaluation can answer the following questions: "Is the effect actually due to the program or due to the receptivity of selected subjects or target groups; is the effect actually due to the program or is it due to other competing interventions" (p. S17).

In a 1993 article, McKinlay further argues for health promotion efforts to move from the level of the individual to aspects of the social system (organizations, communities, and broader social policy). This author recommends the use of "appropriate methodology", appropriate to the purpose of the study. The traditional quantitative approaches (social surveys and experimental designs) require adaptation and refinement when the mechanism for health promotion is socio-political change. For this reason, the author supports the role of qualitative research (ethnographic interviewing, participant observation and case studies).

An argument for organizational health (a booster for local public health agencies) is put forward by Chambers (1992). This author argues that public health agencies should be role models for agencies, including hospitals, in their communities in ensuring the implementation of the principles of the new public health (promotion of health in many areas, i.e., community development and voluntary sector activity). The task of staff in these agencies is to fight collectively the tendency of their agencies towards organizational disarray. Toward this end, this author argues that

there is a need for the following changes: promoting the public's health by a broad range of people and even communities themselves; incorporating the cultural values of diverse groups; reorientation and learning by staff; the challenges facing communities as to the trade-offs between treatment versus preventive strategies; the need for public health professionals to speak out on sensitive political issues (understand the political process of change); ethical accountability (is to citizens in the community, not to the employer); freedom of public health professionals to exercise professional judgement; and, measuring effective organizational processes by the product--"the lives of the clients" (the product must be evaluated in part, at least, from the perspective of the client, requiring the need for a user-focused model rooted in outcome measures and responsive to client needs and aspirations).

In summary, several authors have identified a trend toward a constructivist model for health promotion research. This shift from the medical model reflects changes in epistemology, methodology, and method in the health promotion field. As conceptual and theoretical frameworks are developed, many questions about epistemology, methodology, and method persist. Some of these questions have been identified in the literature about health promotion research, policy analysis, and healthy public policy.

A shift in the transition from individual level to social systems level, i.e., government, organizations, providers, in the health promotion field was identified in the literature. This extends the scientific debate to include the political and social debate. A trend was identified in the literature for "community involvement" and "community-based" programs. For example, it was identified that evaluation research

has had little impact on policy makers. Arguments were made for the involvement of clients in evaluation research. A recommendation was made for community health nurses to use the framework of structure, process, and outcome to measure the impact of nursing interventions. The complicated nature of outcome measurement was acknowledged and further research suggested.

Feminist Research

Feminist research methodology and health promotion policy is a link seldom made in the literature. One author writes about the importance of this connection and in particular the gender aspect. Arguments are made in the literature for gender as a determinant of health. The enrichment of policy when sensitivity to gender is actively demonstrated is articulated. Further research on gender as a determinant of health is recommended.

Gender

In the literature review, Juanne Clarke (1992) offers a critique of the methods used in health promotion research from the perspective of feminist methodology. Clarke's article in my literature review was identified in both the categories of health promotion policy and feminist research methodology.

Clarke (1992) writes that "health promotion is actually the generic and the most ancient health policy known and pursued" (p. S54). She describes the major role that the state plays in the health promotion of its citizens who are members of a society that is experiencing a highly developed capitalist, industrialized and post-industrial economic situation. Government policy even specifies the definition of health. The author contributes the Canadian emphasis on health promotion to the Lalonde

document (1974). The subsequent Epp document (1986) provided the Canadian public with a more contemporary definition of health.

Clarke (1992) acknowledges, as do the arguments of many authors, that positivism is the traditional method of health promotion research. Even though the focus is on human behaviour and its change, the research methods come from the discipline of physics in the natural sciences. This same origin applies to research in the social sciences where positivism became the classic model of research. This model of science was developed as a "method of knowing" by a small and radical group rejecting reliance on authority and tradition. It has become a bureaucratic, specialized complex, sponsored by governments and the military.

In her research, Clarke (1992) often engaged in the methodologies of positivism, consisting of large surveys based on representative samples of the population. Each unit gets the same questions, which then are treated as objects, compared and counted. The author cites Canada's 1985 Active Health Report as an example of a positivist, survey-type approach.

Several challenges to the assumption of the classic positivist research approach are identified by Clarke (1992). One addresses the challenge that came from the sociologists of the interactionist tradition (stressing the "meaning" of events, of language, of the world of social actors). The second challenge Clarke argues has come from the work of Kuhn on the history of science. The argument is that science is the acquisition of more and more truth. When normal science methods are repeated and anomalies emerge in sufficient number, a new paradigm develops. Clarke cites Smith who argues that numerous anomalies have occurred which has led to feminist theory

and methods among other methodological and theoretical developments. The last challenge came from the women's movement. Clarke argues that feminism's approach to science arises from the critiques of the traditional scientific model. The feminist approach questions objectivity, acknowledges meaning, the construction of meaning and the social position of those who are doing the meaning-constructing. It values the experience and position of women as a focus of study. Feminists recognize that there are health experiences that are unique to each gender, in worlds that are different and unequal. The different cultural worlds of men and women affect their language. The author argues that, traditionally, in social research, the male world has experienced privilege.

Clarke (1992) applies feminist theory and research methodology to critique the Health Promotion Survey document. She argues that the survey, conceptually, ignores the differences in health concerns of men and women. There is no discussion of gender significance in the population or designated sample. The author criticizes the data collection instrument for lack of evidence that the questions took into consideration language, nor did it focus on concerns that were most appropriate to Canadians in the 1990s. This argument is a powerful one because Clarke moves on to ask the next question, how is the information used? The answer is that biased findings, oblivious to gender differences, contributed to policy formation for health promotion. Hence, questions about women's health were not asked. The results are federal government policy (Epp, 1986) where the gender bias of the threats to health and of the health promotion strategies is unnoticed. Three threats to health are gender-related: economic inequities; preventable disease and accidents; and, chronic mental

and physical health. The author argues that the strategies to promote health such as mutual aid and self-care result in a greater workload for women. Clarke (1992) further argues for gender to be considered in all phases of health promotion research and for the initiation of preliminary exploratory research that distinguishes between the health concerns of men and women that is relevant in language and meaning to each of their real-life experiences.

Abby Hoffman (1997) argues for gender to be accorded its proper place as an important consideration in the policy making process. In her keynote address to the Fifth National Health Promotion Research Conference, she spoke about gender as a determinant of health and how health policy might be influenced if gender were more consciously taken into account as part of the policy making process. It is her view that gender, the array of socially determined roles, personality traits, attitudes, behaviours, values, and in particular the relative power and influence that society ascribes to males and females on a differential basis, has not been accepted into the health determinants literature as a serious concept. "Gender is so powerful and so pervasive an influence that it warrants consideration as a determinant in and of itself" (p. 9).

Over time, progressive work has been done on determinants of health but Hoffman (1997) argues that this progress did not come easy. She cites a 1994 policy document, Strategies For Population Health: Investing In the Health of Canadians, produced by the federal, provincial and territorial Ministers of Health. Regrettably a decision was taken not to include gender as a specific concept in the report. However the Women's Health Bureau, Health Canada worked to have added to Health Canada's documentation on population health, a statement which says that Health Canada also

believes that gender and culture are important determinants of health. In support of gender as a determinant, Hoffman encourages expansion of the concept of gender to explain the health status of both males and females.

Further, Hoffman (1997) acknowledges that buying into a notion of gender as a determinant of health, automatically makes one an advocate for women's equality. She argues that implicit in the concept of gender is the view that the social and cultural situation of women impedes their retainment of equality, and conversely that their unequal status impedes their retainment of good health. She refers to the Platform for Action, adopted at the Fourth United Nations World Conference on Women in Beijing in 1995, as making this link between gender, equality and health.

In summary and with respect to policy, Hoffman (1997) argues that the real challenge is "to inject into the policy making process consideration of the potential benefits and risks to women of possible policy options before final policy choices are made" (p. 14). What is needed she says, will be active demonstrations of the fact that gender analysis and sensitivity to gender enriches policy and brings new insight.

In February, 1996, a document entitled Population Health Promotion: An Integrated Model of Population Health and Health Promotion was prepared by Hamilton and Bhatti, Health Promotion Development Division, Health Canada. In this document, the authors discuss the relationship between health promotion and population health. They refer to health promotion as, a process for enabling people to take control over and improve their health. Population health they define as, an approach that addresses the entire range of factors that determine health and, by so doing, affects the health of the entire population. They include in their model the

determinants of health as identified in the document Strategies for Population Health: Investing in the Health of Canadians (1994). Gender is not identified as one of the determinants nor is it mentioned in the document. Perhaps gender is considered synonymous with biological sex which is consistent with the traditional biomedical perspective of health determinants. This serves to underscore the argument by Abby Hoffman (1997) that gender needs to be taken seriously as a determinant of health, in and of itself. The integrated model incorporates the areas for action as identified in the Ottawa Charter (1986) and the various levels in society at which action can be taken. These authors acknowledge the need for ongoing examination of the factors that determine health and the strategies by which the determinants can be influenced. Evidence-based decision making is emphasized and the following sources identified: research studies, experiential knowledge, and evaluation studies.

Davidson et al. (1997) in a synthesis paper explore gender and health as multidimensional constructs. They argue that in the traditional biomedical perspective of health determinants, the possibility that particular determinants, such as gender may influence other determinants such as health services, is often overlooked. They further explain that the National Discussion Group (NDG) of the new Centres of Excellence for Women's Health (CEWH) recognizes that gender is a determinant of health and has developed descriptors of each of the non-medical determinants of women's health status, health behaviour and health services use. They have delineated their application to women and their linkages with other health determinants. The NDG acknowledged that gender, class, and culture permeate the other determinants. These authors argue that there are certain levels at which health determinants may be modifiable and they

present a grid to explore their perspective (psychosocial and modifiable; sociodemographic and somewhat modifiable; and biological and not modifiable). These authors developed checklists for researchers and policy makers so that they can consider the complex way that gender and other health determinants influence health outcomes.

The relationship between gender and other determinants of health, particularly income is the subject of a synthesis paper by Love et al. (1997). The purpose of their paper is to forge links between the dominant paradigms in social epidemiological research and critical, feminist scholarship. They argue for a critical perspective into research itself (who controls the research agenda, the data, the analysis, the release of findings, and the timetable). Following a review of two texts Why are Some People Healthy and Others Not (1994) by Robert Evans et al. and Unhealthy Societies: The Afflictions of Inequality (1996) by Richard Wilkinson, they identify policy and research implications. They agree with the authors of both texts that it is important to examine the non-medical determinants of health. Love et al. support the view that the analysis of social determinants of health is incomplete when gender is not taken into account. They argue that the proposals for policy or further research arising for the analysis of the pattern of morbidity and mortality must consider not only the contributions of income but as well the social and political issues creating the gendered access to and distribution of wealth and other resources. They argue for continued study and activism of the persistence of the gendered and racially divided division of labour, both in the household and in the paid workforce. They suggest that special attention be given to the gendered division of caring. They cite the work of

Baines et al. who challenge the assumption that women are "natural" care-givers which ignores the social construction of gender with unhappy consequences for everyone. Kaufert argues for further research on gender and the determinants of health (as cited in Love et al., 1997). She finds that we have little information on "power and authority" as elements of job satisfaction for women most likely because the researchers assume that these are not characteristics of women's work.

Interdisciplinary Research

Several sub-themes such as political and social theory, concept of health, and research teams were located in the theme of interdisciplinary research.

Political and Social Theory

Stevenson and Burke (1992) critique health promotion research from the perspective of the contemporary political sociology of new social movements. They argue for a systematic and rigorous research practice, coherent theoretical models of health, and close connection with the developments in political and social theory. They claim that social and political considerations need to be brought into planning meaningful changes for health. If they did, the health promotion discourse would include crucial questions such as class, gender, race and other social divisions.

Locating health promotion in the post-modern discourse of new social movements, they argue, has theoretical limits. On one hand, there is a retreat from politics and the state and the problematic conceptualization of community development. On the other hand, in contrast to other new social movements, including the women's movement, the origins of the health promotion movement lie within rather than outside the state. Stevenson and Burke suggest that such a restricted social

base results in political limits to health promotion research. There is a tendency for bureaucratic logic to prevail and for new policy initiatives to be founded in "ready-to-use" measures of health promotion and in community-defined health promotion needs. The authors argue that no redefinition of health or health policy has resulted from either approach. The research, when the health promotion movement shares the discourse of new social movements but not the social base, is contradictory. The research direction they see does not lie in post-modern theory or phenomenological discovery of the diverse meanings communities assign to their health experiences. These authors argue that uncritical adoption of these approaches would "lead to a confused and unfocussed research practice and to a profound depoliticization of the struggle for health" (p. S48).

Additional support of a paradigm shift for health promotion research is offered by Poland (1992) who argues that there needs to be a rethinking of the paradigms of inquiry used in the design and evaluation of health promotion interventions. Poland's thesis is that the theoretical and methodological issues in health promotion would benefit from guidance provided by social theory and its struggles. As argued by the previous two authors, he believes critical analysis is needed to make explicit the political agenda. For example, who has the authority for defining and measuring needs, how is this socially sanctioned, and how are the biases of the authority translated into the design, implementation and evaluation of interventions. Poland identifies the primary areas of debate in the social theory literature as follows: the admissibility of subjective data as "evidence"; the relative influence of structure (the social) or of agency (the individual) in determining human action; the basis for

deriving generalizable "laws" about the social world; the explaining of social phenomena in the context of history; the role of "rationality" in structuring human behaviour; whether social theory and research should maintain a normative or else a positive stance; and, the proper relationship of theory to method.

As a new methodology for health promotion research, Poland (1992) puts forward a model of critical interpretive research. Freire's work in critical education is cited as an example. Facilitating critical consciousness requires fostering people's critical awareness of the root causes of problems they face which are embedded in culture. Applying this method to focus groups can raise the level of discussion and achieve a more complex synthesis of competing perspectives. The results are rich, grounded data and empowered participants. The author argues that meaningful social change requires first an understanding of the people, where they are coming from, their agendas and vocabularies, and experiences of "oppression". The second step is to facilitate the germination of critical consciousness, which is viewed by Poland to be an agenda of empowerment. Poland raises the question as to what degree research methodology and ethical practice of health promotion should be seen as separate exercises. "Should we demand that where possible research itself be empowering and emancipating?" (p. S43).

Casswell (1988) calls for the health promotion research activity that goes beyond the provision of epidemiological data, one that requires a combination of disciplinary methods and theoretical approaches especially from the social sciences. Concentration on epidemiological approaches to research this author believes constrains the development of research for health promotion's needs. "Epidemiological data . . .

have not represented the context of the process which precedes the sickness, and do not either inform the process by which change can occur, or measure the impact of change appropriately" (p. 716). The author further argues that the goals of health promotion are to delineate these processes and evaluate the impact of change at all levels (individual, family, social groups and the government--where decisions about public policies which impact on health are made).

Casswell (1988) acknowledges a distinction between health promotion research and other health related research in that the former has a greater action orientation and a closer link with programs and policies. The author recognizes the significance of both qualitative and quantitative methods in health promotion research. The theoretical perspectives and methods of sociology, community psychology, political science and economics need to be included for their contributions to health promotion research. Public participation is called for and qualitative research methods which provide the perspective of the public on health issues. In addition, "a closer than typical relationship of the researcher with those responsible for programme development and implementation will be necessary for health promotion to fulfil its potential" (p. 717). Casswell recognizes that this approach requires a rare combination of skills from health promotion researchers. As well, long term funding may be endangered in part because of the unmet expectations about what such research can achieve.

Concept of Health

Stachtchenko and Jenicek (1990) argue that as long as health was measured by the absence of disease, it was relatively easy to evaluate preventive, diagnostic, and

therapeutic interventions. The scientific work focused on the causes of disease and on pathogenesis. However, a segment of the literature on health promotion expressed dissatisfaction with the traditional biomedical model of health and its emphasis on the prevention of health problems. They refer to the WHO constitution (1947) where health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The idea that health is seen as a resource for everyday life, not the object of living (Epp, 1986), demands new public health strategies. Consequently, this has research implications for the interaction between individuals and their social and physical environment. Stachtchenko and Jenicek (1990) argue that program initiatives that incorporate both policy and educational components are likely to be the approaches to health promotion of the future. "On the one hand health promotion represents a new strategy within the health and social fields, a political strategy directed towards policy and, on the other hand, as an enabling approach to health directed at lifestyles" (p. 54).

Uncertainties in the health promotion field are acknowledged by Stachtchenko and Jenicek (1990). They express concern that the difficulty in defining and applying the concept of health can have serious implications for health promotion policy: "Policies may be formulated too vaguely, or the policy goal may be stated too vaguely, or the policy goal may be stated too narrowly" (p. 58). It is their argument that research approaches i.e., evaluation of health promotion programs, need to be broad enough to include the range of activities in health promotion (politics, advertising, health education, advocacy for health and healthy living, economics, community development). They conclude that in the area of measurement of health

and health promotion programs, further research is needed which draws on the established epidemiological and social science knowledge and methodology and the work of other disciplines.

A model of health depicted as a nested model is provided by Collins (1995). The author offers this model as an alternative way to conceptualize health. This model is designed in two parts. One part is the individual model. It is comprised of five broad categories (environments of health determinants). These include: psycho-social environment (e.g., social support); micro-physical environment (e.g., indoor air quality, housing); race/class/gender environment (e.g., social construction of gender, education level); behavioral environment (e.g., alcohol use, fitness); and, the work environment (e.g., physical and chemical hazards, workplace demands). In theory, the health of the individual located at the centre of the model will be affected by some combination of the factors identified plus the biological makeup of that person. The second model, the community model, allows for the individual model to be nested within it, at the centre, of the community determinants of health model. The community model has four broad categories of factors influencing health. These include: the political and economic climate, within which the community is located (e.g., global political trends, power sharing within a support group); the macro-physical environment (e.g., outdoor air quality, contamination of food sources); degree of social justice and equity in the community (e.g., fair income distribution, publicly insured health care); and, the extent of community control and cohesiveness (e.g., existence of vibrant community groups addressing community identified needs, community involvement in local planning). In both models, this author argues there is

inter-relatedness of the categories and a reciprocal relationship between the two models. The two levels of activity (individual and community) where health interventions can occur, represented as a model within a model, asserts the importance of multiple factors and their dynamic relationships (logically linked and inter-dependent) effecting individual and community health. Community is conceptualized as "an aggregation of individuals with some shared experience" (p. 320). It could refer to a geographic community (neighbourhoods), cultural community (women's groups) or societal community (Canadians). Collins argues that the strength of the "model within a model" conceptualization of health arises not from its components, but in the way these determinants of health are organized into interactive, nested "levels" of activity.

Research Teams

The specific role that Universities can play in research and public policy development is addressed by Torrens, Breslow, and Fielding (1982). The authors recommend that universities establish truly interdisciplinary research teams and establish interdisciplinary research laboratories. As well, there is a need, they identify, for a neutral body to determine the implications of research findings for future public policy and to make them explicit (what is possible and valuable). This same body could develop mechanisms for dissemination of the results so that the findings are readily available to policy makers.

The report, Promoting Heart Health in Canada (as cited in O'Connor & Petrasovits, 1992) was the way that heart health policy at the national level originated

in Canada. The report was developed based on scientific and epidemiological data as well as experience in clinical and community settings.

The public health systems in Canadian provinces conducted heart health surveys. These surveys provided a scientific baseline for assessing the risk of cardiovascular disease in the population as a whole. The findings identified that two out of three Canadian adults have one or more of the major risk factors--thus confirming the need for a public health approach to heart health. The findings provided a basis for planning and evaluating community-level interventions. As part of the Canadian Heart Health Initiative (Health and Welfare Canada, 1992), 10 provincial heart health demonstration programs are in place. The heart health programs are grounded in the principles of community participation and ownership, and the mobilization of community resources. Principal investigators in each province are responsible for the progress in their respective provinces and are known as the agents of change. The task of developing a research intervention protocol in each province with coalition members and that meets the requirements of the provincial and federal funding agencies is a challenging one. It is anticipated that documentation and process evaluation of the community interventions will make a significant contribution in the field of heart health. This Canadian initiative is founded on science, policy and community.

One of the debates that surfaces, is how much scientific research is needed before public health intervention is justified. Historically, public health has gone ahead with interventions before a firm basis was established as long as it was felt that more good than harm would be done.

O'Connor and Petrasovits (1992) advocate for more collaborative opportunities for scientists and public health practitioners to work together, sharing scientific and clinical perspectives. There is a need for those who work in public health to develop skills for translating scientific findings and communicating them to policy makers and the general public.

In summary, an argument was made for political and social theory to be brought to health promotion research. This would ensure that class, gender, and race are brought to the health promotion discourse. Ensuring that this includes making explicit the political agenda was deemed important. An argument was made for research itself, to be empowering and emancipating. A combination of disciplinary methods and theoretical approaches for health promotion research was supported. The action orientation of health promotion research and the link with programs and policies was articulated. In the area of measurement of health and health promotion programs, an argument was made for research to draw on the work of other disciplines. The need for interdisciplinary research teams was established.

Empowerment

The need for research to retain the "people" perspective is presented by several authors. Community participation, it is argued, can not be separated from the wider concept of political and organizational life. The importance of marginalized groups being involved in community development and empowerment is identified in research findings. The need for critical social theories to be taught in nursing education programs is suggested.

Communities

Raeburn (1992) identifies the danger in health promotion research for researchers to lose the people perspective. In general, "research is regarded as an endeavour which is value-free, objective, technological, reductionist and driven by a desire for knowledge" (p. S20). The model option suggested by Raeburn is "action by people to meet their own self-determined positive health and wellbeing goals pursued through personal, group and community development in a context of supportive policies, resources and environments" (p. S21). In support of this model, Raeburn offers four principles for health promotion research, as follows: Adopt a community perspective (local-interest or culture-based groups of individuals working together on common goals); have an empowering philosophy (the people being studied have a meaningful stake in what is going on); start with individual and group needs and wishes (the need to know what the population of interest wants for themselves rather than the population being "done to"); and, use simple and meaningful data and evaluation systems (research methods such as "naturalistic"--quasi-experimental, survey, qualitative, participatory, ethnographic). Again the issue of what constitutes a "scientific" enterprise surfaces, as who is going to fund and publish research that first and foremost serves the interests of the people not our academic journals or public funding issues or research colleagues. "We must not allow the propensity of science, research technology and even of health promotion policy to depersonalize people and get in the way" (p. S23).

It is the argument of Steven Shea (1992) that the research agenda for community health needs to address the challenge of dissemination for both funding agencies and

the research community. He says that, in research reports, it is the perspective of research, not community action that dominates the literature. This author acknowledges the academic discipline bias towards researchers publishing in the scientific literature and the publication bias towards quantitative research findings. "More than elegant research is needed for successful community programs and good public health practice" (p. 786). In the community model which focuses on mobilizing a broad range of people and organizations outside the health care system there is potential for the participation and contributions of both universities (academic) and health departments (community).

Brown (1994) reports on a study conducted in the United Kingdom (U.K.) where primary care increasingly centers on general practice. Practice teams in inner city Sheffield were involved mainly through the use of interviews with 23 general practitioners, 30 practice nurses, 11 health visitors, and 7 district nurses. The study design utilized a grounded theory approach to explore concepts of community and participation. The author discusses a number of tensions and issues concerning community participation when primary care is organized around general practice (a medical practitioner's list of registered patients). Several practitioners expressed their feeling of a tension concerning the degree of coherence between the practice boundaries and their sense of a local community. A tension emerged between the practice list of registered patients as the organizational basis of community and other concepts of community. What became clear is that the organization of general practice is in many ways the organization of community and therefore the organization of who participates. Two dimensions of participation uncovered were, individual-collective

dimension and professional control-lay control. In the first instance, individual participation has to do with taking up the mechanisms of information, choice, and consultation. In the second instance, collective approaches have a greater prominence (WHO, 1978 policies and many community development initiatives). Patient participation groups can be located somewhere between. A tension existed for professionals about the amount of control they hold in any participation activities. Another tension became evident and that was the tension between professionals and lay participants. The importance of marginalized groups, i.e., single parents and people with disabilities being involved in community development and empowerment was emphasized in the findings. The author also found a tension between the practice list and community, a locality with a related tension between disciplines who have different origins and roles in defining community, i.e., the attachment of health visitors to general practice teams (some resistance at the anticipated loss of a community dimension to their work).

Brown (1994) concludes that as a number of disparate concepts of community emerged, it is surely important that people define their own communities and that organizations be flexible enough to interact with the plurality of communities and yet prioritize those with greatest need. The argument that developments in community must be accompanied by changes in organizations so that the latter are receptive and flexible for people to participate. This author argues that any concept of community participation cannot be separated from the wider concept of political and organizational life. Both concepts of community and participation are contested

concepts. Based on the findings of this study, Brown puts forward a tentative definition as follows:

> Community participation concerns a social and political process founded in part upon individual rights to choice, information and consultation but including other tangible collective mechanisms and rights of involvement and voice along with organizational and community development strategies that enable the participation of all groups in society. (p. 343)

Fulton (1997) reports on a study which describes British nurses' views on the concept of empowerment. The theoretical framework was comprised of critical social theory and the work of Freire and Habermas (as cited in Fulton, 1997). The participants (n=16) comprised two focus groups with eight nurses in each group. The nurses were a mix of experienced and newly qualified nurses from a variety of settings. A thematic approach to taped interview transcriptions (using open ended questions) was brought to the analysis of data. Four categories emerged from the data and they provided the framework for the emerging themes. The categories and themes are as follows: empowerment (decision making, choice, authority); having personal power (assertiveness, knowledge and experience, negative connotations); relationships within the multidisciplinary team (medical power, autonomy in relation to medical staff, autonomy within the multidisciplinary team); and, feeling right about oneself (confidence, low self esteem, being manipulative). "Member checks" were applied by having one participant from each focus group read the preliminary report and confirm it as a true account. These study findings suggest that nurses in this study showed signs of being oppressed and striving for liberation. Fulton concludes that critical social theories as an empowerment paradigm need to be taught in the education of

nurses. Toward this end, this study was a precursor to an Empowerment for Practice unit offered at Southhampton University School of Nursing and Midwifery.

Chalmers and Bramadat (1996) argue in support of participatory or action research. When defining participatory research, they refer to the work of Kirkpatrick, and Brown. Participatory research is defined as, "a strategy that brings researchers and local participants together in joint inquiry, education and action on problems of mutual interest" (p. 723). Chalmers and Bramadat view participatory research as another means of facilitating community development through empowerment. The community acquires data that can be used in processes to facilitate change.

Health Promotion Policy: Programs

Several themes are discussed in the literature pertaining to health promotion policy and programs. These include: Interdisciplinary; Education; Community; Concept of Health; and, Informed Public Policy.

Interdisciplinary

Bringing a sociological approach to work site health promotion programs is the argument of Walsh (1988). Walsh notes that the literature on work site health promotion programs has been concentrated mostly in scientific journals on health education, occupational health, and public health. Sociological analysis of health promotion has been relatively rare. Some of Walsh's colleagues support the view that the "risk factor approach" to health promotion is limiting. Risk factors do increase the probability of becoming ill, but a risk factor approach ignores the physical, social and cultural environment. "Gender, marital status, and social class are among the most

robust variables social epidemiologists associate with patterns of disease" (p. 571). He argues for more refined descriptions by participants in their own definitions of both "fitness" and "health." Walsh recommends two research approaches for work site health. One is tightly-designed studies that seek to compare two or more different strategies aimed at achieving the same result. The other approach will address some of the broader sociological questions, using a combination of qualitative and quantitative techniques, conforming to accepted methodological standards and building on established sociological literature.

Pilisuk and Minkler (1985) take a political economy perspective in examining the issue of social support. Their argument is that a danger lies in the assumption that since supportive ties exist among individuals, families, neighbours, and small groups of people, self-help can be made to flourish despite major cutbacks in health and human services on the city, country, state or national levels. Given that social support is essential to health, then economic arrangements, individualistic values, and dispersed families mean that large numbers of people are at risk, especially when local communities are unable to provide any assistance. Pilisuk and Minkler further argue that the caregivers, historically women, are thus stretched in many roles i.e., participation in the labour force plus caring for a family member or neighbour, making it difficult for them to meet the needs of their immediate family.

Pilisuk and Minkler (1985) conclude that family and community effectiveness in the provision of social support is heavily dependent upon the broader economic and social environment. To over-emphasize the singular influence of social ties on health, and to ignore the broader context within which those social ties must operate, is to

misuse the findings on the relationship of social support to health. Health professionals need not only to educate people on the value of social ties but also the dependence of such ties on the larger political and social environment. "Health professionals need to work collectively as advocates for a less ruthless and more caring environment" (p. 104).

An example of an interdisciplinary research team initiative is provided by Friel, Hudson, Banoub, and Ross (1989). The disciplines were Science (Biochemistry), Nursing and Psychology. A study was done to determine the effect of a breast feeding promotional campaign on the attitudes and knowledge of adolescent females. Pre and post-campaign surveys and quantitative analysis of data were used. A total of 463 girls, 16 years of age, from grades 10-12 in two high schools, participated in the study. The breast feeding campaign ran for five weeks and included commercials in newspapers and on television. The researchers concluded that television positively influenced attitudes toward breast feeding.

The Canadian Heart Health Initiative (Health and Welfare Canada, 1992) is an example of research goals consisting of the development of a national data base on cardiovascular disease risk factors and the implementation, evaluation and diffusion of community-level demonstration programs. Additional impetus for the survey came from an earlier cardio-vascular disease risk factor survey conducted in Nova Scotia; it later served as a model for other provinces. This earlier survey was developed using a peer review process in which experts reviewed draft protocol at an open "critique session", also attended by representatives from the organizations and professional associations who would be involved in implementing the Nova Scotia survey. Besides

the prevalence of risk factors, data included people's awareness, knowledge, attitudes and behaviours concerning those risk factors. Each respondent was interviewed at home, and in addition made a clinic visit (2,000-2,400 individuals between 18-74 years of age in every province participated). All samples were representative of the adult population in the province concerned. Provincial public health nurses administered the questionnaires, took respondents' blood pressure, height and weight measurements and a blood sample for lipid analysis. Each province appointed a Data Interpretation Committee (DIC) to scrutinize the survey results. The presentation was made to the DIC by the Principal Investigator in each province. The DIC consisted of a chairperson and a panel of scientists, mostly from outside the province, who reviewed the methodology and the validity of the interpretation. The study report notes "the provincial departments of health assumed responsibility not only for the funding and conduct of the surveys, but also for making the required public health nursing staff available to do the work" (p. 11). The provincial data is compiled into a national data base--a key resource for research in epidemiology, policy development and program evaluation.

All 10 provincial health departments made commitments themselves to develop and implement a five-year heart health demonstration program. Funding came from provincial and federal National Health Research and Development Program (NHRDP) levels. All provinces adopted a public health multifactoral approach to cardiovascular disease prevention. Interventions included work site programs, school health programs, and public and professional education. All demonstration protocols were reviewed by on-site scientific panels convened by the NHRDP. For project evaluation,

the NHRDP requires that the programs have a scientifically valid component for evaluation (tracking systems to monitor, over the long term, cardiovascular disease mortality, morbidity and risk factors, and demonstration site level evaluation). The evaluation guidelines were developed by Health and Welfare Canada, and evaluation continually feeds back into the program.

Furthermore, policy implications of new technology and scientific knowledge for government, voluntary health organizations, the health professions and the private sector were discussed at the 1992 International Heart Health Conference in Victoria, Canada. Themes ranging from biomedical and epidemiological advances to community mobilization of resources were explored.

Education

The discipline of medicine received a challenge in the U.S. when Healthy People 2000 Objectives was issued by Dr. R. W. Sullivan (1992), Secretary of the Department of Health and Human Services. In the area of research basic biomedical research will include such projects as: development of a vaccine to prevent AIDS; knowledge gain about cancer and heart physiology to develop more effective treatments; and, improved understanding of the neurosciences. Clinical and behavioral research, it is recommended, should focus on how to effect change in the health-related behaviours of adolescents, minorities and the undereducated. A similar emphasis is also evident in Canada.

It is the argument of a team of health researchers in Australia (Coonan & Mendoza, 1990) that schools have considerable potential to address many of the inequities in health and social service delivery. These authors refer to the Ottawa

Charter for Health Promotion (WHO, 1986) as a reference point for the fundamental conditions for health such as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.

A profile of health education in Australia was provided through a survey of South Australian schools, sampling one in five schools. The survey investigated health education policy, community involvement and concerns, health education issues, staff, special needs/social justice, resources, health education barriers, curriculum content, and schools as healthy environments. Based on a response rate of 65%, it was found that 32% of schools had a health policy, 37% did not, and 31% did not or could not respond. Of the schools that had an education policy, 29% believed their health education policy reflected the needs and concerns of the community, while 24% did not. Forty-seven percent of schools did not answer the question and many of these indicated they were uncertain of community needs and concerns. Based on these and other findings of this research project, Coonan and Mendoza (1990) conclude that new models for health promotion in schools are required. These models must be intersectoral, multidisciplinary, must involve the whole family unit, and must use special focus campaigns.

Policy development was part of the 1991 World Health Organization, United Nations Educational, Scientific, and Cultural Organization, and United Nations International Children's Emergency Fund sponsored Consultation on Strategies for Implementing Comprehensive School Health Education/ Promotion Programs held in Geneva. At that time a strategic plan for policy development was formulated. The plan included: activating a nucleus of committed individuals to initiate the process and

advocate for school health education; gaining an understanding of how national policies are developed and assigned priority; identifying key decision makers and determining how they can be reached; gathering data to include health problems of children and teens; gathering evidence on effective interventions in schools so that it can be used by political parties and governments and for background papers, documents and forums; organizing and presenting data to policy decision makers; forming alliances with initial stakeholders (parents, teachers) and influential groups (religious and political figures), organizations and institutions, the media, non-governmental organizations (NGOs), women, youth and teacher organizations; developing collaborative arrangements between education and health; intersectoral collaboration (social welfare, communications, food and agriculture, housing, industry, transportation); securing human, material, financial and community resources; and, stimulating the interest of international organizations, foundations, business and professional groups. The documented linkages between the health status of children and their level of education is only one of several convincing arguments for the bridging of education and health discipline boundaries.

United Nations (UN) agencies have made a significant contribution to health policy on a global scale. Their process is inclusive of key players in policy development. Although the UN agencies work on a global scale, their methods can be applied to smaller communities.

It is the argument of Mullen et al. (1995) that settings (communities, schools, work places, health care sites) are an important dimension in health education/ promotion policy, programs, and research about program needs, feasibility, efficacy,

and effectiveness. They concur that the settings used in research and practice are social structures and they provide channels/mechanisms of influence for reaching defined populations. Program developers capitalize on existing social structures rather than creating alternative structures. Intervening at the policy level to facilitate healthful choices is a possibility settings offer. "Settings often are the focus of funding and traditions of health education/health promotion practice and training" (p. 330).

Mullen et al. (1995) argue that settings play a large role in the evaluation of programs. "Settings influence the choice of indicator of success for health promotion, health education programs" (p. 330). The examples they give are: worksite programs have looked at cost-effectiveness and worker productivity indicators; and, health care programs have tended to use health status measures. When communities are the setting, these authors agree that policy making organizations within the community will receive the main attention because this represents an innovative direction for health education practice and research. Two of the gaps they identify in the literature are: the influence of policy relations between settings; and, approaches to marginal and special sub-groups.

Community

Reynolds and Chambers (1992) make the distinction between the "users" and the "producers" of community health information. Users, they say, must be able to access and use community health information in order to assess the need for health programs in their community and the impact of these programs. The necessary methodological and analytical skills for valid interpretation of community health information are often lacking. Producers, who collect and analyze community health information, often lack

information about the specific needs of the users. The community health information published in scientific journals often fails to reach potential users.

To meet the need for readable community health information, the Faculty of Health Sciences of McMaster University produced several community health information publications which they titled, Infowatch. For the purpose of monitoring and promoting the health of residents of Hamilton-Wentworth, these reports on specific community health topics were directed to local communities.

Reynolds and Chambers (1992) cite an example of how the Infowatch publications affected policy. The issue of child pedestrian injuries was addressed to neighbourhoods where child pedestrian injuries were high. As part of a community development project, problems and solutions were identified in the publications. This prompted a public meeting held by the local planning department where the publication information formed the basis for community dialogue. The authors put forward this initiative as a means of strengthening the link between health data and policy formulation.

It is the argument of Mason (1991) that medicine can respond to underserved populations through neighbourhood and community programs that address the needs of low-income people, minorities, and the elderly for preventive services. Resident and medical student rotations can be established through linkages with local health departments and voluntary agencies.

Based on the existing research base, Ruby Takanishi (1993), Carnegie Council on Adolescent Development, identifies some essential elements for developing health policies for adolescents. A comprehensive approach is vital, one that recognizes how

adolescent health problems are interrelated, and the importance of mental health as a key factor in overall adolescent health. Also needed is an integrated approach that recognizes the value of social supports, enhanced by social policies that provide better economic opportunities for youth. Other policies are needed that will produce safe neighbourhoods, decent housing, education, food and health care. Education of those who have contact with adolescents needs to occur. Programs need to be generated by, and based on the community.

Brännström, Emmelin, Dahlgren, Johansson, and Wall (1994) report on lessons learned from a long-term prevention program in Sweden. The emphasis in international documents for the active participation of the public in the planning and implementation of public health programs, in part, inspired the project. The aim was to describe and discuss factors that promote or constrain community participation in health programs. The focus was a comprehensive community-based program for prevention of cardiovascular diseases and diabetes, established in 1985 in a small municipality in northern Sweden. Evidence was gathered using, a cross-sectional survey of the general public, semi-structured open-ended interviews of actors at various levels, and, notes from official records. The results were interesting: the right of definition about the health program remained with health professionals; and, the actors defined community participation in terms of the medical and health planning approach (the means to transform health policy plans into reality by conveying to citizens the need for changing lifestyles through transmitting health knowledge and increasing consciousness among the citizens). Hardly represented among the actors was participation as a means of identifying problems and demonstrating power

relationships and as elements in promoting local democracy. Despite the program being characterized by consensus between the actors, and the public wanting the preventive programs to continue, debates and arguments about interpretations, social interest, personal conflicts, and ideological constraints were observed.

There is much emphasis in the literature on population-based health promotion. Based on the understanding that a barrier to the realization of population-focused public health nursing could be the organizational structures in which public health nurses work and the role socialization that occurs there, a project was begun in the Nursing Division of the Hamilton-Wentworth Department of Public Health Services. It was called New Agenda and the purpose was to support, encourage, and facilitate the participation of public health nurses in the development and implementation of population-based health promotion activities. The authors, Halbert et al. (1993), published their work with the New Agenda which in itself is an example of nurse involvement with interdisciplinary colleagues. The Nursing Division demonstrated its commitment to support population-based health promotion activities by public health nurses and made changes in Nursing Division policies and practices, and advanced a consensus among public health nurses regarding the practice of population-based health promotion. A series of four workshops were introduced to ensure that the structural barriers to the development of public health nursing roles were eliminated.

Halbert et al. (1993) describe the consensus building approach to the workshops. Consensus was built upon the following four areas: the meaning of population-based health promotion; the application of the principles of population-based health promotion to a hypothetical problem; the application of population-based health

promotion to an actual health problem or determinant of health; and, application of population-based health promotion in the day-to-day activities of the public health nurses. Future strategies, in addition to the workshops were identified: ongoing team discussions; learning package development and implementation; workshops; public health nurse role modelling; mentorships; nursing consultations; and, continued administrative support. The document that served as a model was the Ottawa Charter for Health Promotion (WHO, 1986).

Syme (1997) presents reasons for the limited success of information and educational interventions (individual or community-based). They are as follows: we have not always insured the relevance of our programs to those being targeted; the intervention methods are not always appropriate to those involved in our projects; we focus on communities without regard to the fact that sub-groups within communities differ from one another; and, we tend not to consider the social context in which people live and work. Syme argues that professionals will face extraordinary challenges in letting go of power so that communities can use their expertise to build on their strengths and address what they define as the needs of their communities.

Glick, Hale, Kulbok, and Shettig (1996) describe their experiences in applying community development theory to assess the need for a community-based, nurse-managed primary care clinic (Westhaven Nursing Clinic project). Citizen participation was included in the identification of needs of public housing residents, planning of culturally appropriate services, ensuring acceptability and use of services, and empowering residents to take responsibility for their health. These authors conclude that community development theory is applicable to communities, diverse in

geography and culture, and that it enables nurses to be effective advocates for the most disenfranchised community members.

Concept of Health

Green (1985) discusses the question of how health is viewed as the critical difference between models and assumptions derived from the health fields (biomedical, public health, biobehavioral, and public health education) and those derived from education (comprehensive school health model). Is health viewed as an ultimate outcome or as an instrumental outcome? One reason for the difference is that the missions of the two sectors (health and education) differ. There are risks of misplaced emphasis if health services research (on children and elderly) insist on outcomes where the most significant measure of success for health promotion may be in cognitive, developmental and behavioral changes. Also, there is a risk if health services research concentrates exclusively on interventions within the health services when most of the forces influencing the health of both children and the elderly are in other settings. Green acknowledges that the approach to health research, programs and policy is determined by how health is viewed. These three activities require the recognition that health is affected by forces outside the health care system.

Informed Public Policy

Wintemute (1992) uses the experience of the U.S. in prevention of motor vehicle injuries, childhood drownings, and firearm violence to argue for researchers to continue developing knowledge that serves as a basis for informed public policy. He wants clinicians to advocate for behaviour change by their patients. He also urges clinicians to advocate for policy change as concerned community leaders. These

problems have many causes and the epidemiological research approach to their study has been rapidly and widely adopted. The research data have contributed to a wide array of prevention strategies. For example, the 1974 U.S. Congressional decision to withhold highway funding from States that did not adopt a 55 mph speed limit and widespread stiffer penalties for violence involving firearms. New Zealand's national pool fencing requirement is a further example.

Anderson (1991) describes The New York City Needle Trial as an example of a public health initiative for AIDS prevention that exemplifies the practical limitations on health promotion, and the use of a restrictive research process to organize public policy. This was a pilot program to provide clean needles to drug users. In order to have a remote chance of acceptance, it was packaged as a controlled clinical trial; a scientific experiment.

After much controversy and vehement criticism, the clinical trial began in 1988, three years after it had been suggested and after two years of planning and design. Since the New York City Health Department Headquarters was the only "acceptable" site for the needle exchange, this is where the project was located, thus introducing further limitations such as accessibility. The confusion over a U.S. needle exchange policy grew. A project (1989) where city health officials set out to demonstrate that the exchange scheme was a valuable scientific experiment in the prevention of HIV infection was read by politicians and the public as an endorsement of drug use. Anderson (1991) concludes that invoking the prestige of medical science, as demonstrated in this example, does not result in acceptance of contested policies. This attempt to formulate public policy in terms of the research process failed. The issue

became so enmeshed in politics that it was confusing as to who was talking as a scientist and who was talking as a politician.

The issue that health promotion research and practice projects are devoid of theory, even though health promotion has become a critical concept in public health is the argument of Rütten (1995). This author uses a theory of complexity and structure to organize the elements of health promotion in a new perspective (new ways of looking at patterns of behavioral risk factors and health-related lifestyles; relating health promotion to policy making; focusing on a comprehensive model of the implementation process; and, recognizing that the reflexivity and recursiveness of scientific analyses are an integral part of the structure of health promotion). A review of the literature revealed four essential elements of a potential comprehensive structural approach to health promotion (a socially oriented lifestyle model; the political dimension of health promotion; intervention measures from "the bottom up" that are sensitive to the social contexts of target populations; and, the transformation or interplay between scientific research and health promotion policy). Rütten argues that it is rare to find a health promotion perspective that focuses on the interrelationships and complex forms of interaction between the elements and concepts presented.

Rütten (1995) writes about the importance of approaches to policy making being flexible to correct its unanticipated consequences. In reality and supported by empirical evidence, policy making can be characterized as a process of "muddling through." Incrementalism describes this process where policy makers strive for step-by-step improvements rather than utopian goals or making fundamental changes. This

is in direct contrast to the assumption that policy making is rational and planned systematically. This author also argues that health promotion programs may count only if they fit the rules of the policy game and contribute to political strategies of those in power or seeking power. In addition, the bureaucratic form of organization serves to hinder the implementation of health promotion programs. "Thinking globally, and acting locally" is associated with the international health promotion movement and characterizes a perspective on implementation of health promotion offered by Rütten.

Stanley (1994) presents a mental health nursing perspective in her arguments for crafting mental health policy. This author outlines a series of steps in the process of crafting policy: information gathering; problem identification; definition of policy gaps; description of the pros and cons of issues; selection of several alternatives; full delineation of proposed solution with research analysis; presentation to policy-making individual(s) or body; establishment of endorsements for policy direction; dissemination of policy; and, acceptance and adoption by public. Stanley introduces the idea of "craftsmanship" (carried out by a skilled worker or artisan). Crucial points for the crafter are the inclusion of variables that can be used by decision-makers, sensitivity of design to difficulties of implementation, attention to the viability of assumptions and the anticipation of counter argument. Who initiates policy needs? The answer is the public stimulus, research substantiation, or government or organizational unit request. The policy needs and challenges related to mental health nursing are identified and include: supply of services to those with mental illness; the care of those experiencing homelessness, poverty and violence; the parity of mental health

care with physical health for basic benefits; and, the factors of discrimination and stigma related to mental health problems.

The importance of nurses on key national policy boards and advisory committees; coalition building around a policy change/consensus and support from all (critical mass of persons) with invested interests; speaking out and strategizing; and, the lobbying and education of policy decision makers are emphasized by Stanley (1994). This author underscores the importance of community (local and regional levels) reporting back to policy makers on the effectiveness of the outcome (satisfaction, dissatisfaction). For this author and others, "policy should be considered not as eternal truths but as hypotheses subject to modification and replacement by better ones" (p. 19).

Rains and Hahn (1995) present an argument, by means of a case example, of policy research, which demonstrates the intricate and unique relationship between research and the policy arena. It is their belief that nursing's involvement in policy development has become a standard and expected part of nursing practice. They define policy research as "the process of producing or transforming data to provide policy makers with feasible options to help solve social problems" (p. 72). These authors cite the work of Hindshaw who conceptualizes policy research in terms of three types of research: policy analysis research (provides information regarding the effects of specific past or current policies by using existing data); policy research (uses traditional scientific methods and primary data collection to evaluate a specific policy or program); and, disciplinary research (research findings, i.e., nursing research, which have policy implications). The roles that nurses can play which

matches the policy situation are identified as follows: the academic, intellectual role (giving neutral and objective advice); the political role (active support of political interests within the political process); and, the advocate role where the nurse assists clients to achieve their goals by providing strategy for the policy process.

The example given by Rains and Hahn (1995) is from the criminal justice system, an evaluation of the effectiveness of a diversion program with alcohol and maryuana misdemeanants in a large, urban Midwestern county in the U.S. The results and recommendations of the policy research conducted by a public health nurse as part of a health policy internship were presented to the prosecutor who concurred with them and planned to assess the fiscal impact of their implementation.

In summary, there is agreement in the literature that health promotion programs can benefit from the work done in other disciplines. The need for health professionals to work together was identified. The role that settings play in evaluation of programs was articulated. The need to bridge the link between education and health was made salient. This includes: research to effect behavioral change; new models for health promotion in schools; and, research to determine the relationship between health status and level of education. The literature was explicit about the importance of community involvement in needs assessment, planning, implementation, and evaluation of programs. The impact of forces on health, outside of the health care system, was discussed. The importance of community leaders advocating for policy change was a strong argument. The expectation for policy development to be a part of nursing practice was articulated. Some cautionary arguments were discussed and these include: the impact of bureaucracy to impede implementation of health promotion

programs; the need for the community to report back to policy makers on outcomes of programs; and, the awareness that science and politics can become embedded in program initiatives and the results are not to the benefit of the community.

Locating My Research in the Debate

In the work of the community health nurse, gender and class issues need to be made visible. I believe they would be visible in research that uses a feminist research paradigm. Clarke's (1992) contribution to health promotion research is significant in that she identifies gender issues. By her use of feminist methodology gender is made salient. This includes the initial research assumptions about gender and gender bias in the research process. Included in the development of Townsend's (1992) arguments are questions about the "social organization" of gender and class relations. In order to meet the health needs of underserved populations, as defined by Mason (1991), a research paradigm is needed for health policy that considers gender, class, and race issues. A feminist research paradigm, with its emphasis on equality, not only would address these issues from the community's perspective but as well from the researcher's perspective. In more recent publications, Hoffman (1997) advocates for the importance of gender in the policy making process. Davidson et al. (1997) also argue that gender should be considered as one of the determinants of health, in and of itself. Further research into the gendered division of caring is supported by Love et al. (1997).

My argument for a research paradigm that incorporates the changes and trends in the current practice of community health nurses, i.e., the increased emphasis on

participation and empowerment is further advanced by Lincoln's (1992) work. Her argument for naturalistic inquiry has had a significant impact on my choice of a research design. As she ably points out, the much needed paradigm shift in the health science disciplines will make research findings more useful to health promotion researchers, practitioners, and policy makers. Harris (1992) also argues strongly in favour of the naturalistic paradigm for health promotion and community development research. In a recent article by Lewis (1996), an argument is made from a nursing perspective that in addition to the teaching of methods to nursing students, epistemology and methodology be taught. Her argument to include feminist theory in the education of the nursing students speaks strongly not only to my use of a feminist research paradigm but also to my teaching role in a university setting. I appreciate the questioning of the appropriateness of the experimental method in public health nursing and I support the work of Hayward et al. (1996) who argue for research that uses alternative paradigms such as feminist theory.

The importance of community nurses measuring the impact of their work is the argument of Barriball and Mackenzie (1993). These nurses cite the work of Clark who supports their recommendation for further research to test the usefulness of structure, process, and outcome to nurses in measuring the impact of their interventions. Clark's argument, for the importance of structure and process to determining that an outcome is beneficial, holds promise in my study of community health nurses as it underscores the value/significance of both structure and process.

When women's experiences are the resources, as in feminist research, Thompson's (1992) three evaluation research questions have a better opportunity to be

answered. In terms of research involvement, feminist research methodology makes visible the beliefs and behaviours of the researcher. This is an important issue especially when Thompson recommends that the researcher become a participant in health promotion policy research.

Empowering and emancipating research is particularly important for community health nurses who play a critical role in the implementation of health policy. I agree with Poland (1992) that the paradigm needs to embrace the experiences of the "researched" for health promotion research, and the potential is created for their empowerment and emancipation through the insights they gain in the research process.

The people orientation in the work of community health nurses requires a research paradigm that encompasses the four principles proposed by Raeburn (1992). In a feminist research approach the four principles would be met and in addition the "researched" are at the centre of the research process.

The research paradigm chosen must play a part in the outcome. The question arises as to whether a feminist approach to research would have achieved the same results, as the one reported by Anderson (1991). Anderson concludes that when clinical science is used in an effort to attain a broader community consensus or political legitimacy for public policy, scientists need to be even more vigilant than usual in guarding against the possibility of refusing effective treatment to an untreated population, either inside or outside the trial. Implementing a health program within the context of a scientific experiment, is not recommended by Anderson; and most definitely not the way to formulate health policy. This experience is in contrast to other authors who have reported having very positive experience with programs that

influenced health policy. In feminist research the "researcher" and the "researched" share the same critical plane and I believe for this reason alone, a more positive outcome would have occurred.

O'Neill and Pedersen (1992) have identified the limitation of what currently exists in the health policy literature and have suggested alternative research methodologies. Their work provides insights into what is needed for healthy public policy research. It is my conviction that a feminist research paradigm for health policy would meet the needs as they are defined in the literature. The insights of Stevenson and Burke (1992) into the conceptual, methodological and political limitations in health promotion research add strength to the argument for a paradigm shift. What is needed, as they see it, is research on healthy public policy that would develop knowledge to assist practitioners in policy analysis.

Stachtchenko and Jenicek (1990) suggest further research that includes the work of other disciplines is the solution. This is a window of opportunity for feminist research methodology. It is especially true because of the interdisciplinary nature of feminist research. These authors also raise the issue of the significant relationship between the conceptualization of health and the research paradigm being proposed; an important consideration for my research. Casswell (1988) strongly supports the need for a paradigm shift in health promotion research. Again this shift is characterized by a movement away from a positivist paradigm to a paradigm that draws upon knowledge from a number of disciplines. The other key point made is the need for health promotion research to have a closer link with programs and policies. An interdisciplinary feminist research paradigm would have the potential to meet these

proposed new directions. For one reason it melds the useful elements from a range of disciplines. For another reason it provides women, explanations that they want and need for change.

Contributing to the case for an interdisciplinary approach to health promotion policy is the argument made by Green (1985) that health is affected by forces outside the health care system. The integrated approach to adolescent health policy, recommended by Takanishi (1993) would be achieved by an interdisciplinary approach. This is a good example of what is meant by intersectoral collaboration. The need for those responsible for housing policy, education policy etc. to collaborate for comprehensive health promotion policy. Research for health promotion programs should be intersectoral and multidisciplinary, and should involve the community. The study by Coonan and Mendoza (1990) is important to my work in that it emphasizes this fact.

A research paradigm that is interdisciplinary is an important consideration for any proposed new paradigm for health promotion. The work of Pilisuk and Minkler (1985) supports the need for an interdisciplinary approach to health promotion research; an approach that would consider social environments in the broader policy perspective. The research paradigm proposed in my thesis will need to have this interdisciplinary perspective.

The results of the study conducted by Friel et al. (1989) reinforce my contention that interdisciplinary research is vital to formulating public health policy. The Canadian Heart Health Initiative (1992) is significant to my work because of the collaborative process used. It also illustrates the efficacy of cooperation between

researchers, practitioners and policy makers. The argument by Torrens, Breslow, and Fielding (1982) for universities to establish interdisciplinary research teams continues to be relevant.

The significance of McKinlay's (1992) article for my research is the identified need to shift health promotion research from the individual level to a focus on government, organizations, and providers. Chambers (1992) also underscores the importance of organizational health, even suggesting that public health agencies be role models for other agencies. Community health nurses play a key role in the implementation of health policy. In my study of their participation in health policy, the research paradigm needs to make visible their work. Feminist research would accentuate the context of their work including the organization and government issues. Although Harris's (1992) concerns are very real, a feminist research paradigm, for me, holds more promise for change, and in particular, changes to the establishment.

In the "work world" of community health nurses I believe the management component is critical. Out of the Health Initiative, described by O'Connor and Petrasovits (1992), a new paradigm for management arose. It is characterized by developing policy by consensus; building alliances with the research and scientific communities; and, assembling and managing coalitions (a balance of science, policy and community).

In their work with communities and by utilizing empowering, participating strategies, community health nurses can influence policy. Their work of implementation can be a link between health promotion research and health promotion policy. Reynolds and Chambers (1992) conclude that a health program can be a strong

link between research and policy. The fact that their program influenced health policy is important.

Advocacy is not new to community health nurses. What needs to be recognized is the vital role they play in health policy development when they advocate for their communities and influence existing health policy for change. Wintemute (1992) makes a strong argument for effective health policy that can come from research. He considers the important advocacy role that clinicians can play in the transition of research to policy.

A feminist research paradigm would utilize the best techniques to solve the problem. Walsh (1988) and McKinlay (1993) argue for qualitative and quantitative techniques in the research process. A feminist paradigm for research is not limited to any one technique or method. The argument is not qualitative vs. quantitative. It is the technique that is most appropriate to address the problem.

With the emphasis on community participation, community-based approaches to care, etc. (Brown, 1994; Fullton, 1997; Raeburn, 1992; Shea, 1992), I find the model of health as proposed by Collins (1995) to reflect the dynamic nature of community work and explicitly show the relationship of the two levels of activity, i.e., individual and community where health interventions can occur.

The research reported by Brännström et al. (1994) demonstrates that active participation of the public in planning and implementation of public health programs presents many challenges for public health professionals. Syme's (1997) argument that professionals face extraordinary challenges in letting go of power so that communities can build on their own strengths is a reality in opposition to the rhetoric of

community participation. Positive experiences in applying community development theory to the process of community assessment (Glick, Hale, Kulbok, & Shettig, 1996) provides a more balanced perspective to the literature.

The issues of community participation and empowerment, both important concepts in my opinion, to studying the role of community health nurses in policy making were each studied by means of empirical research conducted in the U.K. Stachenko's (1994) argument for the importance of community environment is significant for policy development and implementation. Brown (1994) concludes that the concept of community participation cannot be separated from the wider concept of political and organizational life. In Brown's study when health visitors were attached to general practice teams they anticipated loss of a community dimension to their work. These findings support the need for flexible organizational structures where people can define communities for themselves. This supports my argument that organizational structures themselves need to reflect (mirror) and support the activities of empowerment expected at the community level. The findings from Fulton's study of nurses' views on empowerment have meaning for my research as they uncovered nurses' feelings of oppression and striving for liberation.

Halbert et al. (1993) in describing their experience with introducing population-focused public health nursing to a Public Health Service, emphasize the role played by the Nursing Division to ensure success. The vital nature of the organization to the work of public health nurses is significant knowledge for my study of their role in policy development and implementation. The argument of Rütten (1995) adds to the

discussion that the bureaucracy in organizations serves to hinder the implementation of health promotion programs.

The role that nurses can play in policy making is advocated by Stanley (1994), and Rains and Hahn (1995). The work of these authors is important because it outlines the activities nurses need to engage in and the value of their involvement in policy development. Stanley (1994) underscores the implementation aspect of policy involvement and this author calls for communities to report back to policy makers on the effectiveness of the outcome. For me, this suggests the importance of evaluation (outcome) in the process of policy implementation and the need for accountability of policy makers to the community. Rains and Hahn (1995) in their article add an important aspect to the literature in presenting an example of how the policy research conducted by a public health nurse influenced the criminal justice system.

Conclusion

The literature on health promotion policy was reviewed from the perspective of research and programs. A variety of issues were discussed. Only recently are community health nurses writing about the research and program directions for health promotion policy. Their experiences made visible in the literature are much needed and their continued contributions should be encouraged. Arguments were made for a paradigm shift in health promotion policy and the need for nurses' involvement in policy making. The literature is silent on empirical studies which use a feminist research paradigm to study the role of community health nurses in health promotion policy. Locating my research within the context of the debate about paradigm

considerations and controversies was voiced. The following chapter provides an overview of the literature on feminist research methodology.

CHAPTER TWO: FEMINIST RESEARCH METHODOLOGY LITERATURE REVIEW

Introduction

In this chapter many of the debates about feminist research methodology are presented based on a review of the literature. Feminist research is not confined to one discipline. It is interdisciplinary in that feminist scholars in a number of disciplines are creating knowledge by bringing a feminist perspective to their research. Also, feminist scholars from a variety of disciplines are coming together to explore research questions using feminist methodology. The literature review includes arguments from feminist researchers primarily in the disciplines of nursing, sociology, psychology, and anthropology. This chapter is organized thematically as follows: Feminist Research: The Debate; Feminist Research Selected Disciplines; and, Locating Myself Within the Context of Feminist Research.

Feminist Research: The Debate

Feminist research is discussed in this section according to several themes and sub-themes emerging from the literature (see Table 2). Individually and collectively, the perspectives presented by feminist scholars contribute to a feminist understanding about the diverse theoretical and methodological approaches in the feminist research debate.

Table 2

Outline of Chapter Two

Introduction
Feminist Research: The Debate
1. Epistemology, Methodology, Method
    a. Differentiation of Meaning: Methodology Versus Method
    b. Epistemological Issues
    c. Methodological Issues
2. Women-Centered Interviewing As Method
    a. Power
    b. Giving Information
    c. Oppression
3. Research as Empowerment
4. Gender
    a. Reshaping of Discipline
    b. Gender, Social Class, and Race
5. Invisible Work and Silenced Voices
6. Research Design
    a. Methods (Ways of collecting data and analysis; In health promotion research)
    b. Women as Participants, Not Objects
7. Scientific Rigor
    a. Feminist Scholarship
    b. Credibility
    c. Feminist Scholarship/Conventional Standards
8. Funding, Writing, Publishing

Feminist Research: Selected Disciplines
1. Nursing
2. Sociology
3. Psychology
4. Anthropology

Locating Myself Within the Context of Feminist Research
Conclusion

Epistemology, Methodology, Method

A distinction between epistemology, methodology, and method is made in this section. The discussion is organized in three sub-themes which include: differentiation of meaning: methodology versus method; epistemological issues; and, methodological issues.

Differentiation of Meaning: Methodology Versus Method

In a literature review of feminist research, Webb (1993) feminist, nurse, and sociologist, drew on feminist scholarship such as the writings of Sandra Harding to differentiate the meaning of methodology and method. Methodology is "a theory and analysis of how research does or should proceed" (p. 416). Methods, in contrast, are "ways of gathering data" (p. 416). Campbell and Bunting argue that in feminist research, methodology and methods are derived based on a particular theory of knowledge, or epistemology (as cited in Webb, 1993). Webb further cites Klein's argument that feminist research is carried out for women and benefits from McCormack's argument that feminist research involves a set of principles of inquiry; in other words, a feminist philosophy of science.

King (1994) argues that unless these distinctions are understood by nurse researchers and in particular, the difference between method and methodology, truly feminist research will not be possible. By understanding these concepts of method and methodology, nurse researchers can engage in feminist research which can empower women and the nursing profession.

Epistemological Issues

Scholars, Cook and Fonow (1986) who have analyzed feminist methodology in sociology have identified five basic epistemological principles. The first principle is acknowledging the pervasive influence of gender. To feminist sociologists this means defining women as the focus of analysis, recognizing the central place that men have held in sociological analysis, and viewing gender as a crucial influence on the network of relations encompassing research. The second principle identified is focus on consciousness-raising. A researcher's feminist consciousness can serve as a source of knowledge into gender asymmetry. Conscious-raising techniques can be used to elicit data and they can encourage politicization and activism on the part of research subjects. The third principle is rejection of the subject/object separation. Sociologists have explored the fallacy that strict separation of researcher and respondent produces more valid, legitimate knowledge. They have examined ways in which the research process obscures yet reinforces the subordination of women. The critique by feminist scholars points out that quantification has inherent biases. The fourth principle is examination of ethical concerns. They include the use of language as a means of subordination; the fairness of gatekeeping practices, intervention in respondents lives, and withholding needed information from women subjects. The final principle is emphasis on empowerment and transformation. Knowledge must be elicited and analyzed so that women can use it to alter oppressive and exploitative societal conditions. This means that because of the policy implications of an inquiry, it may be important to incorporate the potential target group in the design and execution of the study.

On the issue of epistemology, Thompson (1992) argues with feminists in other disciplines that there is no one feminist epistemology, but there are prevailing concerns which are as follows: all inquiry is value-sustaining, and feminist work is politicized inquiry; separation between researcher and researched does not ensure objectivity; women's experience can be considered as source and justification of knowledge; and, there may be no such thing as truth and objectivity. Empiricists are least critical of conventional qualitative and quantitative methods. Standpoint and postmodern feminists advocate for a more critical stance and struggle to adapt their methods which are mostly qualitative to their ways of knowing.

Bungay and Keddy (1996) argue that "rooted in the area of the sociology of knowledge, experiential analysis provides one the opportunity to think about how knowledge is created, the power relations inherent in knowledge, and how to deconstruct this knowledge" (p. 442). They support experiential analysis as a feminist methodology for health professionals. These authors define experiential analysis as an alternative methodology that is a combination of feminist perspective/research and the sociology of knowledge. More specifically "it is a research process guided by assumptions concerning the power relations governing the experiences of people" (p. 446). They refer to analyzing the language of the data. Languages are reviewed to demonstrate the power relations governing them (deconstruction). Areas of resistance within the discourse can be identified therefore enhancing the possibility for change.

The example provided by Bungay and Keddy (1996) is analyzing the language of an older nurse during an oral history about her practice in the 1920's. She spoke about the distinct approaches of two physicians in the treatment of patients with

pneumonia. One physician's patients recovered more quickly when the windows were open, their beds elevated, and they were given bed baths as compared to the patients of the other physician who were "ordered" to lie flat with no fresh air or bed bath. Even though the nurse spoke about "obeying doctor's orders", when the physician left the hospital she opened the windows, elevated patient's beds and gave them bed baths. The authors identified this situation of a nurse resisting written "doctor's orders" even though she spoke about the power of these "orders", as an example of the potential for resistance among marginalized groups.

Methodological Issues

As defined by Stanley and Wise (1983) "feminism is not only a set of beliefs but also a set of theoretical constructions about the nature of women's oppression, and the part that this oppression plays within social reality more generally" (p. 55). These authors argue that feminism directly confronts the idea that one person or set of people have the right to impose definitions of reality on others (Stanley & Wise, 1991). Their argument about "feminism" within the research process is further discussed in Chapter Three: Methodology, page 138.

In defining feminism, Hall and Stevens (1991) refer to the work of Harding (1987) who emphasizes that women's experiences are pluralistic and we can only speak of "feminisms." These feminisms share three basic principles as follows: a valuing of women and a validation of women's experiences, ideas, and needs; a recognition of the existence of ideologic, structural, and interpersonal conditions that oppress women; and, a desire to bring about social change of oppressive constraints through criticisms and political action (Chinn & Wheeler, 1985). Additional authors

who support this argument are Acker, Barry, and Esseveld; and, Klein (as cited in Hall & Stevens, 1991).

In the nursing literature, critical theory and feminist theory are discussed but their distinctions are not made clear. Although I chose feminist theory, and critical theory is not central to my work, clarifying the differences from a nursing perspective is important because of the blurring of both theories even though they inform each other, and the problems this creates for nursing. To deal with this issue I turn to the work of Campbell and Bunting (1991) who argue for differentiating feminist theory and critical social theory. They discuss the similarities and differences in world views and assumptions of feminist theory and critical theory using Harding's categories of epistemology, methodology, and method. They cite the work of nursing scholars (Allen, Benner, & Diekelmann) who also argue that the two theoretical perspectives share differences and similarities. For example, both critical theorists and feminist theorists share a presence in many different disciplines. Other disciplines as well as nursing are making efforts to incorporate these paradigms with those of their own discipline. As with nursing, feminist research has faced questions about the relationships between ideology and method. With reference to Harding's (1987) framework, method is viewed as a technique for gathering evidence; methodology as a theory and analysis of how research does nor should proceed; and, epistemology as a theory of knowledge. Epistemology concerns the questions of what can be known and who can be a knower and the relationship between the knower and the known; what criteria beliefs must meet to be considered knowledge; and, what is the authority against which truth is measured.

The original group of scholars (early 1920s) in the evolution of critical theory in Germany was interdisciplinary. The Marxist roots of critical theory dictated that knowledge should be used for emancipatory political aims. In contrast to phenomenology, where individual personal meanings are the perspective to understanding patterns of human behaviour, critical theory involves an understanding of societal structures such as class structures. In the critical theory paradigm, knowledge is not discoverable or universal but is created and this created knowledge and interpretation are grounded in language. The most frequent method used by critical theorists has been critical review or "critique." Epistemological issues in feminist theory include: women's experience can be a legitimate source of knowledge--women can be knowers; subjective data are valid; informants are "experts" on their own lives; knowledge is relational and contextual; and, definitive boundaries between personal and public or personal and political spheres are artificial, as are sharp distinctions between theory and practice. In support of this argument Campbell and Bunting (1991) cite de Lauretis; Hartsock; and, Wheeler and Chinn. Methodologic issues in feminist research as viewed by Campbell and Bunting include: research should be based on women's experiences; artificial dichotomies and sharp boundaries are suspect in research involving women; the context and relationships of phenomena should always be considered in designing, conducting, and interpreting research; researchers should recognize that the questions asked are at least as important as the answers obtained; research should address questions women want answered; the researcher's point of view should be described and treated as part of the data;

research should be nonhierarchical; and, interpretations of observations by the researcher should be validated by and shared with the participants.

Both critical and feminist theories are emancipatory, however, feminist theory is distinguished in that it focuses on women. Both theorists agree that social structures have resulted in class oppression but feminists choose division and domination according to gender as the fundamental oppression. The current scholarly debate on racism encouraged within feminism is not part of critical theory. Both feminist and critical theory recognize that information is composed of historical and contextual influences. Critical theory emphasizes rationality whereas feminist theory recognizes that feelings are also included, respected, valued, and seen as having emancipatory potential. Feminist theorists insist on sharing their insights with other women. The original critical theorists wrote for the intellectual world. Critical theory investigations that use dialogue in methods, are scarce. However, in feminist branches of many disciplines, dialogue research is used in many forms. Campbell and Bunting (1991) suggest that in other disciplines critical and feminist theorists meet and write in separate forums. However, nursing seems to be ahead of other disciplines in meeting the need for discourse and mutual information sharing between critical and feminist theorists.

The argument is made by Webb (1993) that feminist theory and critical theory show some similarities but the differences are as follows: feminist theory places gender centrally within the research, respects and values feelings and experiences, calls for a more equal partnership within research, and claims the importance of making feminist writings accessible to all.

Webb (1993) cites the work of Lather who locates feminist research distinctly within the post-positivism or post-modernism debate. The debate arises from a recognition of the inadequacy of positivist assumptions in the face of human complexity. Lather argues that post-modernists recognize that it is no longer possible for all topics to be studied by a single methodology.

Hammersley (1992) argues against a distinctive feminist methodology and an attempt to set up a separate methodological paradigm. The author identifies four themes found in most discussions of feminist methodology and challenges each one. The themes are as follows: the ubiquitous significance of gender and gender asymmetry; the validity of experience as against method; rejection of hierarchy in the research relationship; and, emancipation as the goal of research and the criterion of validity.

Although Hammersley (1992) holds the view that the increased attention to gender is a valuable product of feminism, the pre-established priority of gender over other variables is not supported. The author argues that direct experience as against reliance on method is not distinctive to feminism but, for example, common in discussions of qualitative methodology. With respect to hierarchy, the argument is made that the proper relationship between researcher and researched is not able to be "legislated" by methodology, but depends on the specifics of particular research investigations. Hammersley argues that the emancipation goal proposed by feminists is found in the non-feminist literature as well. The author argues against tying inquiry to pragmatic goals and defends the view of inquiry i.e., the scholarship that science and universities rely on. In summary Hammersley does not support setting up of distinct

methodological paradigms because, in this author's view, it may create an obstacle to open debate.

An argument for the exploration of how realist philosophy and feminist methodology are or can be articulated is made by Maureen Cain (1986). The author deals with the issues of the nature of feminist research, the meaning and implications for research and policy of adopting a feminist standpoint, and the relationship with and status of researched populations. Sociology of law is embedded in the authors arguments. Cain argues that the criteria to define feminist research ie. by, on, and for women, rather than being treated as empirical givens would be better treated as interpreting the social and political character of by, on, and for relationships. This argument is founded on the belief that it is a social and political movement which provides the criteria for what is feminist. The argument is further developed to include the view that accepting the notion that "woman" is a socially constructed category, it becomes necessary to do research not just on women but also on the social processes of gender construction and constitution "The by, on and for women criteria for research to be feminist must separately and together be used and defined with attention to the social relations which constitute and give rise to feminism" (p. 259).

Feminist methodology in nursing research is further discussed by Webb (1984). What contributes to her research being "feminist", as she sees it, is that her study included the experiences of women, from their viewpoint; their feelings and needs as they expressed them; in a language style that was theirs; and, results that would be meaningful and useful to the women themselves, other women and nurses.

Webb (1993) refers to the work of Bernard who reviewed 90 nursing research reports published in two 5-year periods in Nursing Research. This author found no study which met all of the following eight criteria for feminist research, and four or fewer criteria were fulfilled in 73 reports. The conclusion reached by Bernard is that little feminist research is being carried out in nursing or that it is not being published. The eight criteria are as follows: the researcher is a woman; feminist methodology is used (including researcher-subject interaction, non-hierarchical research relationships, expressions of feelings, and concern for values); the research has the potential to help its subjects; the focus is on the experiences of women; it is a study of women; the words "feminism" or "feminist" are actually used; feminist literature is cited; and, the research is reported using non-sexist language.

Grounded theory as feminist research methodology is the argument of nurse researchers Keddy, Sims and Stern (1996). They concur that "an established qualitative method, grounded theory (Glaser & Strauss) can be considered both a feminist method and methodology, provided the methodologist is grounded in feminist philosophy" (p. 448). Grounded theory allows for the voices of participants to be heard. For these feminist researchers, feminist research is creative and evolving. These authors cite the work of Kirby and McKenna, and Wuest where feminist methodology is described and grounded theory discussed.

In summary, epistemology, methodology and method are three distinct concepts and clarification of these terms contributes to a greater understanding about feminist research. Feminist scholars particularly in the disciplines of nursing and sociology have much to say about them. Issues were discussed such as epistemological principles

of feminist research, a comparison of feminist theory and critical theory, and criteria for feminist research.

Women-Centered Interviewing As Method

The following discussion is about women-centered interviewing as method and is organized in three sub-themes of power, giving information, and oppression.

Power

Anderson (1991b) argues for the need for critical scholarship; that which makes transparent what is taken-for-granted. This could be, for example, the power relationship between the researcher and the informant. Anderson addresses the issue of power in the interview relationship. The question is asked, to what extent do the informant's requests for information challenge the power relationships within the researcher/informant relationships. Anderson refers to the work of Richer who raises the issue of the benefit to informants for participating in research. It is this author's view that the findings from research become a commodity: exchanged with universities, publishers, etc. Foucault is quoted by Anderson as seeing power relations as permeating every aspect of social life and the interaction between researcher and informant as being no exception. Anderson concludes that when informants want their concerns addressed, it is up to the researcher to heed them.

In the interview, the researcher needs to be sensitive to ways of equalizing power between the women and themselves (Oakley, 1981). The process of the interview needs to be critically examined. With respect to power, Webb (1993) cites Wise who calls on feminist researchers to acknowledge power where it exists and learn to deal with it wisely as feminists.

The balance of power in the research relationship is discussed by researchers Seibold, Richards, and Simon (1994) in their study of women and their experiences of midlife and menopause. They argue that power can be with the participant during the gathering of the data, but it is the researcher who has power of analysis afterwards. These authors raise the issue of therapeutic elements in the research relationship. They ask the question, at what point does the researcher suggest or facilitate counselling? They do not have the answer but wonder about "where the feminist researcher draws the line between acting as a concerned woman and taking on a therapeutic relationship" (p. 397).

Giving Information

Webb (1984) gives examples of feminist method in nursing research from her own research experience, interviewing women about hysterectomy. She cites the work of Oakley as a frame of reference when discussing the interview process. Medical domination is an issue which surfaced even in the interview experience when Webb felt constrained in her role because of the control of physicians and the concern that if she diverged from the approved research protocol by giving information to women, the study permission may be withdrawn. The "gate-keeping" function of the physician was played out when Webb was told she could not approach patients herself requesting their participation in the study, but had to depend on physicians to explain the study and obtain written consent. Permission to conduct the study was only to collect data, not to give information or advice. However, she developed a feminist method, established intimacy with the women and invested her subjectivity in the

research. In return she learned the depth and richness about their feelings and experiences.

It is Anderson's (1991b) argument that there are issues that arise in an interview when the researcher is also a feminist scholar that may not be entirely resolved within the phenomenological perspective, even though, phenomenology is concerned with the intersubjective construction of meaning and considered to be an alternative to the science paradigm that values detachment and objectivity.

In the interview experience, Anderson (1991b) became aware of the need for the women in her study to have more information about their illness; a similar experience as Webb (1984). Anderson reflected on the processes by which illness is constructed in everyday life and viewed the requests for information as part of the social production of knowledge. Anderson believes that the issue of biasing the data (by giving information to the women in the interviews) comes from the paradigm of science that would argue for "the true social reality." Munhall (1988; 1993) argues that a priori one must declare that one is a nurse in the first instance and a researcher in the second instance. It is a moral and ethical imperative that is in keeping with feminist methodology and method. Anderson argues that knowledge is socially constructed and the field work experience can be viewed as an occasion for informants to reconstruct their notions about illness--to reconstruct medical meanings.

Oppression

Devault (1990) cites Daniels who argues that women who are positioned differently learn to speak and hear quite different versions of "woman talk" adapting to distinctive blends of power and oppression. If we actually talk with those we

interview we speak in ways that open the boundaries of standard topics, and we can create space for respondents to provide accounts rooted in the realities of their lives. From her own research experience, Devault recalls respondents who would stop in the middle of a sentence to inquire, "is this really what you want?" They were prepared to translate into the vocabulary they expected from a researcher rather than proceed in a more familiar manner. The author claims that a feminist sociology must open up standard topics from the discipline, building more on what we share with respondents as women than from disciplinary categories that we bring to research encounters. This requires researchers to interview in ways that allow the exploration of incompletely articulated aspects of women's experiences. It is important for researchers to take responsibility for recognizing how the concepts learned as sociologists may distort women's accounts; interviewing needs to be grounded in accounts of everyday activity.

Devault (1990) argues for feminist researchers to be conscious of listening as process, and work on learning to listen in ways that are personal, disciplined, and sensitive to differences. Preserving women's speech is an issue for feminist researchers and Devault argues that more complete representations of talk can provide a resource for analysis built on distinctive features of women's speech. In the literature there is evidence of interchange between traditional approaches to qualitative sociology and the newer insights of conversation and discourse analysis. Duvault cited Mishler to support the statement that there is evidence of a heightened awareness of transcription in linguistic research and especially at the borders between conversation analysis and other qualitative approaches.

Research as Empowerment

The process of research can empower the disadvantaged and the oppressed, and the hope for this lies in feminist critical scholarship in nursing (Anderson, 1991b; Hedin & Duffy, 1991).

Parker and McFarlane (1991) used Duffy's eight criteria for feminist research as the framework to conceptualize an empowerment model for research (the empowerment of nurses in the process of conducting research). They cite examples from their own research of 1200 pregnant women, documenting the frequency and severity of physical abuse during pregnancy and its effects on maternal-infant health. In relation to criterion one (the principal investigator is a woman) the authors talk about their working relationships with each other and with a consortium of nurse researchers. They give the example of the assistance provided to them by consortium members as an empowering experience. Criterion two (feminist methodology is used) is exemplified by the experience of the researchers to empower the pregnant women by nursing advocacy, support, and informational options. They argue, with Duffy, that the purpose of feminist research is to change society and create a social system that implements the ideology of equality. Investigating the physical abuse of women during pregnancy, as a burden on the health care system is a shift from viewing the physical abuse of women as a family problem. The study has the potential to help the subjects and researchers is criterion three. The authors argue that not only was their study designed to assess for abuse but also to intervene with counselling and referral to the local shelter when abuse was detected.

Criterion four (the research is focused on the experience of the women) is supported by the approach used to collect data. Both open-ended and closed-ended questions were asked, to emphasize the attitudes and feelings of the women. Parker and McFarlane (1991) cite the national study by Strauss and Gelles which has been quoted to rationalize the lack of services and legislation supportive of battered women. Straus and Gelles reported that women were equally as violent as men. Further evaluation of their work showed, for example, that the scale they used counted a woman pushing a man in self-defense as equivalent to a man pushing a woman down a flight of stairs.

The last criterion addressed by Parker and McFarlane (1991) is criterion five (the purpose of the investigation is to study women). Dissemination and utilization of research findings are viewed by the authors as political endeavours and includes raising the consciousness level of scientists and the general public. Through presentations, lobbying efforts, and requests, the researchers were successful in making domestic violence a priority agenda for the health agency at one of the study sites. The researchers argue that incorporation of feminist principles into nursing research is a natural and timely endeavour.

There are two ethical questions that feminist researchers need to ask themselves (Thompson, 1992). "Is my research project exploitive of or empowering to participants and other people involved in the project?": "How can I avoid oppressive objectification of my research participants?" Again, the work of Cook and Fonow (1986) acknowledges the idea that feminists should consider the policy implications of inquiry, and when possible, provide their subjects with tools for action.

Helen Meekosha (1989) brings a perspective from Australia to the discussion. In particular the issue is one which confronts feminist researchers who are hired as consultants by the state. Governments are protective of information they gather, while feminist researchers recognize that those who provide information to researchers have a stake in its use. Meekosha argues that the process of social policy research is as important as the findings and outcome. Again, the argument is made that feminist research is research for women, not on women. Meekosha supports the argument that feminist research is committed to improving women's lives and cites the works of Roberts; Oakley; and, Stanley and Wise. Consultation can and often does enable the state to delay taking action on social problems while at the same time pacifying the groups by conducting further rounds of workshops, public meetings, and discussions. So often, the findings of social research recommend more resources, and improved social measures to alleviate hardship. However, in practice, the reverse of the recommendations is eventuated i.e., cutbacks in funding, and abolition of grants and allowances. An argument is made by Meekosha that the political and research context needs to be addressed by the researcher. Karapin argues that government can favour social research that requires policy makers to define the problems and social researchers to provide missing information to solve problems (as cited in Meekosha, 1989). The theoretical framework and analysis of such research is not open for debate or discussion between the researchers and the government client.

In contrast to governments who define problems in narrow and constrained terms, feminists argue that experience is important in research and this experience needs to be made visible. Research consultants reports are couched in atheoretical and

apolitical terms. An example provided by Lee is the objective quantitative means of determining social needs as in needs based planning (as cited in Meekosha, 1989). In contrast to this very limiting approach (ie. intensity of needs) the feminist perspective examines who does the caring/meeting of needs, the locale of caring and the social and economic costs and conditions of caring. It is the argument of Meekosha that these issues can only be addressed by explicitly documenting women's hidden experiences in the home, family, and community. In the view of the author, social research commissioned by the state can move towards legitimating existing program and policies, rather than exploring new options. Meekosha agrees with the argument of Weymann, Ellermann, and Wingens, that large bureaucratic research units tend to produce more of the same material but lack flexibility and innovation. Often the language of the reports is so depersonalized that subjects of the research are unable to relate to the material.

It is further argued by Meekosha (1989) that the administrative and bureaucratic context needs to be considered by the researcher. Five broad issues are identified which need to be considered in developing strategies for change. They are as follows: the myth of the neutral and compliant public service; the personal commitment of the minister; the importance of the private agendas of the senior officers; peer group influence about what constitutes an efficient and effective officer; and, the capacity of organized interest groups to influence priorities. The use of research by the state is most likely when a high degree of consensus exists between the researcher and the user about the definition of the problem and the solutions to the problems. Meekosha argues that "a feminist critique of bureaucratic practices written within a feminist

discourse is perhaps the most challenging to a bureaucracy which is essentially a male dominated organizational structure" (p. 263). In fact, Meekosha further argues that the traditional paradigms and methodologies are unlikely to produce research that is likely to challenge the existing state power relations. In her view, feminist research can challenge the hierarchies of patriarchy in class society if it identifies the contradictions at the heart of the state's relationship with women, but it must link into the social movements for change. "The hierarchy of the bureaucracy will attempt to make these links as difficult as possible" (p. 265).

In their experiences of researching organizations for renewal and change, Ristock and Pennell (1996) argue for research as empowerment "an approach to research that seeks to effect empowerment at all stages of the research process through critical analysis of power and responsible use of power" (p. 9). They view practices for which organizations routinely hire consultants, i.e., program evaluations, as opportunities to build workplace democracy through the process of research as empowerment. They pay attention to the "insider-outsider" issues in consulting and argue for the consultant operating within a democratic arrangement. In their orientation, "all workers are consulted, in confidence; the consultant and workers jointly come up with a plan of action; and the workers control the use of the information that is generated" (p. 37). The contributions of both workers and consultant are acknowledged and valued.

In summary, the ability of research to empower the disadvantaged and oppressed was strongly supported in the literature. An empowerment model to empower nurses in the process of research was conceptualized. The need for the researcher to consider

the administrative and bureaucratic context was recommended. Five broad issues needing to be considered in developing strategies for changed were discussed. An argument was made for empowerment at all stages of the research process.

Gender

The study of gender in feminist research is discussed according to the two sub-themes of reshaping of discipline, and gender, social class, and race.

Reshaping of Discipline

Trends in the study of gender in the further shaping of sociology is discussed by Mary Maynard (1990). It is Maynard's argument that the study of gender has added significantly to the topics studied within sociology and offers significant opportunities for advance in theory and methodology. It is underscored in the argument that "the study of gender isn't simply adding another sub-area of the discipline of sociology but that the study of gender is an important means through which sociology itself is being re-shaped" (p. 269). What is underway is a fundamental shift in emphasis for empirical sociology. This shift can be viewed in three ways. First, there is now a greater readiness on the part of sociologists to acknowledge the important interrelationships between the public and the private spheres and that they each contain a sexual division of labour. Second, it has been necessary for some reconceptualization of sociological phenomena to occur. For example, the term "work" is now used by many to include both unpaid as well as paid labour. Gittens; and, Pahl and Wallace argue that the family is increasingly referred to as the "household" to take account of single parents, single people and those living together in unmarried relationships (as cited in Maynard, 1990). Third, it is beginning to be

recognized in many empirical areas of sociology that emphasizing gender no longer means talking only about women. Maynard cites Clark and Critcher and acknowledges that writers in fields such as sport and leisure are also making gender a component of their studies.

An argument for the impact that the feminist critique has had on the tests, assessments, and methodologies in the discipline of psychology is made by Lewin and Wild (1991). The authors argue, yes, there has been progress but that it needs to go further. The feminist critique in psychology has included the following aspects: some tests and measures are unfair to girls and women; assumption of some researchers that women had less of a trait being measured; questioning the traditional conceptualization of psychological variables related to masochism, femininity, masculinity, violence, battery, sexual abuse, and rape; problems with operational definitions; and, tests and measurements being applied in a biased fashion. Several examples are provided by the authors but one stands out from the others. Before the 1990 revisions to the Minnesota Multiphasic Personality Inventory (MMPI), the femininity score was originally validated in 1956 on a criterion group of 13 gay men. This same test is used as an example where test developers have failed to respond to the feminist critique. The authors predict that as more feminists become involved as scholars and scientists in the discipline of psychology the field itself will change, the curriculum will change and the tests will change to reflect the curriculum.

Gender, Social Class, and Race

Questions about the relationship of gender studies to mainstream sociology are prompted by three issues (class, race, and masculinity), according to Maynard (1990).

With respect to gender and social class, the conventional parameters of social class analysis "are at best sex-blind and at worst overtly sexist" (p. 276). The inherent racism of many approaches to the study of gender is in Maynard's view, probably the most serious and important on-going debate taking place. Black women have argued that much of the literature on gender focuses on White women and has been written by them and for them. Ramazanoglu, cited by Maynard, argues for the analyzing of liberation rather than oppression for Black and White women which signals a new direction for gender studies and for sociology in the 1990s. Maynard identifies a growing focus on the study of men and masculinity, leading to a new interdisciplinary field, Men's Studies (Camiletti & Marchuk, 1998; Fareed, 1994; Robertson, 1995). The emphasis on the work that has been done seems more to uncovering the essential characteristics of who men are than what men do and the social consequences of this. Maynard (1990) offers the argument that it is true men haven't been afforded much attention, until lately, in the sociological literature but they have been scrutinized in a sizeable proportion of the literature on women. "Understanding gender relationships overall as the context implies that the focus of concern should be men's power over women and the relationship of masculinity to structures of privilege and superordination" (p. 285).

Alliances and betrayals in the racial politics of two feminist organizations is the research of Ellen Scott (1998). This researcher examined the social construction of racial-ethnic identity and expectations for alliances based on identity in a rape crisis centre and a battered women's shelter in a west coast U.S. city. She argues that women of colour, in both feminist activism and theory, have confronted the practices

(exclusionary) of mainstream feminists in the United States. Women of colour demand that women's experiences no longer be represented solely by White middle-class women. Scott used participant observation by working as a volunteer (field work). Volunteering, for her, was an imperative because of the sensitivity of the topic and her subjectivity as a White woman. In this capacity she was able to develop relationships with the members that gave depth to the interviews and increased trust in discussing racial politics. She constantly asked, "How does my racial identity shape my relationships with the people I am studying?" (p. 405). Her research interests were known to the staff, board and volunteers of the organizations and she spent 21 months participating in these organizations. Scott began individual semi-structured interviews lasting two hours with 37 members of the two organizations after she had been there a number of months. With key members she conducted second and sometimes third interviews. The conversational style of interviewing included narrative description of the history of the organization and members experiences working in a racially diverse context. In summary, the author found that feminist activists in these organizations persisted in the creation of alliances as partnerships for change. "These partnerships were constructed from ongoing negotiation fraught with the potential for betrayal, but also renewed by hope" (p. 422).

In summary, the study of gender has had an impact on the disciplines, particularly on the discipline of sociology. The power of "gender" to re-shape a discipline is an important insight gained in this section. The literature acknowledged that there were gender studies about women but that more recently studies were appearing about men. Understanding gender relationships was recognized in the

literature primarily as men's power over women, and masculine structures of privilege and "superordination." Black women's issues about gender and their representation in the literature were articulated.

Invisible Work and Silenced Voices

Daniels argues that many of women's activities, for example, family, community and volunteer work, are best described as invisible work when applying such terms as work and leisure (as cited in Devault, 1990). Many of women's activities do not fit into either one of these categories.

The parameters of the feminist critique of the social sciences extend to include a critique of the invisibility of women (both as focus of study and as social scientists) to a critique of the method and purpose of social science itself. It is the argument of Sherry Gorelick (1991) that women's experience of a world shaped by structures of inequality produces contradictory relationships among researcher and researched and requires a methodology that deals with difference and the blindness of privilege among women. Gorelick supports the notion that giving voice is not enough. Maguire is cited by Gorelick as saying, "Women know much and may learn more about their own pain, but some of the underlying causes of that pain may be very well hidden from them" (p. 463).

Acker, Barry, and Esseveld conducted research on women going out to work at midlife (as cited in Gorelick, 1991). What the women wanted from the researchers was more of the sociological analysis--an interpretation of their experience. The researchers had to go beyond letting the women talk for themselves and put their experiences into the theoretical framework with which their study was started (a

framework which linked women's oppression to the structure of Western capitalist society). These authors argue for a commitment to "reconstructing women's experience in a way that accounts for both their and our explanations of that experience and the relation between the two" (p. 468). These authors and others agree that the researcher brings to her interaction with the participants the following: social location, culture, motivations, limitations, ignorances, skills, education, resources, familiarity with theory and methodology, the trained incapacities of socialization in dominant institutions, and an outside perspective (useful or troublesome).

Susan Sherwin (1992) argues that many different voices need to be included in the research process; certainly women's voices need to be heard (Gregory & Longman, 1992). It is Sherwin's argument that in the existing health care structures, women do most of the work associated with health care, and "for the most part, are excluded from making the policy decisions that shape the system" (p. 228).

Research Design

Issues about research design are discussed in relation to the following topics of methods, and women as participants, not objects.

Methods

The methods issues raised are about ways of collecting data and analysis, and in health promotion research.

Ways of collecting data and analysis. The topic of gender asymmetry using feminist epistemological assumptions has been addressed by sociology researchers in various ways. The first of these identified by Cook and Fonow (1986) is visual techniques. Feminists have used methodologies such as photography and videotaping

to collect and/or elicit data. The authors use as an example the work of Barndt (1980) who used photo-novela to study the development of social and political consciousness among Peruvian women, participating in a literacy program. Triangulation of methods was another approach identified by Cook and Fonow. This refers to the use of more than one research technique simultaneously. To ensure that the findings may inform and compliment one another, usually at least one quantitative and one qualitative method is employed. Linguistic techniques concerns the borrowing of techniques commonly used by linguists to conduct conversational analysis. Cook and Fonow cite Fishman's analysis of taped conversations between couples in their homes with a focus as to how verbal interaction reflects and perpetuates hierarchial relationships between men and women. Textual analysis can take different forms but one approach is for researchers to address feminist issues through the study of written texts. Some researchers in sociology, as discovered by Cook and Fonow, have refined and developed quantitative ways of measuring phenomena which relate to sexual asymmetry and women's worlds. The collaborative or collective model of conducting research has been adopted by some feminist sociologists. Among other things, this approach provides an audience for sharing information about data collection and analysis. The situation-at-hand methodology involves using an already given situation as a focus for sociological investigation or as a way of collecting data.

In health promotion research. Located in both the health promotion policy literature and the feminist methodology literature is the work of Juanne Clarke (1992). In the article entitled, Feminist Methods in Health Promotion Research, Clarke critiques the methods used in health promotion research from the perspective of

feminist methodology. The significance of her perspective to my work is found in Chapter One, page 38; however, it needs to be said that it represents the only published feminist critique of health promotion research which appeared in the literature review. The convergence of the feminist research paradigm with other research paradigms found in the health promotion literature is an obvious rare and significant event. It signals a need for health promotion research to systematically consider gender in its formulation, conceptualization, data collection instrumentation, data collection and analysis. It invites future researchers in health promotion to attend to this issue because not only does our research not reflect gender issues but more importantly the conclusions and policies formulated also ignore this critical issue (Clarke, 1992; Gregor, 1997).

Women as Participants, Not Objects

The myths of a single, androcentric society; objectivity; historical and cultural abstraction; noninterference; and researcher authority are addressed in a research approach which is grounded in feminist theory and called Progressive Verification Method. The author of this method is Janet Billson (1991). The method was designed to increase the ability of social scientists to relate to women as subjects rather than objects of research in a collaborative mode of inquiry and closer to doing research with, rather than on women.

The Progressive Verification Method includes several stages which are: preparation; contact; data gathering; writing; community reflection; and, revision. The preparation stage includes: review of the literature; formulation of hypotheses from basic assumptions about women; creation of open-ended interview schedule to

test assumptions; and, review of statistical data and history for each community/ group. Contact includes: initial contact with communities; obtaining permission to conduct research in the community; provision of guarantees of anonymity and review; and, establishing first round of interviews. The data gathering stage includes: interviewing and participant observation; keeping field notes; and, continuing review of materials and literature. Community reflection includes: submission to selected community members for review and comment; clarification; and, follow-through on loose ends. The final stage of this linear but often recursive process is revision which includes: incorporation of community reflections into final draft; and, copies to community (whether or not published). Billson (1991) offers this integrated approach to research which has the potential to lessen the chances that researchers will distort, make invisible, or misinterpret diverse life experiences in research.

Savary (1997) investigated the impact of socio-economic conditions on immigrant and visible minority women's health in Vancouver, B.C. This study was informed by a Black feminist theoretical framework (encompasses theoretical interpretations of immigrant and visible minority women's reality by those who live it). A participatory approach to research was used based on action oriented participation. One of the study purposes was to identify the invisible health risks associated with the socio-economic needs of immigrant and visible minority women. Savary argues that resistance has always been central to the struggle of immigrant and visible minority women and women of colour, generally, in Canadian communities. The recommendations coming out of this research will be employed to create pro-active changes to the issues effecting the lives of these women.

Scientific Rigor

The topic of trustworthiness of the findings is discussed in detail in Chapter Three: Methodology, page 169. This section introduces the reader to the concept of scientific rigor and feminism.

Feminist Scholarship

With respect to rigor and standards of scholarship Webb (1984) argues that the honesty about theories and methods forces sociology to face its own shortcomings. The work is scientific in feminist research, reflexivity is fundamental, but it is on different terms from objective science. Feminist research, in her view, is more rigorous because it takes gender into account and insists on the experiences of women. The researcher involves the self in feminist research and feminist research as critique aims to work toward defining alternatives and understanding everyday experience for the purpose of bringing about change. A feminist philosophy of science, in her view, is concerned with making women visible and with theoretical and methodological issues. This stance is justification for feminist scholarship.

Credibility

Webb (1993) attends to the research issue of validity by incorporating the work of Lather who suggests data credibility checks (triangulation, looking for counterpatterns and convergences within the data; construct validity evaluated by reflexivity; face validity, "recycling" the analysis by participants and refining it based on their reactions; catalytic validity, evaluating whether the researcher has been successful in stimulating change). According to Webb, credibility is evaluated by assessing whether participants' experiences have been faithfully represented. For

example, "believability" can be assessed by researchers asking for verification on their research process by other researchers. Literature reviews can be verified for their comprehensiveness, effectiveness of data gathering techniques etc.

Feminist Scholarship/Conventional Standards

Rigor in feminist research is the agenda of Hall and Stevens (1991). They find the nursing literature lacking in an encompassing discussion of rigor in feminist research. What is generally used to evaluate standards of scientific rigor (discussion of reliability and validity) reflect the reductionism and objectivism embraced by positivist-empiricism. They acknowledge that nurse researchers involved in feminist research have few guidelines for dealing with reliability and validity issues.

It is the argument of Hall and Stevens (1991) that these goals are scientific and profoundly political. They are supportive of the perception that the positivist philosophical stance denigrates subjective experience and that subjective experience is central to nursing's humanistic, interactive practice (Munhall, 1992). Feminist scholarship acknowledges the validity of multiple realities woven by historical, contextual, and relational factors.

The essence of reliability is conceptualized in feminist research as the dependability of the research processes. Dependability, according to Hall and Stevens (1991), is ascertained by examining the methodologic and analytic "decision trails" created by the investigators during the course of the study itself. "Dependability is thus a measure of rigor which, unlike reliability, does not decontextualize the data and does not expect or require that observations be repeatable or constant across observers and time" (p. 19). Validity in empiricist studies refers to a data collection tool

measuring what it is supposed to measure. In feminist research, conventional instruments may fall short and qualitative methods are employed to capture women's lived experiences. The authors argue that feminist research is best evaluated by standards of rigor that reflect the adequacy of the entire process of inquiry, relative to the purposes of the study, rather than by standards that focus only on the accuracy and reliability of measurements within the study. "Reflexivity" means that the researchers examine their own values, assumptions, characteristics, and motivations to see how they affect theoretic framework, literature review, design, data collection, analysis, etc. "Credibility" is one of the tasks in feminist analysis, to construct credible descriptions and explanations of women's experiences that can be understood by both insiders and outsiders. "Rapport" is a criterion of adequacy reflecting how well participants' reality is accessed; for example, trust in the relationship, researcher sensitivity to language, etc. "Coherence" is a quality indicating a unity in the research account, derived from all the observations, records, responses, and conversations involved in the research process. "Complexity" is addressed by locating the analysis in the context of participants' everyday lives; exploring the influences of larger social, political, and economic structures; and providing historical background (Fine, as cited in Hall & Stevens, 1991; Reinharz, as cited in Hall & Stevens, 1991). Congruence among behavioral, verbal, and affective elements of particular observations, verbal responses, and written records helps to support the presence of "consensus." "Relevance" in feminist research, (the appropriateness and significance of research) is judged by whether the questions address women's concerns and by whether the answers to the questions can serve women's interests and improve the conditions of

women's lives (Wallston, as cited in Hall & Stevens, 1991). "Honesty and mutuality" in feminist research for example, are found in research designs that adequately depict women's experiences and genuinely convey respect and interest in the woman's unique experiences. One way to ensure this is offered in Oakley's (1981) method for interviewing which is one of exchange and dialogue. "Naming" is learning to see beyond and behind what one has been socialized to believe is there. It is creating concepts through words which are directly expressive of women's experiences. "Relationality" is reinforced by communal modes of inquiry that are participatory, nonhierarchical, and oriented toward social action in the construction of knowledge. The aforementioned components form a framework for evaluating research about and for women. Hall and Stevens (1991) argue that there is a need for a more relevant, just and complete framework for evaluating research dictated by women's history of oppression, invisibility, and objectification.

Funding, Writing, Publishing

Anderson (1991a) argues for a funding agency that will best serve the future generations of nurse researchers, one that is flexible enough to accommodate the multiple paradigms needed to build a rigorous science of nursing.

Issues with respect to publishing, appeared in the psychology literature. Walsh (1989) examined 228 research articles, using content analysis, that were published in the Psychology of Women Quarterly and Sex Roles over the journals' first decade. Minimal or no information about the scientist, citizen relationship was found in terms of level of participation, informed consent, and feedback. In order for feminists to resolve the identified contradiction between ideals and behaviour, Walsh recommends

the development of appropriate models for both research methods and report writing. Before this recommendation can be realized, Walsh suggests that institutional obstacles need to be overcome. Walsh cites McCormack who argues that the patriarchal social structure and bureaucratic organization of academic research reinforce objectivist methodology. According to Walsh, so do the typical criteria for promotion, tenure, and academic survival. Walsh suggests that editorial boards of feminist journals can ensure that their policies reviewing manuscripts reproduce core values. The American Psychological Association's (APA's) Council of Editors and its Publications and Communications Board can be pressed by feminists collectively to make changes to the publication manual so that "methodology, the research relationship, and human-centered report writing become an integral whole and equally valued" (p. 443). APA's Publication Manual (Fourth Edition), in general, is hostile toward qualitative research.

Devault (1990) argues that feminist work should be an important site for mutual influence. A feminist strategy in sociology for writing about women's lives must extend to the language of our texts; we must choose words carefully and creatively, with attention to the consequences of naming experience. "Part of the task of feminist writing should be to instruct a newly forming audience about how to read and hear our words" (p. 112).

In the writing of her Ph.D. dissertation, Sandi Kirby (1989) longed to have the voices of her research participants speak about their experiences. The clarity of the voices came at the point of working through each piece of information. She was now

ready to write a final report. "Even now, that sense of intimacy remains and that living, breathing data remains ever so" (p. 21).

Feminist Research: Selected Disciplines

Several scholars in the literature write about the importance of feminist research methodology to their discipline. A summary of their ideas is provided in this section according to the selected disciplines of nursing, sociology, psychology, and anthropology.

Nursing

Webb (1993) concludes that the new paradigm for nursing research recommended by MacPhersen, feminist methodology, presents challenges for feminist researchers as they acknowledge and resolve the paradoxes and dilemmas facing them. Parker and McFarlane (1991) argue that although several authors have written about the feminist perspective in nursing research, few authors have written about the empowering aspect of feminist research for nurse researchers. Feminist research methodology, they conclude, can empower researchers and this has implications for many nursing studies.

Nurse researcher, Joan Anderson (1991b), reflects on the social production of knowledge and the process of conducting research from a feminist perspective. The experiences of Chinese and Anglo-Canadian women with diabetes provided the incentive for the author. According to Joan Anderson (1991a; 1997) feminist theories provide the base for the paradigm shift and ensuing feminist research methods to meet the need in nursing for researchers not only to describe the lived experience, but to

unmask the context of that experience. Similarly, Chinn; and, McBride support a feminist perspective in nursing (as cited in Anderson, 1991b). A feminist perspective, they argue, goes beyond an examination of the inter-subjective construction of meaning. It unmasks oppression and relations of domination.

In the view of Keddy (1992) the most significant issue facing nursing scholars and practitioners in the 1990s is related to feminist research, theory and epistemology. Bungay and Keddy (1996) argue that nurses are actively seeking ways of understanding the social forces governing the world so they can alter the misogynist structures of health care (practice). They encourage nurses to discuss their research and share modes of thinking that are new and exciting (feminist methodology) and ones that hold out hope for the future of research in health care.

Torkelson (1996) identifies two aims of the feminist research movement within nursing science and refers to the work of Duffy and Hedin. The first aim is to increase the amount of research on women; and the second one is to recognize the influence of societal discrimination on the concerns of women and remedy those injustices.

Seibold et al. (1994) raise the issue of critical activism in feminist research and suggest the need for further debate by feminist researchers. They wonder how a study of single women and midlife and menopause, when the findings are findings showing only one view of reality, can improve the lot of women. These researchers also questioned whether a study of middle-class women serves to empower women who are less advantaged socio-economically or does it further marginalize them.

King (1994) argues that historically feminism and nursing have travelled separate paths but more recently nurse researchers have begun to undertake feminist research. The imperative, King identifies, for nurse researchers and their feminist research is the need to differentiate between the concepts, method and methodology. The purpose of feminist research, according to King, is to serve as a catalyst for the emancipation of women and the nursing profession. Campbell and Bunting (1991) also raise the issue of empowerment and argue that feminist research empowers all women and can empower nursing research.

Sociology

Cain (1986) argues that in the discipline of sociology, the relationship is the basic unit of sociological science. In terms of the standpoint specificity of knowledge, the author supports the view that the researcher must understand her standpoint in terms of the same theory she uses to understand those she investigates. As researchers we must be prepared to modify our theory so as to take real account of the facts. Cain encourages the approach that when we find a success story, we need to unpack it and locate those elements in it which really make for the success, to use the theory to make sense of rather than to deny the experience, and in the process search for the transformative potential.

In her argument of a sociology for women as proposed by Smith (as cited in Webb 1984), Webb reminds women sociologists that they work inside a discourse (male social universe) which they did not have a part in making. The determinate position starts from women's standpoint in a sociology for women and women are the subject rather than the object of study. Olesen (1994) argues that a major future

question for qualitative feminist research will be the degree to which the various approaches speak effectively to a sociology "for" rather than "about" women.

Feminist strategies for interviewing are discussed by Marjorie Devault (1990), with the focus on talking and listening from women's standpoint. Devault argues that in order to transform sociology (to write women and their diverse experiences into the discipline) we need to move toward new methods for writing about women's lives and activities without leaving sociology altogether. Duvault cites Smith who argues that the routine procedure of the discipline pull us insistently toward conventional understandings that distort women's experiences. In the perception of Stacey and Thorne (as cited in Devault, 1990), the dilemma for the feminist scholar is to find ways of working within some disciplinary tradition while aiming at creating knowledge that will transform that tradition. Devault attends to the issue, women and language.

It is Maynard's (1990) argument that many of the exciting and important developments in feminist sociological theory have taken place in parallel to existing theoretical work. "They have not, as yet, been significantly embraced by or integrated into it" (p. 273). Although Maynard observes that relatively little has been done to articulate the important theoretical and conceptual work of feminist sociology with methodology (theory and analysis of how research should proceed), there is one exception. Maynard cites the ongoing debate on gender and social class which is likely to be critical to the re-shaping of sociology in the 1990s. In this debate feminists are confronting mainstream sociology on the conceptualization, measurement and analysis

of an important dimension of social stratification. Women sociologists are taking issue with mainstream sociology rather than developing their own positions outside of it.

Some of the key themes and areas attended to in British sociology and an examination of the extent to which sociology has been transformed by the feminist impetus is discussed by Ann Oakley (1989). The work of Walby is cited by Oakley as providing four approaches to or stages of the development of the social sciences under the impact of feminism. The first is the almost total neglect of women's social position. Their treatment is in a brief aside or footnote and is associated with a loose, unscientific and often assumed attribution to biological influences of social differences between men and women. The second is the stage of criticism where flaws and fallacies stemming from this practice are exposed, and assumptions, for example, of the determinist nature of sex differences, are reconstituted as research questions or about the extent to which such differences are exhibited across time and between cultures. The additive stage is the third stage--women are added in as a special case, in order to compensate for their previous omission. The fourth is the full theoretical integration of the analysis of gender into the central questions of the discipline itself.

Oakley (1989) argues that increasingly and in the 1980s especially, those who have contributed to women's studies in sociology have concerned themselves with the theoretical integration of women's situation. It is Oakley's argument that "a sociology for woman demands the institution of a different modal form of social relations, one which will apply to the practices of sociology itself and will channel these away from the habit of deriving the concerns of sociology from a limited social agenda set by the powerful" (p. 462). Gittens; and, Askham support her argument that the feminist

sociological energies of the past 15 years have resulted in a more cautious attitude to key social institutions such as the family and marriage, which, under scrutiny, turn out to be composed of families and marriages (as cited in Oakley, 1989). Oakley views Walby's stage four as having two parts. First, the doing of the theoretical work and second, the institutionalization of the fruits of these labours. The feminist critique of science (Harding, 1986) is viewed by Oakley as having much to offer sociology concerning the true meaning of gender politics. This view supports Oakley's argument that a feminist epistemology requires the transformation of social relations themselves.

Devault (1990) cautions against abandoning the traditions of woman talk encouraged by professional training as sociologists to adopt an abstract, controlled, and emotionless discourse. Researchers need to incorporate into their practice distinctively female traditions and construct feminist discourses in the discipline of sociology which do the same.

Cook and Fonow (1986) analyzed the sociological literature of the past nine years for issues in feminist methodology. The question they asked was, what progress have feminist sociologists made in transforming the epistemological and methodological nature of the discipline of sociology? They found that in sociology, feminist methodology even if studies did not involve direct interaction with a target group of women, generally contained an awareness of policy implications. These authors argue that within the field of sociology, feminist methodology is in the process of becoming and is not yet a fully articulated stance. They believe that at this point in time there is no "correct" feminist methodology within the sociology discipline.

Gorelick (1991) concludes that the old way, the top down methods of politics and science is no longer an option. If the goal is to end the oppression of women, what is needed is a political movement and a social science that gives voice to women. Oppression is multi-faceted so giving voice is not enough. Gorelick argues for a social science produced by women of various social conditions that reveals the commonalities and structured conflicts in the hidden structures of oppression, both as felt and obscured. "The quest for such a science confronts and comprises a dynamic tension among the researcher and the researched, struggle and science, action, experience, method and theory" (p. 474).

Scott (1998) argues that feminist writings have created shifts in feminist theory (theory and practice). Women of colour have demanded an expansion of the definitions of women's experiences to include women of colour and the resulting shifts in feminist theory responding to this demand.

Psychology

Peplau and Conrad (1989) define the fundamental issue for feminist psychology as the "dilemma of combining feminism, a value orientation with action implications, and the tradition of psychology as an empirical science striving for objectivity and value-neutrality" (p. 381).

A call for change in the methodology used in feminist psychological research is made by Landrine, Klonoff, and Brown-Collins (1992) based on the argument that cultural diversity in feminist psychology cannot happen without methodological change. They argue that feminist research has the potential to be characterized as a rigorous and sensitive person-centered methodology.

Rather than accept the solution to replace traditional science with a totally new approach, in feminist psychology the more popular position is to reshape conventional scientific practices to serve feminist goals. The process will be an evolutionary one where individual psychologists and research teams work in their own diverse ways to use the methods of science to create new approaches to feminist research (Peplau & Conrad, 1989).

Lewin and Wild (1991) call upon the discipline of psychology to embrace feminist scholars and scientists. Their feminist contribution, these authors predict, will change the field, the curriculum and the tests in the discipline of psychology.

Walsh (1989) also presents arguments from the disciplinary perspective of psychology which hold true today. One of these is to ensure feminist representation on editorial boards and to ensure that feminists on the boards of feminist journals reproduce core values. The need for feminists to pressure APA's Council of Editors and Publications and Communication Board to make changes to their publication manual is much needed. Feminist research report writing and qualitative research reporting need to be respected and more favourably represented in the manual.

Anthropology

Anthropological paradigms of politics and gender are examined using a feminist perspective by Sharon Tiffany (1987). The argument is made that feminist scholarship is more than supplemental information about women added to existing paradigms. Tiffany argues that "a feminist anthropology which would reformulate the 'Science of Man' by asking different questions and by constructing new frameworks that contribute to an integrated understanding of human experiences" (p. 349).

In anthropological studies of politics, Tiffany (1987) found that women were invisible. This failure to recognize the diversity of women's political roles, according to Tiffany, is built into assumptions of male dominance. Another assumption operating is that politics occur beyond the domestic sphere associated with women. The conceptualization of "dualisms" is present in the anthropological literature (public/private; political/nonpolitical). Assumed in the dichotomization relationship is a theoretical and ideological opposition between the nonpolitical, domestic woman and the political public man.

In the anthropological literature, it is common to find women defined as productive and reproductive "valuables." Tiffany (1987) cites Smith who writes that "the failure to analyze women's participation in social systems has resulted in distorted or partial portraits of the cultures we seek to describe" (p. 347). Tiffany argues that the emergence of women's lives and experiences in recent anthropological literature, reflecting the influence of feminist scholarship, is a result of paradigm-induced changes in values and perceptions. Field workers are being sensitized to reflexivity in the research process, researcher/informant relationships, the dynamics of intracultural differences and gender differences in specific social systems.

Support for ethnography in feminist research is the argument of Klein; Mies; Reinharz; and, Stanley and Wise (as cited in Webb, 1993). The criticism by feminists about ethnographies concerns their neutralized authoritative ethnographic voice and homogenized people's lives (Cole & Phillips, 1995). Cole (1995) argues that feminist anthropologists try "to recognize new modes of authority that are experiential, intersubjective, and dialogical" (p. 192). She further argues that new and multiple

subject-positions are recognized by feminists in their texts. Feminist ethnographers, according to Cole, need to maintain what Harding refers to as "robust reflexivity" (as cited in Cole, 1995, p. 200).

Cole (1995) concludes that feminist anthropologists need to continue to use such categories as women and gender. Otherwise there is the danger that difference and multiplicity as dismantling categories may undermine movements to end the oppressions of women in their many forms. Cole argues that what feminist ethnography can contribute to anthropology is an unsettling of disciplinary boundaries. Feminist anthropologists need to be part of what they study and Cole further argues that this challenges the anthropological assumption of "standing outside."

Locating Myself Within the Context of Feminist Research

This section is about what I take away from the debate on feminist research, as reviewed in the literature.

There is strength to be found in feminist epistemology. I believe in research with, by, and for women. I am convinced about the tremendous forces of power and oppression experienced by women. And, I am tired of women's invisible work not being recognized in the private (home) and public (work) spheres of women's lives.

When I write and talk about feminism, nursing, and myself, I do not think of these as separate entities. I am compelled when I think of one, to include the other two. For example, I include feminism and myself in nursing debates; I include nursing and myself in debates about feminism; and my thoughts about myself include feminism and nursing. They are all connected and the sum total is greater than each

individual concept. The outcome when feminism, nursing, and myself are connected is a belief in the strength and power of women. Also, my own consciousness raising has implications for a collective consciousness raising. Why is this important to nursing? Nurses work in oppressive bureaucratic systems and their work is invisible. It will take feminist scholarship and feminist economists to make the invisible, visible.

Caring is generally conceptualized as the work of women. In the "work world" of community health nurses "caring" needs to be legitimated. Feminism celebrates caring and love. It embraces with passion the work of nursing. To do the caring work of nursing, one needs to be educated, intelligent and thoughtful. Feminism would bring more respect to the discipline of nursing, the valuing of women and their work and the promotion of epistemologies within the discipline.

Health, health care and health promotion are the purvue of women in the world. Feminism would place nursing on a more equal foothold with other disciplines. For example, the male dominated medical profession. Feminism would elevate and unite the nursing profession with their Sisters (other nurses). The opportunity for "synergy" leads to a new kind of energy which would effect theory, practice, research, and administration in nursing.

A most challenging aspect of nursing in the current milieu (health care reform) is the quality of work life. The labour unions speak with a labour and legalistic voice but perhaps, for example, if the union (Manitoba Nurses Union), the profession (Manitoba Association of Registered Nurses) and the university (Faculty of Nursing) were working together, the milieu in which nurses find themselves could change. By being united and working toward the goals of feminism, we would have a stronger

and united voice with policy makers and funders. Feminism can serve to be the force that unites these disparate agendas.

Feminism could be the balm (salve) to help promote healing and building "community" within nursing. The different factions of nursing are hostile and confrontational. Nursing is fractionalized around the different levels of Registered Psychiatric Nurses (RPNs), Diploma prepared nurses and Baccalaureate Nurses (BNs). These levels are not supportive of each other and are obstructive to the common goal of nursing.

Within the context of the "work world" of nurses, there are structures that have been in place for ages and never questioned or challenged, i.e., shift work. Also, the "great divide" between hospital and community nursing continues to exist. Feminism would challenge hospital and community ideas in a process of de-constructing meaning and re-conceptualization for the benefit of the "community." Feminism contributes to the building of community and changing structures and the manner in which nursing care is delivered.

Feminisms would embrace the "value plurality" within the discipline of nursing. Also, the language of feminist scholars in the disciplines acknowledges that inherent in words is the concept of "power", for example, informant versus participant and subject versus participant.

The statement made by a friend, "when I wear my glasses, I even hear better", I view as a metaphor for feminist research. The feminist lens, i.e., feminist methodology, not only serves the researcher in "seeing" the invisible experiences of participants but it also contributes to "better" hearing of their voices. It is feminist

research methodology that is going to amplify the voices of community health nurses and make transparent their work. My challenge will be to remain true to the data in a sensitive, thoughtful and honest way.

Conclusion

An overview of the literature on feminist research methodology was presented in this chapter. Several issues were discussed from a number of disciplines: nursing, sociology, psychology, and anthropology. The characteristics and dimensions of feminist research were explored. The value of feminist research methodology from the research experiences of feminist scholars was established. Locating myself within the context of feminist research was articulated. The next chapter describes the application of feminist research methodology to the study of community health nurses and their role in health promotion policy development and implementation.

CHAPTER THREE: METHODOLOGY

Introduction

This study is about women's voices and women's lives. The question is how do we come to hear and know the voices and lives of women? The research answer is through the methodology of feminist science. The method may be quantitative, qualitative or a combination of both. However, I chose naturalistic inquiry (qualitative) within the feminist paradigm, utilizing ethnographic interviews to give opportunity for the voices of community health nurses to be heard and their "work worlds" to be made visible.

The ethnographic interview process was shaped by the explicit theoretical and ideological perspective of feminism (Oakley, 1981). The principles of naturalistic inquiry are in concert with feminist science. For the purposes of this chapter, I will make use of the term feminist research (which includes the principles of naturalistic inquiry). Explicit in "feminism" and "feminist research" is the idea of political movement for social change in women's lives. Feminist research is for women, and upholds the purpose to make a difference in the lives of women (Harding, 1987).

Chapter Three is organized in two main sections: Feminist Methodology; and, Method (see Table 3).

Table 3

Outline of Chapter Three

Introduction
Feminist Methodology
1. Ontology
2. Epistemology

Method
1. Research Design
2. Ethical Considerations
3. Recruitment
4. Sample (The Participants)
5. Gathering Evidence
    a. Description
    b. Context
    c. Transcription
    d. Celebration and Gifts
6. Analysis and Interpretation
    a. Feminist Analysis
    b. Qualitative Approach
    c. Context
7. Evaluation (Trustworthiness)
    a. Credibility
    b. Transferability
    c. Authenticity (Fairness)
    d. Reflection and Reflexivity

Conclusion

Feminist Methodology

According to Harding (1987) "a methodology is a theory and analysis of how research does or should proceed" (p. 3). This same author has described three distinguishing characteristics of feminist research. They are as follows: new empirical and theoretical resources (women's experiences); new purposes of social science (for

women); and, new subject matter of inquiry (locating the researcher in the same critical plane as the overt subject matter).

Further to the definition of feminist research, Christine Webb (1993) defines feminist research and refers to Bernhard's eight criteria. These include: the researcher is a woman; feminist methodology is used, including researcher-subject interaction, non-hierarchical research relationships, expressions of feelings, and concern for values; the research has the potential to help its subjects; the focus is on the experiences of women; it is a study of women; the words "feminism" or "feminist" are actually used; feminist literature is cited; and, the research is reported using non-sexist language.

Similarly, Oakley (1981) presents questions that are characteristic of feminist research in contrast to conventional research reporting: how many interviews were done; how many were not done, etc. Oakley argues for description of the process of interviewing itself. These include the following: social/personal characteristics of those doing the interviewing; interviewee's feelings about being interviewed and about the interview; interviewer's feelings about interviewee; quality of the interviewer-interviewee interaction; hospitality offered by interviewees to interviewers; attempts by interviewees to use interviewers as sources of information; and the extension of interviewer-interviewee encounters into more broadly-based social relationships.

Harding (1987) argues that it is not by looking at research methods (techniques for gathering evidence) that enables one to identify the distinctive features of the best feminist research. She recommends separating out the issues of method, methodology, and epistemology and not using method to refer to all three aspects of research. The

work of Oakley (1981) is a good example of the connections between method and methodology, i.e., how an initial discussion about method can raise methodological issues.

Included in this discussion of feminist methodology are the philosophical perspectives of ontology and epistemology and their importance to feminist research.

Ontology

Silva, Sorrell and Sorrell (1995) provide a perspective on nursing's emerging philosophical shift from epistemology to ontology. By ontology is meant, "ways of being" (p. 2). These authors argue that as the world has become more complex, nurses' questioning has shifted from epistemological questioning to ontological questions. According to these authors, epistemology questions the structure and trustworthiness of knowledge. In contrast, ontology questions the nature and realities of beings. As applied to nursing, nurses question the nature and meaning of their own and their clients' realities and beings.

The lack of involvement of community health nurses in policy development is not just a nursing issue because gender is fundamental in this context. Florence Nightingale did not challenge the link between nursing and gender (as cited in Oakley, 1993b). Feminist research was chosen and applied in this study to disentangle the complex issues contributing to the "reality" and "being" of community health nurses and their lack of voice in the policy development process. Feminist research tries to hear the voices of the silenced and disenfranchised.

As defined by Stanley and Wise (1983) "feminism is not only a set of beliefs but also a set of theoretical constructions about the nature of women's oppression, and the

part that this oppression plays within social reality more generally" (p. 55). They argue that feminism directly confronts the idea that one person or set of people have the right to impose definitions of reality on others (Stanley & Wise, 1991). Stanley and Wise (1990), further argue that feminism needs to be present within the research process and they identify five sites, which include: in the researcher-researched relationship; in emotion as a research experience; in the intellectual autobiography of researchers; in how to manage the differing "realities" and understandings of researchers and researched; and, in the complex question of power in research and writing. These authors raise the issue of "inter-subjectivity" in research and argue that "in spite of our ontological distinctness none the less we assume we can, and indeed we do, 'share experiences' such that we recognize ourselves in others and they in us and can speak of 'common experiences'" (p. 23).

Bartky describes "double ontological shock" which she terms "complexity of reality": "There exists both an awareness that events may be different from their appearance and presentation by others (feminists seeing different from others) and also not knowing when they are 'actually' different and when such difference is 'merely imagined'" (as cited in Stanley & Wise, 1991, p. 279). Stanley and Wise (1991) argue that the feminist view of social reality involves a valid paranoia but that if something is experienced, then it is experienced validly: "If a thing is real in its consequences then it is real to the person experiencing those consequences" (p. 279). This was important to me, especially during the analysis and interpretation of data when I needed opportunity to discuss my interpretation of reality with others. The Chair of my Ph.D. Committee provided me with this opportunity. Colleagues provided support

during the writing process which was affirming of realities. Bartky's identification of "double ontological shock" may help to explain participants' reaction to the summary of findings which they all received. The majority of the feedback was provided by telephone, so that again, the conversation style of communicating was revisited from the initial interviews. As will be discussed in subsequent chapters the feedback was affirming. Many participants responded that their reality was "shocking." They attributed this to "reading" a reality which they live every day. My feeling was that this was true, but in addition they were confronted with a researcher's feminist reality which I believe, for the participants, was an understanding of their reality, mirrored in a different way and one that caused them pause for reflection. Also, nurses became aware of the reality of their "shared" experience. Sharing the findings among nurses was a validation of reality for each nurse and contributed to a sense of solidarity.

As will be discussed further in subsequent chapters, a reality experienced by community health nurses is the invisible nature of their practice. A qualitative method was chosen as a means to uncover the invisible nature of the community health nurses' work and considered the best way to listen to their voices. In the words of Ann Oakley (1993b) "nurses owe it to themselves to lift off the veil that has made them invisible, and make everyone see and understand how important they really are" (p. 51).

Epistemology

"An epistemology is a theory of knowledge. It answers questions about who can be a 'knower'; what tests beliefs must pass in order to be legitimated as knowledge;

what kinds of things can be known, i.e., can subjective truths count as knowledge?" (Harding, 1987, p. 3).

Oakley (1993a) cites Keller who wrote the biography of geneticist, Barbara McClintock. McClintock knew that reason and experiment were not enough on their own. She knew that what is needed instead is a capacity for union with that which is to be known, "a mode of understanding in which the knower and the to-be-known have equal status and in which the knower's different senses are not pressed into the dampening dichotomies of mind or heart and passion, reason or feeling" (as cited in Oakley, 1993a, p. 210).

The component of personal knowledge is one of four fundamental patterns of knowing in nursing identified by Carper (1978): "Personal knowledge is concerned with the knowing, encountering, and actualizing of the concrete, individual self" (p. 18). This knowledge, according to Carper, is broadly characterized as subjective, concrete, and existential. This kind of knowing promotes wholeness and integrity in the personal encounter, the achievement of engagement rather than detachment--"denying the manipulative, impersonal orientation" (p. 20).

As an academic, working in a university setting, the idea of promoting knowledge in a detached, manipulative, impersonal way is very real. Oakley (1993a) cites Rich who argues that the very notion of the university "rests on assumptions of social inequality and competitiveness, and on false ideas of objectivity" (p. 219). The "antidote" for me was in my choice of a feminist research process. A process where the "researcher" and "researched" are participating equally and where value is placed on reflexivity and reflection, created for me a learning opportunity which generated

personal knowledge about myself as a feminist scholar. This was my first experience in conducting a study that is feminist naturalistic inquiry. The participants in the study taught me volumes about my research questions and about myself as a researcher, academic, and human being. It is also true that personal and professional knowledge was gained by the participants. The following examples were offered by the participants in their feedback from the distribution of findings. Examples of individual personal growth were included in the following comments: "I will keep this summary at my desk and think more about it, a learning experience for me"; "I am continuing to work at understanding the feminist aspect." Collective consciousness was expressed in these comments: "It's nice to know I'm not alone"; "the need to nurture the collective really stood out for me." The necessity of nurses' involvement in policy development and implementation was expressed in the following comments: "Your work is a beginning to taking the need for community health nurses' involvement in policy development to the implementation stage"; and, "how do we get your findings to the policy makers?"

Feminist researchers know that personal values are brought to intellectual work. "The academic theorist or researcher, influences what is known" (Oakley, 1993a, p. 214). The personal perspective does shape knowledge and feminists make it a point to know when and how this happens in the research process. For the feminist researcher, the research does not have an ending, at least not until it has a socio-political impact. For this reason I look forward to sharing the findings further with participants in a public forum at the time of defending the research. This will give nurses the opportunity to strategize together around issues of implementing the research

recommendations. Also, this will be a celebration and a time to share learnings, both professional and personal.

Harding (1987) argues that in feminist research, one of the characteristics is that the research is located in the same critical plane as the overt subject matter. The researcher is seen not as an invisible anonymous voice of authority, but a real historical individual with concrete, specific desires and interest. Both "researcher" and "researched" share the same level playing field. In my role of professor and mentor to community health nurses, I needed to be cognizant of the power relationship in the interview process. For this reason, Oakley's (1981) approach to interviewing was chosen. She views the interview as a discussion or guided conversation in which both the interviewer and interviewee share information and contribute to the research process. This is in contrast to a traditional interview process which is hierarchical; where the interviewer has power over the interviewee.

The power aspects exist not just in the interview process, but also when "reading" the interviews and "writing" about them. The relationship of the "knower" to the "known" became an issue in this research; for example, the reading/analysis and interpretation of transcribed data. Schweickart (1991) addresses the issue of reader-response criticism and she argues for the engagement of feminist criticism, toward a feminist theory of reading. Culler argues that models or stories of reading are organized around three problems (as cited in Schweickart, 1991). The first of these is the question, does the text control the reader, or vice versa? Reading always involves a subject and an object, a reader and a text. The second question raised is, what constitutes the objectivity of the text? The third problem is the ending of the

story. "Readers may be manipulated and misled but when they finish the book their experience turns into knowledge" (p. 530). Feminist criticism, it is argued by Schweickart (1991) would move the thesis of reader/response criticism from the reader, an active producer of meaning, to the recognition that there are many different kinds of readers. Culler raises the question that if the experience of literature depends upon the qualities of a reading self, what difference would it make to the meaning of literature if the self were female? (as cited in Schweickart, 1991).

In addressing Culler's concerns, I offer the following perspectives. I took measures to decrease the distance between reader and text. I tempered the language such that I tried to achieve maximum accessibility for the readers of the text, e.g. women. The text in the dissertation findings chapter is written such that the text does not control the reader but invites the reader as a participant in a discovery of knowledge. In other words to keep the discouragement that happened to me when I reviewed the scientific literature from happening to my readers. The intent was to have my writing embrace the reader. The concept, inter-subjectivity, was important to my work. Inter-subjectivity in the reading/analysis of data promoted shared meaning making. Kirby and McKenna (1989) argue that inter-subjectivity is necessary: "An authentic dialogue between all participants in the research process in which all are respected as equally knowing subjects" (p. 28). In this study the prominent activities of reading (transcription) and writing (dissertation), two important areas of political struggle, are crucial components of a feminist research process, interpreting the world in order to change it. For me, this struggle was motivated by the power of evidence to make change happen. For others, my advice is, be prepared to give a full

commitment to any feminist research process and accept the struggle which in the end is very worthwhile.

Method

A research method "is a technique for, or way of proceeding, in gathering evidence" (Harding, 1987, p. 2). In this study, women-centered interviewing was utilized to ensure that the voices of the community health nurses were heard and their work made visible. Their interviews were tape recorded and a semi-structured interview schedule was used which included questions about policy development and implementation involvement and questions about the work of the community health nurse so to establish the work reality context.

Included in the discussion of method are the areas of research design, ethical considerations, recruitment, sample, gathering evidence, analysis and interpretation, and evaluation.

Research Design

The methodology including ontology and epistemology is feminist science. All elements of the method, which is naturalistic inquiry and more specifically women-centered interviewing, including interpretation and evaluation are shaped by the tenets of feminist science. The ethnographic interviews, again an element of method, were themselves predicated upon feminist science. Therefore this study is feminist naturalistic inquiry (see Figure 1).

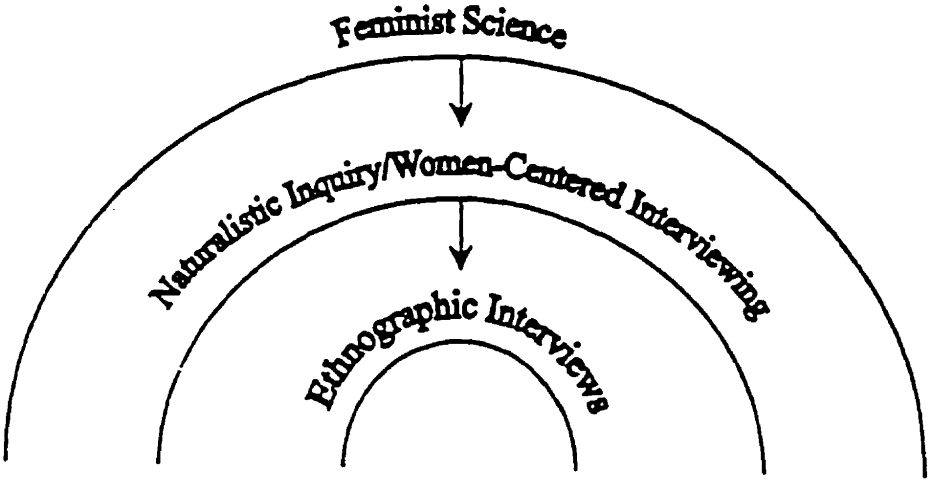

Figure 1. Research design

Lincoln (1992) argues that naturalistic inquiry is more resonant with human, social, behavioral, and cultural phenomena. When describing the naturalistic paradigm, Lincoln and Guba (1985) refer to the work of Willems who defines "naturalism" as it is proposed in behavioral research. What Lincoln and Guba conclude is that in naturalistic inquiry "no manipulation on the part of the inquirer is implied, and the inquirer imposes no a priori units on the outcome" (p. 8).

Lincoln (1992) makes her argument for naturalistic inquiry as a replacement to the positivist, conventional model of inquiry. Although I am respectful of Lincoln's perspective, that one paradigm should replace another is challenged. To not replace, offers another lens that is complementary and helps us to understand better the world

of social/cultural/historical phenomena. Thus, naturalistic inquiry should be brought to research in the health promotion field. The ontological, epistemological, and methodological differences of naturalistic inquiry include the following: a relativist ontology; a monistic, subjectivist epistemology; a hermeneutic methodology; and, both quality criteria of trustworthiness and quality criteria for authenticity (Lincoln, 1992; Lincoln & Guba, 1985).

This study has elements of ethnography but the emphasis of these elements is not made completely clear in the literature. For example, Patton (1990) describes ethnography within the discipline of anthropology as characterized by immersion in the culture through intensive field work. Wolcott (1980) argues that the above is true but what makes ethnography distinct is "the matter of interpreting and applying the findings from a cultural perspective" (p. 59). The debates in the discipline of anthropology concerning ethnography and feminist ethnography are articulated by Cole (1995). The literature on feminist ethnography raises further questions. Feminist ethnography is theoretically grounded in field work and gender. For the anthropologist, gender is subjected to a cultural analysis. Feminist ethnographers have criticized ethnographies characterized by "authoritative ethnographic voice and homogenized people's lives" (Cole & Phillips, 1995, p. 2). These authors argue that feminist perspectives on anthropology remain unrecognized and are considered not to be legitimate. The debate and lack of consensus within the discipline of anthropology about ethnographic research persist in the literature. There is no right answer in the debate, what is ethnography and feminist ethnography. This lack of consensus as to a clear meaning of ethnographic research and the debates about ethnography and

feminist ethnography within the discipline of anthropology caused me to reconsider its relationship to my work. However, the ethnographic interview was of significant importance to this research.

Irrespective of discipline, culture/cultural context is a salient element in feminist scholarship. Although culture was not central to my research questions (gender and power were central), components of culture were uncovered as they related to bureaucratic systems. However, I hesitate to declare this study, feminist ethnography because of the following reasons;

1. Gender and not culture was a primary concern.
2. There was no application of participant observation.
3. There was absence of field work.

In fact, opportunities for field work were limited. In retrospect, it would not have been possible to do field work because of the lack of involvement of community health nurses in policy development and implementation in the field. I had identified assumptions prior to collecting data and this lack of involvement in policy making was one of them.

Patton (1990) argues that orientational qualitative inquiry begins with an explicit theoretical or ideological perspective that governs decisions at all phases of the research process, i.e., in my case feminist theory. He further argues that the extent to which any study is orientational is a matter of degree.

As with grounded theory (Glaser & Strauss, 1967), an inductive strategy was used. In the case of my research, the themes, concepts, and subconcepts emerged

from the data and I maintained an open mind. It is the argument of Stanley and Wise (1991) that the research experience itself is subject to ongoing "theorizings" (p. 267).

To summarize, in the decision about the research design I used in my study, the argument can be made that there are elements of ethnography, orientational, grounded theory and others; and in spite of their distinction, sometimes these elements overlap. For the reasons cited previously, I chose to identify my research design as feminist naturalistic inquiry, specifically women-centered interviewing (Levy, 1998). I felt the need to put a label on my research so that scholars and colleagues will know what I have done.

Community health nurses, working in two public health nursing service delivery agencies in an urban setting, were recruited for this study through a letter of invitation. Thirty-one nurses were interviewed using a semi-structured interview schedule which in addition to health policy, explored areas such as work environment, health promotion needs, and the opportunity for women's voices to be heard. The transcribed data from tape recorded interviews was analyzed using qualitative methods in the form of content analysis. Themes, categories, concepts, and their relationships emerged from the data. Feminist theory and analysis were brought to the interpretation of data. Feminist approaches to research were applied at every phase of the research process.

Ethical Considerations

Ethical approval was obtained from the Faculty of Nursing Ethical Review Committee (see Appendix A). In preparing the proposal for their review, I followed the guidelines provided by the Faculty of Nursing Ethical Review Committee for

proposal submission, and I incorporated the criteria of the draft Code of Ethics for the Canadian Women's Studies Association/l'Association canadienne des études sur les femmes (CWSA-ACEF) (Kirby, 1991).

Access to the two official public health agencies was obtained from the appropriate contact persons (see Appendix B). The procedures for gaining research access in both settings were followed.

A consent form was used to inform the participants and ensure confidentiality was being maintained by the researcher. At the interview, two copies of the consent form were signed by each participant. I kept one copy and the participant kept a copy. Written into the consent form was the idea that participants could withdraw from the study at any time (see Appendix C).

The anticipated issue of power in the researcher/participant relationship based on my former role as teacher of the participants ("historical power residue") was written into my proposal to the Ethical Review Committee. Before proceeding with each interview I planned to compare "our" realities since the students graduated. Women-centered interviewing with an emphasis on "power with" and not "power over" was identified as the approach to gathering evidence. The issue of power in my relationship with participants who were former students is discussed further on pages 159 and 174.

During the latter phase of recruiting participants, I met with the Chair of the Ethical Review Committee, Faculty of Nursing to seek advice about obtaining the final four participants and I followed up this meeting with a letter to her (see Appendix D). Approval was provided to have a notice posted in each public health

office, requesting four more participants for the study. The contact persons (access) were again approached and they facilitated this contact.

An issue of an ethical nature arose at the time the summary of findings was distributed to all participants for their feedback. One of the first participants to respond asked if she could distribute copies of the findings summary to the public health nurses working in her office. I was confronted by the reality of "action" versus "confidentiality." I consulted with the Chair of my Ph.D. Committee who advised me that even though the participant was comfortable to disclose her participation in the study, this was not desirable as there may be consequences for her as an employee and she should not put herself at risk. The participant understood and was accepting of the plan that information about the study would be made available to the public health nurses, once it was completed. For the time being, the study was considered research in progress.

Recruitment

Thirty-one community health nurses were recruited for the study. They are employees of two official public health agencies, The City of Winnipeg Department of Health and Manitoba Health. As per the agreed upon protocol, a list of the public health nurse employees was provided to me by the appropriate contact person in each agency. A letter of invitation, asking for volunteers to participate, was mailed by the researcher to the community health nurses working in each public health nursing office in Winnipeg (see Appendix E).

The letters of invitation were mailed on February 18, 1994. The first interview took place on March 21, 1994. By June, I had recruited one-half the required sample

size. A follow-up letter which encouraged participation was mailed to the nurses at their office (see Appendix F). In September, letters were sent to the two agency contact persons requesting that the nurses be reminded of my study and the need for 10 more participants (see Appendix G). By December, 1994, 4 participants were needed to complete the anticipated sample of 30 nurses. I prepared a poster notice which was distributed to the public health nursing offices by the agency contact persons (see Appendix H). In fact, 5 nurses responded, thus completing the recruitment phase of the research (finalized within the year).

At no time did I recruit nurses on site. In the fall of 1994, I was invited to a meeting of the Community Health Nurses Interest Group briefly to discuss my study and after that meeting, I received telephone calls from at least 3 newly recruited volunteer participants.

Some of the motivators to participate that came from the nurses were as follows: the perception that nurses who were not involved in policy development be recruited first; a sincere willingness to help; curiosity and the opportunity to learn; a researcher's willingness to listen; a belief that community health nurses should be involved in policy development and they were not; and, a desire to want to change present circumstances through the research process.

Any hesitation about community health nurses not wanting to participate in what may be seen as an academic exercise was unfounded. The reason I feel confident about this is because the feminist research paradigm I used is based on the value of women's experiences. The interview process was a means of listening to the work experiences of community health nurses and recognizing their work. My initial

concern that this research may not be of interest or thought to be needed by community health nurses and may be viewed as an academic exercise, self-motivated to meet a degree requirement, was not borne out.

Sample (The Participants)

The sample was obtained in a convenient way, as previously mentioned on page 150 by circulating a letter of invitation to community health nurses in the two official public health/community health agencies, requesting their participation in the study.

Consistent with this research methodology, the exact number of participants was not known; however, it was expected that at least 30 nurses would consent to participate based on prior research experience with this population and an expected participation rate of at least 50% of the population. In fact, 31 nurses participated. The number of participants required for this study depended on the saturation of data. Gathering evidence stops when there is a substantial degree of repetition in the data. Although there was no attempt to have equal proportions of nurses from each official agency, by happen chance, the sample consisted of 15 nurses from one agency and 16 nurses from the other agency.

A demographic profile of participants can be found in Table 4. The majority of the nurses were female (n=30). They were primarily white Caucasian and there were no Aboriginal nurses in the sample. Again the majority of the nurses (n=23) were full time employees. The remainder (n=8) worked part time. Two nurses were planning to retire within a year. Of the 31 nurses, 25 worked at the field level, the practice level with individuals, families, groups, and communities; while 6 nurses held administrative positions. The field level included 2 nurses who were working in the

Table 4

Demographic Profile

Gender		Race/Ethnicity		Full/Part Time	
Female		White Caucasian		Full Time Employees	
n=30	96.8%	n=29	93.5%	n=23	74.2%
Male		Other		Part Time Employees	
n=1	3.2%	n=2	6.5%	n=8	25.8%
Position in the System		**Satisfied/Dissatisfied with Work**		**Health Problems**	
Field level		Satisfied		n=4	12.9%
n=25	80.6%	n=23	74.2%		
Administrative level		Dissatisfied			
n=6	19.4%	n=5	16.1%		
		Partly satisfied/partly dissatisfied			
		n=3	9.7%		
Education		**Years of Work Experience**		**Other Responsibilities**	
Baccalaureate Degree		Years of Work Experience as a Nurse		Married/Partners	
n=29	93.5%	(1-5) n=3	9.7%	n=25	80.6%
• Nursing n=28	90.3%	(6-10) n=6	19.4%		
• Other n=5	16.1%	(11-15) n=12	38.7%	Children at Home	
• Graduates, Faculty of Nursing, University of Manitoba n=24	77.4%	(16-20) n=5	16.1%	n=20	64.5%
		(21+) n=5	16.1%	Single/Separated/Divorced	
Graduate Degrees				n=6	19.4%
n=2	6.5%	Years of Experience as a Public Health Nurse			
		(1-5) n=6	19.4%		
Students in Undergraduate/ Graduate Programs		(6-10) n=11	35.5%		
n=4	12.9%	(11-15) n=10	32.3%		
		(16-20) n=2	6.5%		
Certificates/Diplomas		(21+) n=2	6.5%		
n=6	19.4%				
		Experience in Home Health Care i.e., Victorian Order of Nurses (VON)			
		n=5	16.1%		

field but in special programs. Three nurses working in administration held supervisory positions, and the other 3 nurses administrated special programs. I asked the nurses about their satisfaction with work. In spite of the fact that every nurse had concerns about some aspect of their work, the majority responded that they were satisfied with work. Four nurses volunteered information on health problems and this information was not pursued further.

Of the 29 nurses who held baccalaureate degrees, 3 nurses held more than one undergraduate degree. As would be expected, an overwhelming majority of the nurses earned baccalaureate degrees in nursing. The other undergraduate degrees were primarily in Arts and Education. As was anticipated, the majority of the participants obtained their degrees at the University of Manitoba and in the Faculty of Nursing (n=24). Twelve of the nurses were my former students. Of the 4 students in the study, 2 were currently undergraduate students and 2 were graduate students.

Over half the sample (n=19) worked with the same agency for over 10 years. Two of these nurses remained between 16 and 20 years and 2 nurses remained beyond 21 years. During the course of this study, there was very little movement of nurses within their agencies and no movement between agencies. Overall, nurses when they join one of the two official public health agencies, remain there and they remain for the majority of their careers.

Not only were these nurses busy at work but they had many responsibilities outside of the workplace. Of the 20 nurses who had children living at home, 11 nurses had an average of two children who were young and growing. Nine nurses had an average of two teenaged children living at home. The majority of the participants

(n=25) were married/partners. Whether it was children and/or other community responsibilities, my perception was that these participants were committed to their work, families, and their communities. In fact, many times the issues they were helping clients with, were the same as they were coping with in their own lives. Great demands were placed on these nurses both in the public and private spheres of their lives. My distinct feeling was that they valued their careers, their families, and their communities; and, they seemed enthusiastic about giving generously of their time to meet the needs in all spheres of their lives. They even made time to participate in this research. In fact, the interviews were conducted on participants' time. I believe this group of participants, although dedicated, committed, and highly energetic, were subject to the burdens of meeting expectations within their personal and professional lives.

The analysis of demographic data raises some critical questions. What is clear about the demographic profile of the participants is that they are intelligent, well educated, middle class women, with life experience, and who are privileged in society (compared to many other women). One would think they would have power in the workplace, within the structures of public health nursing. And yet, as will become evident in subsequent chapters of the dissertation, this was not the case. In the reality of their "work worlds" they were oppressed.

The power of patriarchal bureaucracies is real, when a group of remarkable women, 30 community health nurses, suffer from oppression. Upon reflection, all of us should be concerned about this phenomenon. In this study, oppression was systemic and a question arises as to the relationship of oppression in the workplace and

oppression in the private lives of these women. How does acceptance of workplace oppression in the public sphere of life relate to oppression in the private sphere of women's lives?

It is beyond this study to contemplate the private worlds of these women, but if educated women are subject to oppression in their work lives perhaps they suffer from further oppression in their homes. Although not reflected in the demographic profile, minority and women of colour may be a particularly vulnerable group within the workplace setting.

Gathering Evidence

This section includes a description of the process involved in gathering evidence such as the description of the process, the context, transcribing the interviews, and the need to celebrate. Kendall (1997) argues for the use of the term "evidence" defined by the Oxford English Dictionary as clearness, obviousness, and conspicuousness. When evidence is less crisp and clear, then the legal interpretation of this term becomes relevant; "we need to use critical appraisal skills to make judgements about its admissibility" (Kendall, 1997, p. 5).

Description

Data were generated using a semi-structured interview schedule developed by myself and based on a review of the literature spanning several disciplines for the purpose of guiding the interview (see Appendix I). The importance of understanding the social reality in which nurses' work was considered in all sections of the interview schedule. The questions were used as a guide in an interview process which took the form of a conversation. The written questions were passed to the participant for

her/him to look at prior to beginning the interview. Written permission was obtained from each participant in the form of a written consent which outlined the confidentiality of the information, and more specifically, permission to tape the interview. The participant was given the option to stop the tape recorder at any time. The interviews lasted approximately 1 1/2 to 2 1/2 hours.

The majority of interviews took place in my home (n=17). The others took place in the participant's home (n=6), the participant's office (n=6) and at the University of Manitoba, Faculty of Nursing (n=2). The decision about the interview location/setting was made by the participant based on the location that was most convenient and comfortable for them. Perhaps their decision to come to my home was related to their comfort level with making home visits.

The process used to develop the interview schedule included a review of relevant literature, an analysis of that literature for key themes and concepts, thoughtful consideration of research assumptions, frequent thinking back to the research questions and awareness of contextualizing the research in the practice experience of the community health nurse. Five seemingly appropriate categories evolved from the process and include: general questions, policy development and implementation, health promotion needs, women's voices, and other. Questions were designed to facilitate the participants' journey with the questions vis-a-vis the focus of the dissertation. This approach offered participants the opportunity to talk about work and their relationship with the community without being constrained.

After the interview, when the tape recorder was turned off, I asked the participants to comment on the interview schedule and the interview process in

general. My field notes indicate that the interview schedule worked well and that the interview process was mutually rewarding. The unknowns about health care reform created anxiety for the nurses; job security was one issue they discussed. They were interested in my thoughts on nurses' involvement in policy making, and agreed that this just was not happening. The feminist focus of my research was of interest to the nurses. I discussed with them why I chose this focus. To my amazement, all participants (31 nurses) considered themselves to be feminists. They viewed feminism as associated with equality for both women and men.

It is important in using an interview schedule to gather comparative information about it and make appropriate changes to questions along the way. One example, for me, was the need to re-phrase how I asked the questions about policy development at local, provincial and national levels. Rather than asking one question, I asked three separate questions for each level of involvement and in a more conversational style. In a feminist research process, the experience of the participant is valued and helps to shape the research process at all phases, not the least of which is the gathering of data.

This research process, including the interview schedule, was pilot tested in an interview with one community health nurse and was found to be feasible in eliciting rich and detailed data. This aspect of the study was conceptualized and applied as part of a feminist research course requirement; the results were invaluable. This interview was conducted with an experienced community health nurse and the interview took place in my home.

The interview guide was shared with each participant prior to beginning the interview. According to Kirby and McKenna (1989) by sharing the interview guide with the interviewees, the focus of the questions might change, and the result may be a better interview. I expect that this interview experience was representative of an eagerness for community health nurses to share their work experiences and contribute to the development of knowledge. Further, being silenced in their work experience, having limited opportunities to share perspectives, and experiencing lack of recognition represent three reasons as to why community health nurses had much to say about their work when interviewed. Another facilitating factor was my experience in using the interview schedule and process in subsequent interviews. Although the interview experiences did not seem lengthy to either myself or the participants, I felt some pressure to complete the interview process and not have it continue beyond three hours. One of the nurses contacted me two weeks following the interview, to add information about the aspect of rewards in nursing. Her telephone call was supportive and informative. She had obviously thought about her experience after the interview.

Context

Achieving an egalitarian arrangement in the interview process is an important consideration, identified in my "conceptual baggage" (Kirby & McKenna, 1989). In my role as professor and mentor to community health nurses I needed to be especially cognizant of the power relationship in the interview process, i.e., the co-creation of the database. For this reason, Oakley's (1981) approach to the interview process was chosen. She views the interview as a discussion or a guided conversation in which both the interviewer and interviewee share information and contribute to the research

process. Being more than an instrument of data collection, gives the interviewer the opportunity to be asked questions and contribute to the sharing of information. I found the experience very rewarding because my role was not objectified as I have experienced in traditional approaches. The feminist approach to data gathering allows for both "researcher" and "researched" to be partners in the research process. This partnership extends past the interview process to the reading/analysis of data. Schweickart (1991) argues that reading always involves a subject and an object. Inter-subjectivity promotes shared interpretation of the findings. This involves the reader choosing to take control of the reading experience rather than submitting to the power of the text.

Wheeler and Chinn (1991) define empowerment as "the growth of personal strength, power, and ability to enact one's own will and love for self in the context of love and respect for others" (p. 3). The researcher can be empowered by the approach used as well as the participants. For the researcher, not only is this in the receiving of information solicited and the information volunteered, but by being able to bring one's own experience to the interview. Through the application of the empowerment concept, shared power in the research process is ensured. Ristock and Pennell (1996) argue for research as empowerment; "an approach to research that seeks to effect empowerment at all stages of the research process through critical analysis of power and responsible use of power" (p. 9). It is their argument that when one analyzes power critically, material and discursive perspectives are brought to questions of power. Their work is advancing development of the feminist research process.

Kirby and McKenna (1989) argue that it is much more difficult gathering data from research participants whom we know. The tendency they say, is for old patterns to surface which may be counterproductive to data gathering. Although this may be true, it was not the case in my data gathering experience. Perhaps there are several reasons for the difference. One of these is my relationship with some of the participants which is best described as a mentor relationship. There was a greater need for both of us to maintain a relationship which mutually supports career aspirations. As a result, constructive interaction patterns came forward in the interview. I was much more concerned about addressing the historical power relationship of the professor/student relationship, than the familiarity relationship. For this reason, I took time before each interview to talk with the participants about their work and my work so we could establish a level playing field. Consciously realizing through discussion that our lives had continued to evolve since "teacher-student" days was an important aspect in transcending historical power relationships.

The conversation style of interviewing was a form of structure and combined with an interview schedule provided a very useful approach to data collection; one that kept both researcher and participant goal directed. Also being aware of one's "conceptual baggage" is a feminist approach to ensure that certain issues are addressed as they relate to all aspects of the research process and importantly the power relationship in the research process.

Briefly commenting about pets, flowers or children is suggested by Oakley (1981) to break the ice. Since the majority of the interviews were conducted in my home, the participants received an exuberant welcome from a Yorkshire Terrier who

also insisted on sitting on my lap during part of each interview. My kitchen provided a comfortable place to conduct the interviews "around the kitchen table." My pet provided a source of comfort to both "researcher" and "researched" and I believe helped to strengthen the interview bond. She also provided a source of humour when she barked while the recorder was taping.

Transcription

The transcription of audio-taped interviews was a critical aspect of my qualitative research. Speed and accuracy are skills of the professional, experienced transcriptionist. The researcher needs to bring the best skilled person to this activity. One needs an individual who has experience in transcribing. Prior to locating such an individual (half way through the process), I had employed new undergraduate and graduate students. I learned that the process skill, of the transciptionist, was essential. I had to hire a research assistant to review for accuracy the tapes and transcriptions completed by the students. I also listened to all tapes and critiqued each transcribed interview for precise exactness. I entered the analysis and interpretation phase of the study with confidence knowing that the transcribed data/text I was working with was completely accurate, beyond a reasonable doubt. I learned that transcribing data is an art and a challenging one, requiring superior skill. It is especially challenging when the interview is conducted in the form of a conversation.

Celebration and Gifts

An important aspect of the research process is to celebrate "researching" (Kirby & McKenna, 1989). The participants and I expressed enthusiasm and satisfaction with the interview process. The opportunity for us to participate in a shared experience for

knowledge development was extremely rewarding. At the close of each interview, I knew that the collaborative process of interviewing had worked, and I knew that I had a rich source of data that not only would address my research questions, but contribute to the creation of additional research projects. By not using a rigidly structured interview approach, I believe both I and the participants were able to experience what Sandra Harding (1987) calls, the "logic of discovery" (p. 6). It is through this process that women's experiences provide "new empirical and theoretical resources" (p. 6). I felt the goal of establishing rapport had been achieved.

Each interview experience included refreshments such as tea, coffee and cookies/cake. This was important in terms of the need to celebrate each interview experience and placed a value on hospitality. Hospitality, it is argued by Oakley (1981) is an important consideration in reporting feminist research. When the interviews were in my home, I offered the hospitality. When in the home of the participants, they provided the hospitality similarly. In fact, upon reflection, one of the aspects of hospitality was their invitation for me to arrange the interview in their home in whatever location I wanted. That decision involved their permission and our search together for the right spot with electrical outlet access for the tape recorder.

In one instance, I took a lunch to a participant's office and we ate together. On another occasion, I took the participant to lunch in a nearby café. These experiences occurred toward the end of the recruitment process. I left one of the participant's homes being given a loaf of homemade bread. On one occasion, when the participant asked if she could borrow one of my books on feminism, I bought her a book and took it to her office.

Analysis and Interpretation

A feminist perspective was brought to the analysis and interpretation phases of the research. There are three critical aspects to this discussion which include feminist analysis, qualitative approach, and context. They are each discussed as they applied to this study.

Feminist Analysis

"A paradigm is a world view, a general perspective, a way of breaking down the complexity of the real world" (Lincoln & Guba, 1985, p. 15). In using a feminist research paradigm, a feminist approach to research is brought to all phases of the research process, including the data analysis and interpretation. What makes this paradigm unique is that it makes good use of interdisciplinary feminist scholarship that women in the disciplines of science, sociology, women's studies, and other disciplines have developed and continue to develop. In their work about research methods from the margins, Kirby and McKenna (1989) believe that a feminist approach to the analysis of data requires inter-subjectivity and critical reflection on the social context. Each piece of datum is given equal opportunity to "speak" in the analysis. In order to understand the data, including the "silences", and effect change, these feminist scholars argue for the understanding of contextual patterns and how they are sustained and controlled. In other words, it is important to examine the social reality within which people exist and function.

Qualitative Approach

A content analysis of taped, transcribed, and written notes was applied to the data. A qualitative approach was chosen for this study because I felt that the best

answers to the questions about health promotion policy development and implementation would come from the community health nurses themselves. The argument put forward by Jayaratne and Stewart (1991) supports a qualitative approach by feminists in research where it is felt that women's experiences have not been freely articulated or conceptualized. This is especially true in relation to health policy development and implementation and the involvement of community health nurses. Given the four assumptions previously identified operating in this research (see page 7), I felt that a qualitative method would provide the much needed articulation/ conceptualization of the community health nurses' experiences in policy development and implementation.

The data collected from the interviews with the community health nurses were analyzed using qualitative methods in the form of content analysis. The perspective of feminism was applied to content analysis producing a context mindful product. Themes and key concepts related to the themes were identified from the transcribed data. Aronson (1994) argues that thematic analysis focuses on identifiable themes and patterns of living and/or behaviour. The relationships of the themes and concepts were analyzed and interpreted using feminist theory.

Burnard's (1991) stage method of analyzing qualitative data, Kirby and McKenna's (1989) concept of "hurricane thinking", and Aronson's (1994) pragmatic view of thematic analysis were useful to the process of data analysis and interpretation.

During the interviews, I made notes about observations and later, at the end of the interview, I took time to reflect back on the interview, reviewed my field notes,

added to them and documented insights gained through reflection. This information was useful to me in the analysis of data. For example, it helped me to know where to place emphasis in clustering data to form categories and yet again in formulating themes.

Immersing oneself in the data is a stage where the transcripts are read intensely and notes made as themes or concepts emerge. The next stage of open coding is where I documented the main ideas which were forming categories and these were freely generated. I also found colour coding of main ideas with transparent markers useful. By working directly on the transcribed text (right hand half of each transcribed page) I was able to associate the categories with the exact words of the nurses and the context in which they were spoken.

Having teased out the categories, I began to organize them under higher-order thematic headings and for the first time began to collapse similar categories. It was at this point that I began to see the categories taking shape. The "hurricane thinking" concept of Kirby and McKenna (1989) was a conceptualization that I applied. By organizing the categories around a key question at the center of a page and adjusting the categories in terms of stronger and weaker ties, I began to see the relationship of the categories to each other and to the question. At this point, I had my final list of categories.

As was previously mentioned, my Ph.D. Committee Chair reviewed the categories with me. Rather than the cut and paste method recommended by Burnard (1991), at this stage I laboured by hand to make the associations among the evidence-based categories. Through this process and by re-reading the transcripts, I began to

combine related themes and the thematic analysis took shape. This is where I became aware of the volume enhancement of each voice when the voices of others were added to the analysis.

The writing process and interpretation of evidence using a feminist perspective was concurrently applied. I kept notes about the relevance of literature sources in a file so I could refer back to these when writing the discussion chapter. Feminism provided me the lenses to look through and interpret the findings. This includes for example the following: oppression, silenced voices, power, gender, race, relationships, alienation, marginalization, struggle to be heard, Sisterhood, diversity, and the private and public worlds of women's lives. Many drafts were formulated until a final version was achieved. This process was facilitated by consulting my Ph.D. Committee Members and colleagues. This aspect of the analysis and interpretation can not be completed in isolation. It is important to compare interpretations of reality with others.

Once the findings chapter was written, I created, using the conclusion comments from each section of the evidence, a summary of the findings which I distributed to each participant for their feedback. The nurses' feedback was conveyed by telephone and for some, in writing. This was the first time the participants knew what other participants stated and the response was validating and positive. This feedback was integrated into the dissertation.

My open-ended interview schedule included sections on health promotion needs and women's voices. As I was analyzing these data at a beginning phase, I became aware that the evidence was repeating with other sections of the interview schedule

and also the evidence was beyond the scope of my research questions. For these reasons, these data will be analyzed at a later date. For me, this said that the conversational style of interviewing produces very rich data, issues are discussed as they occur to the participants and sometimes the evidence can go beyond the questions of the study, thus paving the way for future research.

Context

Community health nurses are prepared at the baccalaureate level. Their university education prepares them to function independently and inter-dependently in community health nursing roles. Upon graduation there is the leadership expectation (from nursing educators, practitioners, and administrators) that in their nursing careers they will be involved in policy development and implementation. As will be discussed in subsequent chapters, they are not involved in this very important role. While analyzing and interpreting the evidence, I was aware of this expectation of students and graduates. The question "why not" was a motivating factor for me in the analysis process.

The context of health care reform was articulated by the nurses in the evidence they provided; another advantage to a conversational style of interviewing. Also, the context of health reform was discussed by many participants and more so once the recorder was turned off. The implication of job security was a salient issue. Nurses expressed a high level of uncertainty about their roles, their jobs, and the nature of the re-structuring of community health care. When involvement in health policy is not a priority or considered an integrated aspect of community health nursing roles

(CPHA, 1990), there is even a greater chance it will not happen when nurses are expected within the context of health care reform, to do more with fewer resources.

Nurses provided evidence about the reality of their work environment. Open ended questions about accountability, work rewards, determining health promotion needs of communities, and who listens to nurses, produced lengthy discussions. This evidence was extremely useful as a context in which to understand their roles in policy development and implementation. The thematic/content analysis was a labour intensive activity. I did not use a computer program to manage the data. This intensive and lengthy process demanded considerable time investment. I looked to various means of maintaining my focus and cultivating inspiration. To this end, I burned scented candles, listened to favourite compact disks and moved my work to my garden where positive energies were found in the beauty of flowers and songbirds.

Evaluation (Trustworthiness)

The evaluation of naturalistic inquiry or trustworthiness of the findings (adequacy) uses various means to determine what traditional research refers to as reliability and validity (accuracy). Included in the discussion of evaluation are issues related to credibility, transferability, and authenticity. The critical processes of reflection and reflexivity are discussed in depth in Chapter Five, Discussion (see page 363).

Credibility

Guba proposes that for the purposes of naturalistic inquiry "credibility" replace the term internal validity (as cited in Lincoln & Guba, 1985). Validity is used by Ristock and Pennell (1996) to mean, the integrity and value of research. These

authors argue that validity "is achieved through accountability to the participants and to those who will be affected by the outcome" (p. 50). According to Webb (1993) credibility speaks to the issue of participants' experiences being faithfully represented and member validation.

Lather refers to face validity as meaning that the data are taken back to the respondents to establish data credibility (as cited in Ristock & Pennell, 1996). Member checks (Lincoln & Guba, 1985) provide participants the opportunity to determine whether the researcher has adequately represented their realities.

During the interview process, I asked each participant their views on having the opportunity to review a summary of the findings. In each case, the response was positive. All participants reacted by commenting to the effect that this was an interesting approach, one they valued, not having been asked before for their feedback on findings prior to the completion of a research project. Time to do this was not an issue for the nurses.

For me, as the researcher, I felt my comfort level increase with the plan to distribute the findings and talking to the participants about this at the interviews. Upon reflection I believe this was a good way to end each interview (an intensive personal and professional experience) knowing that our contact would continue, thus making "closure" not so final.

I wrote the findings chapter so that it would be interesting and understood by those who would read it and not only for an academic audience. I distributed the summary of findings to all participants. This consisted of the conclusion sections verbatim from the dissertation. Reflecting back on this process, I am reminded of my

feelings of vulnerability now that I was exposing my work to my critics; work that I had invested in emotionally and intellectually. At the same time I believed in the process and valued the opportunity to obtain feedback from participants.

Ristock and Pennell (1996) cite Lather who argues that construct validity requires that we recognize and confront the theoretical traditions within which we are operating and be willing to challenge and change them. The research design needs to be flexible to allow for this to happen.

An example to illustrate this kind of validity, requiring a flexible research design, occurred during the person-centered interview process. As researcher, I embraced feminist theoretical constructs of women's realities. Also I talked about feminism with enthusiasm. I remember, in this conversational style format, wanting to teach, to make theoretical and practice linkages, and to respond with verbal and non-verbal enthusiasm when my research premises were affirmed. As a participant in the research I needed to remind myself that central to the interview process were the participants; this required that I adjust my interview participation accordingly.

Lather's articulation of catalytic validity (as cited in Ristock & Pennell, 1996) or Acker, Barry, and Esseveld's articulation of worthwhileness (as cited in Webb, 1993) is achieved according to Ristock and Pennell (1996), "when participants, and the broader community affected by the research feel energized or re-oriented in some way by the project" (p. 50). Consciousness raising was an important aspect of achieving worthwhileness in this study.

Again, during the interview process various comments were made by the nurses which indicated to me that a form of "consciousness raising" was taking place.

Comments, for example, such as, "I haven't really thought about my role in policy development before now" and "I really need to become involved in policy issues." Other nurses commented, "Until now I have not made the connection between feminism and my work" and "This work situation sounds pretty bad, doesn't it." Another nurse commented, "I haven't thought about rewards or that I should even expect rewards in my work." My response to these comments was primarily to listen and not interrupt the connections being made by each participant.

Lincoln and Guba (1985) encourage peer debriefing as a useful technique to establishing credibility. Lincoln (1992) suggests that for naturalistic inquiry, the term confirmability replace the term objectivity. Webb (1993) refers to the term confirmability as "believability" of the research.

To achieve believability of the research I consulted with other feminist researchers to verify my work. I was fortunate to have a network of feminist scholars who were willing to review my work. This took place at the formal level with the Chair of my Ph.D. Committee and Committee Members. At the informal level, colleagues provided me with constructive feedback. This process was of enormous benefit during the research phase of analysis and interpretation of the data.

Lincoln and Guba (1985) argue that auditability be a criterion of rigor in qualitative research findings. Lincoln (1992) proposes that dependability replace the term reliability for naturalistic inquiry.

The consultation process when brought to feminist research, ensures that another feminist researcher could follow the "decision trail" being created. Part of the reason for this is that the research is not conducted in isolation and the "decision trail" has

through a consultative process, as well as feminist colleagues, discussed and tracked the general progress of my work so I know that they would come to comparable conclusions. Throughout the progress of this research, I was afforded several opportunities to present my work at national and international conferences. The constructive criticisms provided by peers/conference participants served as valuable consultation to my work. Also, the distribution of a findings summary to participants confirmed dependability.

Transferability

Guba suggests that for the purposes of naturalistic inquiry the term transferability replace the term external validity (as cited in Lincoln & Guba, 1985). Since the method used in this study is qualitative, the findings have theoretical generalizability and they do not have statistical generalizability (Yin, 1994). I do not see this as a weakness but a strength of a research process which seeks to hear the voices of women.

Again with reference to my presentation of this research at national and international conferences, audience participation raised issues of transferability. Having me repeat the study in another country was one such response. In another instance, a nurse suggested repeating the study with hospital nurses or with community health nurses in a rural area. Another nurse commented, "We are experiencing similar things as your findings; now the question is, what to do about it?"

Authenticity (Fairness)

Authenticity (Lincoln, 1992) speaks to issues of imbalances of power and representation, false experiencing, misunderstanding, impracticality, and disempowerment. Hall and Stevens (1991) suggest that authenticity is addressing issues of reflexivity where researchers consider their own values, assumptions, characteristics, and motivations to examine how they affect all aspects of the research process.

The issue of disempowerment will be used to illustrate authenticity in my research process. I made a concerted effort to examine the "researcher"/"researched" relationship from a perspective of power and familiarity. The goal was to empower the participants not to disempower them. Ristock and Pennell (1996) argue for research as empowerment. It was important for me to examine and analyze my use of power in the research process and to use power responsibly.

I began each interview with an update of the participants' experiences since my last contact with them for those participants who were former students. This way, I could be supportive and acknowledge their experience in nursing roles. I think that acknowledging I was a student helped me to create a more "level playing field." An atmosphere of acceptability also helped to build a comfort level where the goal was power "with", not power "over". Conveying mutual respect and recognition was helpful to facilitate a shared dialogue.

It was important for me to examine my values and their contribution, both positively and negatively, to the research experience. I was very aware of this process when analyzing and interpreting the data. It did matter to me what participants'

response would be to the findings but I had to be honest with myself and true to them in my interpretation, whether they agreed completely or not. Sandelowski (1986) argues for some distance in the research relationship so that experiences can be interpreted in a meaningful way.

Another dimension that contributes to the credibility of the findings is "value plurality." This entails privileging tensions, contradictions, and opposing views held by participants within the context of the findings. For example, when the explanation for lack of nurses' involvement in policy development and implementation included "administrators were too busy", this was in my interpretation lacking in insight. I included however this example in the analysis.

Reflection and Reflexivity

Discussion of these elements of a feminist research process are explored fully in Chapter Five, Discussion (see page 363).

Conclusion

In this chapter I presented an overview of feminist methodology including ontology and epistemology. An argument for feminist naturalist inquiry was developed. In particular, women-centered interviewing served as the research design. Ethnographic interviews shaped by the tenets of feminist science were conducted with 31 community health nurses. Ethical approval was obtained from the Faculty of Nursing, University of Manitoba prior to the commencement of the study. Highlighted in this chapter was the gathering of evidence, the analysis and interpretation of data and the evaluation (trustworthiness) of this study.

CHAPTER FOUR: FINDINGS

> I think the system hasn't changed, I think the acknowledgement that it should change is there, but not how to make that change and how people will respond to it. I think that's where you're going to make a difference to the entire population, not just to us in community health.

The findings presented in this chapter are based on an analysis of data collected in a conversational style of interviewing with 31 community health nurses. The interview schedule, comprised of open-ended questions was developed from an extensive review of the literature and from my own clinical and teaching experience in community health nursing. The findings are presented in three sections. The first, Section A--Agency, Invisible Work, and the Missing Voice of the Community: The Context, represents the findings from 10 questions with a focus on general work issues such as accountability and rewards. Section B--Frustration, Alienation, Resistance: Community Nurses' Involvement in Health Policy Development and Implementation, includes the findings from eight questions which pertain to the nurses' understandings of the meaning of policy development and implementation and their involvement in both these activities. The last, Section C--Equity, Vision, and Hope: The Canon, includes the findings from two questions about recommendations for change and additional comments.

Section A--Agency, Invisible Work, and the Missing Voice of the Community: The Context

To begin the conversation, I asked the nurses to respond to 10 general questions about their work. This semi-structured interview guide covered a wide range of work related issues including accountability, the rewards of work, definitions of community and health promotion, and the identification of community health promotion needs.

Themes

Based on analysis of the data provided by the nurses, six themes were derived from the interview data in Section A. These themes can be seen together in Figure 2.

Agency, Invisible Work, and the Missing Voice of the Community: The Context
1. The invisible nature of the work of the community health nurse.
2. Work as measured production.
3. The missing voice of the community health nurse in health care reform.
4. A tension exists in the scope of practice for community health nurses, and in particular, around the issue of community involvement.
5. The lack of public understanding about the role of community health nurses.
6. Agency structures are contributing to tensions.

Figure 2. Themes (Section A)

Theme 1 *The invisible nature of the work of the community health nurse.*

Many nurses commented about the work that they do, which is often in isolation, is not seen by the agency because it is done in people's homes. The public does not see it, and even colleagues do not see all of it.

One nurse explained the isolation in terms of the independent nature of the community health nurse's work. This nurse provided the following perspective.

> And that's partly because of the nature of all the kinds of work that I've done in the past, which is very independent. You know, when you are a community nurse, you are the only one in that community, and people don't look over your shoulder to see how you screwed up, or how you've done well. It's only the exceptional things that get noticed either way.

Work remains invisible often times because there are no opportunities to talk about it or to discuss successes. As one nurse commented with respect to work not rewarded,

> I think some soft type things are unrewarded like having a breakthrough with a family, a family that you may have been working with for a month, and finally something really positive happens. There's not always venues to talk about that. I mean that may happen more often than you have time to share in a one, or a few hour monthly branch office meeting. And so you just kind of carry on with that, knowing yourself, feeling somewhat self satisfied that things are going well. But there's not a lot of encouragement, or opportunity to talk about that.

Isolation in work was expressed by another nurse, however, this particular nurse voiced recognition of the team support which helped to counteract the effects of isolation.

> I think that's one of the things that really makes community health such a satisfying place to be, because there is so much job satisfaction; but there's also that team support. There are lots of times when we're very isolated too, when we're sort of out there in the community with none of our co-workers, but you know you can always go back to the office and find somebody. If you're troubled or, you know, concerned about something, you can always find somebody that will say . . . no I think you did the right thing, and you did a good job. So you can get it if you need the positive feedback . . . you can get it.

When talking about work that is rewarded and work that is unrewarded, one nurse commented about the invisible nature of the work because of where it was conducted.

> The problem is so much of what is done in people's homes. So all the reward we get then is the thanks that we get from the people that we work with. Not by our agency. That's not the stuff that our agency sees.

The visible things that nurses do are the things that get rewarded according to another nurse. However, the essence of public health is caring which was not rewarded because it was less tangible.

> Whether they be extra committees. Whether they be participating in some sort of research that may be going on. It may be working with community groups. It seems the tangible extras are those things that are rewarded. And then to varying degrees, the things that are not rewarded are the less tangible. Again the caring that perhaps you convey to the various populations that you deal with, or to colleagues, or whomever you may be dealing with, or the amount of time that you spend. You have to just go the extra mile, but it's not necessarily a tangible extra. It maybe's just included in a home visit, or whatever you would want to call it. and so, you know, those kinds of things seem to be less rewarded. And I think that's unfortunate that some of that may not be captured as much. Because really that stems from the essence of public health, and that's what community health nursing is all about.

Theme 2 *Work as measured production.*

Nurses commented, throughout the interviews, on the constant reminders about the quantifiable approach to their work. For the nurses, support, caring, comforting cannot be counted in the same way as numbers of visits, referrals, etc.

Since the scope of community health is broad, the nurses' knowledge base was being challenged on a daily basis. Several nurses commented on the invisible nature of the preparation and research needed. One nurse, in particular, spoke about the lack of validation for keeping current in one's knowledge base. There seemed to be no way of "quantifying" this aspect of practice in the current scheme of things.

There existed the tendency for work that was not quantified to remain invisible, unrecognized and perceived by the nurses not to be valued or validated. As one nurse commented,

> When I think of public health nursing, the first demand's on the nurse, and her knowledge base. I think it is expected that you rise to the challenge, and prepare yourself for what you need for any particular situation, not all situations. But as the situations arise, you realize, O.K. I don't have this information, I need to research it. And there's just a general sense, and expectation that that will happen. And there's not a lot of recognition given to the fact that that is a strain, and a constant stress, and that nurses are doing it on a daily basis, week after week, month after month. You never know everything in community health. For nurses, every week a new question will come up, at least in public health. That's my experience in public health. And I don't feel that that's validated enough.

Another nurse commented on the inability to quantify all the activities in working with groups. As she stated,

> You did so much in a day. Yes, and a group of three people in an apartment that you've managed to get together for some kind of a parenting group. Looks like you saw three people. And you forget to write down the things that you did to try and get them together, to try and get them talking, to try and get a room, etc.

One nurse talked about her worries that she was not making enough visits. The concern was that performance as a nurse was being measured by the number of visits she made.

> I used to be really worried and ask our clerk every month for my stats and say, how many, what was my average for this month? We used to really fret and sweat about, now is it that you visit five afternoons and then you get one extra afternoon for charting on top of your morning; that's your office morning; and doing all this counting and keeping very close track.

This same nurse, when discussing issues around accountability, talked about it in terms of accounting for her work in numbers each day.

> I'm very aware of the obligation and expectation that I am going to fill in my dailies. That does take into account pretty much all of my time and I have to account for that. And the clerk puts all that into computer and my supervisor checks that over. Things have changed somewhat and are continuing to change about that. But as far as accountability, I know that those pieces of paper have to be filled in. I have to account for what I do and where I go and how many people I see.

The difficulty in trying to quantify nursing practice in the community was expressed by one nurse in the following way.

> I think that's a hard thing to put down, to equate health promotion with statistics of what we do. I understand their problem (the agency), as well, because it's difficult to look at actually what we do, and write it down. And say they (the nurses) did one health promotion, and two health preventions, and three something else.

Another nurse expressed the difficulty in trying to quantify care in cost efficient terms.

> The taxpayer, the minister, the directors of branches. You know, they represent my agency. There's heavy emphasis right now on, cost . . . efficiencies. Where we (nurses) would be coming from is somewhat different. Because I don't think we start with, what can the economy afford? I think we start with the individual, and the family. And I think most of us are at core, what people think of nurses as being, caring. So we start with, how can we help, inform, educate, counsel; so this family won't have pain; so they will be able to support each other.

Theme 3 *The missing voice of the community health nurse in health care reform.*

Several nurses volunteered comments about the current health care reform in the Province of Manitoba and the absence of their voices. Many nurses made comments about the fact that nursing as a profession was not valued in the health reform movement.

One nurse noted that in all of her work, not much of it was unrewarded, but what was unrewarded happened because of the lack of respect for the nursing voice in health care reform. In her words,

> I guess I have the perception that most of the work that I do is, has a benefit somewhere along the line. Whether it's from trying to get Civic Properties to make sure our lights are fixed, or the heating finally gets fixed, or writing reports about issues, or doing performance appraisals. I mean, I see those pieces. I don't see too much in my work that is unrewarded after a while. I guess in the larger picture I find that the public health nurse, nursing voice isn't as prominent, or respected in the health reform movement. So I've found that unrewarded. I've found that to date we haven't really been acknowledged, or taken where I think our rightful place should be, in the health reform system.

Another nurse who was involved in presenting to the Health Reform Group conveyed her feelings about the experience.

> I'm just thinking back to last year when we really had to fight. I wouldn't call it exactly fight, but we had to present to the whole Health Reform Group. How are you, as community health nurses, going to deal with the shortened hospital stay given the staffing you have? Can you work at your best potential and deal with this without an increase in staff? Does it mean you have to cut other programs? And I was part of that committee, and it was just marvellous to see how we wouldn't let go of that health promotion. We are not robots. We don't just go out there and see women when they come home from hospital.

A lack of understanding about health care reform was noted. One nurse expressed the misunderstanding of her own colleagues who saw it as a financial issue when indeed she viewed it as a quality of care issue.

> When I tried at one of our meetings to bring forth my enthusiasm of going to this hospital convention, the supervisor just said, "health reform, health reform... whoever understands health reform. Nobody understands it." And I said certainly I understand the philosophy and I certainly agree with it. But it was just like, what is she talking about? I really feel they are so tied up with the economical issues that they do not see the purpose of health reform. They believe it's all cutting down on dollars. And they do not understand the philosophy behind it. and the philosophy behind it is nothing to do with the dollars. Although it will automatically reduce dollar needs, because people will be healthier, and I strongly feel what we need in the community is people able to make people healthier, in their own being and not more public health nurses who do the same thing. Although the PHNs, whether they understand they are doing it or not... are doing a great job for the people in the field... as I know them, the group I work with.

Another nurse expressed her frustration in not being heard in the health reform movement.

> In the time of health reform... community health wasn't really part of phase one. You know... and then to say that the focus was community. So I feel a little bit stifled and the fact that I've got a lot of ideas and so do my colleagues. We have a lot of ideas that we could implement... and direct our program into the community but they're not being heard right now.

In talking about the rewards in her work as a supervisor, one nurse talked about the needs of her staff and in particular with health care reform.

> I think most of my rewards, they're indirect, relative to why we're in the business. Most of my rewards come from the people I work with. And being the supervisor, I'm the middle of the sandwich. So they come from both directions. So, in looking at the staff I supervise, they've got a very good coach and a very good teacher. When you see that you've put a light bulb on for somebody or when you see your staff grow. That is one of the things that makes me feel rewarded When I can be at the place where some of the disruptive things stop. When I can protect my staff from the bureaucracy, so that they can focus on being clinicians. That satisfied me. Although I would say, I've learned you can't protect them, too much. Because, in order for them to grow and progress, they have to know what's happening. And with health reform, you can just see the cascade effect, or the kick down effect. The psychological adjustments that people had to make. I mean, the people superior to me sort of hit the wall, six months to a year, before I did.

Theme 4 *A tension exists in the scope of practice for community health nurses, and in particular, around the issue of community involvement.*

Many nurses commented about the tension existing in their practice with home visiting and in the evolving community development kinds of activities. The involvement of communities for some was seen as a decanting of responsibility while for others, it meant community development, self sufficiency and empowering communities, etc.

The expanded scope of practice presented a conflict interaction for one of the nurses. She described her work situation in the following ways.

> There's so many layers and this priorizing always enters into it. I guess like anyone I go up and down so far as okay, where do I put my priority today, this minute, this week, whatever. I always am in conflict within my priorizing for the individual person who phoned me up in a panic, or I am priorizing for example for the larger meeting, a community meeting that might be looking at planning. Or going out and doing some networking in the community to find out their resources, or to find out exactly what service does this place have to offer, or whatever it is. I always am in conflict there.

Several nurses expressed difficulty in making the transition to more community involvement. For one nurse this was a difficult thing to do when program obligations for home visiting were in place. This nurse expressed the tension in this way.

> The nurses themselves feel that it (change) should come from management. But I think, the way things are going now, it's the grass roots nurses that can make the changes. If they've identified that they work in the community. They know the community's needs. If they find an area where they feel there's a gap in service, or that needs some attention. Then I think, at least I'm being optimistic here, that management would say, "Yes, well then maybe that's an area you should focus on." But I guess we're still obligated to the hospitals that we assess all mothers post partum within 24 hours. And with the staffing, and the weekend coverage, we work 7 days a week, 24 hours a day and we have a nurse on call at all times. It's very hard to let go.

The need for governments to provide the same services in different communities was identified as an approach, at odds with community development. At least two nurses commented on this situation.

> We sort of seem to be waffling between individual, regional differences within this Winnipeg region and then there's all the different suburbs. And in doing these term positions, that's one thing that I've noticed in working part-time in my office and part-time at another office, is that there is diversity of needs, according to the population in different parts of the city. Sometimes the goal of equality of care and making sure that the same services are offered in different communities, doesn't always work because of the fact that different communities have different needs and it's up to us

> as nurses to develop the needs for our community. If somebody has an idea about a health promotion program, it may be appropriate to deliver it in several communities across the region. Although we do have the freedom to sort of start on our own.

The second nurse saw this same issue of treating everyone equal as the political nature of government services. The nurse commented,

> I think the agency would like to move from program based to more of a community needs kind of base and would like to be able to say... in this community, you get this health promotion activity and in this community you could have cardiovascular health, another community could have AIDS or STD or whatever. But I think because it's a political party, they try to treat everybody equally. Where in each community, they don't have the same kinds of needs. And I think that's a struggle for the government to deal with. And a reason why I think they have problems with health promotion or defining programs for health promotion and why it takes so long is because they're trying to cover everybody.

The nurse as expert was expressed by one nurse as a barrier to communities identifying their own needs. As this nurse noted,

> I think we've been doing, we have been determining needs, or thinking we've been determining them. And I think the community should be determining them. Now that sounds good. But how then do you get that. And now with health reform, and a lot of issues, we're looking at trying to reinvolve the community. Like it's sort of a vicious circle. Years ago the community was more involved. Then we sort of pushed them away, that we're the experts. And we were sort of doing, I know what you need. and I'm going to get it to you one way or the other. Now, because of costs, and also maybe we're just learning that, people aren't going to respond. They do not want to have any assistance, they don't want to have behaviours change. They don't want to change. Or they don't even know that they have a problem. So I think there's the difference. I think we've been identifying needs instead of communities, and individuals identifying their needs.

The idea that community development was not an approach for every community was talked about by one of the nurses. Her experience cited, was about organizing parenting classes.

> So you're working with a community, a community of mostly mums. At that point I think it was all mums. So they thought they could run the program on their own. And that they would volunteer, you know, they would give time back that maybe this was an area where they didn't have to pay taxes, in order to make sure that it was running. Well, one group split off, and we gave them the space. They could have space wherever they wanted, but they chose our office. And we had a link but not a planner. It died. It died within about two months. And the attendance was poor right from the beginning. And part of it was because the people, who said they'd do what they did, had young families. And they couldn't be consistent. Then the next test was, well my personal test or non systems test, was all these people said they would volunteer. Now, what will happen if I ask them to volunteer? Well, they felt good about volunteering, but the numbers that volunteered were way less than the people who said they would. And so I think it's one of those nice ideas that the community thinks they can run things, but when they really realize how much energy it takes to keep them on track, sometimes they can and sometimes they can't. I mean we have other success stories within our branch where the community's taken it, run with it, and it's continuing to function well. But I think there always needs to be an alternative for families.

Theme 5 *The lack of public understanding about the role of community health nurses.*

This particular theme was a concern expressed by many nurses. When so much of the work goes unseen (invisible) even other nurses were not aware of what the community health nurse does.

With reference to her work in the schools, one nurse noted her experience this way.

> It doesn't matter that we've been in the schools for twenty years, they (teachers) still think we go home at noon hour, if we've been in the school in the morning. And they know that we're going out to make family visits. So it's not just the people in the community. It's the teachers. It's people that we work with on a regular basis. And it's definitely other health professionals, you know, physicians, even other nurses. You really don't know what, what each other does sometimes. And there's still the tendency to think that it's that first aid stuff.

The lack of role understanding was expressed by another nurse in terms of health promotion work.

> And when you're dealing with crisis you don't have any money for things that aren't crisis. And it's a real dilemma for public health, it's a big dilemma. I mean our budgets get cut, and because nothing's happening, and it shouldn't happen if we're doing a good job, we shouldn't have something to see, so the politician can't say, oh look at this... nobody got measles this year, isn't that wonderful. But the big thing is we had seven cases of measles, and public health came in and did this, this, and this, but that other piece that is so important is not known, like if we had really pushed maybe we would have had those seven children immunized and we wouldn't have had all that and we wouldn't have costs. So I think now people are beginning to understand that it's helpful, good to have health promotion, but whether we have a lot of money, and priorities I don't know.

Two nurses expressed views about the lack of role understanding by the public in terms of the community health nurses not promoting themselves. One nurse made the following observation.

> We had a discussion on how to promote ourselves more because, especially looking at the groups coming in. Looking at the private agencies coming in. They are able to put out brochures, or speak about what they do, or promote themselves. And I think that this government certainly has had no interest in doing that about community health. It amazes me the number of people who don't know what we do. And people that are surprised, or usually happily surprised, or amazed that we will do the kind of things that we do. We are probably rewarded when there's an outbreak, or an epidemic of a disease. And so from a disease-oriented point of view they can see that you have a purpose in controlling the whooping cough epidemic somehow, by education people, or controlling an epidemic of E coli, or meningitis. So I think in that way they can see the role. I think certainly new parents can see the role, but that's on a very individual basis that they would phone back and say, "thank you for the information or for what you've done." And Child and Family Services, actually we have worked quite closely with them. We have a group for young mums and certainly the outreach worker has been able to ask us to do things, and can say, "you know, that's great that you can do that" or "can you promote it, in some way."

The second nurse raised the same issue but framed it in terms of not being rewarded.

> What comes to mind there, is we're not rewarded. But I think that is based on the fact that they (the public) are not knowledgeable about what we actually do. And I think a lot of that has to do with the fact that we don't advertise ourselves enough about what service we do. If we did that, I think that you would have more acknowledgement and the rewards. So I'm not quite sure how to answer it, in a very succinct manner. But we're not rewarded for a lot of our effort, our caring, our commitment.

The scope of the community health nurse's role as being broad was talked about by another nurse in terms of the lack of public awareness.

> Unless it touches their lives. Unless you're there and they (clients) say, "Well, what exactly do you do?" We tell them, and they're surprised that we can do all the things that we do. Sometimes they just see a very narrow role, like "Oh, you just go out and see babies." Or you get to the school, and a teacher will say to you at lunch time, "Oh, you're going now, so I guess you're off now." "Well, no I'm not off now, like I have another visit." "Oh, what do you do?" "Well, you know, I go out and I visit in the community." "Oh, do you?" They have no idea, you know. And the same thing with clients. They have no idea that you're out there visiting people.

Theme 6 *Agency structures are contributing to tensions.*

Several nurses offered examples of tensions in their work as community health nurses related to existing agency structures.

For example, one nurse identified a professional issue resulting from the way work is structured in her agency.

> Often times I don't think the accountability towards each other is as obvious. Nurses tend to often go their own little ways. And often I think it can happen probably in community because you have your particular district, and you're not going back and forth to one another and sort of getting input on, what could this be? Whether it be, a bit of professional jealousy, or a little bit of intimidation. One's got a program going the other one doesn't. And you know, I don't want to look like, I'm not able to get these things going. So sometimes I think there's a little bit of professional concern there, and then we aren't as accountable to each

> other. But the bottom line is, we're all trying to do the best job for the client within the community. And I guess you always have to keep that global picture, or you can lose sight of that standpoint.

The overtime issue was referred to by many nurses. One nurse talked about her experience of not having overtime even acknowledged as an issue.

> Sixteen hours a week of unpaid overtime and nobody ever said, "you nurses shouldn't do that." And, in fact, the expectations came down, do more, do more, do more. Serve on more committees. Do this, do that. Refusing to acknowledge that unpaid overtime is even an issue. Telling people now who are working overtime, no you can't come into the office, we don't want to see you. Forcing it into the underground, instead of saying, how come there is so much overtime. We want you to have a balanced life. How can we help you do that?

The lack of recognition of the overtime issue forced nurses to put restrictions on their time. One nurse voiced her concerns in this way.

> Well, that's the work overtime issue. Now that doesn't count the committees. And I can tell you that what's happened now is because we've had a problem in our agency, and because of the sheer fact that everybody is recognizing that staffing levels are going to continue to decrease. I think a lot of people personally are saying, this just has got to end. I might have been able to do, 12 hours or 10 hours or 16 hours a week. I took the first week of my vacation and did all my chartings despite the fact that I should have been on vacation. Now people (the nurses) are saying, "fine, I guess I just can't visit those clients any more. I'm not going to serve on committees. I'm not going to do a whole lot of things because the system isn't recognizing it."

Overtime and the financial compensation issue was spoken about by another nurse. This nurse referred in particular to the demands on her time orienting staff.

> No, No. Your salary stays the same, you don't get any time off. I mean if you work overtime, you put in for overtime. But it's during that time you don't have a moment to yourself, anyway. And then you have to do all the work, but then you have to explain to this individual or help them through their thinking processes, working through their nursing processes. So even if they go out on a visit on their own, you have to help them with analyzing it after. And where are they at with that visit? Do they need to phone the mother back, or go back because they missed some things, or

whatever? So, no I don't think I ever felt really rewarded for that as much as I think they (the agency) could have done.

One of the nurses expressed her frustration about not even having time to take back the overtime hours. As she stated,

> You're catching me at a bad time because we just had a planning meeting for our office where we expressed concerns. We tallied up in actual time, how our time is spent; 87% of our time is taken up in activities. Leaving no time, 13% free for sick time, for taking your overtime, for just all the things that you're not able to do. And that's very frustrating. And we expressed some solutions, such as: hire contract staff to do weekend post-partum, stuff like that. Various solutions. So that you're not taking us out of the community during the week, because you're making us work on weekends.

Again, weekend coverage as an issue was voiced by a second nurse.

> Yes, for presentations, all sorts of things. Prenatal classes, everything. It takes a lot of giving from yourself as well, because a lot of those things are done over, and above your hours. And I'm not saying that you're not paid for it, because you certainly are paid for it. But, you know, it's not done within your work time so then you're staying extra time to do it. Weekend coverage is not rewarded I don't feel. And yet it's a very important part of that service to the community.

Not having control over the structures, and the tensions between service priorities and identified needs was voiced. For example two nurses made the following comments.

> Yes, there's lots of barriers that are, that I think are slowly breaking down. I really feel that things are moving and changing. But, the structure has lots of political and other considerations that I don't have a whole lot of control over other than to keep plugging and saying, How about this? How about that? This is a need, you know.

> Well, I think to a certain point, we're supported within our department. Only to a certain degree though. I think we're supported sort of theoretically. But when it comes right down to actually providing, doing, meeting the need, it's difficult. And a lot of it comes to just how much time you have. And priorities that have been set, you see. So I might identify this need, but other priorities have been set for service, providing

> service. And then that's where you get a clash. You can also have a clash within your work environment too. I haven't had a lot of that.

In this next part are presented the categories and data upon which the themes were constructed.

Data and Categories

Several categories arose from the data in Section A in relation to questions about accountability, rewarded work and health promotion needs. More specifically, nurses were asked about explicit and implicit accountability, work rewarded and work not rewarded, definition of community and health promotion, and the identification and support of community health needs. Table 5 is organized according to headings, representing the questions, and the resulting categories and subcategories.

Explicit Accountability

When asked the question, "To whom are you explicitly accountable for your work as a community health nurse?", three distinct categories emerged from the data: organization-related accountability; client-related accountability; and, profession-related accountability. Table J1 in Appendix J on page 416 illustrates the categorization that arose from the responses to this question.

Interestingly, when asked about explicit accountability, nurses overwhelmingly noted the organization or agency as the dominant locus of accountability. Clients and professional associations were subsequently identified as the bodies to which nurses were accountable (in general).

Furthermore, within the organization-related accountability category, nurses identified more of their accountability in the employer/employee relationships subcategory. Overwhelmingly nurses viewed their accountability to another nurse in a

supervisory capacity. In most cases the supervisor would be nursing personnel and likely another female co-worker.

Table 5

Categories and Subcategories

Agency, Invisible Work, and the Missing Voice of the Community: The Context	
Categories	Subcategories
Explicit Accountability	
1. Organization-related accountability	a. Employer/employee relationships
	b. Agency
2. Client-related accountability	a. Clients
	b. Community
	c. Financial
3. Profession-related accountability	a. Professional nursing/standards of practice
	b. Personal standards
	c. Peers/colleagues
Implicit Accountability	
1. Profession-related accountability	a. Personal standards
	b. Professional nursing/standards of practice
	c. Peers/colleagues
2. Client-related accountability	a. Clients
	b. Community
	c. Schools
3. Organization-related accountability	a. Agency
	b. Employer/employee relationships
Work Rewarded	
1. Agency rewarded	a. Work contributing to financial viability
	b. Work contributing to agency functioning
	c. Innovative ideas
	d. Work contributing to agency visibility
2. Personally rewarding work	a. Work with clients
	b. Work with communities
	c. Work with programs/projects
	d. Work with staff/coworkers
3. The nature of agency rewards	a. Monetary rewards
	b. Working conditions
	c. Feedback
4. The nature of personal rewards	a. Feedback
	b. Client utilization of services
	c. Good feelings

Work Not Rewarded

1. Client based work not rewarded
2. Agency based work not rewarded
3. Personal based work not rewarded
4. Invisibility of work not rewarded
5. How work is not rewarded
   a. Time
   b. System

Defining Community

1. Meaning the same
2. Meaning similar but different
3. Meaning not the same
4. Unknown

Defining Health Promotion

1. Meaning the same
2. Meaning similar but different
3. Meaning not the same
4. Unknown

Determining Health Promotion Needs

1. Organization determines the health promotion needs
   a. Public health nurse
   b. Agency/department/other agencies
   c. Students
   d. No one
2. Client/community determines the health promotion needs
   a. Community
   b. Clients
   c. Schools

Listening to Health Promotion Needs

1. Organization listens
   a. Employer-employee relationships
   b. Agency
   c. Colleagues
   d. Not the organization
   e. No one
2. Community listens
   a. Agency
   b. Individuals in the community
   c. The public/community

A few nurses looked beyond the individual work situation and located their accountability at the macro level with the Minister of Health. Clearly, most nurses voiced accountability to their organization/agency/employer, whereas only a few voiced that they were accountable to the government.

Nurses voiced that they could not be accountable to the community in current agency structures. The ideal situation, from recent literature, directs accountability to the client (client-related accountability), but overwhelmingly the nurses related their explicit accountability to the organization.

The professional-related accountability category was the least supported category. Because of the independent nature of the work of community health nurses, peers and colleagues were conscious of professional standards and they felt accountable to the profession, however, they expressed more explicit accountability to the agency/organization. Interestingly, the quantifiable distance (in terms of data volume) between profession-related and client-related accountability categories is closer than the distance between organization-related and client-related accountability categories. The greatest distance (location) occurred between organization-related and professional-related accountability (see Table J1 in Appendix J on page 416).

Organization-related accountability. The responses, provided by the nurses to form this category, clustered around accountability to persons, positions and/or governing bodies connected to the organization itself.

Two subcategories were found in the organization-related accountability category: employer/employee relationships; and, agency. Within the employer/ employee relationships subcategory, the majority of nurses (n=14) said they were accountable to their supervisor. Three nurses specifically identified accountability to the Director of Nursing. A couple of nurses named the Minister/Medical Officer of Health as the person to whom they were accountable. One nurse identified accountability to the people one works for while another stated she was accountable to

her staff. A total of 21 nurses identified their accountability to elements in the employer/employee relationships subcategory.

A total of 17 nurses identified accountability with the subcategory of agency. Within this subcategory, 13 nurses noted they were accountable to the organization/ agency/employer and four named the government (Provincial Health/City Health Departments) as the agency to which they were accountable.

Client-related accountability. This category represents comments made by the nurses which were concerned with the recipients of nursing services. Within the client-related accountability category, three subcategories evolved. Most nurses (n=13) identified that they were accountable to their clients such as the general public and the consumer of public health services, including one nurse who specifically identified accountability to families. Other nurses (n=6) observed that they were accountable to the community. Beyond nursing services at the aggregate level (client, family, or community,) three nurses voiced general accountability to the taxpayer (financial).

Profession-related accountability. This category was formed based on professional accountabilities present in the practice of community health nursing. In the category of profession-related accountability, three subcategories evolved from the data. In the professional nursing/standards of practice subcategory, five nurses identified their accountability to the professional association. In the personal standards subcategory, five nurses said they were accountable to "myself." In the peers/colleagues subcategory, fewer nurses (n=3) identified accountability to peers or colleagues.

Implicit Accountability

When asked the question, "To whom are you implicitly accountable for your work as a community health nurse?", the same three categories emerged from the data as in the previous question, but this time they were ranked in a different order: profession-related accountability; client-related accountability; and, organization-related accountability. Table J2 in Appendix J on page 417 shows the categorization that emerged from the responses to this question.

When accountability was considered implicit, organization-related accountability was overwhelmingly identified the least. Within this category, more nurses now identified accountability to structures at the macro level, i.e., government.

The majority of nurses identified accountability to the profession. Personal standards were identified more frequently than professional association or peers/ colleagues. The emphasis that nurses placed on this category was directly opposite to the accountabilities identified in Table J1 on page 416, where organization-related accountability was overwhelmingly the dominant locus of accountability.

Client-related accountability was not the dominant locus for these nurses. Compared to Table J1 on page 416 even fewer nurses identified accountability to the community as client. When accountability was considered implicit, however, the subcategory, schools, appeared in the data. The locus of accountability to the client was moved closer to the dominant locus of accountability which was the profession, the difference being only one response.

Profession-related accountability. Accountability surrounding the professional practice of community health nursing formed the basis of this category. Three

subcategories were found to exist in the profession-related accountability category. They included: personal standards; professional nursing/standards of practice; and, peers/colleagues. The majority of nurses (n=9) identified "myself" in the personal standards subcategory which included two references to personal standards. In the professional nursing/standards of practice subcategory, a lesser number of nurses (n=3) identified accountability to the professional association and this included comments such as professional judgement and the nursing profession. In the peers/ colleagues subcategory the least number of nurses (n=2) identified co-workers and each other.

Client-related accountability. The recipients of nursing services clustered together to form this category. In the client-related accountability category, three subcategories were identified. In the client subcategory, the majority of nurses (n=7) responded that they were accountable to the client/public/people they worked with. One nurse identified accountability to families. In the community subcategory, fewer nurses (n=3) identified accountability to the community. A schools subcategory evolved and two nurses identified accountability to teachers/principals.

Organization-related accountability. This category was formed based on the clustering of governance structures of an organizational nature, identified by the nurses. In the organization-related accountability category, two subcategories emerged from the data. The majority of nurses identified responses in the agency subcategory. Five nurses identified accountability to the government (Manitoba Health/City Council) and one nurse identified accountability to the organization/agency. The employer/employee relationships subcategory had fewer responses; one nurse

identified accountability to the team and one nurse identified accountability to the Medical Officer of Health.

Explicit and Implicit Accountability Combined

When responses to the questions of explicit and implicit accountability were combined the results reflected a locus of accountability similar to Table J1 on page 416, explicit accountability. The combined accountability categories are illustrated in Table J3 in Appendix J on page 418.

Work Rewarded

The question, "What work do you do that is rewarded?", elicited responses from the nurses that were grouped together to form four categories: agency rewarded work; personally rewarding work; the nature of agency rewards; and, the nature of personal rewards. Table K1 in Appendix K on page 420 shows this categorization and the complete set of examples.

Three compelling messages were present in the work rewarded question. Work that the agency rewarded was noted as the dominant form of rewarded work. The most visible work was that which contributed to agency functioning. The least visible (unseen) work rewarded was work contributing to financial viability and work which included innovative ideas.

Secondly, there was a difference between the work that the nurses perceived to be valued and rewarded by the agency, and the work that they themselves found personally satisfying and rewarding. Agency-rewarded work was primarily work that benefited the agency and work subject to quantification. In contrast, the work that the nurses found rewarding was that with clients and the community, even though these

rewards were perceived by the nurses as less visible (and less likely to be rewarded) to the agency. The nature of their reward was found to be primarily appreciation for the kind of care and service provided to the client and community.

Agency rewarded work. This category represents the kind of work the nurses felt the agency officially recognized. Within the category of agency rewarded work, four subcategories were elicited from the data: work contributing to financial viability; work contributing to agency functioning; innovative ideas; and, work contributing to agency visibility.

In the subcategory, work contributing to financial viability, nurses identified work that benefitted the agency. The nature of the work cited could be measured quantitatively, such as the number of visits.

Nurses identified several activities that clustered to form the subcategory of, work contributing to agency functioning. Again, these activities directly benefitted the agency. Examples included membership on committees, and organizing/planning programs. These activities were quite tangible and quantitatively measured. The less quantifiable activities identified included community development and networking with clients and communities. For some nurses, these activities were an integrated part of their practice that was encouraged and supported by the agency. For others, these activities were rewarded by the agency because of the benefits they would bring to the agency, for example recognition and funding.

In the subcategory, innovative ideas, nurses identified these to be; something different, being involved and creative, and a complex case. Few nurses identified activities rewarded by the agency in this category.

The next subcategory that emerged in the data was, work contributing to agency visibility. More specifically, the nurses identified, for example, work that was in the public eye, the tangible extras (committee, research, working in community groups), and whatever the agency thought was the current thing to do. For the majority of nurses this work was perceived to undervalue their work with clients and again was seen to benefit the agency.

Personally rewarding work. This category was formed based on the nurses' identification of work that they found to be personally satisfying. There were four subcategories found in the data, as follows: work with clients; work with communities; work with programs/projects; and, work with staff/co-workers.

Within the work with clients subcategory, nurses identified, for example; post-natal visiting, high risk families, and one-to-one work with people.

In the work with communities subcategory, nurses identified, for example; community development, community needs assessment, and putting something in place for community and it works. There were fewer examples given in, the work with community subcategory than in, the work with clients subcategory.

The next subcategory identified was, work with programs/projects. Within this subcategory nurses identified, for example; families who come back to health promotion programs, group education projects, and "work I do with schools."

The subcategory, work with staff/co-workers, was founded on activities such as; helping to stop disruptive things for staff, protecting staff from the bureaucracy so they can be clinicians, and facilitating staff to do community development and needs assessment.

The nature of agency rewards. This category captured the many ways in which the agency rewarded the nurse's work. In this third category, the nature of agency rewards, three subcategories emerged from the data and they included: monetary rewards; working conditions; and, feedback.

The monetary reward was identified as the paycheque. Working conditions included, for example; getting time back and independent decision making. Examples in the feedback subcategory included: praise; appreciation from support staff and administration within the office; and, positive performance appraisal.

The dominant form of agency reward was seen to be monetary, followed by feedback and closely followed by working conditions.

The nature of personal rewards. Personal work rewards assumed many different forms. This category captured how nurses were personally rewarded. Within the nature of personal rewards category were found the subcategories of feedback; client utilization of services; and, good feelings.

Some examples given by the nurses in the feedback subcategory included the following: appreciation from clients/consumers as shown by thanks from a post-partum mom; appreciation from the community as shown by city councillors; and, support from co-workers/colleagues/team members.

Work Not Rewarded

When asked the question, "What work do you do that is not rewarded?", five categories emerged from the data. These included: client-based work; agency-based work; personal-based work; invisibility of work; and, how work is not rewarded.

Table K2 in Appendix K on page 422 shows this categorization with the complete set of examples.

The most compelling message, in the work not rewarded question, was that all five categories were supported with concrete examples of work done that was not rewarded. Whether the work was with a client, agency or personally based, there was overwhelming agreement among the nurses that the work of the community health nurse was not rewarded. As one nurse responded, "all the work I do" and another nurse stated, "any work that you do as a public health nurse."

Client-based work. Nurses identified many aspects of their work with clients that was not rewarded. Included in the category were the following examples; the real work with families and being able to assess accurately, the broad parameter with which we work, the day-to-day stuff, drudgery (caseload stuff), and a lot of organizing. One nurse, for some of her families, was left to ask herself, "did they really benefit by my visiting"?

Agency-based work. Work that was primarily associated with the structure and function of the agency formed another category of work not rewarded. Nurses made many observations and comments in the agency-based work category. Some examples included: program development; paper work (charting, writing); specific programming i.e., programs in the schools; committee work; weekend coverage; and, orienting a new employee. Nurses in supervisory roles provided examples. Some of these included: "there is not much reward for my work from the people over me"; trying to justify the public health nurse's existence every year in the budget process;

and, the political things--system's things--reviewing and responding to a paper (i.e., a government brief or agency proposal).

Personal-based work. Work that was of a more personal nature or requiring a personal commitment formed this category. In the personal-based work category, nurses provided the following examples: "all the work I do"; getting more education; "any work that you do as a public health nurse"; and, trying something innovative/ creative.

The invisibility of work. Much of the work of the community health nurse was felt by the nurses to be invisible and because it was not seen, it was not rewarded. The invisibility of work category, was formed based on the nurses' observations and comments. For example; "so much of what we do is done in people's homes and the agency doesn't see it", "the little things that don't look glorious" i.e., spending time with a post partum mom who has depression, research/preparation, and "the less tangible--caring, the amount of time you spend, the essence of community health nursing." Much of the work that was invisible was client-related. It appeared that it was the interpersonal skills, i.e., counselling; the ability to accurately assess; and, the human contact.

How work is not rewarded. The ways that the nurses felt they were not rewarded by the system were voiced by the nurses and formed the category, how work is not rewarded. Two subcategories were identified: time; and, system.

In the time subcategory, some examples included: "we don't take our breaks and don't get the time back"; and, "public health nurses have to have a strong work ethic

when I think of all the time that is not rewarded, I could make the same salary and do half the work."

A subcategory identified as system emerged from the data and was based on the nurses' observations and/or comments. Some examples included: "we are made to feel we aren't working hard enough"; "we are not rewarded from the top of the system"; and, "when you're dealing with difficult situations, everyone's trying to cover their ass." The general feeling was, as one nurse stated, "the agency doesn't do very much rewarding." In the system subcategory, nurses commented about the lack of resources. Examples included: "we don't have on-site daycare"; and, "when we ask for more nursing time we get more physician time" (in the clinic).

Defining Community

The nurses were asked two questions, "In your work with communities, how do you define 'community'?" and, "How does your agency define 'community'?" In most instances the responses were parallel. There was general agreement about the meaning of "community" held by the nurses and their understanding (perception) of the definition held by their agency. Fourteen nurses said the definitions were the same. Six nurses said the definitions were similar but with some difference. Six nurses responded that their perceptions were different, and five nurses responded that they did not know whether the agency's definition of community was the same or different than their own definition.

According to the nurses, "community" held a wide range of definitions. It clearly was not confined to geographic boundaries or neighbourhoods or aggregates. With the input of the nurse's perspective, community was best defined as a

relationship of geography and common bond, with the emphasis on one or the other changing in a dynamic fashion. Nurses have their practice experience to bring to the formulation of definitions and clearly have a unique perspective to offer.

Meaning the same. Nurses who responded that both definitions were the same provided the following characteristics shared by their own definition and by the definition held by their agency. The definitions of community formed groups of common characteristics: geography; aggregates and groups; geography and aggregates; and, cultural bond. The examples provided by the nurses can be found in Table L1 in Appendix L on page 425.

What is unique about the definition of community when the nurse and agency share the same definition is that it can be defined geographically, i.e., geographically defined neighbourhoods, but is not necessarily defined by boundaries. It can be defined by distinct needs, groups with shared interest. Further it can be defined in relation to the agency one works for, i.e., "the area that I serve" or anyone that's not in the employ of the Health Department. One nurse stated "it is not for me to decide on the definition but the community defines what community means for them."

Meaning similar but different. Six nurses responded that their definition of community was similar to the agency's definition, but with some differences. The similar characteristics and the corresponding differences in the definition of community formed various groups and were identified as follows: geography and aggregates; geography; and, the system. These categories with specific examples can be found in Table L1 in Appendix L on page 425.

What is unique about the definition of community when the nurse and agency share similar but differing views is agreement that although both definitions are primarily geographically defined, the concept is not confined to this definition alone but community can also be a group of people who share a common interest; it can be spontaneously formed and it includes politics. The nurse's definition is more broadly defined and not confined solely to geography or needs, for example the post partum community.

Meaning not the same. The six nurses who responded that the definitions were not the same, held the following understandings which formed groups of common characteristics. These groups included: geography and common bond; geography, common bond and universe; and, geography and aggregates. Specific examples can be found in Table L1 in Appendix L on page 425.

The uniqueness found in the definition of community when the nurse's definition and the definition held by the agency are stated as not the same is the following: the nurses viewed community as being very broad, even extending to include the global community/universe. It was more than a piece of geography in which neighbourhoods exist, it was a sense of community. Agency boundaries on paper cannot "make" a neighbourhood. A sense of belonging, togetherness and cohesiveness may exist in a geographic location, but they are not confined to geography/ neighbourhood and they do transcend geographic boundaries.

Unknown. Five nurses responded that they did not know whether the agency's definition was the same as the definition they held. Comments and observations offered by these nurses were grouped into two categories: written communication;

and, verbal communication. Specific examples are recorded in Table L1 in Appendix L on page 425.

These nurses share many of the unique characteristics as identified by nurses in the previous groupings. For them, community included the ideas of geographic boundary/neighbourhood, shared common interests, but of particular significance, community is not static as defined by geographic lines, the line is invisible. The uniqueness is found in the idea that community has continuous movement, it is not static. One minute it is geographic and the next minute it is a common factor. The nurses did not know whether their view and the agency's view were the same or not because for them the definition held by the agency was not articulated, made visible or even known to exist. The nature of this issue is one of written definition and oral understanding.

Defining Health Promotion

In question seven and eight, the nurses were asked, "In your work with communities, how to you define 'health promotion'?" and "How does your agency define 'health promotion'?" Most of the responses were parallel in that the nurse's definition of "health promotion" and their understanding of their agency's definition were thought to be the same. Fifteen nurses responded that the definitions were the same. Three nurses said they were the same but with some difference. Six nurses responded that the definitions were not the same. Seven nurses replied that they did not know how their agency defined health promotion.

Reflecting back on the two questions with respect to the definition of health promotion held by the nurse and the agency in instances where the definition of health

promotion is not the same, a tension exists in the two points of view. The tension seems to be in terms of how the work of the community health nurse is measured. The agency definition reflects its need to measure the work in concrete terms, i.e., number of visits--their definition is more concrete; an attempt to quantify in defining the work of health promotion. The nurse, on the other hand, defines health promotion more abstractly, the work of health promotion is somewhat invisible, i.e., enabling communities to use resources; things people aren't recognizing as a problem; promoting self-esteem; empowering people; observing a community for needs and opportunities; it's the community development work. The agency definition has a program orientation for the most part. Their definition, according to 18 nurses, is not readily recalled, or understood by the nurses.

Approximately six nurses included the definition of community in their definition of health promotion. It was these nurses who introduced the ideas of lobbying and community action, community based care, and community development in their definitions of health promotion. It is this language and these values that will facilitate the shift to community accountability in community health nursing practice.

Meaning the same. Nurses who responded that the definitions of health promotion held by themselves and the agency were the same, contributed to the following clusters of health promotion characteristics which included: enabling people; empowering people; interventions to influence health; and, healthy lifestyles. Specific examples can be found in Table L2 in Appendix L on page 428.

When the nurse's definition and the agency's definition of health promotion were thought to be the same, one of the unique characteristics was the integration of

individual, family, group, and community, and a suggestion of a community development intervention focus. Additionally, some of the nurses used the word "community" in explaining the similarity of their meaning and the agency's meaning of health promotion. On occasion, an agency program perspective was introduced into the nurse's definition. For example, one nurse commented, "watching your community for needs and opportunities." This same nurse articulated, what seemed to be, an agency perspective on the importance of nurse as facilitator and not key provider. In the words of this nurse, "my role is facilitator (catalyst); if it becomes key provider, we keep evaluating to see if we can play a lesser role."

Meaning similar but different. The three nurses who commented that the definitions of health promotion were similar but different made the following observations and their comments were grouped as follows: lifestyles and self-actualization; anticipation; and, enabling and individualism. The examples they provided can be found in Table L2 in Appendix L on page 428.

The uniqueness about these thoughts is that the nurse and agency agree that in the definition is found the concepts of lifestyle issues, proactive/anticipation approach, enabling people to use resources so they can maintain wellness as defined by them. The nurses found that the agency's definition was not as specific as their definition and was remiss in the individualism of health promotion. For nurses it was things that were not immediately recognized as a problem by people; those things which were abstract and invisible and not concrete.

Meaning not the same. Six nurses responded that the definitions of health promotion held by themselves and their agencies were not the same. Five groups of

characteristics evolved and they are: enabling and health care reform; educating; lobbying and community action; issues/needs; and, community based. Specific examples can be found in Table L2 in Appendix L on page 428.

The uniqueness in these responses is found in the skills for health promotion i.e., empathy, love, caring, sharing information, lobbying, community action, that community health nurses possess. They saw health promotion as helping communities identify needs and working on solutions. The value of health promotion to health reform was voiced from one nurse's perspective, but not so from the agency's perspective. The agency seemed to define health promotion in terms of a program orientation but even more so in terms of programs for which they can get funding. Five of the six nurses included the concept of community in their definitions.

Unknown. There were seven nurses who responded that they did not know the agency's definition. However, there were 11 nurses, in addition, who expressed some doubt or hesitation about the exact definition of health promotion held by the agency. The comments the seven nurses made for not knowing the definition of health promotion held by the agency basically concerned written communication; and, verbal communication.

The seven nurses provided the following comments and ideas about their definition of health promotion and these are presented in groups of characteristics and included the following: enabling; education; mental health; community development; and, prevention. Examples of their comments can be found in Table L2 of Appendix L on page 428.

The uniqueness in these responses is the emphasis on the idea of promoting self-esteem, i.e., mental health promotion, and the idea of community development.

Determining Health Promotion Needs

When asked the question, "Who determines the health promotion need(s) in your community?", two categories emerged from the data: organization determines the health promotion needs; and, client/community determines the health promotion needs. Table M1 in Appendix M on page 432 shows the categorization based on the data.

Overwhelmingly, the dominant locus of needs determination was viewed by the nurses to be needs identified by, the organization. Within this category, overwhelmingly, nurses identified, the public health nurse (PHN) as the person who determines the health promotion needs in their assigned communities (n=21). This was followed by, the community determining health promotion needs (n=11) which is approximately half as many nurses as in, the public health nurse subcategory. These findings are consistent and parallel with the findings from the accountability question. The ideal situation would be that the community determines the health promotion needs. As with the accountability question, this requires a shift from an organizational locus of determining needs to a community locus of determining needs.

Organization determines the health promotion needs. Within this category, several sources were identified by the nurses. Overwhelmingly, the majority of nurses identified the public health nurse as the one who determines the health promotion needs in the community in which they work. A few nurses (n=7) identified, the

agency/department/other agencies. One nurse identified, students and one nurse identified, no one.

Client/community determines the health promotion needs. In this category, there were three sources identified: community; clients; and, schools. Of the eleven nurses who identified, community, one saw this as broadly as, constituents. Six nurses identified, clients. A few nurses (n=3) identified, schools and more specifically, they referred to teachers.

Listening to Health Promotion Needs

Two categories emerged from the interviews when the nurses were asked the question, "Who listens to your expression of the health promotion need(s) in your community?" One of the categories was, organization listens and the other category was, community listens. Table M2 in Appendix M on page 433 shows the categorization found in the data in response to the question.

The dominant locus of listening to health promotion needs was, the organization. Within the organization, nurses overwhelmingly identified, the supervisor as the person who listens. This was a strong finding in terms of the organization listening and again, as was previously noted, these supervisors were women. Only two people at the macro level were identified--the Minister and the Regional Director.

In nursing roles where much of the work is done independently or in isolation, very new nurses identified colleagues as listeners to their expression of health promotion needs (n=5). Nurses who responded that, the organization does not listen and, no one listens, gave clear messages that the organization should be listening.

The weakest listeners of the nurses' expression of health promotion needs was, the public/community, when they are the recipients of services. This finding was consistent and parallel to the previous findings (see pages 191 and 211) in that accountability and determining of health promotion needs were predominantly, organization-centered. The community-centeredness was always weaker. These results are interesting especially at a time in history when the theoretical and practice ideals are community ownership for health.

Organization listens. This category included subcategories arising from the data which were related to organization structures and functions. The subcategories included: employer/employee relationships; agency; colleagues; not the organization; and no one.

The majority of the responses were in the organization listens category (n=47). The subcategory of employer/employee relationships (n=26) included personnel/ positions within the organizational structure. Overwhelmingly, nurses identified, the supervisor, as the one who listens to their expression of health promotion needs (n=17). The next most dominant example identified was, team/management team (n=4). The Minister and Regional Director were identified by two nurses and they are persons at the macro level in the organization. The team leader, public health nurse and staff were also identified.

The subcategory of agency (n=11) included examples in the structure of the organization such as the agency (n=6), the department (n=2), the City Council (n=2), and administration (n=1).

The subcategory of colleagues was identified by five nurses. Three nurses specifically stated that the organization does not listen and two nurses responded that no one listens.

Community listens. The second category which evolved from the data was community listens (n=20). This category included the subcategories of agency (n=9), individuals in the community (n=7), and lastly the public/community (n=4).

Various systems in the community were identified to form the agency subcategory. These included another agency/hospital, identified by four nurses. The school system was identified by three nurses; one nurse identified churches; and, one nurse identified the media listens.

Several individuals in the community were identified. These included: the Police Chief/Commissioner (n=2), teacher (n=1), social worker (n=1), politician (n=1), family practitioner (n=1), and other (n=1).

The final subcategory which evolved from the data was the public/community (n=4). This means that only four nurses thought that the public and community listened to their expression of health promotion needs.

Conclusions

A central concern for the participants was the sense of invisibility associated with the nature of their work. The setting, i.e., working in the homes of clients, removed nurses from the public domain. Additionally, this setting contributed to collegial invisibility, that is, other colleagues were removed from the place of practice. An interesting paradox surfaced in the data. Participants valued their independence but expressed concern about being invisible and practicing in isolation.

There were consequences associated with invisible and isolated nursing practice. These included: supportive feedback from colleagues on an ad hoc basis; lack of recognition and undervaluing of work by the agency; and, lack of understanding of work by the general public. These consequences contributed to an erosion of power among community health nurses.

Participants expressed a lack of public understanding concerning the role of community health nursing practice. When the public does see community health nurses in action, it is but a snippet or piece of their work.

Participants expressed the need to promote themselves within the public domain, and educate the public about their work. Nurses expressed that again there were consequences to remaining invisible in the public eye. For example, when the public does not know what you do, you do not garner public support. It is interesting to note that "public" included other professionals. The need to promote and make visible community health nursing was a great concern to the participants.

Contributing to the invisibility of nurses' work was the measurement of their productivity. Many important aspects of nurses work are not amenable to quantification, i.e., support, caring, comforting, and group work. According to the participants, work that was not measured was not valued by the agency. Nurses challenged the assumed relationship between measurement and effectiveness of practice.

Nurses articulated that their voices were not being heard within the health care reform arena. Again, nurses identified that their profession was not valued by the decision makers. Such silence was not only related to the decision makers but was

attributed to internal forces. For example, some community health nurses were not informed and lacked understanding about health care reform.

Participants struggled with the tension that arose within their practice milieu. Home visiting and working with clients one-on-one was challenged by the need for community development and the empowerment of communities. This conflict was conceptualized by several of the participants as mutually exclusive activities. Sources of this tension included: time constraints; heavy workloads with individual clients; a crisis management approach; and, a conflict of values, i.e., who community health nurses perceive to be the client and who the agency perceives to be the "new client." The agency's viewpoint fluctuated and changed, thus creating inconsistencies for the focus on community health nursing practice. The work structures appeared to confine and/or restrict participants' practice, that is, nurses have traditionally worked with individuals within families, groups, or aggregates but not with the community-as-client. This new focus constitutes a shift in the practice of community health nursing. This shift may also contribute to interprofessional tensions among the nurses themselves. Some of whom are resisting the new practice paradigm.

The issue of overtime was identified as problematic by some of the participants. Instead of addressing the sources of overtime, agencies were described as paying the overtime but not examining the need for additional staffing. Participants also observed that the staffing has decreased as the workload has increased over time. The implications of this are many, not the least of these which include morale issues, restriction on the agency's ability to promote community development, and nurses feeling pressured to prioritize and yet meet the agency's expectations to do it all. In

effect, this is creating a classic double bind for these nurses. Work that is rewarded undergoes transformation within this context of work pressures.

Section B--Frustration, Alienation, Resistance: Community Nurses' Involvement in Health Policy Development and Implementation

Nurses were asked eight questions about their involvement in policy development and implementation in Section B of the interview schedule. The range of the conversation included the meaning of policy development and policy implementation, and the nurse's involvement in these activities.

Themes

The following themes were derived from the interview data in Section B. These themes can be viewed together in Figure 3.

Frustration, Alienation, Resistance: Community Nurses' Involvement in Health Policy Development and Implementation	
1.	Nurses are experiencing frustration as a consequence of their lack of involvement in policy development.
2.	Nurses are alienated from the policy development process, but are marginally involved in policy implementation.
3.	Nurses are "out of the loop" of policy development and implementation.
4.	The hierarchical structure within which nurses work is contributing to a sense of powerlessness with respect to their involvement in policy decision making.
5.	The impact of health care policy on nursing roles results in more work.
6.	Nurses redefine policy to be congruent with the practice context.

Figure 3. Themes (Section B)

Theme 1 *Nurses are experiencing frustration as a consequence of their lack of involvement in policy development.*

Many nurses expressed frustration with their lack of involvement in policy development. For some it had to do with the rhetoric that promotes their hopes and vision for health policy in health care reform. It is a vision that puts the community in the forefront of health care reform. Instead nurses are seeing policies that in no way support their vision or reflect a community focus and a renewed emphasis on health promotion. The potential for their involvement exists because of their expertise but in reality this is not borne out and the result is frustration.

In the words of one nurse there did not seem to be policy supporting a community direction.

> So I don't think we really have a policy, you know any kind of policy implementation as to the direction that we're supposed to be taking. Other than you know, our health care system will have more of a community focus. And I don't think right now that the policies reflect that.

For another nurse health policy that supported health promotion would direct more resources to the community.

> I feel a little jaded. For example with the document that was put out a couple of years ago by the Filmon government, and the talk to move services to the community, and the talk of valuing health promotion more. And then I experienced cutbacks in our work scenario, and more work added to each nurse. Less ability to do health promotion. So it's just, theory and is not meant in practice. There's a lot of lip service given to the "wonders of health promotion", but very little resources being directed that way.

Yet another nurse expressed frustration that what is written on paper in support of health promotion has not happened in practice.

> You know, you look to this book and that book to follow the guidelines for immunization. It's not written anywhere. And it's very frustrating.

> Usually you end up asking another public health nurse how to do it. Because there's nothing in writing. Or if it is, it's in three different books. And by the time you read it, it's easier just to ask someone.

For some nurses the very lack of policy to give direction was creating problems. As one nurse expressed,

> And I think with that particular policy (investigation of communicable disease, i.e., pertussis), it was developed between the province, and the City. And it was hard to come together. I don't know if it was philosophical differences, or whatever, but, you know. It wasn't just nursing, it was Medical Officers of Health having trouble, you know, coming together on it. . . . I think there were tensions. And, in some ways, I think that the client was the one who maybe was at the disadvantage, . . . And to a certain extent the nurses were trying to pull together, as best they could, to present certain information that was consistent. . . . You know. And it's sometimes hard to work when you don't have consistent messages.

Another nurse expressed how frustrating it was for her in her lack of involvement in policy development related to structure. "I was responsible to three different people. A nursing supervisor, a medical officer of health, and an area director. Who was, of whatever discipline. Now that's very frustrating."

In identifying her need to be involved in health policy development one of the nurses cited immunization policy and the territoriality and anger expressed by a physician.

> Well, I want referral to pediatricians, I don't want everyone to use pediatricians as their local GPs. I'd like immunization to be put back into public health. Those are some of the first kinds of immediate changes that jump out at me. And they (physicians) fight you for it, being involved in offering diphtheria, tetanus clinics. Um, you know, DPT clinics at the school level, and sometimes when you're not sure if a parent understood, what it was we're asking, you could phone the doctor to find out. Did they have it already? Well, I've had doctors scream at me, "you don't touch that kid, that's my patient. I give all the immunizations for that, you keep your hands off them I don't care whether the mum gave you permission or not." And "woo..." I mean, this is crazy.

The idea that nurses know the need of their communities and are not involved in health promotion policy development fuels frustration. The lack of opportunity to participate in policy development was expressed by one nurse in the following way.

> Who knows the communities' needs, but the people who are working there. That's the frustration with the job, there's not a lot of opportunity. And often you know we're asked to sit on a committee or do a task ... to give them guidance for policy development, and then it's like nobody even contributed. You get back the policy, and where did this come from? Very frustrating. . . . It really saps your energy to participate, cause you just feel well why would I bother. They're going to do it, what their agenda is anyway. It would be naive to think otherwise.

Yet another nurse expressed her frustration in the lack of recognition that she and her colleagues have the skills to make a contribution. In the words of the nurse,

> I would like to be involved in policy development. My colleagues also would like to be. Very often we'll offer input, written input, as this nursing office is sending this recommendation. That's what's not rewarded. But thank you for sending it, and that's it. I mean, where better can you get ideas as to what's going on, in the field. Than from your field staff who are currently implementing the policies. We would like input, not because we want to work less, or more. Not for those kinds of reasons. It's because we're the ones carrying out the activity. We know the pros and cons of doing it this way, versus that way. Like, give some credit for people's assessment skills. We're experienced. . . .

There were a few nurses who expressed frustration with the lack of leadership for health policy roles by their administrations. For one nurse, the solution to negative administrators in a time of potential opportunity for change, was for her to leave the organization.

> Policy development is expected to reflect philosophy and should presently change, because of the push towards health reform. So I feel that definitely policy should be developed, in accordance to the new health reform and the new philosophy. And I do believe just like the Lalonde report, it effected change. It will effect change, but presently administration is very difficult ... I think we're willing, I think in the field, we are really quite willing ... oh we're resistant too ... because of the, maybe the lack of skills, but those skills can be gained. But they

> (administration) are very resistant to change, because they do not have the skills. And so it's very confusing to them, to have to change track ...after following certain policies for years and years, you know, without change. So we're really at a time of change and there is a lot of resistance for change, and I suppose one has to accept that. And I suppose I feel somehow, that I will effect more change from getting out of that restricted environment, which I feel I'm being restricted .. in. And going somewhere else, where I can effect change more effectively.

The idea, expressed by one nurse, that non-threatening managers are desired negates the thought that a nurse with skills in policy development or other desirable attributes would ever be hired.

> Boy, there's a lot of frustrations in my job. And still how much I liked it. . . .Well, for example when there's openings in management and you have colleagues who have their Masters, who you feel are certainly qualified. . . . And they apply. But they don't even get a interview, they get paper screened. . . . I think what is desired is, non-threatening managers. Non-threatening to their superior.

When nurses were asked to participate in policy development, it was seen as "add on" to their current workload. In the words of one nurse,

> Well I'm aware that lots of policy development happens in our department, without our input. There are certainly efforts being made now, more than in the past, to change that, and to ask for our input, and not just ask, but have us on the committees that develop policies. It's frustrating, when all of a sudden we hear, oh.. now it's policy that you're going to start doing this. And it's like... Oh, when were we asked, whether we had time, or anything like that. So there's some frustration that way. It feels ... again lots of times it's for political reasons.

The frustration of having more work added to an already heavy workload was expressed by a nurse who was already working long hours and on her own time.

> And you get asked to do other things. I guess that sort of wears a bit slim though, too. After a while that becomes sort of frustrating, if you already have a heavy load and then the way of being recognized is more work. Like that's okay, for a while. Maybe that's okay, at first, I suppose. And I'm not saying I'm not happy about that, but it does happen. My husband just sort of laughs. He thinks it's quite funny. Like not exactly funny. "Well you're good at this, so you just get more of it. And what about the

> others, you see, that maybe aren't so good, what are they doing?" You know, because he'll see me working long hours and on my own time.

The need for policies to change and the frustration with the "old ones" was voiced by one nurse in the following example.

> And the policies are all so old. And all very loosy-goosy, and very general. And I think a lot of new nurses that start with our department are very frustrated that it is not so cut, and dried.

Another nurse expressed frustration when written expectations of health promotion policies were not happening in practice, nor the involvement of nurses.

> As I mentioned, I don't think public health nursing has much of a say, right now, in current health policy. For me and my understanding of policy it is a set of statements that describe the direction that resources are going to be funnelled through. So, on paper, it indicates health promotion, community based services, and disease prevention. But in practice, it hasn't yet happened, or, at least in city public health nursing, we haven't felt involved in either affecting that policy, or really influencing it.

Theme 2 *Nurses are alienated from the policy development process, but are marginally involved with policy implementation.*

Alienation for some nurses was expressed in terms of lack of time to be involved in policy development and the lack of knowledge/expertise on the part of policy makers. The ideal situation would have the community involved in policy development. Such community involvement was seen as being of greater significance than the nurses involvement, even though the nurses involvement was seen to be important.

The fact that there is no time to be involved in policy development was expressed by several nurses as a factor contributing to their alienation from the process.

One nurse voiced her interpretation of the situation in the following way.

> Keeping up with the numbers (clients) and then the needs are greater. The needs of the clients are greater, so even though we're seeing the same number of people you are needing to respond quicker and maybe people are needing more visits than they used to. . . . So there's less time. . . . There's less time to develop programs or work on policy development.

The timing of the request for input into policy matters was an issue expressed in the commentary of another nurse.

> The only problem is very often, we are asked to provide input on policy matters, last minute. And like everything else, when time is of the essence, that is less important than dealing with a person. . . . And of course that's probably wrong. But in the short term that seems the right decision. And I think that's how policy development is working.

The idea that the policy makers do not have the expertise or knowledge base about health promotion was expressed by the nurses. As one nurse said,

> Because I don't feel that many people have the knowledge base in that field, like I really don't think that there are that many experts in the health care system that have the knowledge on policy development and implementation of programs at a community level, in health promotion any way.

Yet another nurse agreed and provided the following insight.

> Well and also I don't think the awareness in health promotion is really there. I don't think there's a high level of awareness among the people in power. And I'm not talking about our management team. I'm talking about ... you know maybe ministries at higher levels.

The current trend towards involving the community in health policy decisions was raised by one nurse who was apprised of the current and future directions for health promotion.

> It would be ideal. I think in most cases it should be the client,... and then public health nurses. Now as far as policy development for health promotion ... I don't have a sense that public health nurses really have much of a say. I mean we have been to meetings, on occasion when there have been ... announcements that were going to be made related to health reform. We were told to be there. You know, be there. Speak your mind

> but don't speak too much and there's an implicit, not an explicit, censorship surrounding what you can and can't say regarding policy development.

Theme 3 *Nurses are "out of the loop" of policy development and implementation.*

Even though nurses voiced their exclusion from policy development and implementation processes, they shared many insights about ways and means for them to be part of "the loop." The important connections that they voiced included the linkage of policy development and implementation with community development, politics, policy awareness, good communication, good assessment data, evaluation mechanism, standards of practice/care and doing what is best for the client/community.

As expressed by one nurse, there is a critical linkage with community development and policy making. In discussing her need to be involved in the policy process, she commented,

> Community development interests me. And I think I've watched people who do that, and they're very good at it. One of my colleagues being one of them, and she's very good at that. I wish I had some time to spend with her, and learn how to do it. I would say that there's probably a lot of us who don't know how to do community development. I mean, we do a little bit anyway. But in the bigger picture. In the global picture, I guess, because some people do it a lot better than others. And it would be nice to know. But then there's, the rest of your work has to be done, too.

That politics or political strategy are part of policy development and implementation was voiced by several nurses. One nurse commented on the indirect approach that was operating politically.

> I want to be involved. But, at least at my level, it seems that the politics are unattainable for me to be involved in. So I'm having to influence other people, who influence other people. It's. . . . Up the ladder, and behind the scenes. And so being politically wise, and strategic is something that at least I'm not skilled at. And public health nursing is vulnerable, I think, in

> articulating its value. Or articulating why it should be involved in policy development, because we don't have the statistics to substantiate what we're doing. We don't have the long term results tracked. . . . And so we say that we're effective in maternal-child health issues. We're effective in communicable disease issues. But we don't have people tracked in their health behaviour, and the outcome piece articulated, and published, . . . So it's long term. So right now my perception is it's more of a political strategy. Rather than here are the stats. Here's the reports. This is proven. At least in Winnipeg.

Yet another nurse voiced how things had changed and no longer could she go directly to the policy makers.

> I guess there's more policy development at the directorate level. That's, what they're into now. More even than supervisory, on the whole. No, there's real confusion as to what our connection is. Well when I started, we did get program development from them, and guidelines, and you know we could access them directly. If you had an idea or a question, or wanted to clarify policy. You could call them directly. And now, no way. It's the Regional Director. Actually I don't know. It's fuzzy there. They (the directorate) report to the minister. So it's kind of circuitous, through the minister, and then down.

One nurse felt that the linkage of policy makers and those at the grass roots level needed to come together. In her words,

> Well, it's always a balancing act, I mean. And that's why I'm trying not to get too rigid because there is a definite need for that sort of decision making ability, at the grass roots level. But the upper management can't not pay attention to the grass roots level but at the same time the grass roots level cannot do everything themselves. And I fear at the moment that there's almost so much independent practice at the grass roots levels that nobody's got the big picture. And to me the policies are your big pictures.

The lack of awareness, a confusion about existing policies was also identified. One nurse commented,

> Yeah I do think community health nurses should be involved in policy development. I certainly do. There's this age old problem of City Health, Manitoba Health. I think it's great to have worked for both because it's definitely a major stumbling block every time a policy comes up. On who will do it? And who will do it, how? I think it's a real problem. I think it's a real problem for outside agencies, too. Hospitals just can't hardly

> deal with it. They don't know either. If they send someone home on one street, what is the policy? And if they send someone home two streets over, does that policy change? And that's really difficult. . . . And it's really too bad. It doesn't help our image.

Another nurse expressed the confusion she felt and in her words expressed it this way.

> You know, we love to get excited about the community idea, because that's where we are. But we're sceptical because we don't know what that means. Does that mean Public Health will get more? Or what kind of community base? Or, will the clinics gets more? . . . I'm not involved in policy implementation. It seems to be done, to me.

The insightful need for evaluation mechanisms was voiced by one nurse in the following way. "And to me inherent in implementation is that a policy doesn't stay the way it is forever. I mean, you've got to have some built in evaluation mechanism."

The need for good assessment data was expressed by another nurse.

> So I think often, at an individual level, you're doing stuff just based on what you know to be so, but you may not have all the information. There's not a lot of really good assessment data. Your students do a wonderful job. I love getting their stuff because their data is complete. That as a practitioner you don't have a chance to do.

The quality of client/community care was given as a reason for policies which would ensure high standards of care and also continuity of care.

> But I'm really concerned about maintaining the standards. Maintaining the level of care and again, based on a vision. So that's why I feel strongly that there need to be policies, and not just policies from my particular employer but they have to be larger policies that are going to impact on the community because it's as we mentioned, an interdisciplinary approach to care. We all need to be going in the same direction.

Doing what is best for the client, even if it meant an individual approach and the interpretation of existing policies, was expressed by a few nurses. One nurse referred to "skirting around policy."

> I find that community health nurses also have the ability to skirt around policy. For the benefit of their clients. . . . We do a lot of that. We get involved with people, you know. Where to get money. How to get money. How to move. How to get a better tenant. How to get a health inspector. You know, all these things. That to somebody who's not involved with community health, or not involved in health care. They can't understand what we're doing. Like somebody said, "where were you yesterday, I tried to reach you." I was baby sitting. This is a public health nurse. What do you mean you were baby sitting? Well she (client) had to go to court. And she had nobody to look after her kids. But she had to go to court. It was so she could get more support from her husband, ex-husband, whatever. And I said, isn't that interesting? I don't think that was written into my job description. And we laughed about it. Because we do all sorts of weird things that skirt around policy. I imagine we're not supposed to be baby sitting children.

Another nurse expressed similar ideas and voiced a personal interpretation of policy.

> And I find nurses very individual in that. Some nurses strictly respect policy and others do not. Others will take the middle of the road approach, others usually not, and some occasionally will. And then some will a lot more often. So it seems to be interpreted in a very personal way.

Theme 4 *The hierarchical structure within which nurses work is contributing to a sense of powerlessness with respect to their involvement in policy decision making.*

Issues related to the hierarchical structures included such things as the need to be heard, being heard in a negative way, the various educational levels of managers and the need for working relationships based on mentorship rather than power.

The distance between the nurse and the policy makers was voiced by one nurse in this way.

> I acknowledge that when you're at the local level and you have a small piece of the pie that you're directly involved with, you can't necessarily know the implications of what you suggest for the whole. So, having a broader view of the whole agency and the other involvements. It would make sense to me that the person who had more decision making power would filter what you say through that.

For one nurse, not being heard had significant resource implications.

> We are asked to be involved sometimes. Recently, in the last couple of years, it was related to health reform. So we got into committees, in each of the offices, and brain stormed what were the pros and cons of early discharge. And we basically said that there weren't enough supports. And the person who was asking us for our opinion agreed that there weren't enough supports. Yet it went ahead anyway. Policy was made, that women would be discharged earlier and earlier from the hospital. . . . If they had truly listened to what both the nurses in the hospitals, and the nurses in the community said, there would be more community nurses.

For another nurse not being heard meant creative solutions were not being implemented.

> Nobody wants to be seen as wasting dollars. You were supposed to tighten up, and be very creative in doing what you do, and how you do it. Well, we can offer lots of suggestions for how to be creative. But they're not listened to.

One nurse voiced being heard but only in a negative way. "If you don't implement it, the way it's supposed to be, you would hear about it. It seems to be a negative focus rather than a positive focus. A fearful type of focus."

Educational levels in the hierarchy varied and that professionals with lesser education were making decisions for nurses at the practice level who had more education was voiced by a nurse in this comment.

> In our department in the nursing management group, there are very different levels of education. And I think that has a great impact on

> management's skill, and being able to relate to a university prepared nurse. . . . And they are certainly not masters prepared. Some are currently working on a BN. Some are RNs who never did get a BN, but who had public health training, in whatever the system was years ago. Management training, in terms of, on the job. But not the educational background that I would like to see. If the standard is I need a BN to practice, to be a community health nurse, I would like my manager to have education far beyond that.

The need for a working environment which promoted mentorship and not power relations was voiced by one nurse who said,

> One of the best few years that I had working as a staff nurse, and as far as working with a supervisor, was my supervisor. I hired her for her first job. . . . I had been her mentor. She worked as a community health nurse, then got into management herself. Then I, of course, left management, had my children, worked part time. And eventually I was hired, transferred into her nursing area, and she was my supervisor. That was a wonderful arrangement. And, in that kind of an arrangement she could tell me that, you know, I could just go and take a jump, a flying leap. . . You know what I mean. Or that's where I would say I got more positive feedback, too. Because there was not any kind of supervisor power. . . . That power wasn't there really. It was a wonderful experience to work in that kind of arrangement.

Theme 5 *The impact of health care policy on nursing roles results in more work.*

Nurses expressed their concerns about the increase in workloads and fewer resources to do the work. Documentation done by the nurses did not reflect the nature of their work, nor was the documentation used by the agency in a meaningful way.

One nurse commented not only on the increase of work but also the increase needs of the clients/community.

> Keeping up with the numbers (clients) and then the needs are greater. The needs of the clients are greater, so even though we're seeing the same number of people we are needing to respond quicker and maybe people are needing more visits then they used to. . . . So there's less time. . . . There's less time to develop programs or work on policy development.

Having to do more with less was expressed by another nurse. "Yeah, I think monies are being directed for some resources, but not extra staffing resources. So basically you have the same number of people trying to do more work."

For one nurse all the documentation being required was not serving a purpose.

> Documentation ... it's quite interesting. There are a lot of official sorts of information that have to be done. Housekeeping kinds of duties... such as travel and expenses and statistics which I hear pile up and nobody's looked at in eight years or so or whatever it was, but they're piling up some place for someone to put into computer someday. And I agree, I would just like to see something done with them. But as far as our documentation goes, there are a few areas where you would like some direction and they aren't there. What do you want on this documentation. How do you like it done? That's one of my areas ... I teach documentation and what format would you like? Do you want a lot; do you want a little? Well it depends on who you're working for. There's no real policy or guidelines. I'd hate to have to go to court with some of the files.

For another nurse, not only did the documentation not reflect the work level, but the link of documentation with policy development was missing.

> Policy development.... Well we've just gone through a revision of our data collecting ... procedure and we've said for a long, long time, well the ten years I've been there and many years before... that ... the dailies did not reflect our work load, ... and it's taken a long time to work through it. I think for me, ... I've learnt that policy does take a long time to develop, and it takes a long time to work it through, before you can actually put it into place and say this is how it's going to be. I think, in the past I sort of thought, well you need a policy, you just do it and you write and you get it done. But if it's going to be effective and you've got people on the side, I think it's going to take time to have the input, back and forth. I think we're moving into policy development. I think people are asking for a lot of policy. For example I'm just trying to think... we we're talking about one the other day. It has to do with um... responding to ... a call ... well it comes in at four thirty and whatever... what is the policy? And of course we don't have a policy, as such. We have a statement that says... you get a call in at four thirty, you have to determine whether it needs to be handled or not handled. It isn't a policy that says at four thirty calls coming in will be put to the next day, that sort of thing. So I think we have some people who would like things a little more cut and dried and then there's other like myself who'd like to have policies a little more open.

Theme 6 *Nurses redefine policy to be congruent with the practice context.*

Throughout this research, participants commented that they quickly discovered approaches to "get around" or unofficially redefine top down policy. In doing so they made policies relevant to their practice context. One example was driving a mom to a court appointment. In the words of the nurse,

> This mom has had a great deal of difficulty with the system. But now she's been to court. She's got her answer, she comes back to her kids and doesn't take off and not show up. She is a more responsible person which is what you're trying to teach her.

In reality, and out of necessity, this work must remain invisible because of detrimental consequences to those who "redefine policy."

Nurses redefined policy to be congruent with their practice context to benefit the clients' quality of life, i.e., promote the health of the client. They made a conscious decision based on personal values not to implement the policy as they understood it. The possible consequences to the nurses for subverting agency policy were considered to be of lesser importance than the health needs of the clients.

Nurses who are excluded from policy development respond to their situation of powerlessness by resisting the implementation of policy. As one nurse voiced,

> Like this latest deal that has just happened. Again, policy was implemented, we weren't asked, we were told we had to implement it. And it's a real sell job to get us on board, and then we have to sell it to the general public.

Implementing policy in "one's own way" was voiced by another nurse and suggests a reinterpretation of policy as to whether it is implemented or not and operating are the nurse's own values as a part of the process. "Especially where it

directly affects us and the care that we give clients. We need to ensure that policy is implemented, if that's what we've decided to do."

Another nurse responded that when policy is not written, otherwise "implied", then it gets implemented in many different ways and often in ways that are rewarded.

> Policy implementation is a lot of what we do, expect I don't think it is written down. The danger is that every single individual could be implementing an implied policy in a hundred different ways. For example, the practitioner knows that family violence is a need but the reward is for Centre Plan or counselling is needed but the practitioner doesn't have the counselling skills. So are we really meeting the needs of our community?

These themes were founded upon the data and categories presented in the next part of this section.

Data and Categories

Several categories evolved from the data in Section B in relation to questions about how nurses defined policy development and policy implementation, their involvement in policy development, and their involvement in policy implementation. In Table 6 are illustrated the categories and subcategories according to headings which represent the questions asked of the nurses.

Defining Policy Development

When asked the question, "What does policy development mean to you?" the responses from the nurses were clustered into aggregate data according to certain characteristics which were embedded in the interviews. The common characteristics were as follows: a guideline which offers direction; a linkage with agency philosophy; the multi-layeredness of policy development; and, distance-alienation from policy development.

Table 6

Categories and Subcategories

Frustration, Alienation, Resistance: Community Nurses' Involvement in Health Policy Development and Implementation

Categories	Subcategories
Defining Policy Development	
1. A guideline which offers direction	
2. A linkage with agency philosophy	
3. The multi-layeredness of policy development	a. Practitioner (micro level)
	b. Agency/community (meso level)
	c. Government/legislation (macro level)
4. Distance--Alienation from policy development	
Defining Policy Implementation	
1. Hierarchy and authoritarian voice	
2. The multi-levels of policy implementation	a. Practice (micro level)
	b. Agency/community (meso level)
Policy Development Involvement	
Involved in policy development	
1. Local level	
2. Local, provincial, national levels	
Not involved in policy development	
1. Hierarchical structure--A sense of powerlessness	
2. Expertise not recognized	
3. Lack of time--Not a high priority	
4. Silenced by the system	
5. Lack of knowledge--Lack of interest	
6. Gender issues	
Should be involved in policy development	
1. Grass roots contact	
2. Impact on implementation	
3. Involved at all levels (local, provincial, national)	
Recognition of involvement in policy development	
1. Lack of formal recognition	
Policy Implementation Involvement	
Involvement in policy implementation	
1. Upholding rules/following direction	
2. Role implications	
3. Authoritative approach	
4. Reshaping policy at the field level	
Not involved in policy implementation	
Should be involved in policy implementation	
Recognition for involvement in policy implementation	

In defining policy development, the majority of nurses (n=22), put forth the following ideas; a set of rules, concreteness, clarity, i.e., black and white, and for the most part written. Overwhelmingly, nurses in this study equated policy development with "rules." They also voiced that these rules directed practice (n=19). A few nurses (n=2) saw policy development as a philosophy, a vision and as a means of transforming vision into action.

The multi-layeredness of policy development was present in the data. Policy development was predominately viewed as occurring at the practice level. Although it was identified to occur at the agency/community level, one half of the sample saw policy development taking place at the government/legislative level.

The dominant feeling expressed by nurses, was that of alienation from policy development. This was the reason given why several nurses lacked an understanding of policy development. Alienation from policy development can result in a kind of powerlessness at all levels of policy development, including the practice levels. Again, the powerlessness or lack of influence through the lens of gender surfaced, i.e., "the old boy's club."

That policy development is a top down activity was expressed by several nurses. Not only does this finding reinforce the idea of multi-layeredness of policy development, but it also suggests a hierarchical structure to the process.

No nurses in the sample included the concept of "process" in their definitions of policy development. In part, the operational definition used in the study defines policy development as a process and as such contributed to an expectation in the data. Only a few nurses voiced their uncomfortableness with the area of policy. Since very few

nurses were involved in policy making, the expectation which follows is that more nurses would be uncomfortable with a process in which they have little experience.

The idea that policy development would take into consideration the community's needs was commented on by several nurses. As one insightful nurse noted, "policy development means some dialogue with those whom it would effect." Nurses expressed the notion that policies are relevant to what is happening with communities or trends in health care.

A guideline which offers direction. Many nurses (n=12) understood policy development as a guideline which provided direction for activities within health care agencies. These activities included standards of practice, programming, and agency expectations. The following five excerpts are from nurses who shared this common characteristic in their understanding of policy development. As one nurse commented, "Policy is more to do with rules. And I think maybe policy should be guidelines, but it is generally seen as rules. Once a policy has been instituted, it's extremely difficult to get it changed." A second nurse stated, "It means top down programming. It is sort of strict--seems confined. For example, we do have policies and procedures for immunization and for communicable disease follow-up." The other three nurses voiced the following characteristics.

> It is some sort of direction that you're going to go and guidelines for doing that . . . something that guides what you do: how you do things, what programs you have . . . whether you have programs and that sort of thing.

> I guess in a simplistic sort of way, it means to me that our department, or whatever, or group of professionals would decide that there's a certain need. Maybe it's sort of a rigid way of thinking. But there should be some sort of a plan, or a set of standards as to how you will carry that out.

> Any policy development that I've been involved with has usually come from an incident, or an experience that's actually happened in the community. We have certainly asked for firmer policies on things. Whether you can or can't do certain things or what exactly is expected. And there's very little written in black and white on what is to be, what is expected.

In addition to policy development being seen in a positive way such as providing direction for health care activities, some of the nurses identified a tone of negativity present. This tension was expressed in the following way. Even though policy development is something that guides direction, once instituted it is extremely difficult to change. It is strict--seems confined and although requests were made for policies, there continues to be very little written to guide practice expectations. These comments reflect criticisms around policy.

For other nurses, policy development included: written directions; written expectations; and, dialogue with all groups involved in public health promotion. In the words of one nurse, "What's written on the paper. Policy development means some dialogue with those whom it would effect. And putting down on paper the direction that the group would like to take, to deal with an issue." The second nurse commented,

> Policy sounds to me like something formal. Some kind of plan that your agency develops, about what your work will be; what your activities will be; and how they'll be delivered. The policy is how you do what you do, within the mandate of that agency.

A linkage with agency philosophy. A few nurses (n=3) understood policy development as linked with agency philosophy. These nurses observed that a vision or philosophy provided the basis upon which policy was developed. As the philosophy changed so would policy development. This happens by bringing philosophy and

vision to the applied level of practice. In other words, the policy transforms vision into action. As two nurses commented, "It [policy development] is expected to reflect philosophy. It should presently change because of the push towards health reform. It will effect change." and "I think that policy development has to stem from a vision." Another nurse stated,

> It [policy development] brings up ideas about general public health kind of practice, that's put in place, that's more than just philosophies, and the concepts, and the standards that are floating by. But something that's solid. That's in writing. That says that we will now be doing HIV pre-contact tracing.

The multi-layeredness of policy development. It became clear from the data that nurses viewed health policy development as occurring at three layers or strata; micro, meso and macro. At the micro-level, policy was developed in relation to the practitioner. At the meso-level, there was the agency-community policy. And finally, at the macro-level there was government policy and legislation. As two nurses voiced,

> I think of it on a lot of different levels. On the big systems level, like the government policy development--right down to our department, and our agency. We are talking about wording, standards, policies that help to guide or direct our practice and our role. It is something that is necessary to enable us to do our job, to guide us in our activities.

> It's like a guideline, a framework, a direction. It should be broad, meaningful, have an impact for a large number of people. It can be a direction for many people to use in whatever they are trying to address. Policy needs to be developed with input from many different levels.

a. Practitioner (micro level). At the level of the practitioner, policy development was seen to provide the underpinnings of practice, standards of practice, roles, and the boundaries of practice. In addition to guiding practice, the nurses viewed policy development as establishing standards of practice within the community setting. At the micro-level, policy shaped day to day practice and guided

interventions. Policy provided parameters. The idea was expressed of a bottom-up approach to policy development with the need ideally coming from the community. In the words of one nurse, "Policy development means the development, or the identification of principles, and standards for practice. They are written and they provide, the underpinnings for practice; the guidelines for practice." A second nurse commented, "Well, policy development to me means those broad ideas that guide how you're going to implement any kind of practice. For example, do we service all of the schools or do we service public versus private?" Yet a third nurse voiced, "Any policy development I might be involved with has to be a need coming from the community that may come through the public health nurse. It is black and white. They've got to be very practical." Two other nurses made the following comments,

> Well it would address various concerns, or issues that are part of what you would be involved in with your practice. And they may be issues that arise as you go along. Or perhaps they would just be to ensure standards of practice. The policy would be developed to delineate what is expected, and who will carry out the various expected roles. To ensure that whatever the issue, or concern is, will be addressed.
>
> The policies would be guidelines for practice. If there were concerns about the boundaries of whatever you were doing, a policy would be in effect such that you could say, this fits within the realm or scope of our practice and this does not. Policy provides the framework from which you can branch out. A lot of people dislike policy.

b. Agency/community (meso level). At the agency or community level, policy development was seen by the nurses to provide a sense of direction for the agency. For example, it guided health promotion and disease prevention programming that the agency would undertake. In working with individuals, families or communities, policy development was seen to provide assessment guidelines. Furthermore, policy development was viewed as directing resources for agencies. One

example was stated as, "A set of statements that describe the direction that resources are going to be funnelled through. So on paper it indicates health promotion, community based services, and disease prevention." Another example was provided by another nurse, "Guidelines for public health nurses to follow in terms of doing an assessment. Whether this be of an individual, post partum family, or community, or whatever."

c. Government/legislation (macro level). At the macro level the following comments made by the nurses suggest that policy development is the purvue of government and is established for the good of the population.

> Policy development can be a global, statutory type of thing. And policy development can be working on regulations, can be working on allocation of resources, to support policy. Sometimes what comes first is a major directive--there's been a government decision, that's fairly global. And there's new policy. There's new direction. In a lot of policy, quite often practice will be effected first. Seeing needs, meeting needs, sorting out, standing operating practices on a common sense basis.

> I seem to be thinking legislation a lot. Drinking age, driving age, health policy. So looking at government policy about how they want to re-structure and re-organize the system. With all this restructuring of the health care system; I do feel that those are all policy things that are going to be filtering down, and are filtering down to our practice.

Although policy development was considered by nurses to occur at the micro, meso, and macro levels, there were two distinct polarized points of view. Approximately one half of the nurses (n=16) viewed policy development at the micro--practice level while one half (n=15) viewed it at the macro--government/ legislation level. Only a few nurses broached policy developed at the meso or agency level. Regardless of the level identified, nurses overwhelmingly understood policy development from the reference point of practice.

Distance--Alienation from policy development. Distance or alienation from policy development was a common idea expressed by the nurses. They commented that there was limited opportunity provided for their input concerning policy development. Nurses accounted for their "distance" in terms of structural issues. For example, when they were asked to participate, these nurses could not because of time constraints. Beyond structural issues, the idea was expressed that the process took place beyond the work world context of the nurse--it was a higher level of activity. In the words of one nurse, "How come I don't know much about policy development? It's because, no, we're not involved. It means decisions about how health care should be run or the services that should be provided." A second nurse commented, "Lots of policy development happens in our department, without our input. Policies are made and we're not asked or we're asked when we don't have the time." Yet a third nurse stated,

> Probably something that I don't do. And I don't know if I have too much of an influence, or a say in policy development. I always think of other people doing that. People higher up. And I don't know, as one person, if I have much of a say in policy development.

Gender issues in policy development were expressed. Although "weak in volume", one participant clearly viewed policy development along gender lines. "To me it means a couple of politicians making up some rules and regulations for people to live by. It's usually the old boy's club."

The consequences of not being involved in policy development, that is, being excluded from the policy development process, led to a feeling of powerlessness and a sense of alienation among the nurses.

> Policy development means to me that decisions being made about health care should involve us, of course. That's what that means. There's a trend now, and in fact it was in the paper, again today. Taking monies away from certain groups, and putting it into more community based care. But what does that mean? We haven't seen it. How is it being put into the community? And we see some hospitals who are trying now to get some of their nurses to go out, and do follow up work in the community.

Another consequence of not being involved in policy development is the perpetuation of a lack of consciousness/awareness about the need to be involved. This is evidenced in the following nurse's comment. "You know you've got good questions because I don't know if I've ever sat and thought about them very much."

Defining Policy Implementation

Nurses were asked the question, "What does policy implementation mean to you?" Their responses formed clusters of characteristics which individually were insightful and collectively provided a spectrum of thought about the definition of policy implementation.

The nurses understood policy implementation at the work level (micro) and at the meso level (agency/community), however, they did not identify how policy is implemented at the macro level, for example, at the level of regional health boards. This finding has implications for nurses working in the rural areas and will be discussed later. Explicit in the findings is the idea that policy implementation is primarily initiated at the macro level in a rigid hierarchical manner--process.

Along with the hierarchy of implementation idea is the identification of policy implementation as an authoritative process. The message is that the instructions come from "on high" and the nurses (worker bees/drones) are responsible for the

implementation at the practice level. The idea that policy implementation is an authoritarian policy-flow is out of touch with practice.

Only two nurses identified the process of evaluation in their definitions of policy implementation. When evaluation is not viewed as part of the implementation process, the lack of nurses' involvement in evaluation is well documented. As will be discussed later, although evaluation at the grass roots with communities is desired, perhaps it does not happen because one is going against the current (hierarchy). Then nurses look to a higher order to do the evaluation. The implications, to be discussed later on, suggest that evaluation is fundamental to the policy implementation process.

The alienation of nurses not only from the policy development process but also from the policy implementation process is evident from the data. When policy does not arise from the practice context when it is developed, then resistance to implementation may occur among those who are directed to implement the policy. When policy development is achieved in a consultative mode among the nurse, client and agency--then the implementation of that policy would likely not meet with resistance. One would not have the situation as described by a nurse whereby the implementation of policy necessitated going out and finding someone with whom to "do" a program. This is an example of agency program objectives being met and not client needs. The idea was expressed that health professionals were entrenched in a system which has all kinds of safeguards to protect it, and one of these is the nature of the policy implementation process itself. The process (hierarchical) ensures protection of the status quo.

Many of the policy implementation examples had an exclusive focus on medical policies. Where are the policies that directly influence nursing practice? Who is setting nursing policy? These questions will be addressed in the discussion chapter.

A common idea flowing through the data was the idea of dwindling resources in the implementation process. The implications of dwindling resources are profound. For example, this reality may serve as a catalyst to challenge the status quo and encourage change.

There were some very insightful comments made by the nurses representing a latitude of ideas. One nurse talked about the idea that personal values shape how rules are followed. The stance that the nurse assumes in relation to policy is not determined by the work but by a range of personal values.

One nurse talked about the idea of flipping the hierarchy as an approach to changing the process. This nurse recognized the ideal (in current literature). In her view policies need to come from people who are asking for the change.

The successful experience of policy implementation was talked about by another nurse who saw a way to enhance the ideal. Communication, both written and verbal, was viewed as a key factor in bridging the gap between policy development and policy implementation.

One nurse, in particular, provided some very insightful commentary on how to successfully implement policy--a process which needs to be consultative.

Hierarchy and authoritarian voice. Several nurses commented on the hierarchical nature of policy implementation and the accompanying authoritarian voice. Excerpts from the database provide the following characteristics which include: a downward

flow from administration to nurses in the field; nurses are instructed to follow-through with policy implementation; no consultation; and, "given orders" but, yet they are expected to fully understand the policy. One nurse commented, "Someone from up there, coming from admin . . . coming to us, and letting us know what the new policy is, and then I would be expected to follow the policy." A second nurse voiced, "I think of, for instance, the agency telling me what I have to do, basically. It's the 'how' we do it." Yet a third nurse stated, "I'm to do what the policy says. And not only to do, but to be aware of what the policy says so that I can do it." As noted previously on page 231, one nurse summed up the problem in the following comment, ". . . we weren't asked, we were told we have to implement it. And it's a real sell job, to get us on board, and then we have to sell it to the general public."

The multi-levels of policy implementation. Unlike the definition of policy development where the multi-levels included micro, meso, and macro; a macro level of policy implementation was not visible or identifiable in the data. When nurses defined policy development, they defined a macro level. When the nurses defined policy implementation, only two levels were identified. The micro level or practice level was the dominant level identified, however, the meso level or agency/community level was also strongly identified. It is at the micro level that policy gets transformed into action.

The nurse who made the following comment was insightful with respect to the implementation of policy at all levels and the communication needed to facilitate that process.

> It can occur at many different levels. There has to be a good communication for that to occur. There has to be that bridging of the gap

> between setting policy and then implementing it, and then having the resources to support it.

a. Practice (micro level)

Policy implementation at the practice level was seen by the nurses to be dependent on resources. The prioritizing of resources was viewed as an issue. One nurse identified the ideal situation where the public "asks" for the change. Another insightful comment was made by a nurse who included "measurement" or evaluation as part of her definition of policy implementation. Examples provided by the nurses included the following: "The implementation is, actually the hands on or the doing, whatever the policy is supposed to be, like implementing it into the community. Putting it into practice I guess." "Policies have to be very practical. You've got to be able to use them. Implementation can be relatively easy when policies come from people who are asking for a change." "Well, to me, that's the actual, either trying out of what it is and then measuring how it works", "a policy is only as valuable as the implementation process, and the evaluation process", and

> There are projects which are getting funded, and that is positive. But the whole practice itself is being more strained just because of economic realities right now. No additional resources are coming to assist the community health nurse in implementing policy.

The authoritarian nature of policy implementation (rules) was a characteristic of policy implementation at the practice level. Examples included the following excerpts: "Well until there is change, the policies that are there now are pretty strictly implemented as long as they cover or safeguard the status quo." "Following policy/procedures, and giving care according to some rules." "If a policy is set out, then as a person working within that particular organization, you are expected to

follow and implement whatever has been set out for you." "Well I guess that would come down to various individual responsibilities in terms of carrying out whatever standards have been set." Like rules, policy implementation was reported to be indexed in written form. "Well, it just means carrying out of the written mandate, of the written policies, the standards, the guidelines."

An important observation was made by one of the participants. She indicated that implementation of policy entailed comparing one's personal values [vision] in relation to that policy. In her words,

> In policy implementation, you always have to account for personal values, as well. Not everyone is malleable. Not everyone will do exactly as you say. Not everyone buys into the vision in exactly the same way. As long as you have some parts of the vision, you're doing OK, I think.

b. Agency/community (meso level)

Some examples of policy implementation at the agency-community meso level included: reference to the hierarchy; the agency determining the objectives related to policy implementation; the prioritizing of resources; and the ideal of balance between the employer and the employee. In the words of these nurses, "Ah, it means a couple of administrators making sure that those policies are being utilized, at a little bit lower level. Because usually the policies, come from the hierarchy." "Policy implementation should be balanced between the employee, and the employer. And should be worked on together." "I think about following the objectives that have been laid out in the policy which establishes the purpose of the program." and "It means taking the direction that the agency has set, and trying to work with the community to implement that. It means priorizing of resources, according to that direction, that is set."

In relation to unsuccessful policy implementation, when the agency is meeting its own needs the potential for unsuccessful policy implementation exists.

> For instance the Nobody's Perfect program. If you decided that program is something you're going to have then as an objective you would implement it somehow. Like you would send your nurses out to find somebody to do it with.

Policy Development Involvement

Findings are presented in Table N1 in Appendix N on page 435 in response to the questions about the nurse's involvement in policy development. Included are summaries of their responses as to whether the nurses thought they should be involved in policy development, and whether they received recognition for their involvement in policy development. Every nurse (n=31) indicated that they *should* be involved in the formulation of policy. Of this number only seven nurses identified that they were involved in this process. Additionally, very few nurses (n=7) received recognition for their contributions.

Nurses were asked about their involvement in policy development at local, provincial and national levels. Of the seven nurses who had the opportunity to influence policy formulation, few were active in contributing to policy development at all three levels. For example, two nurses were involved strictly at the micro level of local policy development, whereas two other nurses were involved at all three levels of local, provincial and national policy development.

The few nurses who were involved in policy development were involved at the local level. Only two nurses were involved at all three levels (local, provincial, national) and of these only one was the most directly involved.

Examples from the data indicate that those nurses who were involved in policy development, sometimes--on an intermittent basis, remained at a low level of influence.

The three strongest reasons for nurses not being involved in policy development included: hierarchical structure; expertise not recognized; and, lack of time.

Every nurse in the study voiced that they should be involved in policy development and at all three levels (local, provincial, and national). Their arguments included: having grass roots contact at the local level; and, policy development involvement impacts on implementation.

There was very little formal recognition given for involvement in policy development. In fact peers were seen to give more recognition than the agency. Over one-half the sample of nurses interviewed did not expect any recognition for being involved in policy development. This inability to be recognized for policy formulation activities reflects the value of the process and is in keeping with the finding that only a few nurses were involved.

Two nurses commented that they had more opportunity in their rural public health nursing experience for participation in policy development than in the urban setting.

It is worthy to note that the nurses who were involved in policy development were among the last 16 participants in the study. Those nurses who were involved sometimes were among the first 15 participants in the study. A nurse who was involved in policy development made the comment that she and some of her

colleagues decided to wait and give the ones who were not involved in policy development, the first opportunity to participate in the study.

Involved in policy development.

a. Local level

One nurse, in her experience as a community health nurse at the field level (micro level), provided the following example which further illustrates the "at arm's length" scenario of the community health nurse's role in the shaping of policy.

> Not all the time, but at different times throughout the years, I've been involved in policies that were developed. I can think of one of the policies that we had developed for our departments. It was called "The Working Alone" policy. The process that we went through to develop that as a department. Administration came forth with the policy as a result of an expressed need on the part of staff. They were concerned about their safety in the community and looking for some sort of inservicing or information on how we could keep ourselves safe. From that, a policy was developed, a draft. And then it was brought back to us as community health nurses. We were told to go over it and offer our input. Then it was taken back by administration and revised again, and brought back to us. And we had the opportunity to review it once or twice before the final draft of that policy came out. So now we each have it. And we have each had to sign it. And we know what it says, and we feel like we had a role in developing it.

It is of note that the above example relates to workplace safety (occupational health) as opposed to a public health policy per se. The context of the policy development is important to note. It related to an issue within the confines of the agency (structural domain).

> I am on a committee that is trying to be involved in policy development. . . . We were asked to form it. It actually came out of an inservice is what happened. There was an inservice on working weekends. And, again, on shortened hospital stay. And then we discussed the kind of policies that we felt we needed if people were coming out a lot earlier, and we wanted direction. And a policy procedure manual came out of that.

This same nurse commented on attending meetings in the community, such as one which focused on how to attract single parents back into the work force. The purpose of the meeting was not to develop policy, but the potential for policy development was a good possibility.

One nurse was asked about her involvement in her administrative roles (meso level) and the example given was the development of standards.

> I guess policy, any policy development I might be involved with, has to be a need coming from the community that may come through the public health nurse. It might be voiced by schools, or day cares, or hospitals, or whatever group out there. And I don't like coming up with a lot of policies that aren't going to go anywhere. So they've got to be very practical. You've got to be able to use them.

One of the nurses was working at the macro level on policy development about communicable diseases with the Medical Officer of Health for the region involving the school boards.

An example was provided by another nurse who was a member of a team of health care providers who dialogued and connected with the main policy makers in the organization. It was done in this way because the team of community health nurses looked at the issue from a practice perspective and the policy makers were looking at it from a surveillance, monitoring and policy perspective. It became obvious to this nurse that both perspectives were needed in order to formulate an effective policy. Of note is the value of a different "lens" being brought to policy making. If the people with the expertise are not involved, this lessens the chances to have successful (appropriate) policy. The need for policy development to occur, in the example, came about because of structural reorganization (out of necessity). In the words of the nurse,

> Yes, I would say most on the team have been. An example that I can give is in 1992 when we started to follow Hepatitis B. And that had been followed by the nurses in the general public health nursing program, with the Provincial Government. Because for Hepatitis B, one of the main ways of transmission is sexual transmission, it was decided that we would follow it. When we did take this on, we realized that we needed clearer guidelines. We needed clearer identification of protocol to follow. And I guess those would all fall under the guise of policy, in many ways. And so we worked with Winnipeg Region public health nurses. And we worked with people at 800 Portage. They're sort of a little removed from us, but they are the people that are to set policies.

This same nurse concluded her comments by saying that this example was not representative of the process overall, it was atypical. "No, not really, usually policy is made from above, and then it comes down--which isn't the best way to do it, by the way."

b. Local, provincial, national levels

One of the participants was involved in policy development at the micro (practice), meso (agency) and macro (municipal government) levels. Apart from participating in the writing of policy, this nurse functioned to influence policy through professional health associations at the provincial and national levels. The example provided by the nurse was work done with the Manitoba Public Health Association (MPHA). This nurse understood that there were several channels open which could be used to shape policy. For example the MPHA has been active in shaping policy in conjunction with the Canadian Public Health Association (CPHA). Additional examples given by this nurse were the Healthy Communities Project and Plan Winnipeg. This nurse also identified that policy development is a definite role of governments. Despite her inclusion and participation in policy development, this nurse placed the responsibility and accountability for policy development with elected

officials. As this nurse stated, "And policy development, I really think is a role for government . . . to set policy. I really feel it is their responsibility as society's voice . . . the elected officials voices, to make policy development happen." The down side to this view according to this same nurse was politics.

> And it's unfortunate that politics play such a big role in what happens in policy development. It's not always done in the best interest of society. And, I think our democracy, and our political arenas are very important. And they're very healthy when people can discuss, and talk, and express their own opinions. And if that can happen, that discussion can lead to what is best for all, rather than what is best for a few before election time.

Another nurse was involved many times in developing papers that were used by governments to formulate policy. The example given was the Minister's Advisory Committee on AIDS. This experience was not representative of community health nurses being invited to participate in policy development at the ministerial level. This nurse felt that there were other factors besides experience that garnered the invitation to participate in policy development and these were gender and sexual orientation. "It was more of an accident that I was involved as a community health nurse. At the time, I was involved with Village Clinic and in my agency working in STD."

This same nurse has been involved in policy development at the local micro (practice), meso (agency) and macro (municipal government) levels; the provincial (ministerial) level, the national level (National Society on AIDS) participation on boards and engaging in strategic plans for organizations. This nurse talked about the values that operate in practice that become policy but no one verbalizes a practice policy. Also policy that effects practice requires an enormous amount of publicity and political will to make the policy on paper become real.

> But, there is that other kind of policy, you know, that's the lived policy. That's the active, the real world. And, looking at my position now, as a public health nurse. I would say that my activities can inform the activities of others; like I think we can ensure core values. But they are not necessarily going to be reflected in the philosophy of the agency, or in the job description, or in anything else for that matter. Not necessarily. They may, but they're not. There isn't a process in place, that engages people in an active philosophy. Because a philosophy needs to be evaluated and changed over time, as well.

At the time of the interview, this nurse was not involved in policy development other than at the provincial level of the MPHA. This nurse's experience was atypical when compared to the six other participants and the degree to which this nurse has contributed to policy formulation surpasses all other participants.

Nurses who were "sometimes involved in policy formulation" voiced examples of their involvement at local and provincial levels. At the local level, involvement primarily included participating on committees to develop policy and procedure guides or having a say at staff meetings. For one nurse the substance of policy development related to nursing practice within the context of a family planning clinic. Another example arose from practice in the community. In this example, the nurse effected a serendipitous change concerning policy. The nurse assessed the situation and determined that the practice (stores buying back infant formula from Medical Services clients) was not acceptable. It was only after the media became involved that the policy was changed. Other nurses found local involvement outside the agency, either on committees or personally taking up community issues.

At the provincial level, examples included committee work with profession-related associations. Of note is the MPHA which appeared to provide a major source of policy development for public health nurses. As one nurse stated, "Outside of the

agency, an example is at the provincial level involvement, i.e., my work with MPHA." While another nurse commented,

> At the provincial level, I'm a member of the Community Nurses Interest group and MPHA. The effort was to promote the role of public health nurses in immunization as it once was, instead of what currently exists, done by the family doctor.

One nurse offered an example that demonstrates the frustration of involvement on a "sometimes" basis. The issue is one of competing priorities--time/work. Limited time and work commitments are supporting a feedback approach to policy development rather than a fully participatory involvement. Part of the frustration is that the issue is not being dealt with.

> We're being brought in, and then we are being laid on, at the same time. We are being involved in some things that are going on and then other things come along, and they are sort of laid on. And I'm really trying to sort this out, because I don't think you can be involved in everything, and I haven't sorted out which I think is fair to be involved with and which just has to come down. . . . "here it is . . . have a look at it . . . what do you think . . . give me feedback," as opposed to the grass roots case.

In these practice related examples, nurses commented that the policy developed affected change to "very minor things."

> Maybe, in a very minor way. I'm on a committee for rewriting the policy and procedure guide as it relates to post partum visiting, i.e., infant assessment and maternal assessment. Those very minor things. Our work has changed. We used to visit later in the post partum period and now we're seeing newer post partum families.

> When we had our family planning clinic . . . it's not a closed exercise but I had developed a policy/procedure manual for it and we did also for single's prenatal classes. It kind of depends on whoever designed the program. Some of the programs that have been established and in place for a long time have been developed by the directorates and people in the directorate, or sometimes the management, and sometimes if we develop a program then we'll develop the policies.

> I discovered that a corner drug store was buying back infant formula from Medical Services clients who were issued the formula by prescription. I went to the drug store and asked, and they threw me out. And I realized I was on to something. And so I raised it with my supervisor, who kind of told me not to bother. The other person I was with, who worked for the federal government, tried to raise it with his supervisor. The same thing, no one wanted to touch it; it was too hot, too political. So it did manage to get into the media, and then everything got blown off. And the policy changed.

The following example endorses the idea that policy development occurred outside of the work context. "From my personal life experience, for example, decisions in my own community such as bus routes, etc."

Not involved in policy development. Nurses who responded that they were not involved in policy development provided insights into their lack of involvement and gave the following reasons for why they felt disenfranchised from the policy development process. Their reasons clustered into categories such as: hierarchical structure; expertise not recognized; lack of time; silenced by the system; lack of knowledge; and gender issues.

a. Hierarchical structure--A sense of powerlessness

Nurses voiced a sense of passive agency with the process of policy development. Their role was one of recipient of policy to which they respond. They voiced little or no direct involvement in developing policy. A top down approach effectively removed them from this process.

> It's happening to us, rather than us having effect on it. So I am not terribly surprised that I haven't had any experience in three years of my career. I'm sure many, many nurses haven't had any chance or any say.

> Never have I been involved directly; always in an indirect manner. They (administration) will sort of come and say, this is what we're looking at, we need some feedback. So they take our ideas, and then look through them.

> I do think that with all this restructuring of the health care system, policy decisions, i.e., tobacco legislation, drinking and driving age (health policies) are going to be filtering down, and are filtering down to our practice. Looking at government policy of how they want to restructure and reorganize the system. I see it as being done up there, and filtering down. . . . Unfortunately.
>
> But I do sit on committees. I've been on lots of committees. I'm not saying people don't listen. They don't always agree with what I might think. But, I couldn't honestly say that people aren't given an opportunity to share your ideas. But, I don't know that they always listen to you. Well they may listen and make their own decisions.

This top-down "flow" or hierarchical order served to alienate and distance nurses from contributing to policy development. Nurses recognized their position in relation to the hierarchical structure. That is, they understood the "missed opportunities" to share their ideas about policy.

b. Expertise not recognized.

Nurses would like to be involved with respect to policy development. However, their assessment skills are not readily recognized. Nurses are situated in the field setting at the juncture between policy development and policy implementation. They are requesting recognition of their knowledge and experience.

Despite this knowledge and experience, nurses remained alienated from policy development within the context of their agency. One participant observed that she shaped policy as a member of the provincial and national public health associations. This was not the case, however, within her own agency.

> I would like to be. My colleagues would like to be involved. Where better can you get ideas as to what's going on in the field than from your field staff who are currently implementing the policies. We are the ones carrying out the activity. Like, give some credit for people's assessment skills, we're experienced.
> Well as far as the agency level. We get asked a lot for our feedback, but I don't really feel that it's policy development. I feel that I have a lot more

> to say on policy development through MPHA, and through CPHA than I do at work, and even non nursing. I mean, my non nursing activities, influencing policies of either different political agendas or strategies for women. I mean I feel I have a lot more say there, and are a lot more involved in that than at the agency level.
> I would like to be involved in policy development. Especially with what's happening to health care, I think if you're going to change how health care, the service is delivered, you'd better get out there and ask the people who are delivering it right now. And is there a need to fix it? Or can you? Or do you have to do away with it? Or can't you build on what you have?

c. Lack of time--Not a high priority.

Policy development was not viewed as a priority. Consequently, nurses observed that little time was available to devote to policy development. Engaging in policy development required "extra time" and nurses indicated that their current workload demands precluded this activity.

For many nurses, the act of policy development would require a reduction in the time available for community-based work. When public health nurses did contribute to policy development (i.e., committee members), their work had to be "covered" by those nurses remaining in the field.

> Policy development doesn't have a high priority. I think our agency works very well, in that when we are asked, we speak. But very often there is little time to say, "wait a minute, this should be changed."

> I think that it would be encouraged. But again, for some nurses the question might be, well, where is my time, where is this coming from, do I take it from my community and continue to develop this? Or do I run to catch up to my community and, you know, do this at home? And, that's the concern . . . where does the time sort of fit in?

> What is happening is public health nurses working in the field are developing policies for programs by sitting on committees for this purpose. Although this is good, given the workload that we have, it's just one more task for us to do. When nurses are taken out of the field to sit on committees, to a certain extent, other nurses need to pick up their responsibilities.

d. Silenced by the system

A couple of participants felt silenced by the system. That is, channels of communication (e.g., committee minutes) were monitored (edited) in order to maintain the status quo. Silenced at work, one participant had her voice heard through the political arena. The agency's fear of negative publicity also served to silence some of these nurses.

> I'm not involved per se. Yes, I feel silenced by the system. The system is telling us to keep our mouths shut. The minutes of our meetings are edited as a means of preventing change and protecting the status quo. I have the ability to influence, because of my involvement in political parties.

> The message is don't do anything high profile that will cause negative publicity to the health department. The message comes from the bureaucrats at the top. We can offer lots of creative suggestions . . . but they're not listened to.

> I felt I influenced provincial development of policies more in the rural areas because my voice was stronger than in the city. There's many more people whose voices have to be heard in the city. I think if there was a community voice rather than an individual voice, with individual programs . . . then we could influence policy development.

e. Lack of knowledge--Lack of interest

Beyond structures that impeded the involvement of nurses in policy development, there were "personal" limitations. Not all participants were interested in policy development. For example, one nurse identified that it was an area of weakness for her. In the words of this nurse, "Policy development and implementation, this is probably my weakest part that probably means the most to you. And because it is weaker, might tell you volumes already." Another participant expressed a lack of interest in the topic.

> I think it would be ideal to be involved where policy is being developed but at this point it's not a very strong interest for me. And if there was no

> one else involved, I think I would panic and think, someone's got to do it, I'll do it. But I am seeing some capable people, or people who I feel are quite capable, and have lots to offer in the area, are being involved. I think there is more consultation starting to happen.

f. Gender issues

Moving beyond the lens of hierarchical agency structures, nurses recognized that gender influenced their presence at the policy making table. As a female dominated profession, nursing was dismissed as capable of formulating policy. A paradox was revealed by one participant who noted that it was the "men in suits" who develop policy and yet were ill informed about health matters in the field setting. Examples voiced by the nurses include the following:

> Actually I was going to say being in nursing and being a female dominated profession, I don't think many nurses get to that point [developing policy]. You look at the health care reform. Where are we? We don't have any place there, any voice or say.

> I know that the STD nurses are currently involved with policy development, regarding HIV contact tracing. And that's a sticky-wicket. But we're being asked what does it mean? What kind of questions? What does a partner mean? What does sex mean? All these things. So that when you talk to people who don't understand health, these are the kinds of questions they have. And these people are very often our policy makers. They are all requesting information from their advisors who are more connected with health. The problem is, the bottom line it's those, I want to use the term "suits" [men in suits] who make the policy, . . . who make decisions about policy, and who don't really necessarily understand the issues behind them.

Nurses who were not involved in health policy development, but responded they should be provided several examples of barriers to their involvement. These barriers included: lack of time and energy; lack of familiarity with policy/political process; and gender issues.

a. Lack of time and energy

As one nurse stated, "Yes, I should be involved in policy development. There's just not a lot of time left over, by the time you do all that other stuff." Yet another nurse commented,

> At this point, it would feel like a luxury to have the time and energy to do that. I, philosophically, am in belief of supporting policies which I feel support health from a public health nursing point of view. But, it would feel like a luxury to have the time and energy. It's not a very big priority right now for me.

b. Lack of familiarity with policy/political process

In the words of one nurse, "Yes, I think it is one of my responsibilities. But like anything else I'm not familiar with, I tend to avoid. I have all kinds of strengths but I'm not a leader." Another nurse voiced,

> I want to be, but at least at my level it seems that the politics are unattainable for me to be involved in. And so, being politically wise and strategic is something that, at least, I'm not skilled at. And public health nursing is vulnerable, I think, in articulating its value. Or articulating why it should be involved in policy development, because we don't have the statistics to substantiate what we're doing. We don't have the long term results tracked. And so we say that we're effective in maternal-child health issues. We're effective in communicable disease issues. But we don't have people tracked in their health behaviour, and the outcome piece articulated, and published, and so it's long term. Right now my perception is it's more of a political strategy, rather than here are the stats. Here's the reports. This is proven.

c. Gender issues

One nurse provided the following explanation,

> Definitely we should be involved. That's one of the things that always bothers me. No matter how much schooling and education you get as a nurse, they (government) still don't take us serious at all. They don't listen. And you know we have so many nurses at the masters and doctoral level. Have they been asked their ideas for the health care reform? It's not because we are nurses. It's because we are females.

In addition, participants provided reasons as to why they should be involved and how they could be involved in policy development. Why they should be involved included: nurses are at the field level; and, a nurse's responsibility (employer/employee working together). How they could be involved included: facilitative leadership; and, having a field representative.

The importance of nurses working at the field level was voiced by several nurses. Their comments include the following:

> Oh yes. I don't think there's any question, because who knows better. If you don't have that feedback at the grass roots level, you are making airy fairy policies which is probably why some of the things don't work. . . . And I think you should be involved in policy development at all levels. I think that's your responsibility as a citizen.

> Yes, they (nurses) are in the field and they are working it. And to me they would have a very valid input in developing it, along with those that are experts in policy making per se, or putting it together, or wording, or all those things that are involved.

> I think that it's important to be involved at various levels (local, provincial, national). Because, so to speak, you're at the grass roots. You're dealing with concerns that arise in your everyday practice and whether they affect the nursing profession, or whether they affect the community. I think that, a lot of times, there are details that would normally not be taken into consideration, if it's dealt only at higher levels.

Participants viewed "that it is the nurses' responsibility" to be involved in policy development. Participants viewed nurses as accountable; and policy development involvement as a responsibility, a societal expectation. This finding also may suggest a form of advocacy which may entail policy development (protecting the vulnerable and the weak).

> Yes, I think we should. But then I think some of that is the nurse's responsibility. I mean, how many people are at the Community Nurses Interest group meeting the other night? I just go back to the office, and bawl everybody out when there's hardly anyone there.

Nurses also identified that "there should be a balance of employee (community health nurse) and employer (administration) working on policy development together."

Policy development involvement, as voiced by participants, could be encouraged/fostered through a facilitative leadership style. As one nurse observed, "facilitative leadership is the ability of the agency to allow leadership to facilitate, and not drag and push; there's a big difference."

A second approach to fostering involvement in policy development entailed the use of a field representative. That is, having a grass roots person (i.e., the nurse) involved in policy development. "Yes. I think by having a field representative involved [in policy development]."

Should be involved in policy development. All participants (n=31) in the study voiced an overwhelming need to be involved in policy development at local, provincial, and national levels. Nurses are the front line workers; they know where the action is; they know what is going on; and, they have a good sense of what is needed concerning policy development.

The rationale for involvement included: having grass roots contact at the local level; and, being involved in policy development impacts on implementation. Even though there was unanimous agreement among the nurses to be involved at all three levels, several nurses emphasized that they should be involved especially at the local and provincial levels.

a. Grass roots contact

Two nurses commented, "We have the grass roots contact, with the clients that we are delivering the service to." and "When it came to structured formal policy, the

people in the field could be used more. . . . I'm very grateful to be protected from it sitting and haggling over wording for three days worth of meetings." Other nurses provided the following reasons:

> The field should be involved in policy making and some of the committees have begun to ask for representation from the field, and so that's been a positive change that we see because I think we provide a different perspective, especially when we are looking at multi-disciplinary types of programs. I would like to be involved in policy development at provincial and national levels.
>
> I think you should be involved locally for sure, and because that influences the other levels to a certain extent, I think you could be as a public health nurse. You could be on committees that made decisions about policy.

b. Impact on implementation

The following four examples illustrate a strong belief of the nurses that involvement in policy development impacts on implementation.

> I certainly do. It is important and makes a difference to implementation. Not being involved in policy development poses a problem in the implementation phase. For example, Manitoba Health and City of Winnipeg can have different policies. Nurses in hospitals discharging patients can be very confused. A patient being on one street can be serviced under one policy while a patient being discharged on a street over can be serviced under a different policy.
>
> Oh yes, there's many things that we've complained about and wanted to have changed, and we have expressed the need to be much more, individual in our communities, and not laid on "you will do, all of you will do, this, this and this." And if it's in the district that doesn't need it, as far as I am concerned, why are we doing it?
>
> Definitely I would say yes, we should have some input anyway in policy development. We sometimes wonder if, even at the supervisory level and the assistant regional director, if they themselves actually know what we, the field nurses, do in a day.
>
> Policy implementation, now, that should be up front from the beginning. A policy is only as valuable as the implementation process and the evaluation process. So, whoever the policy makers are, should include

> those who would then actually implement (fulfil) the policy. And it's not that easy to do.

c. Involved at all levels (local, provincial, national)

As three nurses commented, "Absolutely, community health nurses should be involved in policy development at every level (local, provincial, national)." "I certainly feel that you have to be involved, in all the levels (local, provincial, national)." and "Definitely, and if not nationally, for sure at local and provincial levels. Although, I wish knowledge and exposure to what was happening in other provinces came more easily." Two other nurses provided the following rationale.

> Yes, I should be involved as a supervisor and I truly feel community health nurses at the field level should because they're the ones that are really closest to the issues, and can really assist with the implementation of those. For example, how would it work the best, how should it be approached.

> Community health nurses should be involved if not at national levels, certainly at local and provincial levels. I think you definitely should have some field people involved. Because I think that when you don't, things get missed. And I should say also that, at this time, I'm involved in a forms committee. That is identifying forms to be used at the provincial level, all around the province.

Recognition of involvement in policy development. Participants (n=7) observed that on occasion the agency provided them with recognition for their involvement in policy development. There was limited recognition offered by peers (n=2).

Of the seven nurses who said they were involved with policy development four responded that they were recognized. Three responded that this recognition came from the agency and one nurse responded it came from peers. Of the six nurses who said they were involved sometimes, four responded the recognition came from the agency. One responded they were recognized by their peers. Nurses overwhelmingly stated

(n=18) that they had no expectation that they would be recognized. They indicated that the value of their work in policy development would go unrecognized.

There was very little formal recognition, if any, for the nurses involvement in policy development. This was particularly notable among peers. Informal recognition by the agency took the form of time to work on agency related projects.

a. Lack of formal recognition

For some participants, agency structural problems around time, lack of flexibility, lack of recognition and the need to allocate dedicated time to policy development, i.e., committee work, were evidence of lack of formal recognition.

> Sometimes, they'll (administration) just go the other direction if you say something. They begin to know what your opinions are and brand you as sort of coming from the past (approaching retirement). Well if she said that, maybe we shouldn't do it sort of thing.

> Having "committee work" on my resume, I think this helps you get the job . . . but just try to arrange to have the hour off early to go to your committee and see how much recognition you get. It's difficult.

For one nurse, formal recognition from the agency was in the form of a letter of acknowledgement, "I think I will be recognized but I am not exactly sure. Any involvement, i.e., committees, is recognized by the agency and often times in a letter of acknowledgement."

There were instances where peers provided the recognition for policy development involvement. As one nurse commented, "the agency does not recognize involvement in policy development but the people I am developing policy with, recognize my contribution."

For other participants the agency did provide time for policy development. As one nurse commented, "I felt a little bit of recognition by my agency who gave me time to work on a community development project and re-assigned my other work."

Another participant observed the following, "I am recognized in a minor way, yes. If I request time off to work on the policy and procedure guide for post partum visiting, then it's given to me. I imagine that if we produce a useful document, then, that would be appreciated and recognized."

Policy Implementation Involvement

Findings are highlighted in Table N2 in Appendix N on page 436 in response to the question about nurses' involvement in policy implementation. The nurses were asked about whether they should be involved in policy implementation and if they were involved, were they recognized for their contribution.

All but two of the nurses (n=29) responded that they were involved in policy implementation. All the nurses who were contributing to policy development, responded they were also involved in policy implementation. The contrast between those participants who responded affirmatively and those who responded negatively was significant. Two nurses responded they were not involved in policy implementation, while the majority of nurses voiced that they were involved. The nurses not involved identified gender and victim issues as reasons for their lack of involvement. Those involved in policy implementation expressed their involvement in terms of being distanced from the policy development process. The process seemed to be a "top down" approach and not at all participatory. One nurse included the evaluation component in describing policy implementation. Yet another nurse

expressed that for satisfying and rewarding implementation activities, the policy had to be violated.

The majority of nurses felt they should be involved in policy implementation.

Approximately one-half of the sample of nurses felt they were recognized for their involvement. Equal numbers felt that the recognition came from peers, agency, and the community. Fewer nurses did not expect recognition than those nurses involved in policy development.

Nurses were capable of discerning the fact that although they were not involved in policy development they attended to policy implementation by virtue of their practice. Nurses may have voiced that policy development and policy implementation are legitimate roles however, in the case of policy development nurses are clearly alienated and implementation is forced.

The findings suggest a policy process which is shaped and implemented on the nurses' own terms. In implementation--nurses are re-defining policy through their actions. They make the practice work and policy congruent. There exists a top down discordance between policy and the nurse's practice.

In summary, firstly nurses re-define policy in relation to practice. Resistance is a parallel process (different ways to get around policy). Similarly when implementing policy, they are "re-shaping"--translating policy into their reality. When policy does not fit with the practice reality nurses extend or contract the policy.

Involvement in policy implementation. Nurses who were involved in the policy implementation process described their experiences as including: upholding rules; role

implications; authoritarian approach; bureaucracy; and, ways to reshape policy at the field level.

a. Upholding rules/following direction

Participants were quick to observe that their practice was directed by policy. Nurses were capable of discerning the fact that although they were not involved in policy development they attended to policy implementation by virtue of their practice.

The general tone of the data revealed that participants viewed the policy implementation process as prescriptive. One participant observed that within the context of "prescriptive policy" there was a sense of autonomy. This autonomy appeared to be accorded to the nurses based on adherence to policy, in other words, autonomy existed by virtue of the rules and regulations around practice. In the words of two nurses, "My practice is based on policies, and mandates so that while I'm practising, I would be implementing policy. We're constantly getting memos, saying this is the policy, and here's how you do it." and "I think that the supervisor recognizes that we can follow policy, otherwise I don't think we'd have that autonomy. Also there is a book of policies as it applies to our practice--a book of do's and dont's." In addition, two other nurses made the following comments.

> Well, I think in all your work you are implementing whatever policy happens to be, very specific for the clinic and for travellers. There's definite policy there. And in terms of health promotion, I think it's a little looser, but certainly within a framework. I mean you can't just go about with your own philosophy, and influence people in that way. There's definite guidelines.

> Yes, well I think part of my role as a manager is to implement the policies or whatever that's given to us. The directions that are given to us to give direction and support so that they can be implemented.

b. Role implications

Nurses involved in policy implementation experienced challenge to their role. For one nurse, the change in policy to discharge post natal women early meant that community health nurses had to take on this "other" work. As in previous data, it is implied that new policies are implemented without additional resources to support the translation of policy to practice. In the words of one nurse, "Implementing policy is trying to work with the community to implement what the agency has set. And it means priorizing resources according to that direction." Another nurse commented,

> If you could say that policy is, for example, shortening hospital stays of post natal women, then yes, I suppose we are. Because when post natal women are discharged earlier from the hospital, it impacts on our role. And we have to pick up the extra duties that are not being met then.

Working at the field level was seen by nurses as being an advantage regarding implementing policy.

> And now that we (public health nurses) are involved in it from the grass roots, I guess it's just I'm not used to taking on that responsibility. Maybe it's good. It is probably good because actually we're the ones that are doing the task, or working at the field level. So we are best able to it.

However, one nurse commented that even though nurses were strategically positioned for implementation at the grass roots/practice level, there was some inexperience with the general process of implementing policy. This nurse could have been referring to "policy development" in her comment or perhaps thinking about one phase of policy implementation such as evaluation; identified by the majority of nurses as absent. However, one participant did recognize the need for evaluation. "Inherent in implementation is that a policy doesn't stay the way it is forever. You've got to have some built in evaluation mechanism."

c. Authoritative approach

There was some suggestion of an "authoritative" nature to policy implementation. For example, one nurse expressed role violation on two accounts. Not only was she not involved in policy development, but policy implementation was "commanded" of her.

For another nurse, policy implementation involvement meant "upholding" policy. This understanding precludes the questioning of policy or nurses as autonomous practitioners.

For another nurse policy implementation had a "victim" nature to it. The negative effect of a pattern of not being involved in the policy development process was the reality that implementation was met with apathy and disenfranchisement. Voices not being listened to resulted in a "hopelessness" and "victim" mentality.

Nurses commented about the "slow" nature of the implementation process. Any kind of change was viewed by nurses to be basically "slow." The issue of poverty was cited by one nurse and the nurse's role in making people aware of food banks and how to access them. Beyond the cumbersome nature of bureaucracy is its structure which serves to ensconce this authoritarian stance in relation to community health nurses. The reasons provided by one nurse were the many layers of bureaucracy in the governance of health care and all the factors equated with changing times. In the words of three nurses, "Implementation is easy if you've got the direction and the power." "I was not involved in making up the policy . . . and I was told to implement it." and "In a general sense I am involved with policy implementation. The policies

that are made you uphold as a public health nurse." In addition, two nurses provided the following explanations.

> No, it seems to be done to me. . . . You almost feel like it's something that's being done, to you, as opposed to being involved in the process. Now chances are that I should be asked. I should be involved. My views should go to our union reps, and our administration, who then should represent us in the political arena. Some of that's happening. But I don't know how well we're being listened to, right? We hear Vera's on the news quite a bit, and we appreciate some of the things she's said. We feel we could have a much stronger voice, no doubt about it. We seem to be sort of lying back letting these things be done to us.

> It's a slow process. I work for a real upper bureaucracy and all changes are generally slow. I think it's harder and harder to implement new policy because of times. . . . We decided that more people should have access to food banks, so we tell people about the food banks. We tell them where they are. We tell them how to access them. That is policy implementation. But it's just one of the things we do.

d. Reshaping policy at the field level

Throughout this research, participants commented that they quickly discovered approaches to "get around" or unofficially reshape top down policy that does not work universally. This reshaping enabled participants to temper existing policies, thus making them relevant to their practice context. With respect to policy implementation, one participant commented how community health nurses reshape policy. The example provided by the nurse was a home visit to a woman with a new baby. The nurse stayed with the other children to enable the mother to go to court to obtain financial support and resources. From the agency's perspective, such action would likely be viewed as "skirting around policy." Existing policy prohibits nurses to "babysit" client's children. Another example provided was driving a mom to a court appointment. "Public health nurses do a lot of this, they are very skilled at how to make things work." This work of the public health nurse was referred to as

"intangible" because it is contrary to agency policy. As noted previously on page 231, the outcome was satisfying and rewarding for the nurse. "She's got her answer, she comes back to her kids and doesn't take off and not show up. She is a more responsible person which is what you're trying to teach her."

Nurses refer to this kind of work as "intangible." However, in reality and out of necessity this work must remain invisible because of detrimental consequences to those who "reshape policy."

Not involved in policy implementation. Two participants responded that they were not involved in policy implementation. Data from the interview transcripts of the two nurses who indicated they were not involved in policy implementation suggest that "implementation" may have been viewed as "development." The following comment provides insight as to the nurse's lack of involvement.

> No, I'm not involved in implementing policies. It seems to be done to me. We were not involved in any of the decision making to do with the restructuring of the department. We should be involved when policy implementation directly affects us, and the care that we give clients.

The second nurse, who graduated within the past three years, felt that one had to be in an administrative position to be involved in policy implementation. In her words, "you need to have an administrative position to be involved in policy implementation." She felt that there was a good possibility for her to be involved in policy implementation given her career path. Again this participant's view of policy implementation engenders policy development. It was clear, however, that the majority of participants were able to differentiate between development and implementation.

Should be involved in policy implementation. Overwhelmingly, (n=30) nurses felt they should be involved in policy implementation. Although there were some insightful observations in response to the question, "Should you be involved in policy implementation?" very few nurses elaborated much further than "yes." Perhaps the reason for this limited response was that the question was so obviously positive and followed the previous question, "Are you involved in policy implementation?" Many examples were provided by nurses to this question and it was explored fully. Since fewer nurses were involved in policy development, they had much to say about why they should be involved in this process. It is for these reasons that the data related to policy implementation was not extensive.

Comments made by nurses who implied that their involvement in policy implementation was obvious included: "Anyone who is in the health care field is going to be acting on or according to some sort of policy." "I'm the one doing the program." "There would be no point in having a policy if you were not going to implement it." "The work that we do is directed by those policies." and "We are the ones that do it every day."

Several nurses included in their responses that policy implementation was a legitimate role for community health nurses. In the words of one nurse, "Both policy development and policy implementation are legitimate roles for community health nurses."

Nurses were aware that their support was necessary for successful policy implementation. As one nurse responded, "Implementation includes being supportive and positive and trying to find ways to make it work." However, as with policy

development where nurses found ways to reshape policy, nurses were finding ways to implement policy "in their own way." As stated by one nurse, "Especially where it directly affects us, and the care that we give clients. We need to ensure that policy is implemented, if that's what we've decided to do." Yet another nurse commented,

> But there's just not a lot of time left over by the time you do all that other stuff. Sometimes they (administration) just sort of take your idea. Like with the lice issue, like we just started doing it (implementation) our own way. And then when others saw how it worked nicely, then they adopted that style.

One of the supervisors spoke about the implementation of policies according to what is rewarded in the agency.

> Policy implementation is a lot of what we do, except I don't think it is written down. The danger is that every single individual could be implementing an implied policy in a hundred different ways. For example, the practitioner knows that family violence is a need but the reward is for Centre Plan or counselling is needed but the practitioner doesn't have the counselling skills. So are we really meeting the needs of our community?

One nurse commented that in the implementation role there should be more of an emphasis on community development.

An overwhelmingly majority of participants responded that they were more involved in policy implementation than policy development. Some of the forms that implementation took was voiced to be, often a program in response to needs in the community, being a consultant, liaison or a resource developer, taking politicians out on home visits, implementing policy during the pertussis outbreak, and public education. Some of the supervisors saw their roles as "implementing the policies or directions that are given to us to support" and "implementation is at every level, from job descriptions to the philosophy of the agencies and including evaluation." Another

supervisor saw her role as "being responsible to see how our health department's mandate or the priorizing of our services works at the branch level."

From the participants' perspective the implementation process, "is easy if you've got the direction and the power." For one nurse implementation was mandated in that "policies that are made, you uphold as a public health nurse." For another nurse involvement in implementation was a way "to maintain credibility within the profession and within the organization."

Recognition for involvement in policy implementation. Seventeen of the twenty-nine participants (59%) involved in policy implementation responded that they were recognized for their involvement. The sources of recognition can be found in Table N3 in Appendix N on page 436. Most of the recognition (n=11) for the implementation of policy was on behalf of the agency. This makes sense in that it is an expectation of the agency that nurses implement policy. Unfortunately one participant observed that this recognition was not always positive. Her reward was an increased work load. "Like in this whole health reform thing. . . . the way our department recognizes what you do is more work." Closer scrutiny of these numbers reveals that the number of peers offering recognition was limited. It may be that nurses do not place a high value on recognizing policy implementation. This is speculative given the limited available data. However this finding, i.e., limited peer recognition, is in keeping with earlier findings that nurses overwhelmingly do not expect recognition for involvement in policy development (see page 264). Only two participants reported that communities recognized their involvement in policy implementation activities. Perhaps the community does not understand or recognize

the role of the community health nurse in policy implementation? It may also be that policy implementation is essentially invisible work and thus is not amenable to public recognition.

Conclusions

Community health nurses stated that currently there exists a lack of policy direction for community health nursing in general. Although they believed that the health care emphasis will shift to the community, current policies do not reflect this shift. Even a few years ago when the government spoke about moving services to the community, what nurses experienced was simply cutbacks which translated into fewer nurses doing more work as workloads increased. Additionally, health promotion has not been valued by the government in that very few resources have been directed to supporting health promotion initiatives. These cutbacks and limited health promotion resources have left public health nursing vulnerable. As government action moves away from the rhetoric espoused, nurses are becoming increasingly frustrated.

In addition to the general lack of policy direction, community nurses identified limited department/agency policies to guide practice decisions in the field. Therefore, nurses practiced according to their interpretation of action needed in a given situation upon consultation with another colleague. Policy is either non-existent, or if it does exist, it is not specific to allow for a unified practice interpretation. Nurses found this situation frustrating and not a desirable approach to policy implementation. When policy does exist, it is interpreted on an individual basis resulting in disparate application in practice. Sometimes interpretation and application of the policy was based on the perception of what was rewarded by the agency. In contrast, nurses

stated that they implemented policy with a personal interpretation of that policy even though they had to account for their decisions. This personal interpretation was made in the best interest of the client. The example given by one nurse was briefly staying with a client's children so the client could keep her court appointment and fulfil her commitment and need to obtain maintenance/child support from their father. In a bureaucratic and hierarchical health care system, inconsistent messages or differences in interpretation of policy not only exists among the nurses, but can exist at all levels of government. Such inconsistency has a direct impact on the work of community health nurses and makes it difficult for them to do their work because they value consistency in interpretation of government and agency policies. It is particularly frustrating when nurses are accountable to several different people in an organization who may judge their practice based on their own unique interpretation of policy.

Some nurses stated that resisting change and maintaining the status quo were common characteristics found in administrators/managers of health care. After following certain policies for years, these managers were resistant to having them change. Participants suggested that field nurses were much less resistant to having policies change than were the administrators. Nurses argued for policy change, particulary policy with respect to the immunization of children. They wanted to reclaim their role in administering immunization to children and in particular in the schools. They also wanted policy to guide overall documentation activities. Additionally, nurses wanted their superiors to have at least higher education than themselves. In a hierarchical system and in relation to power, the need for working relationships based on mentorship was advocated by one participant.

Some nurses argued that few people in the health care system had the expertise to develop policy and implement programs at the community level. In general, nurses felt that the people in power at the level of government ministries were not really informed in the area of health promotion. At the level of practice, some nurses identified their own lack of knowledge about community development and viewed it as an "add on" to the rest of their work. Some nurses felt that they lacked the political skills to be involved in influencing policy development. Even if the evidence was available, but it was not, nurses felt that political knowledge was very important in influencing political decisions.

Because the needs of communities were known to participants, they agreed to sit on policy development committees, but found the experience frustrating. When the policy was made known by the agency, it did not reflect their input or their ideas. As a consequence, nurses were discouraged from participating on future policy development committees. They saw no evidence that they had an influence on policy formulation.

When nurses were not involved in policy development which was generally the case as suggested by this study, they looked upon this as an act of omission of recognition. If governments and agencies did recognize their expertise, for example, their assessment skills, they would definitely be involved. Continuous policy development without them was frustrating for these community health nurses. However, a paradox existed. Nurses wanted to be involved in policy development but they were usually not. When they were involved, their perspectives were sometimes not valued or accorded legitimacy and thus, policy development became a "make work

project." Whereby they assumed more work, i.e. policy development committee, without actually shaping policy. To other nurses looking on, the question arises, "What are the benefits and what is the price of being involved in policy development?"

Sometimes nurses experienced a "last minute" invitation to participate in policy making. This placed nurses in a difficult situation, i.e., having to choose between policy involvement and patient care needs; the nurses choose the direct client practice need even though they were aware that they had the potential to influence policy that would impact on many more people than one client. Nurses also commented on the "implicit censureship" existing at meetings about what can be said about policy development; for example, nurses were told to attend and speak up at health reform meetings but not to speak too much. This silencing served to add to the alienation from policy development already felt by nurses.

Nurses observed that the hierarchical structure within the health department made it more difficult for them to participate in policy development when at one time they had direct access to health policy makers. In the recent administrative restructuring, nurses viewed policy as coming down to them with little, if any, input from their level at the grass roots. Thus, at the practice level, there were many individualized nursing practices without commitment to the policies which arose from the higher levels. Between agency policies differed and further complicated nursing practice in the field. In one neighbourhood, there could be two community health jurisdictions, i.e., Manitoba Health and City of Winnipeg. Clients, community health

nurses and home-care discharge nurses were sometimes confused as to which policy applied.

Nurses redefine policy to be congruent with their practice context. In redefining policy, resistance is a parallel process. When policy does not fit with the practice reality, nurses find different ways to get around policy. They establish congruence of policy and practice through an act of subversion which is a consequence of a process which marginalizes and alienates community health nurses from the whole policy arena.

Resistance is a consequence and a way for women to take power in a situation in which they are powerless. This outcome has major consequences for the community when policy is redefined by nurses. This struggle filters down to every level of health care delivery and culminates at the practice level. Nurses wanted the situation to change, but until it does they were prepared to continue to redefine existing policies and subvert the system for the benefit of the community. Until the lack of involvement in policy development issue is attended to, it is certain that this action will continue.

Section C--Equity, Vision, and Hope: The Canon

Two additional questions, posed toward the end of the interview, were asked of the participants. These questions included recommendations about how nurses would change their work, and additional information.

Themes

Two themes were derived from the data and they are presented in Figure 4.

Equity, Vision, and Hope: The Canon
1. Nurses want equity in terms of gender, programming and professional status.
2. Community health nurses have sustained vision and hope.

Figure 4. Themes (Section C)

Theme 1 *Nurses want equity in terms of gender, programming and professional status.*

The equity issue in Section C of the findings will not go away. The two components common to the responses by nurses have to do with gender and nursing.

In relation to the delivery of services, and professional models operating, two nurses commented. The first nurse suggested the following:

> Broaden the minds of administration. I give it enthusiasm instead of restriction. Equality for both genders so not just service to women but service to men as well. Everyone would be trained as helpers. Not just the medical or psychiatric models.

The second nurse expressed her views in this comment.

> There has to be more input from the bottom up. It has to be a two way street and there has to be an indication that the philosophy can, and will change--Because of pressure from providers, from the actual service providers. There has to be a real dialogue--to talk about the philosophy and make it a really living thing. Public health nursing has become very focused on women i.e. maternal child; when communities include men. They're just not in the picture because of the way the service is structured. Part of it is that women are comfortable with women. That's fine. But it has to be more inclusive.

In relation to the education of physicians another nurse responded, "I'd like to see physicians come with us on home visits too. Residents get half a day of community with the nurse. We always try to take them to the very worst places."

One nurse suggested the approach of hiring more men. "Hire more men . . . maybe the whole profession could get working with them."

Increasing the value of nursing work was voiced by one nurse. "I would change the value that was placed on it, by the decision makers (within government). I'd like to have the perception of the work we do valued by the consumer, by the community."

Equality for men and women and how this would effect nursing's power base in society was expressed by another nurse.

> Having public health recognized more as a force in our communities. Our work, skills, and knowledge are so instrumental when we talk about working with communities, and policy, and health promotion. We have to change our structures and our power bases in society. We need equality for women and men. We (society) need(s) to recognize the choices women make as being very valuable (i.e., raising families and staying home or having a career).

The tension within the doctor/nurse diad was expressed by nurses. As one nurse commented, "Adding another nurse to the clinic. Encouraging people to understand that nursing's there for them. Figure out what the distinction is between nursing's role and the physician's role (need distinct policy as to what is each role)."

A second nurse expressed her views in the following comment.

> Maybe if the community run clinics are run in some kind of a partnership with nurses and physicians, it will work well with the nurse in the front line--and definitely doing a lot of the educating and group work.

In the office, gender issues were identified by another nurse. "I'd get rid of the nurses doing the clerical tasks. I'd change the disparity between how men in the office are treated, and how the women are treated (i.e., what's considered clerical tasks, workload issues)."

The following theme was derived from a final open ended question, for nurses to add whatever they wished to the interview.

Theme 2 *Community health nurses have sustained vision and hope.*

In spite of the fact that community health nurses voiced their lack of involvement in health promotion policy development and implementation and expressed many limitations within the context of their work environment, they adhered to having a vision and hope. The hope is their hope, but also it is women's hope, and it is hope for community health nursing.

For one nurse, the work with clients was the sustaining force.

> I've said so many negative things today about the place where I work. Why am I there? But I think it's just a sign of the times. That must be the same in many agencies. What keeps me there is the actual work with clients. Because the satisfaction doesn't come from all the bureaucratic garbage. I derive a lot of satisfaction from the University work too. It's a whole "other perspective."

Other nurses supported this research project for its importance in the overall need for community health nursing research. As one nurse commented,

> I guess the shift has to come with our expectations of what we want from health care. I think we're seeing some of that and I think research like this is going to support it. But it's hard to get ahead when you're always just right at the edge of financial things. But I'm encouraged. You can only live in hope and I think people are starting to think.

Another nurse expressed her view in the following way,

> I'm really glad that you're doing this research now. I wasn't quite sure I understood it before, but I think it's a really good idea. I'm going to ask you for the names of some books I can get from the library over the holidays.

Flexibility in the work system was voiced by one nurse as a contributing factor to her work achievement in her community health nursing role.

> Within our work, it's very flexible, independent . . . what I do day to day. It's completely based on my own assessment of the needs and how I'm going to schedule things. And I think that's an important part of our practice. It's nice not to have to go into the office, and say . . , okay, there's your assignment for the day. And that's the only way it works and I think that's why it works really well having a small community, just not quite small enough. You always have to be accountable to a certain extent, but not too much accountability for where you are and when you're there. That system works very well for me and it works very well for my kind of community.

Reducing the hierarchy and providing a participatory work environment was voiced by one nurse as progressive change.

> I think it's very important for us as CHN's to recognize that we can't just keep saying "they" (they need to change). We need to be "they." And in order to reach those goals and to be recognized and to be valued the way we would like to be, we need to become those decision makers. And we need to have that presence and that involvement. I think that's the direction our agency's going. You don't see our supervisors anymore, they're never in the office. Although this may be a frustrating thing for staff, I think that it's a really good thing for us. Because we are becoming "they" and that's a really positive change I've seen in the last year or so.

This same nurse summarized the insightful necessities for policy/political involvement by nurses as visibility, values, skills and self-esteem.

> We are not becoming more involved with policy decision at the big systems level yet but certainly out in our community, we're becoming much more visible. And I think that as time goes on and we gain confidence in our ability to go out and speak to our beliefs and our values, we will become more involved at higher and higher levels. We're developing a lot of really strong people that will have the skills and the confidence to go on and be more politically active. I don't think I had the confidence in my own abilities to be a political person, and to represent

> my views and my beliefs in a really effective way. And that's coming because I work in an agency whose values and beliefs you believe in.

An experience of change in approach to the structuring of the community health nurse's work elicited a response of anticipation from one nurse.

> Things are going to change. I'm going to be part of a pilot project for mobile nursing. This means I will work out of my home and only go into the office occasionally. This will be a very different working arrangement and new to our agency.

In a few but powerful spoken words of one nurse who said, "I have a vision and I have hope."

In the next part of this section are presented the data and categories reinforced by the preceding themes.

Data and Categories

The final two questions of the interview resulted in rich and powerful data. The findings are organized by utilizing the headings of recommendations and additional comments. Table 7 shows the categories and subcategories that evolved from the data.

Table 7

Categories and Subcategories

Equity, Vision, and Hope: The Canon	
Categories	Subcategories
Recommendations	
1. Practice (micro level)	a. Community issues
	b. Role issues
	c. Professional issues
2. Agency (meso level)	a. Structural issues
	b. Administrative issues
	c. Personnel policies
3. System (macro level)	a. Organizational issues
	b. Program delivery issues
	c. Equity issues
	d. Professional issues
Additional Comments	
1. Practice (micro level)	
2. Agency (meso level)	
3. Profession (macro level)	

Recommendations

Question one in Section C, "If you had the power and the means to change things about your work--what would you change?", elicited thoughtful and strong recommendations from the nurses. These comments were made without hesitation or the need to ponder the question. The broad categories which evolved, again constituted various levels of activity--the practice or micro level, the agency or meso level and the system or macro level. These levels are not seen to be mutually exclusive but instead overlapping.

Practice (micro level). Subcategories which formed related to the practice of community health nursing included: community issues; role changes; and, professional issues for practice.

a. Community issues

Two nurses spoke about the need for health policy to be determined at the field level. In the words of one nurse, "I'd have more policy determined at the field level, and going up and based on actual community needs." In the words of the other nurse who spoke adamantly about the nurse advocacy role, "We need nurse managed clinics, doing community determined work, not losing the advocacy role in our work with newborns and preschool children."

One nurse spoke about the need for direction to come from the community.

> The direction wouldn't come from government about what programs etc. should be in the community. Support would be given for each community to be individual, and identify its needs and the support given for professionals within that community to develop, be given the skills and supports to develop community based resources. Policy would be based on that community so I want them to give a basic kind of support. Like a basic line of direction . . . you go out there and work in your communities . . . give us the resources and the facilities to do that. And let us develop individual communities. And let the policy development come from the people instead of so top down. I think there's a fear that if they asked PHN's at the field level which direction we should go that nurses would pick a nursing or a personal kind of direction and develop policy related to that. They have to realize that you're going to pick the community kind of need and that when you're in there working with your community you'll pick community needs and develop policy related to that. You're not going to develop it, just for your own sort of professional or personal needs.
> Supervisors would give the strength to people in communities to do that but the size of the communities would need to change. They are too large the way they are now. They should be defined by a sense of community where people can buy in and belong to it. And want to be involved in it.

The need for input from the bottom, up was expressed by another nurse. "There has to be more input from the bottom up. It has to be a two way street and there has to be an indication that the philosophy can, and will change."

This same nurse articulated that the neighbourhood versus real community needed to be the focus of organizing work. "We need to look at other ways of doing our work. We need to work with real communities for health promotion . . . not neighbourhoods."

The need to broaden the base of public health was the comment by one nurse.

> I'd like us to have the ability to do more of the community outreach types of things. I'd like support to broaden public health to community health. I'd like support for the types of groups that I think we could do. I'd like us to be more involved in the school.

Utilizing other resources which are currently not being applied as much as their potential warrants was the insightful comment of another nurse. "Utilizing other resources, i.e., physical education and recreation to deal with idle teenagers in a church basement."

Yet another nurse commented on the need for community based health promotion. "I want more community directed/community based health promotion 'building a healthy community'."

b. Role issues

Four nurses made suggestions that involved community health nursing roles.

One nurse suggested the introduction of a new role. In her words, "It would be the introduction of a family clinical nurse specialist role."

Two nurses were strongly supportive of changes to the nurse's role in the clinic setting. As one nurse commented,

> I'd love for the clinic work to be more nurse managed--where clients would sense that nurses can be seen as a primary caregiver with many of their issues. I'd love for society and the client base to recognize that.

A re-examination of the way community health nursing is practiced, was the suggestion of two nurses. One of these nurses commented,

> Re-examine the way we practice, i.e., generalists with one nurse who is more of a specialist, but instead we take her to work in another area. We keep doing this because it's been done forever by public health nurses. Working with other groups on policy development, i.e., schools, day cares, Family Services. Bringing us together and having more uniformity in the guidelines for follow up between the public health agencies involved, eg. communicable diseases.

The other nurse suggested,

> I would like to change people's attitudes. I would like to see PHN's work closely together with a lot of other disciplines, i.e. access to our own social workers, dieticians. Why can't we all work out of one place, i.e., Child and Family. So that it wouldn't have to be just you. I share a lot of information with workers in other agencies but I don't get one shred of information back. This would raise nurse's profile as well as their professional status. I wouldn't move staff around frequently. I can't imagine spending all your time, and effort trying to get something going. And before you even see it going, being pulled out, and put somewhere else. You miss out on the reward which you need (recognition).

c. Professional issues

The need for community health nurses to have power and respect was voiced by two nurses. As one of these nurses responded, "I'd have more power and respect given each community health nurse."

The issue of breaking the silence, was expressed by one nurse.

> And you know . . . not this threat of your job for speaking, you know . . . what you were trained to think. You have skills you learned, and you assess something, and you're not allowed to speak it. The silencing has increased with health reform. You think, will I have a job.

One nurse commented on the need for community health nurses to have more autonomy in their work of assessment and implementation, "We need more autonomy given to nurses to provide what is assessed (what the community identifies as needs)."

Agency (meso level). Categories pertaining to agency issues evolved from the data and included suggestions for changes to: structure, administration and personnel policies.

a. Structural issues

Five nurses commented on the need for joint work activities. Three of the nurses expressed their views as follows:

> Have us teamed up, say a joint district--have more joint kinds of things. There's lots of stuff--tons of issues we could do together. The whole thought of working with someone else, and tossing ideas back and forth and planning, and running something with someone else. Sometimes it can seem rather overwhelming, or that there isn't a lot of support, or whatever, doing it on your own.

> We'd hire more nurses. I would like to see two or three nurses, in every community or geographic area. So we can collaborate with each other, i.e., let's team together and do this program for seniors. I'd like to see other agencies working together with us, i.e., I tried with a social worker --I'll say "let's go out to the home together." I've never been turned down yet.

> Having the ability to change our system in how we work, in working more collaboratively, and bringing people's unique abilities to the table interdisciplinary, to make the best for our society. That's what I would want to change--how we structure ourselves completely.

The need for more policy to provide stability was expressed by two nurses. As one nurse commented,

> There would be more stability--policy and things. . . . so that you could pay attention to your day-to-day contacts with the people in the community rather than worry about what you're going to have to do next . . . or I'm too tired or am I going to get that report in sort of thing.

Two nurses addressed the issue of changes to the size of communities. As one nurse commented, "A smaller community would give me more time and more flexibility."

More resources was identified by two nurses. In the words of one nurse, "I would have more resources, i.e., money (to provide the hooks to get people into groups [food] or VCR/TV or additional staff)."

Changes to the documentation was recommended by one nurse who commented, "I would change the charting system."

Gender issues pertaining to work in the office setting was articulated by one nurse. "I'd get rid of the nurses doing the clerical tasks. I'd change the disparity between how men in the office are treated, and how the women are treated (i.e., what's considered clerical tasks, workload issues)."

b. Administrative issues

Two nurses voiced the need to broaden the minds of administrators. One of these nurses commented, "Broaden the minds of administration. I give it enthusiasm instead of restriction. Equality for both genders so not just service to women but service to men as well." The second nurse had the following comment to make.

> And use all the skills, the positive things, that people have. Be forward thinking. When your staff make suggestions, accept that they are based on careful thought. Respect for one's staff. And the opportunity to function in a health promotion role. So enough staff to be able to do that.

The need for administrators to listen and respect nurses experience was identified by one nurse. "Less work, more time. Being listened to. And more respect for people who have the experience."

The educational level of administrators was identified by two nurses. As one nurse voiced,

> I am a firm believer in the concept of nurse-managed-care. I would like to see someone make policy that states that there has to be a certain degree of education in order to administer these programs. The status quo is no longer acceptable. I'm concerned about the lack of education with our administrators.

Again the second nurse voiced a similar concern. "I would change the choice of management in terms of educational preparation. I would want masters, at least, prepared. Recognition of your staff's positive and constructive qualities."

The need for administrators to develop policy with staff was identified by one nurse. "I would set priorities and staff would be clear on what they area. We would sit together and the practitioners, based on their assessment data, would tell you what is needed. This is policy development."

One nurse articulated the need for trust to increase.

> Trust should extend, not only to working in the community but if you need some time to get some paperwork done--it would be okay to say--I'm going to be at home, call me here today. We'd be a lot more productive with stuff like that. Much more flexible work hours . . . maybe you need to work one evening a week. Social workers can do it, i.e., they call me from home. How can you get any work done in one large room with dividers and phones ringing all over. It's very difficult to keep focused.

The need for dialogue to bring alive the agency philosophy was voiced by one nurse. "Because of pressure from providers, from the actual service providers. There has to be a real dialogue--to talk about the philosophy and make it a really living thing."

c. Personnel policies

The need for flexible work hours was identified by five nurses. Examples from three nurses illustrates this need. As one nurse commented, "For people like myself who are kind of tired and disillusioned, I think there would be more flexible work hours, eg. job sharing." A second nurse articulated a similar idea. "Changing how we do some of our work, i.e. half time positions." Yet a third nurse endorsed the same point of view. "Work time would be more flexible--then our services would truly meet the needs of the community."

Three nurses took the opportunity to suggest that less work and more time was needed. In the words of one nurse,

> More time, less work (duties). So often what happens is you just do a baby visit, and you ignore . . . don't ask the questions to find out if there's anything else going on in the life, because you don't have time. So you do a partial job, more often. That's where the frustration occurs with nursing. There's no time to do what the good part of nursing is--that extra little bit (to lay a hand on a fevered brow).

The second nurse, in an administrative position, commented, "Time and the opportunity to mentor and work in a one-to-one with staff."

The need to hire more staff was suggested by four nurses. Two examples are provided. As one nurse commented, "I want the opportunity to function in a health promotion role. So enough staff to be able to do that." In the words of another nurse, "Adding an additional nurse to the clinic. Encouraging people to understand that nursing's there for them."

System (macro level). Responses from the participants formed categories such as: organizational issues; program delivery issues; equity issues; and, professional issues.

a. Organizational issues

One nurse suggested that there be no one dominant model operating. "Everyone would be trained as helpers. Not just the medical or psychiatric models."

Two nurses spoke about the need to reorganize the system.

> I'd reorganize the community health system to encompass different aspects of community health. There's going to be a lot of place for restorative nursing care in the community. Health promotion would be part of it. . . . probably a chronic disease component and a lot of sub specialities, with school health, adolescent health, preschool health, maternal health, family problems (family violence).

> I'd like to change the whole health care system. Doctors are the gatekeepers--they have all the power in the health care system. I'd like to see nurse-managed clinics, with a nurse as the primary care person. I'd like to see us working alongside doctors, not against doctors (work with the doctor or refer you to a doctor).

The need to know the direction and roles in public health nursing was expressed by two nurses.

> I'd like to see there be a collaborative effort to sit down and to look at where public health is going and the role of the community health nurse . . . who's our boss, what is that role going to be and then to disseminate that information to people because I feel the nurse is the last to know.

> Let me give you an example of the confusion, i.e., who teaches family life, teachers or nurses? We have never been clear about that in 20 years. Community health nursing practice is vague. We need to know how to make choices, eg., should I be doing community work or family work; community kitchen or family counselling?

The need for the structure to change (including money) was suggested by three nurses. Two examples are provided. In the words of one nurse,

> I would certainly change the structure and that includes money. In the clinic I'd change the role that the PHN does now, in that she would be like the physician. She'd have her appointments and her things that need doing, and she'd have support staff. The access point is a very critical one. If clients go right to the doctor, how do we ever get them back because the doctors aren't sharing. Enhance the opportunities for people

> by offering them the best person, i.e., the best person for teaching prenatal care, and nutrition, is the nurse. Then you do the stuff that needs to be done by a physician. So sort that out. The biggest thing would be support to the PHN.

The second nurse made the following comment, "I'd like to see more funding going into health promotion, and into community health. So we could get to the real grass roots of things--the driving issues, i.e., anti-smoking campaigns and safe grads, and healthy communities."

One nurse identified the insightful need for structures and power bases in society to change. In the words of this nurse,

> We have to change our structures and our power bases in society. We need equality for women and men. We (society) need(s) to recognize the choices women make as being very valuable (i.e., raising families and staying home or having a career).

More co-ordination with community health centres was voiced by one nurse.

> Changing the funding (structure). Change the structure of public health in Manitoba so it isn't fragmented. City of Winnipeg jurisdiction would go to the perimeter--rest of province--Manitoba health. Have more coordination between the community health centres and the federal, provincial and municipal jurisdictions.

The need for health care reform to continue was the comment of one nurse. "I don't want to see the change of health care reform halted--like has happened a coupie of times in my career already."

The differentiation of nurse's and physician's roles was articulated by two nurses. As one nurse voiced, "In the clinic, figure out what the distinction is between nursing's role and the physician's role (need distinct policy as to what is each role)."

b. Program delivery issues

Three nurses suggested that there be programs for men as well as women. Two examples are provided. In the words of one of these nurses, "Equality for both genders so not just service to women but service to men as well." The second nurse commented, about including services to men and programs for marginalized groups.

> We need to focus our services more on the whole community, and include men in it too. Maternal child is emphasized in the agency as well, i.e., maternity leaves for staff nurses. We need to provide services to lesbian and gay youth.

c. Equity issues

One nurse suggested the hiring of marginalized nurses. For example, "Hire more aboriginal nurses. They are going to be more effective in the aboriginal community."

The same nurse recommended hiring more men in community nursing. For example, "Hire more men . . . maybe the whole profession could get working with them. Having more staffing so we have more time to actually get involved in health promotion projects, and more resources."

The issue of ageism was addressed in the following nurse's comment. "Maternal child is emphasized in the agency as well, i.e., maternity leaves. We need to look at other ways of doing our work. We need to work with real communities for health promotion . . . not neighbourhoods." This nurse felt that agency policies needed to reflect the needs of all employees throughout their working careers and not the dominant emphasis on maternity leaves, i.e., the mothering role.

Increasing the value of women's decision making was voiced by one nurse who said, "We (society) need(s) to recognize the choices women make as being very valuable (i.e., raising families and staying home or having a career)."

d. Professional issues

The value of work perception was identified by two nurses. One nurse stated, "I would change the value that was placed on it, by the decision makers (within government). I'd like to have the perception of the work we do valued by the consumer, by the community." A second nurse commented, "PHN's are ideal people to do community based health promotion. I want to see us valued for that and mandated to do it."

The idea was extended by four nurses to include recognition. As one nurse expressed, "Women have a caring/humanistic component and would be excellent politicians/leaders. Give the nurses recognition."

Additional Comments

The need for women to support each other was articulated in the following comment, made by the previous nurse who continued to say, "Women need to be supportive of women . . . not compete with each other all the time (it creeps in here and I wonder if it is happening at the Manitoba Association of Registered Nurses [MARN])."

In response to the question, "Is there anything you would like to add that would help me in this research work?", many nurses (n=19) had something further to say. A small number of participants (n=12) responded that they had nothing more to add to the interview.

Involved in the categorization of responses were the issues of ageism and gender. One nurse with experience voiced that ageism was a factor operating in the workplace and as well in public health programming.

> We don't have much opportunity to get involved with women of different age groups, mostly just the ones that are child bearing. It applies to us as workers too. The younger people on staff have quite generous privileges now to take maternity leave and so on. That's not the only developmental stage where women need . . . or any workers need to have some time off and some consideration to whatever needs they have in their life. Like everybody's having a baby and it gets to be. . . . There are no policies for times in a woman's life when she has lots to do but there's not real good recognition that they need time and space to do that. . . . And they need to replenish themselves working conditions could be more flexible.

Other nurses (n=4) identified gender as an issue. This issue of gender is a finding that appeared repeatedly in the data. As one nurse commented,

> I'd feel guilty that I'm not involved--because I do have opportunity. I don't have time but I do have opportunity. I don't have time to be angry and I think that's something with all women, and I talk to women about guilt a lot. I know how my mother has dealt poorly with guilt and I've got her genes . . . most women feel guilty.

Another nurse concluded, "We could talk all day about women's voices."

Yet another nurse made the following insightful comment,

> Nursing has always been women's work and women's work has always been under-valued. Our profession is perpetually dealing with women, but there is a competition around the table. Those who don't share cry hurt. Documentation has to be up to date and on our time. One of our nurses was set as an example. Policy would have prevented this. I think that public health nursing is under-represented in the decision makers of health care policy for the province. It seems to be top heavy with institutional care providers, with physicians, and with men, in the old style of governing.

Several issues were raised by the nurses at various levels. Issues of practice were identified at the micro level. At the meso level issues pertaining to the agency

were voiced. At the macro level there were issues articulated which were of a professional nature.

Practice (micro level). At the micro level of practice, nurses identified issues pertaining to the measurement of their work, the practice of re-defining policy, and the need for community health nursing research.

To illustrate the measurement issue, one nurse commented,

> It's difficult to measure what we do. You don't know if CHN's have done a good job because everyone functions quite healthily. Maybe we can measure it more with dysfunctional families--who do we get off the social assistance roles? Or who goes back to School?

Nurses find ways to re-define policy. For example,

> We do this all the time--find a way to develop policy, or implement policy, or to get things done. . . . When it may not be in line with the policies the way they are. But they can say those policies are outdated. This is what this family needs. Or this is what this community needs. And this is what I need to do. I will find a way to work around the policy. Even our higher ups will support that. We get a lot of good support.

The need for research was expressed in the following comment,

> I'd really like to see more research like yours to support the role of community health nursing, and community efforts. Because community is multidisciplinary, I'm really pleased to see this. I think we need the data to support that this is the way to go. I think this is exciting. I'd like to get in on some of that research just as a more active participant. I'd like to see more research dollars coming the community health way. I'd like to find out where that money is to get the research to support all this.

Agency (meso level). At least two nurses wanted to add to the research data, an emphasis on the need for dialogue on the direction of public health nursing and the role of the community health nurse. For example one nurse made the following comments.

> What a public health nurse does in the city is so different from what a public health nurse does in the province.

> Someone needs to lobby within the health care system against the takeover of nursing roles and functions by medical practitioners . . . at conferences I hear them say they envision themselves going into the schools--and they do not need nurses to do this. I am concerned that physicians are going to move in and claim health promotion.
> Another concern of mine is we don't have a strong voice for nurses in Manitoba. MARN could do more in this regard. Some of it could come from MARN but also our administrators in our various institutions, eg. who did Seven Oaks consult with about their health promotion centre--it was the family practitioners. There is no proactive lobbying from PHN's because it's like . . . we've got enough on our plates, don't give us more. We aren't doing as much work in the schools as we could because they're focusing on post-partum follow-up. What's happened to our provincial health is they've become glorified home visiting nurses. I also have a great fear of giving up some of the holds on post-partum care and newborn baby care.

Two other nurses expressed an interest in the role differences between community health nurses who were employees of The City of Winnipeg and those who were employees of Manitoba Health. The first nurse commented, "I'd be very interested in the differences between those employed by the City of Winnipeg versus Manitoba Health . . we perceive there's a big difference, eg. the role in the school's totally different." The second nurse made a similar comment,

> I would be interested to know if other community health nurses share some of the same concerns, or if it's specific to the agency. I've said so many negative things today about the place where I work. Why am I there? But I think it's just a sign of the times. That must be the same in many agencies. What keeps me there is the actual work with clients. Because the satisfaction doesn't come from all the bureaucratic garbage. I derive a lot of satisfaction from the University work. It's a whole "other perspective."

Profession (macro level). Two of the issues which arose in the data had to do with the interdisciplinary nature of community health nursing and the need for nursing to define its terms such as, "community."

Two nurses commented on the interdisciplinary aspect of their role. The first nurse responded,

> When you're looking at health promotion policy and our role from a community health perspective, we need to branch out into other disciplines to influence how people think about what impacts health. Where major decisions are made about our environment, our water supplies, our food supplies. We are very key in that because we have a bigger understanding, eg. impact of a housing complex on health.

Similarly, the second nurse provided the following example,

> Definitely we work in a pretty interdisciplinary way now, and I think that should definitely continue. I think physicians need a lot of educating--maybe they could be more helpful but I think an interdisciplinary approach is really important too. There are one or two physicians that are supportive of public health but not a lot, generally speaking, they're not helpful. There's lots of areas that we could use other people and work together, eg. custodian at Unicity--he got the room and organized this place for kids to come--he got it started. I guess that's a real community sort of feeling. Others got involved but he got it started.

One nurse provided the following insightful example of the need for nursing to define its terms.

> I think it will be important that nursing defines community to the governments who are saying, we're going to open up these community health clinics. If it's opened in their terms and nursing has very little input, then it's not going to be the true definition of neighbourhood nursing or community. It may end up to be the walk-in clinic--which is going to again self-serve physicians and keep jobs for them. Community had better be defined by nursing, and not by simply politicians, and doctors who say what they don't want to do. And defined by nurses who are working in the community. So that nurses aren't simply doing tasks to make jobs easier for physicians or doing the jobs that physicians don't want.

Conclusions

These results suggest that community health nurses have embraced a feminist stance in relation to the provision of services. Currently, programs are structured which focus on women's health while excluding the health and program needs of men

in the community. The participants were concerned about the exclusivity of these programs and the way they were structured and recommended inclusive programming for all community members; thus, advocating for an inclusive philosophy.

Nurses also identified populations who have traditionally been marginalized from community based health services. Nursing is female dominated and this demographic fact contributes in part to a focus on women's health. This makes sense given that most women assume responsibility for the health of families. Traditional women's roles (caring for children, men, and the elderly) have also contributed to the program focus on maternal/child health in the community. The consequence is exclusion or lack of service provision to men and other groups including those not considered part of mainstream society (e.g., gay, lesbian people). The nurses in this study brought sensitivity to this issue, and they want a more egalitarian approach to many areas: policy development and implementation, the need for gender balance among community health nurses, and the inclusion of community members who have been traditionally marginalized.

Community health nurses expressed the need to work together, to pool resources in the spirit of "professional synergy." In partnerships and collaboration they included other professions as well, such as social workers and physicians. They envisioned nurses and physicians working alongside one another. Public health nursing has traditionally been actualized so that nurses work independently, but also in isolation--the system functions such that nurses engage in solitary practice. The participants in this study recognized the need for collaborative work and the need to nurture the collective. There is a difference between independence and working in isolation.

Nurses enjoy and value their independence but they dislike the fact that the system promotes isolation at all levels of practice; for example, the lack of formal structures that would facilitate collective action.

Nurses stated that there is a need to recognize the value and worth of nursing. In health care, the medical model has dominated so that what is of value is acute care and treatment. In contrast, community health nurses mostly focus on the prevention of illness and the promotion of health. The curative medical model has traditionally devalued primary prevention and nursing care. Consequently community health nurses are marginalized and undervalued by it. The participants were clear about the need to recognize the work of nurses. Recognition for women's work in general is needed.

Despite all of the negative experiences of community health nurses, the bureaucratic barriers and the alienation of public health nurses from policy development and implementation, nurses derived great satisfaction from working with clients and families. The financial forces, i.e., cutbacks, have limited the potential for community health nursing; however, nurses were hopeful and were able to see some changes on the horizon. These changes included but were not limited to health care reform, innovative programming, and the quest for professional recognition.

Community health nurses stated that they want to be active participants in decision making; they want to invest in their agencies and they want to be more responsible and accountable for outcomes.

Nurses voiced the need to be more visible in their communities--communities in which nursing care is provided, the agency that employs them and political

communities. Nurses recognized the power of collective work. For example, they want to function, as catalysts and participants, as women organizing for change.

Participants identified the need for a vision of community health nursing. Nurses observed that at present, a vision for the practice of community health nursing was absent. Hope, in terms of community health nursing practice, was noted as important to the nurses.

The feminist presence found in this analysis and the healthy relationship between feminism and nursing as expressed by these nurses can benefit community health nursing and contribute to a sense of "communitas." When feminism informs community health nursing, it can serve to strengthen the health of communities.

CHAPTER FIVE: DISCUSSION

Introduction

The role of the community health nurse in the development and implementation of health promotion policy is illuminated by this study. Not only do the findings provide insight into this, the main area of the research investigation, but they underscore the work experience of the community health nurse. The collective voice of the community health nurse participants contributed a rich source of data for analysis and discussion.

The World Health Organization (WHO, 1984) defines health promotion as "a process of enabling people to increase control over, and to improve, their health" (p. 3). Health is defined as "a resource for everyday life, not the object of living" (p. 3). The findings of this study have implications for the existing system of policy development and implementation in order to establish health promotion policy that meets the WHO definition. Not only can recommendations be made in relation to the process of health policy development and implementation at all levels of the existing health care system, the second area of the study, but additionally the findings have implications to inform future actions for nursing practice, education, research, and management (see Figure 5).

1. What is the role of the community health nurse in the development and implementation of health promotion policy?

2. What systematic changes to the existing mechanisms of policy development and implementation are required to establish health promotion policy which is congruent with the World Health Organization's definition of "health promotion"?

Figure 5. Research questions

In addition to discussing the findings in relation to the two study questions, reference is made to the four premises of the study throughout the discussion (see Figure 6).

1. Community health nurses have implemented health promotion policy with communities, but they do not participate in health promotion policy development.

2. Feminist approaches have not been brought to bear on the development of health promotion policy.

3. Although individual community health nurses may use a feminist approach to the implementation of health promotion policy, they may not identify the approach as feminist.

4. Feminist approaches for the development and implementation of health promotion policy would constitute a major and positive change to currently existing practice and policy in the health care system.

Figure 6. Research premises

The major findings of the study are discussed within the context of health care reform and the work environment of the community health nurse. Linkages are also

made with existing literature. Recommendations, arising from the findings, are made where appropriate.

A feminist analysis was brought to this study of 31 community health nurses and their involvement in policy making. Lessons learned from the research experience and the qualitative approach to conducting research are further discussed. The expectations and realities of using a feminist paradigm in this study are also examined.

Based on this research, a feminist model for policy development and implementation is constructed and presented. Table 8 provides a visual overview of this final dissertation chapter.

Table 8

Thematic Schemata

Chapter Five: Discussion

Introduction
Discussion of Findings
1. *Women's Work*
    a. Micro and Macro Analysis--Uncovering the Oppression of Women
    b. Women's Invisible Work
2. *The Context of Women's Work*
    a. Context of Health Care Reform
    b. Hierarchy
    c. Women and Power
    d. Peer Support and Recognition
    e. The Value of Work
    f. Evidence-based Outcomes--Quantitative Science
    g. Accountability

3. *Women and Policy Development*
    a. Policy Development With Communities
    b. Urban/Rural Voice in Policy Development
    c. Gender and Nursing
    d. Nurses Who Were Involved in Policy Development
    e. Consequences To Not Being Involved: Resistance
    f. Personal Values and the Implementation of Health Policy

Feminist Model For Policy Development and Implementation

Feminist Paradigm
    a. Feminist Analysis
    b. Reflexivity
    c. Reflection

Summary and Conclusion

Discussion of the Findings

The findings are discussed in relation to three major themes: *Women's Work*; *The Context of Women's Work;* and finally, *Women and Policy Development.* Within each theme are categories and there are 15 major categories in total. These categories and the relationships that bind them together are explored. Table 8 outlines the categories in each of the theme sections.

Women's Work

Micro and Macro Analysis--Uncovering the Oppression of Women

It is evident that oppression is not only present in the lives of women, in general, but it is also visible in the "work world" of community health nurses. Much has been written by feminist scholars about the oppression of women (Frye, 1983, Hooks, 1984; Lorde 1984; Rich, 1977; Waring, 1996). Traditional nursing practice is not feminist; however, an increasing number of nursing scholars have made the link between feminism and nursing (Anderson, 1997; Campbell & Bunting, 1991; Keddy,

1992; Watson, 1991; Wheeler & Chinn, 1991; Wuest, 1994; Yaros, 1991). In the literature, there is present a tension between nursing and feminism. Nursing, for the most part, has not embraced a feminist model (Chinn & Wheeler, 1985; Fahy, 1997; Oakley, 1993b; Shea, 1994). Nurses have looked to more "scientific" approaches to achieve credibility. Although research evidence is beginning to appear in the nursing literature based on a feminist analysis (Anderson, Blue, Holbrook & Ng, 1993; Barbee, 1994; Webb, 1984; Wuest, 1997), this study stands alone in bringing a feminist analysis to an investigation of the work of the community health nurse.

Feminist author, Marilyn Frye (1983), argues that to see the oppression of women, one needs to look at the issue macroscopically. Frye suggests that the microscopic perspective does not serve to make visible the oppressiveness of situations in the lives of women. When you look at issues macroscopically, what is seen is "a network of forces and barriers which are systematically related and which conspire to the immobilization, reduction and molding of women and the lives we live" (p. 7). It was for this very reason that the involvement of community nurses in policy making was studied. The context of the "work worlds" of these nurses was explored so that the forces and barriers to their involvement in policy activities could be made visible. However, I also argue that both the macroscopic and microscopic perspectives are valuable and, moreover, are essential to understanding oppressive forces in the "work worlds" of community health nurses.

It was not until I focused on the microscopic "work world" of community health nurses that I truly began to understand their involvement or rather, their lack of involvement in health policy development and implementation. And, in fact, the

primary focus of the study shifted from a macro level policy perspective to the micro level. That is, the community health nurse directly working with clients became the vantage point. In reality, it was the juxtaposition of the macro and micro lenses and the interplay between these two views which accorded a more complete understanding of the oppression of community health nurses.

In keeping with the feminist tradition of science (Harding, 1987), this study made use of multiple lenses, e.g. macroscopic and microscopic. The "true" nature of the "work world" of community health nurses as context was brought into focus and seen more clearly, and in particular, their alienation and marginalization from the policy development process.

Nurses' work at the community level extends to the general public where there is powerful informal validation of their work. Despite the local or situated "power" inherent in this work, it remains largely invisible and through the agency. Nurses' work at the micro (practice) level is not formally recognized at the macro (government/legislative) levels of organizational structures. This study extends Frye's work (1983) in that both perspectives (macro and micro) are needed to understand women, work, and oppressive forces. For it is at the microscopic work level of the community health nurse whereby macroscopic understanding about nurses' involvement in health policy is made. It is the interplay of microscopic and macroscopic perspectives that uncovers the reality of the nurses' role in policy work. Additionally, understanding these perspectives accords me, as researcher, to "speak" with authority. Other researchers (Kleinman, 1992) have argued for both perspectives (microscopic and macroscopic) in understanding phenomena.

The participants recognized that policy development occurred at the micro level, e.g. practice and at the macro level, e.g. legislation. In reality, only a few of the participants engaged in policy development at the micro level and at the macro level. These perspectives are accounted for in the interpretation of the data (see Chapter Four, Findings on p. 250). Participants voiced that they were largely excluded from policy development at the meso (agency) level. It may be that the effect of alienation polarized or divided participants' involvement in policy development and implementation into opposite extremes. *Policy development* polarization is overtly micro-macro, but *policy implementation* appears to occur at the micro-meso levels. This is an interesting paradox regarding policy development and implementation. Nurses are alienated from policy development, yet for policy implementation, nurses are central to the implementation process. This situation caused substantial frustration for the nurses.

Recommendations:

1. Further research studies that use micro, meso and macro perspectives. Not only would this advance the current state of research, it would have a powerful impact theoretically--by providing a more complete understanding of the facilitative and restrictive factors which impinge upon nurses'/women's involvement in policy development and implementation. In the words of Kleinman (1992),

> The result will be a view from up close in the words of the participants that captures the microcontext of experience, which then can be further contextualized by a view from afar that relates this highly focused perspective to the larger-scale political, socioeconomic, and cultural forces that impinge on the local world. (p. 131)

2. Research that utilizes a feminist research paradigm. One of the great strengths is that there is a range of "feminisms", and then inherent research approaches and the nursing discipline reflects this (Chinn, 1987; Chinn & Wheeler, 1985). The dichotomy of qualitative versus quantitative research is challenged by the range of feminist approaches to science which accommodate multiple ways of "doing" science. The application of feminist principles (paradigm) is of primary importance to science, whether qualitative or quantitative. Therefore, feminist research on policy development and implementation is warranted. Additionally, "feminisms" transcend disciplinary boundaries and approaches to science and it is for these reasons that the feminist paradigm has application to the nursing discipline. Much of the work of nursing is interdisciplinary and especially the work of community health nurses.

3. Nurses need to be part of and present in policy development at the macro/ meso levels. A grass roots approach to policy development is needed and would benefit all groups involved in public health promotion: nurses, agencies, governments, and clients. As it is now, nurses are alienated from policy development and implementation. Involvement in policy development and implementation constitutes an exceptional case. This recommendation needs to be actualized in order to achieve the far reaching goal of formulating policy "with" communities.

4. Nurses need to be conscious of their power and act on it. They need to use their power as a force for change. As nurses become more involved in making change, they will learn to trust the process. Their experience with health care reform seems only to have served to increase their oppression and their ultimate scepticism about all change in their "work worlds."

5. Nurses need to be educated about policy development. This can be done for example, through continuing education programs for nurses who are already practicing. Courses or seminars could be undertaken in partnership with the Faculty of Nursing at the University of Manitoba. The application of distance technologies could be made use of so that community health nurses throughout the province could participate. This could commence with an on-line provincial workshop for community health nurses with plans for follow-up sessions. Additionally, educational sessions could take place at the micro level with interested community health nurses organizing themselves around a policy issue, and with facilitation, strategizing for change. Nursing education at the baccalaureate level needs to address policy and possibly include a practicum. Policy, as a topic, might be integrated in all nursing courses. These learning opportunities could be televised to communities so that practicing nurses could participate and continue their education at the work site. Education through the medium of television would make it possible for anyone from the community to learn, thus strengthening the communities' resolve to participate in policy development. However, distance technologies have limitations; for example, the power of bringing women together in one place is potentially greater.

Women's Invisible Work

Women's invisible work has been the subject of many scholars (Hume & Offen, 1981; Kelly-Gadol, 1987; Luxton & Rosenberg, 1986; McPherson, 1996; Waring, 1996; Weisner, 1987). The lack of recognition for work done by women in the public and private spheres is not a new issue. What is new, and what this research brings

into focus, is the issue when work done by women is "public", i.e., mandated by the government to protect and preserve the health of the public and at the same time the work is enacted or carried out traditionally in the "private" sphere, i.e., the home of the client living in a community. We know from this study that the work in these spheres remains invisible and not valued beyond the nurses and their clients.

Much of the work performed by community health nurses is invisible and remains unknown. For the general public, when services are required, community health nursing becomes visible to particular families and particular care situations. For those who do not require services, nursing remains virtually invisible to the community at large. Additionally, the agency has knowledge of the work assigned to nurses which is measured "quantitatively." Qualitative outcomes and the values held as important by the nursing staff, i.e., interpersonal relationships, and caring remain invisible and thus not formally recognized nor rewarded by the management personnel. Moreover, the agency remains officially unaware of how policy is actualized in the field, and how nurses tailor and "subvert" top-down policy.

Collectively, structural dimensions related to the "work world" e.g., isolation among nurses, quantified workload measurements of agency-derived priorities, moral obligation of nurses to reformulate policy and make it "fit" with the realities of their practice context, and the lack of rewards for the core caring values of nursing, serve to silence these women's voices and contribute to the invisibility of their work.

In patriarchal systems such as the health care system, the voices of women are silenced (Sherwin, 1992). However, as this study suggests, the silencing is complex, and identifying the system as patriarchal does not necessarily identify how the system

needs to be changed. It is true that nurses do not seek to know or understand a system that does not value the very essence of their work. The concept of hegemony, defined as the construction and imposition of unified thinking that serves the interests of dominant groups (Ristock & Pennell, 1996; Stanley & Wise, 1990), can be appropriately applied as nurses live this experience every day and are challenged to step back and critically examine the situation in which they find themselves. This is difficult to do in a system that promotes alienation. The quest of this study, in part, was to make the invisible, visible. The major forces contributing to the invisibility of community health nursing practice are outlined in Figure 7.

- Structural Dimension--Nurses Working in Isolation
- Quantified Workload Measures of Agency-Derived Priorities
- Clandestine Policy Reformulation By Nurses
- Discounting Caring Values

Figure 7. The invisibility of community health nursing practice

Importantly, the "public accounts" or the daily statistics kept by nurses, and demanded by the agency (requiring endless hours of work and personal time) are not included in the statistics used by the Manitoba Centre for Health Policy and Evaluation. Therefore, the work of community health nurses continues to remain invisible at the expense of this purposeless data collection effort. Their work, in the form of these statistics, is not used by decision makers in the development of health policy. Even when quantitative statistics are generated, community health nurses do

not contribute to the development of health policy. Work which could influence policy makers in the form of quantitative accounts remains invisible. Moreover, this data collection is detrimental in that it does not include or encompass much of the important work conducted by community health nurses. It is the argument of feminist activist, Marilyn Waring (1996) that measurements render so much of the work of women invisible. Through feminist scholarship which entails critical reflection on professional and personal circumstances, nurses can challenge the status quo and question rituals, i.e., keeping endless statistics, that are taken for granted.

There is a need for nurses to make "caring" social capital (Cox, 1997). One of the ways to achieve this is to measure the work of nurses in a qualitative way. Rosabeth Moss Kanter (1985) speaks about the value of innovative ideas. These rich contributions by nurses and their outcomes can be measured qualitatively (Kendall, 1997).

There is a need to understand the complex issues embedded in the "patriarchal system." This research has uncovered some of these complexities. Nurses and agencies can take action based on feminist scholarship. This approach enlightens and empowers nurses to become activists within their own community of nurses. Feminist consciousness-raising may be an outcome of the activist process. Two nurses participated in policy development at all three levels; local, provincial and national policy making arenas. Both nurses (one female and one male) were community activists and had experience in how to mobilize communities through their personal and professional community activist roles. There is power in nurses organizing.

Wheeler and Chinn (1991) argue for the importance of women working together to learn and create realities based on feminist values.

Nurses can make the invisible, visible with their power. However, they need to actualize this power. In other words, nurses simply cannot wait for the agency and/or professional associations to take action for them. For example, nurses in this study could call a meeting at Crossways in Common--a community facility, and they could meet, plan, and develop strategies for change. They can share the responsibility for how things are and through the process of feminist political activism effect change.

In the late 19th and early 20th centuries public health nursing and, later, community health nursing evolved from practice in the home, known as home health care; community organizing; and political intervention on behalf of aggregates (Swanson, 1993). Rosen notes that district nursing as we know it today was first developed by William Rathbone in England during the time of Florence Nightingale. He divided the community into 18 districts; each was assigned a nurse and social worker to meet the needs of their communities for nursing, social work, and health education. He consulted Florence Nightingale who provided for the training of district nurses, "health nurses" (as cited in Swanson, 1993).

More than 100 years later, the concept of district nursing with one nurse assigned to a district is entrenched in the organization of community nursing services. Over time the direct support to the nurses i.e., social worker and others has been lost. This study indicates that community health nurses would prefer to work in teams of nurses. At minimum, a "dyad" (two nurses) in the same community/constituencies could serve to decrease professional isolation. This approach also fits better with the

"new public health" primary health care focus. For example, partnerships, collaboration, maximizing human resources, and community involvement.

Recommendations:

6. Nurses' work should be organized so that nurses are working in dyads. Two nurses working in the same area (neighbourhood, district, catchment area) would provide opportunities for them to work as a team, set priorities together and implement strategies appropriate to the context. For example, it may be best for one nurse to make visits in the home on a particular day while the other nurse engages in a community development project. In this way many different strategies can come to strengthen the health of the community. This recommendation addresses a change to the structural dimension of the agency and addresses the issue of nurses working in isolation.

7. A "community development" approach needs to be brought to agency structures and functioning. The challenge is to change agency structures and shift the organization from individual nurses to team (a collective). This shift needs to take place at the conceptual and applied levels. A collective of women working together toward a similar goal--bringing together resources is needed. Sturt (1997) observed, however, that government policy makers and the medical profession through control of the health agenda had a disabling effect on primary health care practitioners. One of the particular consequences was the reluctance of community health nurses to form a collective group which would strengthen their power base. The collective, "community health nurses", need to develop themselves as a community. Nurses have the requisite skills--they apply these skills with communities and community members.

Now, they need to apply these skills to their own community of nurses. Energies that are extended outward (to the micro level), now need to be directed inward (to the meso and macro levels).

8. Marketing strategies need to be established. The public needs to be educated about the work of the community health nurse. In fact, this education needs to occur at all levels (policy makers, decision makers, government, other agencies, and the general public). An image needs to be created that presents the intelligent work of the community health nurse whether it be, for example, promoting the health of a "new mom" and baby in the client's home or community activism where the nurse and community members work together for policy change. This recommendation addresses the invisibility of nurses work in the public domain. An expected outcome would be public support for nurses.

9. Community development needs to be fully understood by nurses and agencies and valued as a health promotion implementation strategy. The concept is not an either/or decision, i.e., home visiting or community development. The decision to visit in the home and engage in community development should be based on meeting community needs so that the goal of strengthening communities is achieved. This may mean bringing clients together who are known to the nurse through home visiting and helping them mobilize for support and the meeting of their collective health needs. Nurses working in the home, in reality, are working in the community for the benefit of the whole community. Based on the data of this study there was a range of understanding as to what constitutes community development.

10. A feminist paradigm brought to management. Nurses themselves have a responsibility for educating and informing the public about their "invisible" work that has a profound impact on their lives or health care. Whether this be the "work of nursing" or the "work of women,"the expectation for recognition is practically non-existent. And so this work remains unvalued, unrecognized, and invisible. The bureaucracy which is male dominated and administratively hierarchical, forces nurses to engage in clandestine and/or subversive policy reshaping. Hooks (1984) noted that women do not shape government policy equally with men. Moreover, and in relation to the findings of this study, "the power the dominant party exercises is maintained by the threat of punishment if the hierarchical structure is threatened" (p. 120). What is needed is a change to the organization of the agencies (the hierarchical nature of agencies needs to be flattened) whereby nurses at the field level are valued for their observations, insights, creativity and understanding of what policy development is needed. Biley and Whale (1996) argue for feminist approaches to change.

11. The effectiveness of nursing practice needs to be documented through research and publication. Research is needed that determines the effectiveness of the work done by nurses (Josten, 1997; Kendall, 1997). In addition, community health nurses need to conduct or participate in research that contributes to improving practice. These research and publication activities can be undertaken in conjunction with nurse researchers and the goal should be toward research in partnership with the community.

12. A demonstration project needs to be planned and conducted to determine the value of nurses working in dyads. Because there are costs involved, having two nurses working in one constituency (district, etc.), the costs and benefits need to be credibly evaluated.

The Context of Women's Work

Context of Health Care Reform

A community health nurse has the burden of authority; that is, responsibility with limited resources and increasing work demands leading to occupational fatigue and an energy-deprived system (Manitoba Nurses' Union [MNU], 1996, 1998). However, dwindling resources can serve as a catalyst to challenge the status quo.

Nurses in this study envisioned a forward strategy arising out of health care reform and yet, what they have experienced is more work with fewer resources. What is needed are energies, resources, and places for connection and support. Included in the nurses vision was the need to improve health not just cut health care costs. The WHO Regional Office has a position on health care reform and states clearly that it must be about improving health. They express concern that in most countries health care reform focuses on cost-cutting and inadequate attention given to the long-term health effects of these interventions (WHO, 1997). In promoting the case for health, the WHO Regional Office, Department of Health Policy and Services, has provided support and established scientific and ethical platforms to review current reform and on which to base future action. Academics, professionals and policy-makers from countries around the world, including Canada, have made contributions to this stance.

Will the community/community health nurse partnership flourish in the ongoing health care reform in Manitoba? Does the empowering process stand a chance in the new structure? Will it be possible to unravel the power relationships which exist? These are questions prompted by the findings of this study as structures and processes change in the organization and delivery of health care services.

Data were collected during the time of health care reform. In addition to "cost cutting", there are issues of concern to women and the health care reform process. It is worthy to note that in the Manitoba reorganization of the health care system, i.e., the Manitoba Regional Health Authorities (RHAs), health professionals (including nurses) with one exception (CEO, Winnipeg Community & Long Term Care Authority) are excluded from these boards. The chief executive officers (CEOs) are predominantly male. With three exceptions, all RHAs in the province of Manitoba are led by men. Ten out of thirteen CEOs are male (B. Hague, personal communication, June 22, 1998). The three women CEOs are in Marquette, NOR-MAN and, Winnipeg Community & Long Term Care Authority. Nurses are involved in the community health needs assessment(s) but are removed from the Boards; they can labour but not make decisions. Frye (1983) in her argument for the macro perspective is correct as the current reorganization of health care demonstrates "who" holds the executive decision-making positions. What is happening in health care reform on a large scale is an entrenchment of the way things have been in the past--women are excluded from decision making. This study on community health nurses is a microcosm of the larger system.

Recommendations:

13. Evaluation research addressing questions about the impact of health care reform. A replication of this study, approximately three years following the introduction of the Regional Health Authorities is recommended. The findings from this study are now observed to be happening on a larger scale. Women/nurses are invisible yet again (see Figure 8).

- Cost cutting; doing more with less
- Microsystem replicated at the macrosystem level
- Women excluded from policy development and implementation
- Alienation and marginalization of women

Figure 8. Experiences of nurses within the context of health care reform

14. Nurses need to be positioned at the management and policy levels of the health care system. As it is now, their absence is evident. This should not be in the form of tokenism but should be based on their intelligence, competence, and value to the system. Nursing leadership at the policy and senior management levels would be engaged in decisions about the allocation of community health resources. One of the outcomes to this change would be that those involved in policy making roles will recognize and act on the fact that nurses who work with communities have something valuable to contribute to policy making.

15. Further feminist research to determine how women are excluded from health policy development. Expansion of my study on a larger scale to examine how

women in other settings are excluded from health policy development and implementation. The assumption is that health care reform is setting the stage, yet again, for the exclusion of women. How women are being excluded from the policy development process is an important question.

Hierarchy

The data reveal a structural impediment in the bureaucracies of community health care. "Getting the work done for the hierarchy" or "attending to the work of the hierarchy of the system" were expressed by study participants. With respect to the main question of the study, nurses' energy is channelled into the maintenance of management policy, rather than the development of health policy in the community.

Ferguson (1984) argues that bureaucracy separates people from one another in their activities and from themselves in their roles; "and our dependency on the very organizations that spawn this fragmentation is perpetuated" (p. 13). In the case of community health nurses and using Ferguson's argument, isolation is a "modus operandi" of bureaucracy. Although isolation is a particular aspect of the nature of community health nurses work (in homes), the hierarchical structures in the bureaucracy are well served and perpetuated by the isolation. For example, nurses are silenced, distanced from each other, and distanced from the very bureaucracy that is making decisions about them. Is it any wonder then, that the response of community health nurses to bureaucracy and hierarchical structures as a means of survival is silence. In the words of Audre Lorde, "your silence will not protect you" (as cited in Ferguson, 1984, p. 3). As well, the destruction of personal relations, and even self

identity is evident because of a process which isolates and fragments interaction with others. One consequence is the rendering of victims silent (Ferguson, 1984). The theoretical construction of bureaucracies by Ferguson and her feminist analysis is consistent with the findings of this study.

Recommendations:

16. To bring a feminist analysis (perspective) to the critique of the bureaucratic structures and hierarchical relationships in health care organizations and in particular those governing the organization of public health (nursing services). This analysis will provide insight into the system based changes that are required to improve the "work world" of women, as well as the care provided to community members.

Women and Power

This study is about the need for change so that women are not cogs in a bureaucratic wheel. It is about the need for taking an active role in policy development and implementation, a role they are systematically disenfranchised from. Contrary to traditional nursing practice, which is not feminist, and where the power is at the top of a hierarchical health care system, community health nurses do have power and can actualize it for their benefit and for the benefit of the community. This study is about the imperative for community health nurses to "exercise their power."

It is important not to categorize these community health nurses as victims. Even though their work lives, like other women's experiences historically, have not been immune to longstanding subordination by men, they like other women are agents of

history. For example, Denfeld (1995) reminds her readers that Victorian society in England inspired the first feminist movement and feminists won social battles which allowed married women to control their earnings (1878), attend universities such as Oxford and Cambridge (1870), and finally vote (1919). As the new millennium approaches, women (community health nurses) are still subjugated to patriarchal and bureaucratic systems.

This research reveals how health care systems create barriers to the involvement of community nurses in policy development. As they exist now, they are systems of domination (Sherwin, 1992) with a "top-down" flow rather than a "bottom-up" approach to decision making. Although the "new" rhetoric in public health ensconces that decisions be made at the community level (Manitoba Health, 1994b, 1997a, 1997d), the existing organizational structures, examined in this study, disregarded their own community: public health nurses.

One of the consequences to the marginalization of "community" is dependency. The findings show that the foremost accountability in the work life of community health nurses is to the organization. Thus, an expectation on the part of nurses is that the organization must make changes to better things in the work milieu. Community health nurses, however, need to apply the same community activism skills that they use with clients/communities to themselves. Community activism could provide nurses an opportunity to nurture each other's strengths and promote self-care as an antidote to burn-out in an oppressive milieu (Styles, 1995).

Women's subordination to men is an issue feminists have identified from the beginning of the feminist movement. However, women have subordinated other

women. A woman in a position of power does not ensure a feminist use of that power. Women can implement power in ways that alienate other women, in ways similar to men who have historically alienated women. The subordination of women by women is an issue for nursing as the profession is predominately female. When the nurses in this study speak about "the men in suits" making policy, it is also true that "women in suits" are quite capable of making policy and in the process alienate other women, i.e., nurses.

Some women stop the promotion of other women in careers and often another woman must come to the aid of her colleague. In the words of Bell Hooks (1984),

> I am alarmed by the violence women do to each other: professional violence, competitive violence, emotional violence. I am alarmed by the willingness of women to enslave other women. I am alarmed by a growing absence of decency on the killing floor of professional women's worlds. (p. 49)

The values of care, responsibility, and community development held by community health nurses are violated when women enforce oppression just as they are when men do the enforcing. In nursing, the question whatever happened to "Sisterhood" begs to be asked. The term Sisterhood is used to convey solidarity or feminist community. Sisterhood involves respecting diversity and does not mean uniformity or sameness. In relation to oppression and power, nurses need to direct their energies to helping themselves; to strengthening their own community.

Recommendation:

17. Ensure that existing management structures are not replaced by a new "oppressive" structure that is disrespectful of power--and does not permit power to be used for the benefit of the nurses and the community/public.

Peer Support and Recognition

There was little formal recognition for the overall work of community health nurses. Nor was there any recognition from peers for those nurses who were involved in policy development. Eighteen nurses did not even expect recognition. They continue to be oppressed and overworked.

Nurses as a "community" (an organized group of persons bound together by ties of social, cultural or occupational origin or geographic location), defined the same as client/community, need to be educated around valuing and recognizing the importance of policy development. This need ties in with the lack of peer recognition which is symptomatic of a serious problem within the agency. When agencies do not support (philosophically and tangibly) nurses' involvement in policy development, then nurses do not support each other. For example, nurses state "I have to pick up the [her] work" rather than "good for her. She's involved in policy development." Nurses conclude that if the agency does not value involvement in policy development, "Why should I?"

Team work versus independent practice was an issue coming out of the research of Gott and O'Brien (as cited in Sturt, 1997). In my study there was this contrast between nurses who saw themselves as members of a team and nurses who saw themselves as independent practitioners. Some nurses saw themselves working with the community as client and some were more centered in individual and family home visits. Gott and O'Brien expressed concern about the nurses' struggle to disassociate themselves from the profession to which they belonged. Bryar and Bytheway argue that "teamwork is not the natural behaviour of practitioners who have chosen to work

outside institutions in community settings where they have more scope for independent practice" (as cited in Sturt, 1997, p. 180). Sturt argues that "the reluctance of community nurses to unite with their nursing colleagues impedes their ability to challenge the degree of control exercised over the macro direction of their work by politics and the medical profession" (p. 11).

Recommendations:

18. Teamwork, and "esprit de corps" be fostered within the agency. It is Hook's (1984) argument that sameness is not necessary for solidarity to exist. McPherson (1996) found in her study of Canadian nursing that women drew strength from female networks.

19. The need to nurture colleagueship not only for the good of nurses but also for the good of the community. A need to nurture the colleagueship which was valued by nurses in this study. A sense of community, of Sisterhood: solidarity and feminist community, involves respecting diversity and does not mean uniformity or sameness (Hooks, 1984).

20. Colleagues need to provide each other with mutual support and understanding. They need to work together and support each other. They need to value and practice collective decision making. What is needed or will occur as an outcome is social consensus and a concentration on process not power. A lack of social consensus promotes alienation. Social consensus would assist nurses as a community to move from the margin to the centre of decision making.

The Value of Work

The nature of how work is valued is a question that arises from the data. The quantifiable aspect of work is valued. Introducing a qualitative approach to rewarding work would at least provide a balance to what currently exists. Participants identified that quality of work was not rewarded by the agency, but it was the basis of the work nurses found personally satisfying. Statistics kept by community health nurses (public health nurses) are not used by the Manitoba Centre for Health Policy and Evaluation. The home care statistics are not available either (C. Black, personal communication, March 20, 1997).

Nurses appear to be functioning in their agencies without a reward system for their work. When asked about rewards many of the nurses responded with "shock" and surprise. Participants were unable to consider being rewarded for their performance. Chinn (1987) argues that as nurses we have been socialized to think of ourselves and our work as not valuable and inferior. Reward comprises recognition for contributions and has the effect of validating their role. Individuals should be recognized and their work valued. This is not a reality for the nurse and agencies should be fostering the reality that work is valued.

What is interesting is that to shift the locus of nurse's accountability to the client/community, the agency will need to re-examine the work that it rewards and the nature of these rewards. The work that nurses find rewarding is very much client, community, consumer driven. Thus, a paradox exists whereby nurses are primarily rewarded by the client, and yet, nurses are accountable to the agency which does not

"reward" them for their work. Nurses become "caught" between their client's needs and their agency's own organizational priorities.

In the experience of these nurses, the health care system is not a system that rewards. In the words of the nurses, "We are not rewarded from the top of the system" and "The agency doesn't do very much rewarding." And, in fact, as another nurse stated, "We are made to feel we aren't working hard enough." Is this any different from the way other women have felt living/working in patriarchal structures in society? The experiences of these nurses mirrors the experiences of other women and their work of caring whether in the "public" or "private" spheres of life.

Recommendations:

21. Critically examine how qualitative data can be incorporated into "the measurement" of community health nurses' work.

22. Establish a reward system whereby there is congruence between what is valued by the client and what is valued by the agency.

Evidence-based Outcomes--Quantitative Science

There is a trend toward what is called evidence-based practice (Clark, 1997; Kendall, 1997; National Forum on Health, 1997). This raises the question about what is evidence? Sally Kendall in the U.K. relates the story of the "singing man." An elderly man was living in the community alone, surviving on little money, depressed, isolated, and experiencing the pain of a leg ulcer. A graduate nursing student (district nurse) treated his leg ulcer, but she also carried out in-depth interviews (experience of living with a leg ulcer), used a phenomenological approach and systematically

analyzed the interviews. Three months after her care, the man was able to come to the ulcer clinic at the Health Centre for follow-up. His presence was known because he could be heard "singing" in the corridor. She concludes that her student took the time to listen to this man's story--documented and systematically analyzed his experiences. The size of the leg ulcer, the more quantifiable measure of his care, was far less relevant than the fact that he was "singing." "These experiences are testimony to nursing effectiveness and provided some of the best evidence for primary health care nursing practice" (p. 13).

The agency measures success/values, in terms of the number of visits, and this is how the work of the community health nurse is determined, i.e., contributing to the financial viability of the organization. Nurses understood, however, that health promotion and disease prevention do not necessarily entail home visits. This is in conflict with the manner in which the agency measures productivity, i.e., the number of home visits. Health promotion is abstract and the nurse views the agency's concern as "not enough heads have been checked for lice", i.e., the agency's need for concrete, measurable quantifiable information. The message is that in health promotion work, the community health nurse is not doing enough.

Recommendation:

23. Multiple evidence-based outcomes, i.e., triangulation, that do justice to the nurses' "work world."

Accountability

Explicit accountability can be viewed as the "official" accountability, the reality of what exists and it reflects what the nurse does from the agency's perspective. Implicit accountability, on the other hand, reflects the "unofficial" position, what the nurses would like to do, what they want or desire. It appeared that nurses want more accountability to the nursing profession and to the client and less accountability to the agency/organization. With respect to accountability to the agency, they viewed themselves more accountable to the macro level structures of government (e.g. Manitoba Health or the City of Winnipeg). Despite wanting to be more accountable to their clients, nurses were pressured by their agency to be more accountable to the agency.

Accountability to the agency represents an old order of management. In the new order, the organization chart is reversed so that the first order of accountability is to the client. The power relationship of the organization with the nurses becomes evident. The system is forcing nurses to be accountable to the organization and is doing so at the expense of the client to whom the nurses provide care. In the nurses' experience, explicit accountability is so strong that it silences implicit accountability.

Nurses feel accountable to where they get paid, the organization, which suggests the power of the patriarchal system. As one nurse commented, "we are employees, not entrepreneurs." Community health nurses in this study are employees of government where there is a need to be politically correct and where the silencing of nurses serves a purpose. In this way and in many other ways the governance of public health services co-opts the work of community health nurses. Kanter (1977) argues

that power increases as one rises in the hierarchy. In a recent comparative study of public health nurses and nurse managers (public health supervisors) concerning power and opportunity in public health nursing work environments, the researchers Haugh and Laschinger (1996) conclude that public health nurses often feel powerless in their work settings.

Accountability is more important than ever in society. The implications are a greater emphasis on the need for nurses to document through research the effectiveness of their practice as well as conducting research that contributes to improving practice (Hockey, 1995; Josten, 1997; Kendall, 1995). I would extend the argument to include partnerships with the community.

Recommendations:

24. Primary accountability needs to be with the community/public. Toward this end, nurses need to view themselves as autonomous practitioners.

25. Research conducted in partnership with the community/public. "Action research" is needed whereby the community/public owns the findings, not the organization/agency.

Women and Policy Development

Policy Development With Communities

Nurses voiced overwhelmingly the need to be involved in policy development at local, provincial, and national levels. They are the front line workers, they know where the action is, they know what's going on; they have a good sense of what is needed in policy development. The policy activity that individual nurses have with

their diverse communities is important, but even more important is the plurality of voices from the diverse constituencies being heard (Comack, 1996; Luxton & Rosenberg, 1986; Wine & Ristock, 1991).

There is much work to be done to transform rhetoric into reality and for communities to be involved in policy formulation. Changes need to occur, i.e., the hierarchical nature of agencies needs to change so that community health nurses working in the field are valued for their observations, insights, creativity and understanding about what policies are needed and what evidence to apply and how to strengthen the partnership with communities. This change in itself would move us one step closer to the "reshaping" of policy by community health nurses and the community--both "publics" working together. Community health nurses are not being heard in the structure of agencies as they now exist. However, the voices of the clients/community are being heard by nurses. This outcome of the study speaks strongly for a partnership of policy development at the community level.

There is a growing expectation in the literature that the community be involved in policy formulation. I would argue that this has a better chance of happening when the community health nurse is involved in partnership with the community. The community health nurse knows how to assess community needs, has the community development skills and the advocacy skills to bring to this partnership. The community health nurse and the community can work together for healthy public policy.

Pat Capponi (1997) cautions against "colonizing our communities" and argues in favor of providing communities the tools they need to "do their work." This stance accords authority and resources to the community. Community health nurses have the

community development skills and advocacy skills to work with communities in this way. Community health nurses, historically, have been strong advocates for their communities.

With respect to issues of class in the "work world" of community health nurses, the argument can be made that they are predominantly educated, white people working in the core of Winnipeg communities. McPherson (1996), in her historical study of Canadian nursing, did an analysis of status-racial relationships. She found "whiteness in nursing", whiteness in terms of social privilege. She also found a difference in the privilege of community health nurses when compared to hospital nurses. Community health nurses were more "privileged" working in the homes of clients (they enjoyed relatively more autonomy and higher wages). Smith, Towers, and MacKintosh (1997) in the U.K. concluded that effective integration of community health and social care involves the need to overcome both social class and cultural divisions. They also discovered, as in this study, the extensive integration of informal health and social care networks between district nurses and home carers. They recommend health/social care integration which builds on working patterns among district nurses and home carers (micro), rather than beginning from the level of joint commissioning (macro).

Recommendation:

26. Apply a community development framework with respect to the establishment of policy.

Urban/Rural Voice in Policy Development

In urban community nursing there is a lack of collective voice. There are many individual voices who have to be heard, but as individual voices they lack volume. This is in contrast to rural community nursing where the collective voice was identified by participants to be much stronger. The reason given for this contrast was the smaller number of nurses in rural public health and their voices are stronger because there are fewer to hear from. Since "everyone knows everyone else" in rural communities, the collective spirit is usually strong and coming together on issues is very much a natural part of the way rural communities function. Community self-reliance is a value found in rural communities. Women in rural communities find the time, interest and energy to meet in formal organizations. Rural homemakers clubs, for example, where these women's groups are the primary source of health education (Bushy, 1991). Many multidisciplinary community participants share in problem solving. Bushy further writes that rural communities prefer less organized bureaucracy and value government that is locally focused. Perhaps because there are fewer people to organize and there is less hierarchy of structure, i.e., more local focus to governance, nurses in rural communities are more involved in policy issues. In urban settings, the reduced volume of voice may reflect the lack of organization of public health nurses in relation to policy development. However we do not know this for certain and further research is needed.

Recommendation:

27. Replication of this study with rural community health nurses to determine their involvement in policy making.

Gender and Nursing

To what extent is the alienation experienced by community health nurses around policy development gender-based and how much of it is attributable to the nursing discipline? This is a complex question and was not the focus of this study. It is difficult to separate nursing issues from women's issues. Apart from the comment about policy development being the prerogative of "the old boy's club", we also know that alienation has other roots as well (see Chapter Four, Findings on page 243). Nursing as a profession has been and continues to be a predominantly female occupation. It is considered a truism to state that nursing is women's work (McPherson, 1996). The "feminization" of an occupation occurs when that occupation takes on the gendered position of female subordination. Ferguson (1984) argues that the feminine role is inherently depoliticizing, in that it requires women to internalize an image of themselves as private rather than public beings. The discipline of nursing is not recognized for its potential to develop or influence health policy. The exceptions include the Canada Health Act (1984) and in Manitoba, the establishment of the Community Nursing Resource Centres (CNRCs) (1994). In the case of the Canada Health Act, the Canadian Nurses Association (CNA) had a longstanding commitment to "Medicare", and a commitment to broaden the definition of practitioner, to include nurses. The CNA had strong knowledge and strong leadership (President and a bureaucrat within the leadership structure). They lobbied hard and were successful. In the case of the CNRCs, there was a strong nursing leader who was "heard" by the government and who lobbied formally and informally. Also there was strong leadership coming from the committee who wrote the report on Nurse

Managed Care (Manitoba Health, 1994a). Other provinces also have had successes in influencing changes to health policy based on a nursing perspective. An example is the strong leadership to influence policy by the Registered Nurses Association of British Columbia (RNABC) in the establishment of the Comox Valley Nursing Centre (CVNC) (1996).

Thirty participants, all women, discussed what their "work world" was about in terms of policy development. For them, it was a gender issue; the issue is gender since nursing is overwhelmingly female. The study confirms a great power differential between community health nurses and policy makers: disenfranchisement, alienation, marginalization, and resistance.

Although limited (e.g. one male nurse) the data suggests that gender may supersede professional orientation, i.e., a male who is also a nurse was one of two participants who was involved at the local, provincial and national levels of policy development. If gender superseded professional orientation, then this is an example of gender and the ability to transcend the oppression of nurses.

Recommendation:

28. Future research to study male community health nurses. This follow up study would include interviews with male community health nurses. This sample would provide a comparative group.

Nurses Who Were Involved in Policy Development

Some nurses (n=7) were successful in policy development. Nurses who were political/social activists in their personal and professional lives were more involved in

policy development at all levels (local, provincial and national). These nurses used the political system and previous experience in shaping policy. In this study, there was congruence between the personal and professional "worlds" of nurses in relation to policy and social change involvement. Also, when nurses are involved in policy development, the nature of the involvement is predominately committee work.

Factors shaping the nurses' involvement in policy development included: personal life experience, gender (case of one male nurse), marginalized status of a particular group in society, i.e., gays and lesbians, and commitment to an activist role. These factors have a personal sense of ethics and morals associated with them.

Nurses found opportunities outside of their work structures to engage in policy development and in particular with the Manitoba Public Health Association (MPHA) and the Canadian Public Health Association (CPHA). Why is it that the MPHA has a higher level of involvement by nurses than the nurses' own agency? Why are nurses able to engage in policy development with MPHA and not within the context of their work environment? MPHA is interdisciplinary and utilizes a colleagial approach. The structure is non-hierarchical and supportive as well as provides recognition to all participants. Nurses found a better fit with MPHA where they were accorded personal and professional respect.

There is something about MPHA that is encouraging--it provides opportunities for leadership among nurses. The MPHA and CPHA are non-hierarchical. Value and power is beyond hierarchy. The valuing of nurses and the power accorded to them is not limited to hierarchy and do exist outside the context of hierarchy. Professional relationships are collectively interdisciplinary and go beyond the boundaries of

specific disciplines. Relationships are characterized by respect and collegiality. There is an invitation extended to nurses to have a voice. There exists mentoring of students and novices. In summary, non-governmental organizations (NGOs) are more feminist in their orientation and community health nurses are making a difference in these organizations. The NGOs demonstrate the potential of community health nurses working in partnership with the agency. At present, nurses find involvement outside the agencies.

Recommendation:

29. Conduct research with agencies whereby nurses have demonstrated their policy development activities.

Consequences To Not Being Involved: Resistance

Community health nurses are functioning in the role of policy broker, i.e., interpreting policy in the best interest of the public. Kaufert, Lavallée, Koolage and O'Neil (1996) established similar findings among interpreters. Nurses bridge the realities of policy with the realities of practice. However, it is a forced brokerage in that community health nurses are disenfranchised, marginalized and alienated from the development and implementation of health policy. In engaging in this form of resistance nurses put themselves at great risk. This clandestine activity is fraught with danger. The ultimate consequence of risk taking behaviours, i.e., subverting policy, could be job loss. Putting the public into public health policy for nurses is a risk taking initiative. Thus, this policy broker work remains invisible to the agency and

public--both recipients of accountability. The work must also remain invisible in order to protect these nurses who could face disciplinary action.

It is the argument of Ferguson (1984) that resisting policy is a form of resistance to organizational oppression. She further explains that resistance is a political act and "bureaucracy's claim to be nonpolitical mystifies the very act of resisting" (p. 117). This may explain in part why community health nurses continue to subvert policy--they are exercising a political act which aligns policy with the practice realities and remains invisible to the organization.

Clandestine activity is a response to the authoritarian nature of bureaucracy (Ferguson, 1984). Nurses in this study are engaged in clandestine activity in reshaping and subverting policy. My study indicates that these clandestine activities are symptomatic of a problem, and resistance works to empower oneself (Scott, 1985). It is Scott's thesis that resistance is a patient, silent struggle by weak communities to assert their rights. Scott's research is an ethnographic study of peasant resistance, "The prosaic but constant struggle between the peasantry and those who seek to extract labor, food, taxes, rents and interest from them" (p. 29). The context of my study is not 1978-1980, and not a Malaysian village, it is the 1990s in a bustling urban city in an industrialized nation. Although the context is quite different, clandestine activity viewed as "weapons of the weak" provides an informed explanation and link with the findings of my study. In response to authoritative approaches, community health nurses are skilled in "the art of resistance" as they reshape policy in the field. Resistance to poor policy becomes realized in each

woman's way. Reinterpretation is also a way of relating to natural circumstances, i.e., how the nurse will use her time.

This study unravels the culture of resistance as community health nurses actualize policy to their practice context. But what we do not know is the extent to which this individual interpretation of policy is happening (subverting, reshaping, redefining policy). When nurses talk about not being involved in policy development and the resulting difficulty "getting us on board" for the implementation of policy, this statement is an identification of resistance. "Women's resistance" is an important concept and it is a feminist piece. It involves subversion. Resistance is a way for women to take power in a situation in which they feel powerless.

There is a need for agencies to recognize nurses as having intelligence and experience to contribute to health policy development. Resistance is what people do when they are oppressed. Women carry this response to relative powerlessness into the "work world."

Recommendation:

30. A feminist model for policy development and implementation. This recommendation is based on the lack of community health nurses' involvement in policy development and implementation and the serious symptom of resistance. The paradox is that nurses are silent around the issues of their marginalization in policy development and implementation, and yet they engage in "high risk behaviour" to reshape policy at the field level. This is a downstream approach to public health policy. Nurses are currently blocked/prevented from engaging in the upstream approach to policy development. When nurses are forced to subvert policy and act as

brokers they are placed in "at risk" positions. A feminist paradigm brought to policy development and implementation would build productively on these resistive acts, transforming material resistance policy into organizational policy. The creation of a feminist model for policy development and implementation has implications for community health nursing practice, education, research, and management.

Personal Values and the Implementation of Health Policy

This study illuminates the understanding that nurses implement policy based on their own personal values and the moral obligation they feel to others. Compassion, concern and love comprise the heroic spirit much needed in contemporary nursing practice in today's society (Lanara, 1996). "The devaluation of the heroic spirit among nurses as well as among other health professionals, a direct consequence of the crisis in the sphere of eternal and moral values, provokes serious apprehensions regarding the future of nursing" (p. 5). Heroism as a nursing value (Lanara, 1996), applied to all levels of the system, whether it be policy making or work environment, would add a measure of peace and power (Wheeler & Chinn, 1991) to the work lives of community health nurses who are dedicated and passionate about their work.

Policy comes down legitimate [legal] channels but is enacted in the field. Based on the data of this study, policy implementation can be understood in terms of personal value sets. Nurses are involved in an implementation process which is public, but it is also personal. Policy implementation becomes personal. It needs to be understood within the context of the individuals' value set. The individual [nurse] may accept it or partially accept it or resist it. In a feminist viewpoint, policy

implementation is also a personal policy. We can talk about the nurse in partnership with the client and the personal implementation of policy. With respect to the third premise of the study, the findings indicate that feminist approaches are brought to the implementation of health promotion policy by community health nurses.

Policy is implemented by personal values; for example, the nurse who accompanied a single mother to her court appointment about maintenance and child support. This finding is about the translation of policy into private action by the nurse and the action is determined by the nurse. Carmen de la Cuesta (1993) views the work done by nurses, such as driving a mom to an appointment, as "fringe work." Whereas, I prefer to bring a feminist analysis to the issue and view the same example as nurses implementing policy based on their own personal values. This may make the "official work" look like "unofficial work" when in actual fact, I argue that it is the implementation of "official policy" in a personal, value-driven way.

This act of resistance, i.e., implementing policy based on their own personal values, when viewed from a feminist perspective, is an example where the personal is political--learned and institutionally reproduced. The personal is marginalized, that is how it is made personal. Moreover, that marginalization is a political act of policy.

Tensions exist in the implementation of primary health care (Jones, 1992). For example, nurses are trying to implement community development strategies such as empowering communities in the absence of clear policy. This situation creates confusion and frustration for community health nurses--for some this is even seen as a decanting (off-loading) of responsibility. Jackie Sturt (1997), in her doctoral research in the U.K., found that health care workers implementing primary health care were

faced with a complexity of messages, i.e., no clear policy as they proceeded to implement empowering formula. In my study, this is further illuminated by the fact that there is no formal sanctioning of these activities and in fact some nurses expressed that program directives were clear: nurses work in home visiting or they do community development activities. The health care system has made both these areas mutually exclusive and nurses perceive these two activities as separate and distinct. What is needed is a framework which supports implementation and evaluation outcomes at the individual (home visits) and community (community development) levels. Every nurse should engage in community development and this work should be factored into the nurses' current workload. In general, the system has failed the nurses and the community with respect to community development.

Recommendation:

31. There is a need for feminist research about nurses' personal values and how these values influence their involvement in policy development and implementation.

In summary, the recommendations of this study are as follows:

1. Further research studies that use micro, meso and macro perspectives.
2. Research that utilizes a feminist research paradigm.
3. Nurses need to be part of and present in policy development at the macro/ meso levels.
4. Nurses need to be conscious of their power and act on it.
5. Nurses need to be educated about policy development.

6. Nurses' work should be organized so that nurses are working in dyads.

7. A "community development" approach needs to be brought to agency structures and functioning.

8. Marketing strategies need to be established.

9. Community development needs to be fully understood by nurses and agencies and valued as a health promotion implementation strategy.

10. A feminist paradigm brought to management.

11. The effectiveness of nursing practice needs to be documented through research and publication.

12. A demonstration project needs to be planned and conducted to determine the value of nurses working in dyads.

13. Evaluation research addressing questions about the impact of health care reform.

14. Nurses need to be positioned at the management and policy levels of the health care system.

15. Further feminist research to determine how women are excluded from health policy development.

16. To bring a feminist analysis (perspective) to the critique of the bureaucratic structures and hierarchical relationships in health care organizations and in particular those governing the organization of public health (nursing services).

17. Ensure that existing management structures are not replaced by a new "oppressive" structure that is disrespectful of power--and does not permit power to be used for the benefit of the nurses and the community/public.

18. Teamwork, and "esprit de corps" be fostered within the agency.

19. The need to nurture colleagueship not only for the good of nurses but also for the good of the community.

20. Colleagues need to provide each other with mutual support and understanding.

21. Critically examine how qualitative data can be incorporated into "the measurement" of community health nurses' work.

22. Establish a reward system whereby there is congruence between what is valued by the client and what is valued by the agency.

23. Multiple evidence-based outcomes, i.e., triangulation, that do justice to the nurses' "work world."

24. Primary accountability needs to be with the community/public.

25. Research conducted in partnership with the community/public.

26. Apply a community development framework with respect to the establishment of policy.

27. Replication of this study with rural community health nurses to determine their involvement in policy making.

28. Future research to study male community health nurses.

29. Conduct research with agencies whereby nurses have demonstrated their policy development activities.

30. A feminist model for policy development and implementation.

31. There is a need for feminist research about nurses' personal values and how these values influence their involvement in policy development and implementation.

Feminist Model For Policy Development and Implementation

This study supports the need for a feminist model of policy development and implementation. It is a reconceptualization of the community health nurses involvement in policy development and implementation. The strength of the model is that it includes in addition to policy development, policy implementation, and it includes the "work world" context of community health nurses.

It was developed by bringing into focus each recommendation generated by the study (empirical evidence) within the framework of structure, process, and outcome. As noted previously on page 34, the relationship of structure, process, and outcome is arguably complicated. The model is dynamic, with associative relationships. The recommendations have implications for nursing education, practice, research, and management. Neither the recommendations nor the implications are mutually exclusive. There is overlap which suggests that the model needs to be applied as a whole in order to ensure the community health nurses' involvement in policy development and implementation and to achieve health promotion policy that enables people to increase control over, and to improve, their health (WHO, 1984).

The model is proposed as a means to achieving "healthy public policy" within the context of primary health care (Hancock, 1982, 1985, 1994). It is an alternative to the medical model and the traditional hierarchical management model applied to

community work. This model is characterized by associative relationships; for example, community development, political action, and policy formulation.

There is strength in a model which has been developed from the margin, i.e., alienation and marginalization of community health nurses (Russ, 1983). The intended outcome for the application of this model is achievement of integrated centrality by community health nurses in the development and implementation of health policy. This model is found in Table 9.

Table 9

Feminist Model for Policy Development and Implementation

Structure	Process	Outcome
EDUCATION		
• Opportunities for continuing education within agency structure	• Seminars • Workshops • Distance Education • A case study in policy--facilitated on site with the community health nurses	• Nursing community informed about policy development and implementation • Nurses informed and exposed to various strategies for change
• Inclusion of policy as a curricular thread in the undergraduate baccalaureate degree	• Examine how policy is taught to undergraduate students and adjust accordingly	• Graduates with their BN degree informed with respect to policy
PRACTICE		
• Establishment of venues/modes which give voice to community health nurses	• Policy development and implementation advisory committees to the agency and government	• Relevant policy development • Increased participation and decreased alienation of community health nurses in the area of policy
• Raise consciousness of community health nurses	• Workshops • Seminars • Staff meetings • Guest speakers (activists, academics) • Guest facilitators (inviting women from other agencies to share their experiences and successes, e.g. a women's co-op)	• Unleashing the inherent power of community health nurses for the betterment of all groups involved in public health promotion (nurses, agencies, governments, clients)
• Nurses working in dyads	• Two nurses are assigned to work in a particular constituency	• Nurses would support each other • Autonomy is preserved and isolation is reduced • Primary health care actualized in the community • Practice implementation of the Quality Health for Manitobans--The Action Plan (Manitoba Health, 1992)
• Consider demonstration project	• Identify geographic area where the dyad concept could be applied • Establish a formative and summative evaluation plan • Secure funding from Manitoba Health for demonstration project	• Evaluation of dyad arrangement

Structure	Process	Outcome

• Establishing policy that legitimates community development	• Education of agency administrators and staff about community development as a health promotion implementation strategy
	  ◦ workshops
	  ◦ seminars
	• Taking the dialogue on community development to macro level decision makers, e.g. Manitoba Health, City of Winnipeg
		• Agency policies that support and legitimate community development
		• Increased support for community development as a viable health promotion strategy

• Community health nurses should be encouraged to bring a feminist perspective and critique to existing bureaucratic structures and hierarchical relationships	• Community health nurses engage in a feminist discourse facilitated by a feminist activist • Explore alternative forms of relations and organizational structures • Reconceptualize "power" with the goal of flattening hierarchical structures • Establish an inventory of existing powers • examine values shared by the collective of community health nurses • Ensure that the current oppressive management is not replaced by a new repressive structure	• Development of an empowerment model with application not only for nurses but for the community as client • Morale of nurses would improve • Energies would be freed • Celebration and validation of values central to community health nurses • Nurses become political activists • Nurses actively engage in policy development • Management structures that are respective of power and use power for the benefit of the collective
• Community health nurses need to reassert their primary accountability to clients	• Community health nurses need to discuss and clarify with whom the primary accountability rests and how to safeguard that accountability ◦ In collaboration with MARN, agency, and government, map out the lines of accountability that are in keeping with the "new public health" and Code of Ethics and Standards of Nursing Practice	• Consensus as to primary and secondary accountability • Nurses and agency will be working toward the same practice goals • The agency reward system and accountability are in concert • Reduction in conflict and tension among community health nurses in relation to accountability of practice
RESEARCH		
• Legitimate research as an integral part of the role of the community health nurse/agency	• Feminist research paradigm • Micro/macro research perspectives • Conduct research which examines the effectiveness and/or outcomes of nursing practice	• A range of feminisms and their inherent research approaches to more fully understand policy development and implementation • Theoretical development of phenomenon

Structure	Process	Outcome
• Involvement of community health nurses in research that improves practice	• Participation on research teams • Assist with data collection • Identify researchable problems	• Addresses quality assurance • Makes the invisible work of community health nurses more visible • Increases the power of community health nurses and agencies with respect to decision makers (power capital)
• Examine the impact of health care reform on the role of community health nurses and agencies	• Foster partnerships with research units, i.e., Department of Sociology, Faculty of Nursing, to determine the impact of health care reform • Action based research to examine the impact of health care reform on the wellbeing of citizens	• Data identifying positive and negative outcomes around community health nursing can be shared with decision makers • Public will invest in understanding how health care reform is affecting their lives
• Feminist research to establish how women are excluded from health policy development	• Agency to foster partnership with feminist scholars and universities throughout the province	• Feminist scholarship and research will capture the realities of women's experience • Action can be taken to better the situation of women based on empirical data
• The need for action research with the community as partner	• Creating infrastructure to support researchers (e.g. office space, computers)	• Fostering of strengths between the agencies, community health nurses and the community • Action research as an endorsement of the commitment to partnership with the university • Community invests in research and claims ownership of data
• Replication of this study with various nurse populations	• Research to determine the involvement of rural nurses in policy development and implementation • A sample of male community health nurses	• Establish the extent to which rural community health nurses are included and/or excluded from the policy process • A comparative group to examine the impact of gender on nurses involvement in policy development
• Conduct research with agencies whereby nurses have demonstrated their policy development activities	• Identify those agencies (MPHA, CPHA) whereby nurses have been encouraged to engage in policy development	• Structures, processes, and outcomes regarding the involvement of community health nurses in policy development • Identification of the strengths community health nurses bring to the policy development arena

Structure	Process	Outcome
• There is a need for feminist research about nurses personal/values and how these values influence their involvement in policy development and implementation	• Feminist research which acknowledges the importance of personal values in the "work world" of women	• An understanding of those personal values which are important to women who work in the public sphere
MANAGEMENT		
• Community development approach applied to agency structures and functioning	• Investing in promoting a sense of community among nurses/staff • Decision making with staff • Formal recognition of contributions made by nurses • More consultative stance between administrators and nurses • Creating a safe environment which permits nurses to freely dialogue and discuss issues	• Cohesive work force • Supportive work environment • Validation of contributions • Promotion of empowerment
• Establishment of marketing strategies	• Promotional activities are directed towards policy makers/decision makers, government, other agencies, public	• An image that presents the intelligent work of community health nurses • Makes visible some of the invisible work done by community health nurses and agencies
• Positioning of community health nurses at the management and policy levels of the health care system	• Strategies partnerships among MARN, MNU, and agencies to advocate the presence of community health nurses in decision making arenas	• Policy that reflects the realities of community health nursing and the community experience • Voice would be established within the existing bureaucracy (a voice for nurses/women)
• Establish a reward system that reflects congruence of value between client and agency	• Community health nurses should consider meeting and identifying work that should be valued and rewarded • Community health nurses need to communicate to the agency work that is valued by all groups involved in public health promotion (nurses, clients, agency/government) • Individual and collective achievements need to be celebrated • Individual and collective achievements need to be made known at all levels of the system	• A system that rewards excellence across the continuum of nursing care • Potential to greatly improve staff morale • Decision makers would be informed about the accomplishments of community health nurses

Structure	Process	Outcome
• Embracing and establishing a feminist model of human resource management	• Management working in partnership with nurses ◦ Consulting and valuing field staff • Recognition of the nurses work which is currently invisible • Formally recognizing the value set held by community health nurses e.g. caring • Assisting community health nurses to educate the public about their "invisible" work • Clearly developed policy addressing primary health care (PHC) • Endorsing and initiating qualitative data collection that captures the nurses work • Critically examining current data collection practices (stats) • Developing a working relationship and partnership with the Centre for Health Policy and Evaluation • Explore alternative models of governance • Actively seeking the opinions and perspectives of community health nurses in the field with respect to policy development and implementation • Workloads should be examined and adjusted in light of policy development activities • Create venues for public participation in health care programming • Adopt a feminist approach to change	• Clear direction with respect to programming and PHC • Establishment of a sense of "communitas" • Invisible work of community health nurses becomes visible • Decision makers and public are informed about the important work of community health nurses • Decreased subversion of policy • Public more informed and encouraged to participate in health care services • Improved morale among community health nurses
• Critically examine how qualitative data can be incorporated into the "measurement" of community health nurses work	• Establish qualitative collection protocols--seek advice with community health nurses as to the important variables	• Workload measures that go beyond the existing data set • Qualitative data would capture the work of importance to the client as well as to the nurses

Structure	Process	Outcome
• Multiple evidence-based outcomes are required to "measure" the impact of nurses work	• Triangulation of various kinds of data • Consult with the community health nurses about less concrete outcomes and how they can be captured by data • Establish what are important outcomes for clients • Examine to what extent community health nurses are currently accountable for outcome-based care and determine areas of potential growth	• The work deemed important by all groups involved in public health promotion (all parties with vested interest) is identified and valued • A more holistic perspective/ understanding of the work provided by community health nurses • Increased client/community participation in health
• Teamwork, "esprit de corps" be fostered	• Recognition of diversity as a strength within the work force: sameness is not necessary for solidarity to exist • A workshop on the benefits of a united community of community health nurses • The creation of a supportive environment where nurses can learn about each other • Re-visioning how a team approach could add "energy" to the agency • Extend concept of teamwork to include other agencies (network of sister organizations) • Establishing linkages with non-governmental organizations (example, MPHA/CPHA) • Nurture the concept of "sisterhood" without excluding men/non-feminists • Generation of social consensus • Need to recognize and reward nurses for their work	• Solidarity • The development of a sense of pride, collective identity where individual strengths are recognized and valued by the collective • Moving community health nurses from the margin to the centre of decision making • Opportunity to discover how nurses have been involved successfully in developing policy with NGOs

Structure	Process	Outcome
• Apply a community development framework with respect to the establishment of policy	• Educate community members about community development • Agency recognizes the potential of a community development approach to policy • Making change to existing structures and processes to accommodate a community development perspective/approach • Identify skills and "tools" that can be developed among community members • The community health nurses function in a liaison role to link community members and agency • Establish partnership and dialogue with various social/cultural groups in the community • Generate awareness of class/cultural issues among care providers • Involve women of colour as care provider role models (through formal channels e.g. nurses or as community workers) • Educate community about the community development process/outcomes • Encourage Faculty of Nursing, University of Manitoba to become involved in inner city neighbourhoods	• The strengths and weaknesses of community development are understood o Concept, "community development" is de-mystified • Policy development is relevant given the involvement of community members • Community can establish priorities around policy • The community is empowered through acquisition of skills and abilities • Respect and dignity for community members regardless of culture and class • The racial/cultural composition of care providers reflects/parallels the ethnic/racial composition of the community

There are benefits to making the invisible, visible. Interestingly, for the agency to remain viable and vibrant, the work least visibly rewarded by the agency would likely be of greatest benefit. For example, innovative ideas generated by nurses and related to policy development, programming, quality of care with clients, and dedication and commitment could strengthen the agency's political position--especially given the competition for health care dollars. Millman and Kanter (1987) found that certain methodologies (quantitative) and research situations (men studying the "work

worlds" of women) may systematically prevent the elicitation of certain kinds of information; yet the undiscovered information may be the most important for explaining certain phenomenon.

Invisible work and potential benefits are further discussed in relation to the consumer/client/community (the public), nursing staff, and agency. Other community members would hear about the "good work" of the nurses and the agency through the informal sharing by the public of positive care experiences.

There would be benefits to the nursing staff. Nurses would recognize each other for their contributions to health care. Nurses can be evaluated and recognized for the work they are doing. Work becomes legitimate. Work would be valued and recognized and nurses would not be operating in isolation. Nurses would be empowered, they would have a say and know they are being heard. Nurses would know that they are having an impact. They would know that not only the volume of their work is valued but also the quality. This would be a challenge to the whole medical system of health care which is based on volume, not quality of care. Nursing staff would create a corporate culture that is collegial and bottom up in decision making.

For the agency there would be many benefits. The agency would incorporate the invisible, legitimize and factor it into evaluations as an agency. Evaluations would show that the agency is meeting its social mandate and allow it to be more visible and viable to funding bodies and to society. Making work visible forces a change in present management approaches (models) and leadership styles. The old style is at odds with management innovation. The management style would have to change

because there are consequences to keeping work invisible. The original management paradigm will not "fit" and therefore it will need to change. Leadership styles will change. The current management style will resist. Making visible is incommensurate with current management structure. The current management structure silences women. In this study I uncovered a range of invisible work. I found that nurses were disempowered, disenfranchised and alienated from the policy development process. A shift is needed to a new management paradigm tempered by feminist management. Feminist means a commitment to the equality of women and men. This commitment is integral to feminist management. We need to re-examine the traditional management model in light of these findings and a feminist model. The shift to a new management paradigm would be characterized by a period of "unfreezing" to allow for the new feminist model.

There would be benefits to a feminist management model: nurses would have more power; invisible work would be legitimized and this would force the agency to a different way of being. In contrast to Carmen de la Cuesta's work on the invisible work of community nurses which she calls "fringe work", I argue for the legitimization of invisible work. If this work is legitimized, it would force the agency to a different way of being. Another benefit would be, the potential for leadership to come from within the organization is greater. A new paradigm would encourage organizational transformation. Labonte (1994) argues that health promotion, viewed as a metaphor (a professional and bureaucratic lens) could be the lever to institutional and organizational transformation. As a result of this shift to the new paradigm, the agency's role and relationship to the public would change. The agency would be more

approachable; to influence the public the agency needs to be able to communicate with the public. What we see now as found by this study are symptoms of an ill management model. A feminist model would privilege the work of community health nurses and listen to their voices.

We need to apply a feminist model which is inclusionary, involves the grass roots in policy development. A model where women are valued and recognized for being intelligent and informed about policy. This model would include the consultation process and reveal caring values (Ristock & Pennell, 1996; Wheeler & Chinn, 1991). Marketing strategies and nurses working in dyads would have the benefit of making invisible work, visible to the agency and the public at large.

Involving community health nurses, primarily women, in formulating health promotion policy would make a difference; for they know the needs of the community and have the community development skills necessary to involve the community in the policy process. The benefits to be derived for community health nurses and communities would indeed become a reality, one which now remains only a rhetorical expectation. Subversion of health policy at the implementation level is symptomatic of a problem--the system of policy development and implementation is "sick." The outcome when nurses are involved in policy making is their reduced vulnerability and therefore reduced need to subvert policy.

Feminist Paradigm

According to Lerner (1986) women's history is the essential tool in creating feminist consciousness in women "by providing the body of experience against which

new theory can be tested and the ground on which women of vision can stand" (p. 229). It is hoped that this living account of the role of the community health nurse in policy development and implementation contributes a feminist consciousness to knowledge development in the nursing and public health sciences. In this way, what nurses have done and experienced will not be left unrecorded, neglected, and ignored in interpretation as has been the case throughout women's history.

Lerner (1986) argues that women have made history, yet they have been kept from knowing their history and interpreting history. In this investigation even though publishing and research opportunities for community health nurses are minimal or nonexistent, they have been agents in writing and interpreting their work experiences through their participation. What Lerner calls "the dialectic of women's history" (p. 5) she argues has moved women forward in the historical process.

The use of a feminist paradigm which values women's experiences and involves them in the interpretation of these experiences is an approach which in many ways preserves and protects "the dialectic of women's history." Women's exclusion from science and theory-formulation, historically, can be mitigated by a research approach which places women at the centre of the research process (Bleier, 1986; Harding, 1987; Kirby & McKenna, 1989; Ristock & Pennell, 1996). The same is true of nurses involvement in policy making. Even though community health nurses are not involved in policy development, their participation in this study is in itself a way of making policy; a way of "legitimizing" resistance. Although nurses did not see their involvement in this research as part of a policy process, they definitely voiced a commitment to contribute to research and viewed their involvement in the study as

such. "The dialectic of women's history," I argue, was "acted out" in an inclusive research process which used a feminist paradigm and ultimately involved the community health nurse participants in a process of writing policy. Participants provided a pathway to linking research with policy and the policy development process.

Feminist Analysis

There is a need to shift the traditional paradigm, i.e., positivist, to a naturalistic paradigm (Clarke, 1992; Labonte & Robertson, 1996; Lincoln, 1992). How the quantitative paradigm is applied (praxis) can silence nurses at the level of research and publishing. The stories that nurses have to tell are invisible because they do not fit the positivist paradigm. Quantitative science, often serves to render nurses' work invisible as they try to "fit" their qualitative experiences into a quantitative, statistical format. In qualitative work, the approach to analysis is one of, what is the best interpretation; not, what is the correct interpretation. There is the building of consensus around truth. Qualitative research and the value of nursing outcomes such as "the singing man" (Kendall, 1997) would have a positive effect on nursing. I believe nurses would find a way to do research and publish when the work they do can be understood and even small stories about a nurse-client interaction published. A feminist management approach would increase the visibility of the nurses' work because it would promote qualitative ways of knowing. The qualitative research approach can be empowering for community health nurses. Qualitative research will promote the ability of nurses to provide evidence. Feminist science is inclusionary--not only of participants, but also approaches to knowing the world. Although qualitative research is greatly needed to

reveal the "work worlds" of community health nurses, (i.e., their stories), feminism also embraces quantitative (or traditional) science (Anderson, 1997). Feminist science accommodates various approaches, but clearly recognizes the strengths and limitations of these approaches.

Feminist research seeks to value the context of the research. Not only did my study reveal findings around policy making--the major focus of the study, these findings have greater significance because the context was valued and questions about the work environment and health care reform included. For example, not only are nurses not valued for their work in policy making, their work in general is not valued or rewarded by governments/agencies, colleagues, nor the public. The inclusion of context helped to foreground the work of the nurses rather than keeping their "work world" as background information to the study (Kirby & McKenna, 1989).

Reflexivity

Fonow and Cook (1991) define reflexivity as, "the tendency of feminists to reflect upon, examine critically, and explore analytically the nature of the research process" (p. 2).

This study provides evidence that nurses are silenced around the issues of health policy development and implementation and in general silenced in their "work world." The question arises, were they silenced when being interviewed by myself in this research experience. In my field notes, one common theme was the hesitation of the nurse participants when questions approaching the policy making section began in the interview. My explanation at the time was their uncomfortableness with the topic because of lack of understanding, and an uncertainty about what I as a researcher

wanted/expected. Reflecting back on this issue, I chose to use a feminist research paradigm which in itself is an approach to create a "level playing field" between the "researcher" and the "researched" (Stanley & Wise, 1991). It is an approach to make visible the voices of women by valuing their experiences and placing them at the centre of the research. The researcher is a participant in the interview process so that the interview is more like a conversation (Oakley, 1981). The silencing issue, although there is a possibility for it to be present, in my opinion, was dealt with by selecting a research process which in itself is sensitive to this issue. The subverting issues around policy making did come out in the data. One can only assume that clandestine activity on the part of the nurses, may be even more prevalent than this study demonstrated. However, for the most part, the nurses indicated to me that they valued the opportunity to talk openly and freely in a research situation which ensured confidentiality. The transcribed data comprised 1,094 pages. My field notes indicate that nurses were reflective about their work.

Reliability and validity are referred to in qualitative research as trustworthiness of the findings. Toward this end, the findings in summary form were sent out to all the participants. Eight nurses responded. Their responses indicated a confirmation of the findings. What was of great interest to the nurses was the collective voice. In other words, knowing what other nurses thought and the affirmation that they, alone, not only held these views but so did their peers. The volume of the voices and the strength of the collective voice was reassuring to the participants. I argue that this research process attended, in part, to issues of silencing and isolation by bringing

together community health nurses who work in isolation and whose work, for the most part, is invisible.

As noted previously on page 150, when a summary of the findings was distributed to the participants, one of the participants requested that she have permission to share the findings with her colleagues. As a researcher I was enthusiastic about the value she placed on the results, however I was uncomfortable with saying yes. After talking this over with the Chair of my Committee, I understood the reasons for my uncomfortableness. There was the ethical issue of maintaining confidentiality of research participation and also the study at that time was research in progress.

Upon reflection, the health promotion policy literature is not easily read. There are two major problems. Firstly, the message is often confusing because the sentence structure and style is "wordy" and the reader is left asking the question, "What is the intended meaning"? Having to dig for meaning and re-read consistently, renders the work invisible because, for example, practitioners, i.e., community health nurses and others will not commit their time to this endless process. And, in actual fact, they do not. Surely, as public health professionals where "getting the message across" is critical to the educative process, our writing could be more "user friendly." Academic writing can be made clear and retain a scholarly nature. In fact, scholarship would increase and researchers/authors would not be producing work whose impact is to silence.

The second problem with the literature is the lack of theoretical basis in the area of health promotion. This phenomenon contributes to the silencing nature of the

literature as understanding by the reader is, in many instances, a struggle. It also contributes to difficulties in the applied sense. For example, nurses are attempting to apply in practice what in theory is unclear. Evidence from this study suggests that community health nurses held a range of understandings about "health promotion" and "community."

The literature can have the same silencing effect on the researcher. In my case, as researcher, it was necessary to re-conceptualize much of the literature before I could proceed to analyze it. In addition, the boundaries of the health promotion policy literature are not clearly defined. For example, the boundaries around theory, research, and practice issues seem to blur. It appears that the health promotion policy literature has two main components. One is research issues and the other is program issues. In both instances there is a need for a stronger theoretical basis.

There is another silencing factor to the literature. For the most part, it is written for those individuals working at the macro level of the health care system, i.e., policy makers or administrators. The micro level or the level where community health nurses practice is silent on their work. As my study indicates, the potential opportunity for community health nurses to publish is rich in possibilities but within the reality of their "work world" they are not afforded this "luxury."

As with the understanding of community health nurses' involvement in health promotion policy development and implementation, both macro and micro perspectives were essential--so too the health promotion policy literature needs to be written to include both perspectives as the concentration on one perspective (macro)

serves only to silence those working at the (micro) level, i.e. practitioners of public health.

The data analysis process for me was akin to making a quilt. The various shapes and sizes of the data were seen and organized in themes, concepts and subconcepts. The possibility of various configurations was considered and pieced together with great thought and care. Was the outcome a thing of beauty or just hard work? The quilt analogy implies that the answer to the question is a thing of beauty, created with endless hours of hard work. Intensive labour equity was critical to the process. Under different circumstances, i.e., non demonstration of individual competency at the Ph.D. research level, other resources would be brought to the research process (research assistants). The usefulness of the findings is yet to be known, but every attempt will be made to distribute/share these findings in ways that will promote their impact.

Were I to repeat this study, I would do some things differently. One of these changes would be to ask the questions in a way which contributes to a more manageable analysis. This issue was particularly true in asking the questions about policy development and implementation--the major thrust of the research. For example, rather than ask, "What is your involvement in health policy development at the local, provincial, and national levels?", I would ask the question, considering each of the levels in a separate question.

I would not include as many questions as I did (43 questions). Two sections of the data were left for detailed analysis at another time. These sections addressing the health promotion needs of women in the community and opportunities for women's

voices to be heard did not further illuminate the two study questions and in part, were answered in other sections.

I would give nurses the subject position of defining the word "love" and distinguishing it from the history of passivity, beauty, and selflessness (among others) that have been associated with it. Love is socially constructed and has been a major factor in producing and reproducing the oppression of women.

Reflection

According to the Concise Oxford Dictionary (1976), reflection means reconsideration; concerned in thought. In this section, I reflect on the personal "me" as a woman, researcher, and scholar.

As a researcher, I have experienced qualitative research and a feminist paradigm, in this study, and the impact on me has been immense. One of the major changes is my approach to research and writing. The research questions I want to pursue can be done because they lend themselves to qualitative research. Evidence can be provided that reflects nursing work. My approach to writing has changed and in fact qualitative research and the feminist paradigm have accorded me the opportunity to speak with authority and in a more clearly understood way. The contrast is writing, motivated by the authority of others and their authority driving the development of ideas. My writing process now makes my ideas more visible and I have experienced empowerment in the research process.

The writing process, at best, was a challenge to my personal learning. This process consisted of bringing together the dichotomies of organization and integration as well as analysis and creative thinking. It is somewhat overwhelming to bring all my

experiences, what I see and hear to the analysis with respect to my research and writing process.

What did this research do for me? I now better understand the role of the community health nurse in health promotion policy development and implementation. Other research questions arise out of this study for future scholarly endeavours. The feminist lens and this qualitative research has transformed my thinking and my ability to see the world and analyze issues with a higher level of understanding. My thinking has been challenged and responded to in my efforts to achieve breadth and depth of knowledge in my research area.

Growth can flourish when my research work is the centre of my experience and all things circumscribed around this. The ultimate growth for me was not relying on the authority of others but respecting the authority of my own work. The value of giving international presentations during this research journey was very useful to my work. A network of colleagues of similar interests developed, support and challenges to my ideas and validation were gathered along the way. For me, the attainment of a Ph.D. degree was not only self-motivated but in "my work world" (the academy) has become a requirement for academic progress.

Many riches and gifts have been shared with me throughout this research process. I have developed relationships with a host of feminist colleagues. I have learned that oppression is real. I now view the world differently as a woman and as a feminist scholar.

This qualitative study was hard work--it was a labour requiring full commitment and "staying power." When I thought I had completed a piece of the work, I soon

discovered that there was always more. I laboured in this research process. I learned what the labour investment had to be--it was beyond what I could have ever comprehended.

The cost of the labour was high. Relationships changed--some friends drifted away. It was a challenge to find the right mix of solitude and human contact (Sarton, 1973). The people in my life who respected this, I valued even more. I learned what that mix of solitude and human interaction was for me. I learned the value of solitude in my life and a greater appreciation for women's scholarship. Connecting with women writers in my professional and personal life was important to my writing process. How they organized their time and their lives were gifts they shared with me.

I learned the need for the intellectual stimulation of colleagues and through them learned the need to celebrate small gains along the Ph.D. journey. The importance of conceptual exchanges with colleagues was learned and practiced.

The struggles were an important and integral part of the Ph.D. experience. What I learned with each one, contributed to my reaching for knowledge and achieving a higher level of understanding. Nothing comes without struggle. Hard work, persistence, and dedication are essential for growth to occur.

I have lived feminism and I have researched it. I became a more authentic person and more authentic in the writing process. This was a major change for me. It was facilitated by the gifts of experience shared by others. There were times in the process when I felt like I was struggling on the margin of the research. I felt I was losing control of the study. What I did not realize at the time was my efforts to make

the participants, community health nurses, the centre of the study, placed me in a position occupied by them in their lack of involvement in policy making--on the margin. However, I learned there were advantages to writing from the margin in my struggle. From that vantage point I had the perspective of both the macro and micro lenses. This was critical to the application of a feminist analysis. Although I did not appreciate this at the time, I now know the value of the margin in my research process (Russ, 1983).

In addition, I have learned what a feminist analysis can lead to. It can lead to the discovery of a jewel. In this study, the jewel or the core finding is recorded on page 314 as follows:

> Collectively, structural dimensions related to the "work world" e.g., isolation among nurses, quantified workload measurements of agency-derived priorities, moral obligation of nurses to reformulate policy and make it "fit" with the reality of their practice context, and the lack of rewards for the core caring values of nursing, serve to silence these women's voices and contribute to the invisibility of their work.

I have drawn on feminist scholarship throughout this Ph.D. process. I now know the importance of feminist scholarship. My view of the world is grounded in feminism. This is a gift of learning I will take with me throughout my life. I also learned the need to be vigilant as a feminist scholar.

Summary and Conclusion

Change to involve community health nurses in policy making will not come easily or quickly. It has taken centuries to establish the current order of doing things.

Action cannot be taken until problems are known. The work of the community health nurse, made visible in the evidence produced by this research, serves as a

catalyst for action. Herein lies an example where the power of evidence has the potential to inform action and forge change through the knowledge empowerment of community health nurses. Their role in policy development and implementation can be a vibrant and dynamic force in shaping the future of health care with communities.

This study reveals the consequences of not involving nurses in policy making. Alienation and marginalization come at a cost. The price is high and ultimately everyone pays; the government/agencies, colleagues and the public. For example, the cost to the government is policy that is not in synch with the practice reality; agency programming is affected in terms of reduced commitment to and subversion of policy; and the public does not receive the quality of care that they need. This feminist research brings into focus the need for the voices of community health nurses to be valued, recognized, and above all to be heard. These actions alone would make a difference to what currently exists in the health care landscape. Nurses can be the architects of replanning/revisioning within this landscape through their role in health policy development and implementation.

The fundamental force that will serve to change these systems is love: defined by nurses. Caring, an expression of love, is the basis of all nursing work (Lanara, 1996; Roach, 1991; Watson, 1991). In the spirit of interdisciplinary health care, governments/agencies, colleagues and the public need to care enough to listen to the voices of community health nurses. These women, through their caring, are a force to reckon with. Furthermore, attending to these research findings is imperative. "Let's hear it for love" (Shields, 1992, p. 362) is a fitting statement of profound significance. The challenge and the place to begin is fostering love within the

collective of community health nurses. This entails women caring for women within the context of work. Responsibility for change rests in the first instance with the collective and secondly with the bureaucracies of community health care--the "work world" of community health nurses.

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APPENDIX A

ETHICAL REVIEW APPROVAL

The University of Manitoba

FACULTY OF NURSING
ETHICAL REVIEW COMMITTEE

APPROVAL FORM

Proposal Number N#93/28

Proposal Title: "The Community Health Nurse's Role in Health Promotion Policy."

Name and Title of Researcher(s): LYNN SCRUBY
PhD Graduate Student
Assistant Professor, Faculty of Nursing
University of Manitoba

Date of Review: September 13, 1993.

APPROVED BY THE COMMITTEE: SEPTEMBER 13, 1993.

Comments: APPROVED with the submitted changes of October 04, 1993.

Date: October 9, 1993 Karen Chalmers

Karen L Chalmers, PhD, RN Chairperson
Associate Professor
University of Manitoba Faculty of Nursing

Position

NOTE:
Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

Revised: 92/05/08/se

APPENDIX B

AGENCY ACCESS APPROVAL

Manitoba

396

Health
Healthy Public Policy
Programs Division

3rd Floor
800 Portage Avenue
Winnipeg, Manitoba CANADA
R3G 0N4

Santé
Division des programmes
gouvernementaux en
matière de santé

3e étage
800, avenue Portage
Winnipeg (Manitoba) CANADA
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November 9, 1993

Ms Lynn S. Scruby, R.N., B.N., M.S.
Assistant Professor
Faculty of Nursing
University of Manitoba
Room 246 Bison Building
Winnipeg MB R3T 2N2

Dear Ms Scruby:

I received the copy of your ethical review approval form. Thank you. This was the final requirement to be fulfilled to meet the criteria for conducting research which utilizes Manitoba government staff, clients or data.

I look forward to learning about your findings Lynn. When you have completed your studies, would you please forward a copy of your work to me. Good Luck!

Yours truly,

Barbara Hague
Program Specialist
Health & Wellness

cc: P. Sarsfield, M.D.

C:\USER\WORD\BARB\SCRUBY2

CITY OF WINNIPEG

HEALTH DEPARTMENT

280 William Avenue, Winnipeg, MB, R3B 0R1
Fax # 947-3957

August 19, 1993

Ms. Lynn Scruby,
Assistant Professor,
Faculty of Nursing,
Room 246 Bison Building,
R3T 2N2.

Dear Ms. Scruby:

The Description of the Project; Description of Population; and Description of Methodology and Procedure with respect to your proposed Ph.D. project has been reviewed and found to be meaningful and timely.

The concepts and issues you have selected to address through your research are quite relevant to public health nursing practice and we would be most willing to facilitate the distribution of the letters of invitation to the public health nurses of this agency.

Please let us know when you would like to have the letters distributed and a mechanism for their conveyance to the public health nurses can be promptly implemented.

On the completion of your dissertation, we would be most interested if you would share your findings with us.

Sincerely,

Mrs. Kathy MacIver,
Acting Director of Public health Nursing.

KK/bls

APPENDIX C

CONSENT FORM

CONSENT FORM

The Community Health Nurse's Role in Health Promotion Policy: An Interdisciplinary Feminist Research Paradigm

I am being invited to voluntarily participate in the above titled research project. The purpose of this project is to find out the role that the community health nurse plays in making decisions about health promotion policy and in carrying out health promotion policy decisions in practice.

I am being invited to participate because I am a community health nurse working with a public health agency in Winnipeg. Approximately 30 participants will be enrolled in this study.

I understand that the researcher obtained my name and address from a list, of the community health nurses, provided by the agency where I work. The person who provided the list is not associated with the study and will not be given any specific information about me or my responses, whether or not I choose to participate.

I can choose not to participate in this study, at any time, and my decision will be respected.

If I agree to participate, I will be asked to agree to the following: To give 1 - 1 1/2 hours of my own time to be interviewed by the researcher, whichever I decide. The interview will be tape recorded and at any time in the interview, I can stop the recorder. I can ask questions before and during the interview.

I understand that this study poses no risk to me.

There are no benefits to be derived from participating in this study.

The researcher is Lynn Scruby, Assistant Professor, Faculty of Nursing, The University of Manitoba. I can contact her by telephone at 474-8936 (work) or 488-0626 (home).

It is my understanding that confidentiality will be maintained by the researcher who will not associate my name with the data. I understand that the researcher is conducting this study for her Ph.D. degree and that her committee members will have access to the information. The committee members are: Dr. Janice Dodd (Advisor), Department of Physiology, Faculty of Medicine, The University of Manitoba; Dr. Keith Louise Fulton, Department of English, The University of Winnipeg; Dr. Parvin Ghorayshi, Department of Sociology, The University of Winnipeg; and Dr. Elizabeth Ready, Faculty of Physical Education and Recreation Studies, The University of Manitoba.

In any report writing and publication of the study, I understand that there will be no direct reference to myself and the agency where I work.

During my participation in this study, I will not have to assume any financial costs.

It is my understanding that I will be given a copy of the consent form.

I consent to participate in the study as described above.

Name:_____ Date:_____

APPENDIX D

ETHICAL REVIEW CONSULTATION

THE UNIVERSITY OF MANITOBA

FACULTY OF NURSING

Room 246 Bison Building
Winnipeg, Manitoba
Canada R3T 2N2

(204) 474-8202
FAX (204) 275-5464

January 13, 1995

Dr. Linda Kristjanson
Chair Ethical Review Committee
Faculty of Nursing
University of Manitoba

Dear Dr. Kristjanson:

This letter is follow-up to our conversation with respect to an additional recruitment approach for my Ph.D. research entitled, "The Community Health Nurse's Role in Health Promotion Policy."

Attached is a copy of the notice that was posted in the public health offices at the City of Winnipeg Department of Health and Manitoba Health. This notice was posted in December. The outcome was positive and I obtained the remaining four participants; and in fact, the response was five participants.

This completes the data collection phase of my research, which was approved by the Ethical Review Committee September 13, 1993.

Thank you for meeting with me to discuss the ethical aspects of this additional call for research participants.

Best wishes to you and the Ethical Review Committee.

Yours sincerely,

Lynn S. Scruby
Assistant Professor

LSS/lc
attach.

APPENDIX E

RECRUITMENT INVITATION (1)

THE UNIVERSITY OF MANITOBA
FACULTY OF NURSING
Room 246 Bison Building
Winnipeg, Manitoba
Canada R3T 2N2
Tel: (204) 474-8202
Fax: (204) 275-5464

February 18, 1994

Dear Community Health Nurse,

I am a graduate student in the Interdisciplinary Ph.D. Program at The University of Manitoba and I teach community health nursing in the Faculty of Nursing. My dissertation addresses the need for research in the area of health promotion policy development and implementation and the participation of community health nurses.

I will be interviewing community health nurses working in two official public health agencies in Winnipeg, namely The City of Winnipeg, Department of Health and Manitoba Health. This is not a comparative study. Neither the name of the community health nurse nor the agency of employment will be associated with the data. Your involvement is voluntary and you can withdraw from the study at any time. Any questions you have will be answered before and during the interview. I would like to tape record the interview, which will take approximately 1 - 1 1/2 hours to complete. You can stop the recorder at any time. The interview will be conducted in my home or your home, whichever is more convenient for you.

Confidentiality will be respected and maintained. The persons who will have access to the data are myself and the four members of my Ph.D. committee. My advisor is Dr. Janice Dodd, Department of Physiology, Faculty of Medicine, The University of Manitoba (telephone: 789-3430). Other committee members include: Dr. Keith Louise Fulton, Department of English, The University of Winnipeg; Dr. Parvin Ghorayshi, Department of Sociology, The University of Winnipeg; and Dr. Elizabeth Ready, Faculty of Physical Education and Recreation Studies, The University of Manitoba.

Your participation in the study would be appreciated and once the study is completed, I would be happy to share the findings with you. If you would like to volunteer to participate in the study please contact me directly at 488-0626 (home) or 474-8936 (work).

Yours sincerely,

Lynn Scruby
Assistant Professor

APPENDIX F

RECRUITMENT INVITATION (2)

THE UNIVERSITY OF MANITOBA

FACULTY OF NURSING

Room 246 Bison Bl
Winnipeg, Manitoba
Canada R3T 2N2

Tel: (204) 474-8202
Fax: (204) 275-5464

June 22, 1994

Dear Community Health Nurse,

In February, 1994, I sent you a letter inviting your participation in my Ph.D. research which addresses the need for research in the area of health promotion policy development and the role of community health nurses.

The response is very encouraging and to date I have collected data from ½ the anticipated number of participants. I still need approximately 15 community health nurses to volunteer for a 1-1½ hour tape recorded interview.

Perhaps this is a better time for you or even sometime during the summer months. I would appreciate hearing from you and setting up a convenient time for the interview even though you may not be available for a month or so.

Thank you for considering this request. If you would like to volunteer, please contact me at 488-0626 (home) or 474-8936 (work), or leave a message at 474-8202.

Yours sincerely,

Lynn Scruby

Lynn Scruby
Assistant Professor

APPENDIX G

RECRUITMENT INVITATION (3)

THE UNIVERSITY OF MANITOBA

FACULTY OF NURSING

Room 246 Bison Building
Winnipeg, Manitoba
Canada R3T 2N2

Tel: (204) 474-8202
Fax: (204) 275-5464

September 15, 1994

Ms. Donna Forbes,
Assistant Regional Director, Public Health
Manitoba Health
5 - 189 Evanson Street
Winnipeg, Manitoba
R3G 0N9

Dear Ms. Forbes:

I am writing to request your assistance in bringing to the attention of your public health nurses the need for additional participants in my Ph.D. research. The focus of the study is the role of public health nurses in the development of health promotion policy.

Public health nurses from the City of Winnipeg Health Department and Manitoba Health are being invited to voluntarily participate in the study. The interview which takes the form of a conversation can be completed in 1 - 1 1/2 hours and is tape recorded. I can arrange to meet with the nurses at a time and location that is convenient and comfortable for them.

The voices of public health nurses are critical to this study. I wish to express my sincere gratitude to those nurses who gave of their time to talk about their work. To date, I have heard from 20 nurses and I would like to hear from an additional 10 nurses. I am anxious to acquire these 10 participants within the next four weeks.

Interested public health nurses can contact me in confidence, at work 474-8936 or home 488-0626. If there are nurses who need further information about the study or would like to talk to me about it, please have them contact me as well.

Again, thank you is extended, to the public health nurses who participated and to you for your assistance in bringing this additional request to the attention of the public health nurses in your agency.

Yours sincerely,

Lynn Scruby

Lynn S. Scruby
Assistant Professor

THE UNIVERSITY OF MANITOBA

FACULTY OF NURSING

Room 246 Bison Building
Winnipeg, Manitoba
Canada R3T 2N2

Tel: (204) 474-8202
Fax: (204) 275-5464

September 15, 1994

Ms. Gwen Howe
Acting Director of Public Health Nursing
City of Winnipeg, Health Department
280 William Ave.
Winnipeg, Manitoba
R3B 0R1

Dear Ms. Howe:

I am writing to request your assistance in bringing to the attention of your public health nurses the need for additional participants in my Ph.D. research. The focus of the study is the role of public health nurses in the development of health promotion policy.

Public health nurses from the City of Winnipeg Health Department and Manitoba Health are being invited to voluntarily participate in the study. The interview which takes the form of a conversation can be completed in 1 - 1 1/2 hours and is tape recorded. I can arrange to meet with the nurses at a time and location that is convenient and comfortable for them.

The voices of public health nurses are critical to this study. I wish to express my sincere gratitude to those nurses who gave of their time to talk about their work. To date, I have heard from 20 nurses and I would like to hear from an additional 10 nurses. I am anxious to acquire these 10 participants within the next four weeks.

Interested public health nurses can contact me in confidence, at work 474-8936 or home 488-0626. If there are nurses who need further information about the study or would like to talk to me about it, please have them contact me as well.

Again, thank you is extended, to the public health nurses who participated and to you for your assistance in bringing this additional request to the attention of the public health nurses in your agency.

Yours sincerely,

Lynn S. Scruby
Assistant Professor

APPENDIX H

RECRUITMENT POSTER

CALL FOR RESEARCH PARTICIPANTS

Four (4) Public Health Nurses are needed to volunteer for the study "The Community Health Nurse's Role in Health Promotion Policy." The researcher is Lynn Scruby.

The tape recorded interview/conversation can be completed in one hour. I can come out to your work and meet over lunch, or come to your home, or you can come to my home - whichever is more convenient for you.

Please phone me today. I can be contacted in confidence at work 474-8936 or home 488-0626. Your phone call will let me know of your interest and the best time to meet.

To date, 26 Public Health Nurses have participated. I would like to complete the interviews in December, 1994.

Thank you.

Please Post

APPENDIX I

INTERVIEW SCHEDULE

INTERVIEW SCHEDULE

General Questions

1. To whom are you explicitly accountable for your work as a community health nurse (CHN)?
2. To whom are you implicitly accountable for your work as a CHN?
3. What work do you do that is rewarded?
4. What work do you do is not rewarded?
5. In your work with communities, how do you define "community"?
6. How does your agency define "community"?
7. In your work with communities, how do you define "health promotion"?
8. How does your agency define "health promotion"?
9. Who determines the health promotion need(s) in your community?
10. Who listens to your expression of the health promotion need(s) in your community?

Policy Development and Implementation

1. What does policy development mean to you?
2. What does policy implementation mean to you?
3. Are you involved in policy development
   at local
   provincial levels(s) ?
   national
4. Should you be involved in policy development
   at local
   provincial levels(s) ?
   national
5. Are you recognized for your involvement in policy development?
6. Are you involved in policy implementation?
7. Should you be involved in policy implementation?
8. Are you recognized for your participation in policy implementation?

Health Promotion Needs

1. What is (are) the explicit health promotion need(s) of women in your community?
2. What is (are) the implicit health promotion need(s) of women in your community?
3. Describe your role in addressing this (these) need(s)?
4. Are you recognized for your role in addressing this (these) need(s)?
5. How do the women in your community organize for change?
6. Are you involved with the women in your community to organized for change?
7. Are there any race, gender, class issues operating in your community work?
8. Is there a form of "silencing" operating in your Community for women?

9. Is there a form of "silencing" operating in your Community for you?
10. In your work with communities, in what area(s) do you feel least prepared?

Women's Voices

1. What leadership opportunities do you have in professional associations?
2. In your work with professional associations, are you being listened to?
3. Are you being recognized for your work in professional associations?
4. What leadership opportunities do you have in "other" (i.e., church) associations
   - In the work role.
   - Outside the work role.
5. In your work with "other" associations, are you being listened to?
   - In the work role.
   - Outside the work role.
6. Are you being recognized for your work in "other" associations?
   - In the work role.
   - Outside the work role.
7. What opportunities are available for you to publish your views about your work?
8. What opportunities are available for you to do research in your work?
9. Are you being recognized for your publishing and research work?
10. Do you participate on a board of directors?
11. What does feminism mean to you?
12. Do you consider yourself to be a feminist?
13. How does being a feminist influence your work as a CHN?

Other

1. If you had the power and means to change things about your work, what would you change?
2. Is there anything you would like to add that would help me in this research work?

APPENDIX J

ACCOUNTABILITY

Table J1

Explicit Accountability[1]

Organization-related accountability n=38	
Employer/employee relationships n=21	a. Supervisor (14) b. Director of Nursing (3) c. Minister/Medical Officer of Health (2) d. People one works for (1) e. Staff (1)
Agency n=17	a. Organization/agency/employer (13) b. Government (4)
Client-related accountability n=22	
Clients n=13	a. Client/public/consumer (12) b. Families (1)
Community n=6	a. Community (6)
Financial n=3	a. Taxpayer (3)
Profession-related accountability n=13	
Professional nursing/standards of practice n=5	a. Professional association (5)
Personal standards n=5	a. Myself (5)
Peers/colleagues n=3	a. Peers/colleagues (3)

[1] Where a discrepancy in totals exists, some participants may have made reference to more than one category or subcategory and therefore the total may exceed the number of participants. Overall, the majority of nurses identified one primary source.

Table J2

Implicit Accountability[2]

Profession-related accountability n=14		
Personal Standards n=9	a.	Myself (9)
Professional nursing/standards of practice n=3	a.	Professional association (3)
Peers/colleagues n=2	a.	Co-workers/each other (2)
Client-related accountability n=13		
Clients n=8	a.	Client/public/people we work with (7)
	b.	Families (1)
Community n=3	a.	Community (3)
Schools n=2	a.	Teachers/principals (2)
Organization-related accountability n=8		
Agency n=6	a.	Government (5)
	b.	Organization/agency (1)
Employer/employee relationships n=2	a.	Team (1)
	b.	Medical Officer of Health (1)

[2] Where a discrepancy in totals exists, some participants may have made reference to more than one category or subcategory and therefore the total may exceed the number of participants. Overall, the majority of nurses identified one primary source.

Table J3

Explicit and Implicit Accountability Combined[3]

Organization-related accountability n=46

Explicit n=38
Implicit n=8

Client-related accountability n=34

Explicit n=21
Implicit n=13

Profession-related accountability n=28

Explicit n=14
Implicit n=14

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[3] Where the totals are greater than the number of participants, in some instances, is a factor of more than one accountability category or subcategory being identified by the participants.

APPENDIX K

WORK REWARDED AND WORK NOT REWARDED

Table K1

Work Rewarded

Categories	Subcategories	Examples
1. Agency rewarded	A. Work contributing to financial viability	a. Quantity of visits (contacts) b. Finishing work on time c. Free labour (putting in extra time)
	B. Work contributing to agency functioning	a. Sitting on committees b. Organizing/planning programs c. Initiative d. Teaching in the evenings e. Community development f. Networking with clients and communities g. Presentations h. Developing a data base i. Effort to make some changes
	C. Innovative ideas	a. Something different b. Being involved and creative c. A complex case
	D. Work contributing to agency visibility	a. Work that's in the public eye b. The tangible extras (committee, research, working in community groups). c. Planning a conference d. Outbreak or epidemic of a disease e. Whatever the agency thinks is the current thing to do
2. Personally rewarding work	A. Work with clients	a. Post-natal visiting b. High risk families c. One-to-one work with people d. Gains made with clients e. Work with families f. Helping someone g. Work with moms and babies
	B. Work with communities	a. Work in rural communities b. Community development c. Community needs assessment d. Putting something in place for community and it works

	C. Work with programs/projects	a. Families who come back to health promotion programs b. Group education projects c. The occasional presentation d. Special projects e. Work I do with schools f. Communicable disease follow-up
	D. Work with staff/co-workers	a. Helping to stop disruptive things for staff b. Protecting staff from the bureaucracy so they can be clinicians c. When things run smoothly d. Challenging work e. Facilitating staff to do community development and needs assessment f. Support from co-workers and the supervisor at monthly branch meetings
3. The nature of agency rewards	A. Monetary rewards	a. Paycheque
	B. Working conditions	a. Getting time back b. Flexibility c. Independent decision making
	C. Feedback	a. Praise b. Appreciation from support staff and administration within the office c. Positive performance appraisal
4. The nature of personal rewards	A. Feedback	a. Appreciation from clients/consumers · Thanks from a post-partum mom · Thanks from new parents · Appreciation from families b. Appreciation from the community · City Councillors · Media · Child and Family Services · Teacher, student, principal c. Support from co-workers/ colleagues/team members d. Tangible feedback · A letter
	B. Client utilization of services	
	C. Good feelings	

Table K2

Work not rewarded

Categories	Subcategories	Examples
1. Client based work not rewarded		a. The real work with families and being able to assess accurately b. The referrals - the basic everyday stuff c. Being available when someone calls d. The broad parameter with which we work e. Counselling and staying longer f. A lot of the work I do with clients g. Having a break through with a family h. HIV counselling i. Post-natal visits j. For some families, I ask myself, did they really benefit by my visiting k. The day-to-day stuff, drudgery (case load stuff)--a lot of organizing
2. Agency based work not rewarded		a. Program development b. Paper work (charting, writing) c. Specific programming i.e. programs in the schools d. Vision screening, some task things e. Committee work f. Question whether our work in the clinic is being recognized and valued g. Basic maintenance that needs to be done in the clinic i.e. clean the fridge h. Traveller's immunization i. Policy keeps us from doing as much as we do in the schools j. Weekend coverage k. Orienting a new employee l. There is not much reward for my work from the people over me (supervisor speaking) m. Trying to justify public health nurses existence every year in the budget process n. The political things--system's things--reviewing and responding to a paper

3. Personal based work not rewarded		a. All the work I do b. Getting more education c. Any work that you do as a public health nurse d. Trying something innovative/creative e. Stress and strain
4. Invisibility of work not rewarded		a. So much of what we do is done in people's homes and the agency doesn't see it b. The little things that don't look glorious (spending time with a post partum mom who has depression) c. The behind the scenes support and encouragement of people d. Research/preparation e. Public health nurse voice is not prominent or respected in the health reform movement f. Our effort, caring, and commitment g. The less tangible--caring, the amount of time you spend. The essence of community health nursing
5. How work Is not rewarded	A. Time	a. We don't take our breaks and don't get the time back b. People can go on leaves but agency doesn't have to pay them c. Clerical staff wonder why you've spent extra time on clients d. Public health nurses have to have a strong work ethic when I think of all the time that is not rewarded. I could make the same salary and do half the work
	B. System	a. We are made to feel we aren't working hard enough b. We are not rewarded from the top of the system c. When you're dealing with difficult situations, everyone's trying to cover their ass d. Policy, re: school health e. The agency doesn't do very much rewarding f. Don't have on site daycare g. Ask for more nursing time and get more physician time (clinic)

APPENDIX L

DEFINING COMMUNITY AND HEALTH PROMOTION

Table L1

Defining Community

Categories	Examples
Meaning the same	
1. Geography	a. Geographic neighbourhoods b. Geographically bounded with distinctly different needs c. "The area that I serve."
2. Aggregates and groups	a. A group of shared interests, space, time b. Includes the housing development and the school c. "I see the school as a separate community." d. A group of people sharing a common purpose, goal, interest e. A group of people with common reasons for being somewhere f. Groups of people comprised of individuals and not necessarily defined by boundaries
3. Geography and aggregates	a. Certain high risk groups within a geographic boundary b. The larger jurisdiction of a district to something as small as a neighbourhood. It includes community centres, community organizations, down to families
4. Cultural bond	a. Cultural parameters, age, socioeconomics b. The community defines what community means for them
Meaning similar but different	
1. Geography and aggregates	a. "It is similar in that it is geographically defined, i.e., neighbourhood but in this instance my definition is expanded to include i.e., our community as work, a school, and community can be spontaneously formed." b. "It is similar in that it is geographic but it is different in that community is not just something that's specifically geographic. It is groups (families, ethnic, cultural, religious) and people who live in specific neighbourhoods." c. "The definition is similar in that it is boundaries/geographic but for the agency the post partum community is the priority now." d "It is similar in that it is a geographic area but community can be a group of people who share a common interest. Politics is another piece of community."

2. Geography	a. "The definitions are similar in that it is people who live, work and play within a certain locale . . . their relationships . . . the impact of industries and commerce on them. The difference is that the agency's definition is neighbourhood based."
3. System	a. "It is similar in that community is defined broadly but the agency doesn't call it community, they call it the system."

Meaning not the same

1. Geography and common bond	a. "Within that chunk of geography called community are different neighbourhoods. Community has its own economic sense. It is more than a piece of geography. The agency defines it as a geographic area." b. "Boundaries on the paper can't produce a sense of community. It's an area of the city where they have the same sense of belonging, togetherness, a sense of cohesiveness. Our agency defines it using city area categorization (neighbourhood based) but you can't make a neighbourhood." c. "It's a shared set of interests which may be in a geographic location but it may be in a variety of other things, ie a shared understanding of what it means to be discriminated against. Neighbourhood, as the agency defines community, concerns are not common concerns. They are not shared as a community."
2. Geography, common bond, and universe	a. "It's everybody, everything. Our work in the agency is fairly limited to post partum families . . . young families. It's not in our job description to be broader. I guess it has to be defined." b. "The same in terms of geographic area or common concern but I go further in that my community fits into the city community and I fit into the community of mankind, and the beasts and everything else that goes to make the community of the earth."
3. Geography and aggregates	a. "Groups of people with a similar interest whereas the agency looks at the whole larger area as the community."

Unknown

1. Written communication	a. "Don't know whether there is a specific written definition." b. "Don't know as they (the agency) are looking at various concepts." c. "It's probably written down somewhere but I haven't read it, to be quite honest."

2. Verbal communication	a. "I've never had the opportunity to talk about it." b. "I'm a little suspicious, but I think we might come to the same point."

Table L2

Defining Health Promotion

Categories	Examples
Meaning the same	
1. Enabling people	a. "When I share information on health--give people the opportunity to enhance or maintain what they have." b. Working with people to help them attain something positive out of life. Implies a sense of community, family, support network c. Assessing where people are in the health continuum and working with them to promote their health d. Giving people tools to carry on with their life e. Helping people identify their needs--help them find the resources or build up their resources to achieve that level of health so they can get on with the rest of their life f. "Watching your community for needs and opportunities. Helping people find goals and set out to achieve them. My role is facilitator (catalyst). If it becomes key provider, we keep evaluating to see if we can play a lesser role."
2. Empowering people	a. Helping/empowering people in that community to maintain and increase their health . . . their sense of well-being, self-satisfaction b. Helping/empowering people to be more independent in terms of managing their health
3. Interventions to influence health	a. Ways we can influence or change behaviours, working with groups of people b. Any activity-intervention that works to improve or maintain the health status of individuals, families or groups in that community
4. Healthy lifestyles	a. Promoting healthy lifestyles
Meaning similar but different	
1. Lifestyles and self-actualization	a. Both the nurse and agency agreed that the definition is about lifestyles but the nurse commented, "the agency's definition isn't as specific as mine-- further increasing

	your energy--self-actualization. For example, family interventions during transition times."
2. Anticipation	a. Both the nurse and agency agreed that the definition is about anticipation--proactively trying to promote their health. The nurse commented, "for me it's things that people aren't immediately recognizing as a problem. For the agency it's not visiting enough people or not checking enough heads for lice."
3. Enabling and individualism	a. One nurse made the observation that the definitions were the same in that health promotion was enabling people to use resources, to be able to maintain wellness as they best define it. The agency's definition didn't state the individualism of health promotion.

Meaning not the same

1. Enabling and health care reform	a. "Community health nurses have the skills (empathy, love, caring) needed to promote health so that communities are able to make people healthier in their own being." This nurse viewed a relationship between health promotion and health care reform but the big difference came from the agency in comments such as, "nobody understands health reform."
2. Educating	a. One nurse saw it as giving information to the community so that it can identify what is and what they as a community would want to work on together. The agency's approach is more like a program but the agency would like to change this approach.
3. Lobbying and community action	a. Another community health nurse found that the agency doesn't define it as broadly but emphasizes education whereas the nurse said. "it is much more than education, it requires lobbying and community action to make a difference in peoples' lives."
4. Issues/needs	a. One nurse commented. "the agency is trying to define it in terms of statistics and health promotion is difficult to quantify." For the nurse, health promotion is working on issues such as breast feeding and family life in the schools.
5. Community based	a. One nurse saw health promotion as nursing interventions that community health nurses can do to promote the health of individuals, communities, groups. The agency, on the other hand, defined health promotion more towards illness prevention but more definitely in terms of programs they can get funding for become health promotion.

	b. Another nurse commented, "for the agency, it is doing programs and providing a service, but for me it is community based and helping people achieve their optimum health. The agency's definition is changing though."
Unknown	
1. Written communication	a. "It must be in the policy manuals, somewhere." b. "To tell you the God's gospel truth, I've never seen anything written. There's a module but it's on hold." c. "It's probably written somewhere." d. "They must have one somewhere. I don't think they define it for us, we define it for them."
2. Verbal communication	a. "I think it's fairly broad and open to interpretation--it's evolving." b. "I wish I knew it, and I should know it but I don't." c. "I think we have a definition but I don't know exactly what it is."
3. Enabling	a. Helping people identify their own needs b. Helping people to know their own role in health
4. Educating	a. Education program, teaching about health behaviours
5. Mental health	a. "I focus on mental health promotion." (in working with maternal/child needs and in promoting self-esteem)
6. Community development	a. "It's the community development things that you do--the networking, assessing health issues. It's all the stuff that isn't disease control and disease prevention."
7. Prevention	a. Preventing illness--things that make peoples lives better

APPENDIX M

HEALTH PROMOTION NEEDS

Table M1

Identification of Health Promotion Needs[4]

Organization determines needs n=30	
Public health nurse n=21	
Agency/department/other agencies n=7	
Students n=1	
No one n=1	
Client/community determines needs n=20	
Community n=11	a. Constituents
Clients n=6	
Schools n=3	a. Teachers

[4] Where a discrepancy in totals exists, some participants may have made reference to more than one category or subcategory and therefore the total may exceed the number of participants. The majority of nurses identified one primary category.

Table M2

Listening to Health Promotion Needs[5]

Organization listens n=47	
Employer/employee relationships n=26	a. Supervisor (17) b. Team/management team (4) c. The Minister (1) d. Team leader (1) e. Public health nurse (1) f. Staff (1) g. Regional Director (1)
Agency n=11	a. The structure/agency (6) b. The Department (2) c. City Council (2) d. Administration (1)
Colleagues n=5	
Not the organization n=3	
No one n=2	
Community listens n=20	
Agency n=9	a. Another agency/hospital (4) b. School system (3) c. Churches (1) d. Media (1)
Individuals in the community n=7	a. Police Chief/Commissioner (2) b. Teacher (1) c. Social worker (1) d. Politician (1) e. Family practitioner (1) f. Other (1)
The public/community n=4	

[5] Where a discrepancy in totals exist, some participants may have made reference to more than one category or subcategory and therefore the total may exceed the number of participants.

APPENDIX N

POLICY DEVELOPMENT AND IMPLEMENTATION INVOLVEMENT

Table N1

Involvement in Health Policy Development

Involvement	
Yes	n=7
Sometimes	n=6
No	n=18
Should be involved	
Yes	n=31
No	n=0
Recognition	
Yes	n=7
Sometimes	n=3
No	n=2
No expectation	n=18
Unknown	n=1

Table N2

Involvement in Health Policy Implementation

Involvement	
Yes	n=29
No	n=2
Should be involved	
Yes	n=30
No	n=0
Unknown	n=1
Recognition	
Yes	n=17
Sometimes	n=2
No	n=5
Not expected	n=5
Unknown	n=2

Table N3

Recognition Sources

Sources of recognition	
Peers	n=3
Supervisor	n=3
Agency	n=5
Community	n=2