Perceptions of Community Health Board Members Regarding Community Empowerment and Participation

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Abstract

Common initiatives occurring in several Canadian provinces, such as regionalization, shifts in funding from institutions to community-based programs, physician resource management, and the creation of local health councils, are leading to an increased emphasis on primary health care. The literature indicates that primary health care will not be achieved without reducing perceived and actual societal inequities, building on the empowerment and participation of individuals, groups, and communities. Professional and public cynicism is based on the historical failures of governing boards, sponsored by the government, to promote community empowerment and participation.

The purpose of this participatory research study was to explore and describe how 15 Community Health Board (CHB) members in one community, located in southwestern Nova Scotia, understood the concepts of empowerment and participation and how they related the concepts to their experiences in community health planning. Participatory research has a double objective, to produce knowledge and action useful to a group or community, and to promote empowerment by the process of producing that knowledge. Through the cycles of listening, dialogue and action, the participants' sense of control and confidence in their own knowledge increased.

Following 15 individual interviews with each member of the CHB, the researcher deducted general themes relating to the concepts of empowerment, participation and community development from the interview data. These themes were used as a basis for a workshop in which the CHB as a group and the researcher participated in dialogue, leading to the creation of a vision for the CHB. The process of dialogue led to a critical consciousness or conscientization, in all participants, of the personal assumptions and structural barriers that influence health. The researcher discovered that her own assumptions regarding the CHB members' understanding of health and the role of theory were challenged and altered.

The empowerment continuum (RNABC, 1992) along with critical theory, especially Freire's philosophy of critical pedagogy (1970), were used as a framework in the organization, analysis and application of the findings. The findings indicated that the CHB members' understandings of the concepts of empowerment and participation, in their own context, were congruent with a community development approach to primary health care. Collectively their understandings converged on the vision of building a strong community, capable of making decisions. In this vision, health care services were viewed as resources, not problems. Actions ensuing from the dialogical session included a strategy to promote increased community awareness and involvement in addressing the identified health issues. The findings have implications for the promotion of personal and group empowerment and the creation of situations in which involvement "makes a difference" for all participants, including health care professionals.

Participatory research engaged the participants in an analysis of issues that transcended beyond commonly held assumptions. The collective theory emerging from the dialogue enabled the participants to visualize a culture that builds on the capacity of individuals and their community. Through the research process participants became critically conscious of aspects in our current health care system that prevented their vision from becoming a reality. Participatory research methodology is recommended as a means to study and advance the social change required to achieve primary health care.

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> I know of no safe depository of the ultimate power of the society but the people themselves, and if we think them not enlightened enough to exercise their control with a wholesome discretion, the remedy is not to take it from them, but to inform their discretion.
>
> Thomas Jefferson

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CHAPTER I

Introduction

Canadian provincial governments have the responsibility to develop health care systems that will reduce spending and increase the wellness of Canadian citizens. Public awareness regarding health care spending and the social determinants of health has increased, resulting in demands for accountability in government decision-making. Common initiatives occurring in the provinces are regionalization, decentralization, shifts in funding from institutions to community-based programs, and the creation of local health councils (Canadian College of Health Service Executives, 1996). Community empowerment, health system integration and health care cost reduction are the provincial objectives from which the above strategies were developed but the desired outcome is not always clear (Lomas, 1996). Health economists state there is adequate funding for Canada's medicare plan (Rachlis & Kushner, 1994; Sutherland & Fulton, 1988). The challenge of the evolving health care system lies in balancing the power between the community citizens, the provincial government and the health care providers.

Nursing associations in Canada are advocating that Canada adopt the concept of primary health care as the central organizing principle in health care reform (Baumgart, 1992). A primary health care system places a greater emphasis on health promotion and wellness, rather than concentrating on illness care. Three key strategies in health promotion include "1) fostering public participation, 2) strengthening community health services, and 3) co-ordinating healthy public policy" (Peterson, O'Neill & Rootman, 1994, p.124). The strategy to shift to primary health care has been largely unsuccessful (World Health Organization, 1991). Reasons cited for this failure centre around the reluctance of those in powerful positions to share power and the reluctance of those who are oppressed to assume power (Labonte, 1989; Oakley, 1989).

The Nova Scotia government has promised a process of health reform leading to a primary health care system. Through decentralization, a reallocation of resources and authority will be issued from central agencies to communities. Community health boards are the political structures proposed to increase community participation in health planning. Eleven Community Health Boards have been formed in the Western Region of Nova Scotia without official regulation by the Nova Scotia government (Shinyei, 1997). The legitimate power these boards will assume is vague, and their ability to influence health care decisions is being viewed with confusion and skepticism by the public. The recommendations in Nova Scotia's Blueprint for Health System Reform (Minister's Action Committee on Health System Reform, 1994) state community development is necessary to achieve primary health care. The definition of community development describes a bottom-up approach, building on the empowerment and participation of individuals, groups, and communities.

Nurses must be integral partners in social change. Empowerment is a process involving the sharing of power. Therefore, professionals cannot promote this process, or health, without participating with clients, colleagues, and community members. Authentic participation goes beyond acting as a resource or facilitator. It necessitates joining in, learning about us and expecting dialectical interactions. Nursing research within a critical theoretical framework is based on dialogue and reciprocity, with the goal of increased consciousness (Stevens, 1989). The discipline of nursing also recognizes that knowledge comes from several sources, thus confirming the need for research using alternate methodologies (Chinn, 1994).

It has been suggested that our construction of democracy results in a social order that maintains alienation and individualism (Hudson-Rodd, 1994). This impedes the sense of collectivity essential for community development; instead competition and power seeking are cultivated. The concept of citizen participation can be identified as a core value in democratic theory (Pateman, 1979). However, authentic participation occurs in cultures that promote social responsibility and justice, rather than individual satisfaction (Wallerstein & Bernstein, 1994).

Although nurses are constantly interacting with vulnerable populations, their practice has largely remained at the individual or family level. Environment, a central concept in nursing's metaparadigm is considered to be the immediate surrounding and context of the client's situation. Chopoorian (1986) suggests that instead of helping people adapt to conditions such as poverty, nurses should be influencing the environment that contributes to people's conditions. Nursing literature indicates that there is a growing support for an emancipatory nursing practice (Kendall, 1992; Greenwood, 1994; Stevens & Hall, 1992; Swanson & Albrecht, 1993). Nursing conceptual models with a critical theoretical basis have been proposed (Kendall, 1992; Maeve, 1994; Stevens & Hall, 1992) and critical theory has been utilized as nursing research frameworks (Allen, 1986; Hedin, 1986; MacDonald, 1992; Parker & McFarlane 1991).

The concepts of empowerment and participation represent phenomena that are theoretically sought after. Often the careless use of the words "empowerment" and "health promotion" neglects to identify the social change and consciousness that arise from the empowerment process (Grace, 1991). A lack of systematic research creates a void in our understanding of how these processes are advanced in practice. Clearly, there are contradictions between the rhetoric of health reform and actuality. The research based on actual experience is often not analytical, neglecting to measure change or validate the perception of individuals.

There is cynicism, based on historical failures, that a governing board sponsored by the government is capable of promoting community empowerment and participation. A decentralized structure does not guarantee a power shift. Information stemming from health promotion projects such as Healthy Cities or third world development suggests that an empowerment process must be experienced by board members, individually and collectively, before they can be critically aware of the issues surrounding the health of citizens in their community (Flynn, Ray & Rider, 1994; Purdy, Adhikari, Robinson & Cox, 1994). Critical thinking enables people to determine and confront the sources of inequality in their own world.

Participatory research methodology allows the researcher to promote and participate in a reflective, dialogical interaction with individual board members and the board as a group. In turn, members participate with the researcher in the analysis and validation of their experiences in order to explore factors affecting empowerment and participation at the individual and group levels.

The educative approach and methods developed by Paulo Freire (1970) are a means of advancing the critical consciousness that acts as a precursor to an empowering experience. Freire's strategies foster an educative process that engages participants to collectively learn and act towards a shared vision.

Purpose

The purpose of this study is to explore and describe the experience of community health board members as they participate in health planning. The researcher's role becomes one of participant and facilitator in the process of experiential learning that a community health board must undergo in order to develop the critical awareness necessary to foster empowerment and citizen participation in their community.

Research questions

1. How do community health board members come to understand the meaning of empowerment in relation to themselves as individuals and as board members?
2. How do community health board members come to understand the meaning of community participation in relation to themselves as individuals and as board members?
3. How do community health board members relate their understanding of empowerment and participation to the health of the community they represent?
4. How do members perceive their ability, individually and collectively, to influence the process of community development in their community?
5. How does the community health board members' understanding of empowerment and community participation and their perceived ability to influence community development change over a period of time (9 months)?

Literature Review

Community development is the foundation of reform and "CHBs should also be the driving force behind community development" (Minister's Action Committee on Health System Reform, 1994, p. 28). Community development is defined as:

> a process in which all members of the community gain *an increase in the control* over their lives, as well as the life of their community, by achieving *equal* access to *participate* in the collective decisions about their needs, and in the development and implementation of strategies which utilize their collective power to meet those needs. (City of Toronto Department of Public Health as cited in Hoffman & Dupont, 1992, p. 21)

Concepts inherent to community development are empowerment and participation. Equity, a core value in our Canadian constitution is also included in the above definition. The relevant measure of success for CHBs will be in the facilitation of meaningful participation and community empowerment.

The literature review locates the concepts of empowerment and participation in theory and research, and describes the factors that enhance or prevent their occurrence. There is a paucity of information describing the actual experiences of empowerment or participation in both individuals and groups. The concepts of empowerment and participation both defy universally affirmed definitions, hampered by diverse levels and contexts (Lord & Farlow, 1990; Powell, 1988).

Community development can be viewed as a process in which individual empowerment is channeled into a collective effort to transform social, community, or political issues. Some models of community development conceptualize this process as a continuum with personal empowerment leading to community empowerment (Hoffman & Dupont, 1992; Registered Nurses Association of British Columbia, 1992). Labonte (1993a) depicted a holosphere derived from the nodes originally placed on the community development continuum. Like the Registered Nurses Association of British

Columbia's (RNABC, 1992) model it focused on the empowering strategies that are necessary to promote community development (see Appendixes A and B for models). Wallerstein and Bernstein (1994) posed unanswered questions. Do empowered individuals create an empowered community? Or, does an empowered community produce a group of empowered individuals? Community development strategies are considered necessary at all levels, individual, organizational, community and politically.

Empowerment

Rappaport (1984) stated that "empowerment is viewed as a process: the mechanism by which people, organizations, and communities gain mastery over their lives" (p. 3). "Empowerment insists on the primacy of the target population's participation in any intervention affecting its welfare. It is the antithesis of paternalism" (Rappaport, 1984, p. xiv). Empowerment has been accepted as both a process and an outcome.

"Empowerment is a social process of recognizing, promoting, and enhancing peoples' abilities to meet their own needs, solve their own problems, and mobilize necessary resources to take care of their lives" (Jones & Meleis, 1993, p. 8). "In addition, psychological empowerment incorporates the establishment of a critical or analytical understanding of the social and political context, and the cultivation of both individual and collective resources and skills for social action" (Israel, Checkoway, Schulz, & Zimmerman, 1994, p. 152).

Labonte (1990) expanded this view by stating empowerment exists at three levels: intrapersonally, interpersonally, and within communities. "Intrapersonally, it is the experience of a potent sense of self, enhancing self-esteem and self-efficacy" (p. 64). Interpersonal and community empowerment results from the collective knowledge and experience that has been constructed. Through participating, individuals gain increased influence and control over the quality of life of their community. The concepts of empowerment and participation intertwine as one becomes empowered through participation and the power and knowledge gained from an empowering experience increase the desire and ability to participate.

Kieffer (1984) conducted a longitudinal study with fifteen members of grassroots organizations. The individuals all were leaders within their groups. The qualitative data were collected from dialogical interviews. The data were analyzed in collaboration with the interviewees, to promote verification and mutual learning. In his literature review Kieffer stated he found no references to previous studies of individual participatory competence.

Kieffer described this process of "citizen empowerment" as the emergence of activism from a prevailing oppressive situation and concluded "while this research sought to illuminate empowering transitions as processes of development, I had never anticipated the consistency and clarity of the developmental model which ultimately emerged" (p. 26). Kieffer (1984) described empowerment as a developmental process that began when a powerless person reacted to a sense of personal violation. The energy was mobilized and sustained by active involvement, critical understanding of power, and the support of a mentor or facilitator. The transitions in the empowerment process revealed consistent stages leading to a "critical awareness" that enabled these individuals to actively collaborate with others in challenging the established systems.

The process, which led to "participatory competence," was likened to growth from infancy to adulthood. However, it was acknowledged that personal growth continued as one constantly dealt with conflicts. Empowerment was maintained by the cycle of experience, reflection and action (Kieffer, 1984). It was interesting to note that all participants had the help of an enabler, facilitator, or mentor as a resource for group or political skills.

Using the phenomenological method of inquiry, Brown (1987) interviewed sixteen nurse administrators in order to learn about their experiences with power and nursing. The interviews were conducted in the form of a conversation, with no attempt to encourage critical reflection in the co-participants. In her discussion, following the data analysis, Brown admitted that her prior understanding based on the literature relating the image of nurses to power was "sterile." Empowerment and participation both emerged as central concepts interrelated within the context of the individual experience.

The empowerment process clearly started with their inner self (Brown, 1987). Individual nurse administrators chose to be involved depending on the assessed potential for power development in any given situation. Empowerment occurred within the context of power sharing and interacting with others. The benefit of a supportive peer group or superior was stated repeatedly by the respondents. The outcome of an empowering experience was described as an affirmation of self, increased energy, and a sense of power. The discovery that power is such an individual, complex phenomenon, yet people acting in positions of power are so often stereotyped, led Brown to suggest the potential usefulness of critical theory in her concluding discussion regarding future research. Research based on critical theory would address the assumptions that uphold common societal images.

Lord and Farlow (1990) conducted a study that attempted to explain the process whereby people moved from being powerless to a feeling of participatory competence. The researchers were concerned that the current emphasis on collective or community empowerment failed to understand the experience of personal empowerment within a community context. Thirty-eight biographical interviews were conducted on individuals overcoming some form of disability. Grounded theory was used to analyze the data.

The interviewees had formerly been dependent on others due to a variety of physical or emotional problems. The analysis revealed the central indicator of empowerment was a sense of personal control (Lord & Farlow, 1990). As a process, empowerment was noted to be both internally and externally influenced. It was always triggered by a personal motivational factor. A positively contributing factor was the connection to someone that listened, supported, and promoted the capacities of the individual. As the individuals experienced further successes their sense of personal competence to challenge the controlling structures grew.

Isreal et al. (1994) designed an instrument to quantitatively measure perceived control, indicating empowerment at the three levels of individual, organization, and community. It consisted of twelve close-ended questions that measured how much influence individuals perceived they have in organizations and communities to which they belong. Though the reliability ratings were adequate, the questionnaire failed to capture the complexity of the community empowerment concept or the process of conscientization (Israel et al., 1994). The researchers suggested its usefulness might be in establishing a baseline measurement, with follow-up surveys to identify changes. Repeated evaluations are possible, as the instrument is easy to administer. The article described the potential use of the tool, but actual research based upon the tool was not cited. Participatory research was recommended as the most appropriate methodology to understand the varied experiences of empowerment at all three levels, individual, group, and community.

Eng and Parker (1994), using the concept of community competence to represent the abstract process of community empowerment, developed a rating scale that was administered to 28 key informants by community volunteers. Forty-one items were measured, 14 being open-ended questions that were subjected to content analysis. The questionnaire was utilized at the beginning of a community development project and repeated one year later.

The researchers claimed the tool was only valid as an evaluation component of the project (Eng & Parker, 1994). They warned that the instrument could not be standardized as it failed to measure issues of awareness and conflict and also various incidents influenced the results. However, participating in the survey design, administration, and evaluation increased the understanding of community competence among the volunteers, which led to further activities established by community members.

Participation

The literature presented a gap in the knowledge of the participatory process in relation to people's actual experience of participation and the notion of citizen or public participation (Powell, 1988). Using a working definition of public participation as "the individual and collective action of people to become involved in and improve their community" (p. 5), Powell found the following questions unanswered after an extensive review of community participation research and literature. "Is there a hierarchy of involvement? Is participation in self-care a prerequisite to participation in collective health promotion" (p. 7)? What factors foster the transformation from a group of individuals participating in order to satisfy their personal needs to a group of people participating collectively in order to address a common goal? Do individuals require success in their own experiences of participation before they can be involved at a group or community level?

Community participation, or involvement, can be "assessed by the level of involvement in and the degree of decentralization in decision-making as well as the development of effective mechanisms for expression of people's needs and demands" (Rifkin, Muller, & Bichmann, 1988, p.932). Participation or involvement have been used interchangeably in this paper though it is acknowledged that there are arguments for involvement (Oakley, 1989) or participation (Labonte, 1993) as being the most empowering term. It is implied with either term that increased local control in problem identification, planning, resource utilization, and evaluation is desired. Public, community, or citizen participation occurs when the government and professionals share the power and authority they currently hold (Oakley, 1989). Participation in health planning is a health enhancing activity (Hoffman & Dupont, 1992).

Community participation can be further defined as the process by which individuals and families assume responsibility for their own health and welfare by building the capacity to contribute to their own and the community's development (Bracht & Tsouros, 1990). Citizens voluntarily participate in either formal or informal activities to bring about a planned change in community life. Drawing upon an extensive review of North American and Western European experiences with the perspective of citizen participation, Bracht and Tsouros (1990) listed possible measures of a community's level of citizen involvement:

> (a) opportunity for and level of decision-making or advising; (b) amount and duration of time devoted to goal activities; (c) representativeness of citizen and leader groups formed; (d) degree of local ownership perceived and/or achieved; (e) satisfaction with the processes of participation; and . . . f) achievement and long term maintenance of effort (p. 201).

At the macro level, the concepts freedom, equity, and citizen participation can be identified as a core values in democratic theory (Watts, 1990). Though democracy and participation are both ambiguous terms, further defined by qualifying adjectives such as liberal or authentic, generally democracy implies a voluntary commitment by individuals to the state; labeled political obligation by Pateman (1979).

Barriers to Participation

Political system.

In contrast to political obligation is political obedience; a state in which individuals must conform to the rules of elite. Political obedience may not become problematic if citizens passively accept the decisions and policies implemented by the members of the government. The status quo is assumed to be natural, thus discouraging questioning or critical analysis (Pateman, 1979). Canadians are realizing their political system is one of elitism (Adie & Thomas, 1987). When justifications of the legitimate force come into question, a crisis in confidence arises, manifest in the loss of individual self-worth and collective identity (Habermas, cited in MacDonald, 1992). Pal (1992) noted there has been a recent increase in democratic consciousness in Canada due to discussions related to the Charter of Rights and Freedoms. This charter has been interpreted to favour individual rights, reducing our commitment to the state. Pal (1992) expressed concern that the attention placed on individual cases, as violations of the Charter will hinder our need to develop a collective community identity.

Programs such as unemployment insurance, social assistance, and medical services are being threatened by the need for fiscal restraint. This has resulted in anger and anxiety for many recipients of these services who have been passively accepting the government's control over these services. "Many communities have learned to feel helpless in controlling their own destinies" (N. S. Task force on Primary Health Care, 1994, p. 79). Enforcing compliance to policies and criteria in order to qualify for financial assistance has created a vulnerable population of powerless individuals dependent on the state. Yet, two organizations that are leaders in providing health care services in Nova Scotia issued statements that implied individual knowledge is the means to empowerment. Reports describing strategies for health reform noted that "Education is the key to empowerment" (MacDonald, 1994, p. iii) and "Personal empowerment positions the individual to act on health issues. This process begins with the dissemination of information on health status, healthy behavior, and the cost of health. Such information is a key factor in allowing people to accept individual and collective responsibility for health choices" (Minister's Action Committee on Health System Reform, 1994, p.33).

Peter Drucker (1993) in his book, Post-Capitalist Society, maintained that government as a "Nanny State" has failed by destroying citizenship. He defined citizenship as "the willingness to contribute to one's country" (p. 17). The upsurgance of volunteers in the social sector is a potential means of creating commitment and civic pride in individuals while establishing bonds between community members.

Autonomous organizations may reduce dependency on government services and reinstate local leadership. Drucker claimed that without citizenship, the political unit will only be held together with power, a "dangerous empire" (p. 72).

The theme of government counterproductivity as a supplier of social programs is echoed in the argument for community developed services (Alary, 1990). The researchers stated that current government cutbacks do not reflect an analysis of what citizens can take on and what government should resume. The institutions are identifying the gaps and requesting volunteers to replace employees, but volunteers recruited to fill specific organizational gaps may only perpetuate the control of the institution. Such volunteerism does not contribute to citizenship.

Many attempts to involve the community are manipulations by politicians or bureaucrats and they result in objectifying or infantilizing people (Madan, 1987). Several researchers have expressed their cynicism that citizen participation will occur or is even desired in our current system (Adie & Thomas, 1987; Brownlea, 1987; Madan, 1987). There seems to be a reticence on the part of the government and health professionals to open up and discuss health planning with citizens and communities. Perhaps this is due to an avoidance to engage in a "proper exploration of the enormous contradictions which the practice of community participation must raise" (Clarke, cited in Hudson-Rodd, 1994, p. 122). Pateman (1979) advised readers that political obligation is only compatible with a revised democratic conception, one that emphasizes the horizontal relationships between citizens. "The practice of political obligation requires that individuals develop the capacities that enable them critically and self-consciously to appreciate the foundation and operation of their political association" (p. 178).

It is paradoxical that the power bestowed *from* the people *to* the government, and further delegated to bureaucratic services, is now being given *back to* the people. It leads to an assumption that undeveloped individuals and communities must receive power from the government. In a critique on the imposed primary health care system in Nova Scotia, Devine (1995) claimed that primary health care appears to be accepted without debate, possibly because no one understands it. Thus far, the locus of control remains at the top, rendering primary health care impossible to achieve. Community development, the essence of primary health care, must be determined by the community as it shifts in response to the felt needs. There has not been evidence indicating that a primary health care system will improve health, nor has there been a public outcry for primary health care in Nova Scotia (Devine, 1995).

Professionals. Human service interventions have four built-in harms: (a) people are only recognized for their deficiencies, (b) money is spent at the discretion of the service providers, (c) active citizenship is intimidated by the domination of "experts", and (d) services may become so coordinated and aggregated that they may form a new environment (McKnight, 1994). The medical model has created an expert, reverent body of knowledge that enables professionals to control the health of the population (Hunt, 1990).

In the post-capitalist society, possession of expert knowledge has become a symbol of status (Drucker, 1993). The largest producers of knowledge are universities, corporations, and the government. Underlying the knowledge production is the dominance of science and objectivity. Standards, certification, and regulations ensure accountability. These have given rise to hierarchies of knowledge, where experts answer to themselves, their peers, or superiors. Dominant knowledge has been mystified, subordinating experience and common sense. (Gaventa, 1993).

In a critique of a participatory research project in Scotland, Hunt (1990) claimed the professional attitudes, professional behaviours, and bureaucratic structures were seen as significant barriers to a community participation process. The reasons listed were: a) inflexibility due to bureaucratic policies; b) a reluctance to share skills and knowledge; c) the tendency to treat individuals, ignoring larger social causes; and, d) an aloofness that separated some professionals from the community. Hunt emphasized fundamental changes are needed in professional pride, beliefs, and behavior in order to ameliorate some of the major health problems. "One inevitable result is the demystification of professional authority and language" (Hunt, 1990, p. 183).

Brownlea (1987) described a decreasing gap between the power base of professional health providers and their beneficiaries as communities are increasing their knowledge and decision-making. He cited several examples where community groups have successfully challenged the traditional political powers that are seen to be creating and sustaining unhealthy environments. "The centre of the circle of ownership for community health actions must become the people themselves who are trying to shift from dependence on health care services to a greater emphasis on health promotion attitudes and actions" (Agnes, 1994, p. 23). This ownership came from meaningful participation in individual or collective health actions.

While not defending the traditional medical model that exerts control, one must recognize that community development theorists are also reinforcing the us/them paradigms that place ultimate community control as the ideal and professional domination as the oppressor (Oakley, 1989; Rifkin, Muller, & Bichmann, 1988). Labonte (1993) argued that a partnership between health care professionals and community members is needed to produce harmonious changes.

Citizenship and Local Health Boards

Political decentralization, exemplified by creating new structures, such as community health boards, does not guarantee a philosophical shift from governmental control to community ownership. The Nova Scotia government is giving power to new structures, not the people (Devine, 1995). Indeed, the changes remain top-down with little involvement with the communities. Community development in Nova Scotia, thus far, has been a project. Devine claimed there is a "widespread history of failure of community development/citizen participation in health care", and an "absence of any empirical, logical or other evidence that increased citizen participation and control . . . leads to improved health status" (1995, p. 17).

In her correspondence, Alison Stirling, a health promotion consultant for the Ontario Prevention Clearinghouse questions the ability "of citizens to effectively influence government or [health] professionals through participation on community health boards that are set-up by those people and/or institutions" (personal communication, July 28, 1994). While a government mandated board is bound to the sponsoring government agency, it may also be free of funding and maintenance problems that often totally occupy non-government voluntary boards (Neysmith, 1987).

Is there a consensus that community participation is an outcome rather than an additional resource to meet the endpoint of the reform process? The board must recognize that such an approach opposes some of the traditional values in our health care system today. Boards seeking to encourage public participation may be distracted from planning by management problems or financial considerations such as reports, budgets, staffing or "housekeeping" duties (Wolf & Armstrong 1991). Trade-offs for increasing community participation may include decreased efficiency, reduced loyalty to the government, fewer structured programs and less government employees (Piette, 1990; Rifkin, 1985).

Indeed, if the role of the CHB is to "drive" community development and foster community participation, then attention should be diverted from setting up the structure to the process of developing a board that has self-confidence, knowledge, members representing the community, and a collective vision (Piette, 1990). The focus shifts from providing services and programs as a strategy for improving health, to developing human effort (Rifkin, 1985).

Considering all the literature available proclaiming the benefits of citizen participation in health planning, one would expect this philosophy to influence the decisions and actions of professionals and health care planners. The literature is based primarily on conditions that *should* foster community involvement, rather than conditions that *did* increase participation. Reports of community involvement in health development tend to be a "literary exercise rather than practice-based" (Oakley, 1989, p. 66). In a survey of the literature on citizen participation, Powell (1988) found only twenty per cent of the literature to be empirical, with the majority of those reports being case studies. The following section attempts to identify factors, from the documentation of experiences and past research in various nations that contribute to the effectiveness of public boards in enhancing citizen participation.

Canada. Nine of the provinces have developed regionalized systems by devolving central authority to regional systems. These systems vary in scope, responsibility and local structures. Health boards govern a region, rather than a single institution. It is still too early to evaluate if these devolved boards have achieved their mandates (Canadian College of Health Service Executives, 1996). Lomas, Woods and Veenstra (1996) note that the outcomes expected from devolution are to be the measures of success rather than the process of devolution itself. Such outcomes include cost containment, integration, and coordination, increased flexibility and improved health outcomes. These researchers mailed a survey in 1995 to members of the established regional and community boards in five provinces, including Nova Scotia. The responses indicated that the majority of board members were committed to the citizenry rather than the provincial government or the providers. The authors cautioned that this study was conducted early in the devolution process and many boards, especially Nova Scotia's RHBs, were in their infancy.

Quebec. In Quebec, a review of the local community service centres (CLSCs) revealed that community participation was low despite a governing board consisting of a small majority of seats being held by the users (O'Neill, 1992). The potential for public involvement was largely exhibited at the initiation, upon where a community had to develop a plan based on the needs of the community. When the centres were operating, participation dwindled and control shifted to the staff and professionals. Broader participation occurred only in a crisis (Hastings, 1983). The only legitimate power the board wielded was in the right to hire or fire staff (O'Neill, 1992). This created a tendency to focus on short-term management problems.

O'Neill (1992) cited four factors that should be considered when supporting the empowerment of community citizen boards: (a) the need for information regarding the business of the system; (b) the requirement of a strong mandate from the community; (c) board members with a strong personalities; and (d) an easy access to community members by the board representative.

Nova Scotia. Though community health boards are just being formed in Nova Scotia at the present, research is available on hospital board trustees in Nova Scotia. Regan, (1994) himself a member of a Regional Hospital board, used grounded theory to interview and analyze the responses from chief executive officers (CEOs), board chairpersons, board members, medical staff, and the senior nursing staff from eight N. S. hospitals in order to study the effectiveness of board trustees in hospital governance. Regan concluded that too many board members lacked a good grasp of what is expected of them. "The reformist call for greater public involvement in the planning and delivery of health care may produce an illusion of empowerment unless the public's participation is tied to carefully planned and well executed board development" (p. 22).

United States. In an attempt to reduce the inequities causing poor health, in the 1960-70s, the government of the United States initiated a plan to help those who were trapped in the poverty cycle (Sidel & Sidel, 1984). The goal was to bring services and control closer to the target population. Projects, such as community health centres, overseen by local boards with consumer representation, were expected to be the foundation for professional and community partnership, eventually growing to a forum for social action. Close to one hundred studies have been conducted in order to determine the outcomes of the health centre movement. Health status, utilization rates, and cost efficiency were all positively rated. However, there was a lack of research on the impact of these centres and their boards on the community. Little attention was given to the communication between board representatives and their constituents (Geiger, 1984). The board members, themselves, demonstrated positive effects. Serving on the board provided an experience leading to further personal opportunities, including political leadership (Hutch & Eng, 1984).

Descriptions of the United States' experience with the "war on poverty" identified such problems as failure to use established community networks, inappropriate board representation, funding reductions, and lack of political commitment. Hatch and Eng (1984) described how community organizers used unrealistic criteria to recruit community representatives. Considering the local leaders to be barriers rather than conduits to the poor, they bypassed the established social networks and recruited individuals they considered connected to vulnerable people. Pimps were enlisting to be on staff in a community health project. These men replicated the same type of relationships they had with their women among other community members (Hatch & Eng, 1984). Oakley (1989) suggested there is evidence that local structures "do not flourish and do not serve authentically as a basis for participation if they are imposed by a bureaucratic decision from above" (p. 35). The reluctance of administrators, health professionals, and funding agencies to share the power was the central reason for the "war on poverty's" failure to lead to social reform (Sidel & Sidel, 1984).

New Zealand and Australia. In New Zealand, which has a system based upon private enterprise, the government formed the Area Health Boards (AHBs). These boards were assigned to coordinate and contract health care services in order to ensure all citizens had access to essential core health services. The members of the AHBs, dominated by administrative and medical staff, were unsure of their roles and were not in touch with their constituencies (MacDonald, 1994). The business and administrative functions of the AHBs have precluded any attempt to foster public participation.

Established in 1988, as pilot projects, by the South Australian government, four health and social councils were evaluated in 1991 (Baum, Sanderson, & Jolley, 1997). The councils demonstrated the potential to promote participatory democracy but the bureaucratic structures continually interfered, restricting their activities. A dilemma arose when the councils found they constantly had to criticize the body that was funding it. These councils lost their funding in 1996.

England and Wales. Community Health Councils (CHCs) in England and Wales were devised as "watchdogs" for the people in relation to health services. However, these structures had no power in decision making and had trouble establishing links to the population they represented. Consequently, after 20 years in existence, the CHCs remain ineffective in increasing community involvement, despite the recent initiatives put in place to increase and gauge "local voices" (MacDonald, 1994; Milewa, 1997; Piette, 1990).

Piette (1990) studied the membership of 207 CHCs during the ten years, from 1974 - 1984. The majority of the members were upper and middle class professionals. The views of the individual CHC members affected the discussions and decision-making of the council, causing a dilemma between consumer and provider representation. Piette (1990) determined that by seeking increased efficiency and expedient decision-making the boards restricted public participation. She listed the following characteristics of a structure likely to promote population participation:

> (a) a strong organization of the community through the networking of sub-groups and organizations;
>
> (b) a two-way communication flow between representatives and their accountable body;
>
> (c) a polyarchy system for representing the population;
>
> (d) the training of representatives of the population; this training may cover: understanding of how experts approach problems; development of self-reliance and of critical consciousness; introduction of leadership, team work and negotiation;
>
> (e) the training of chairpersons or the use of a facilitator;
>
> (f) the avoidance of mandating professionals to represent a community; experts should be given an advisory role for the community organizations; expertise should be distinguished from decision-making;
>
> (g) sufficient time should be given to representatives to organize meetings or to react to decisions. (p. 196-197)

Health Promotion

Patterns that may serve as guidelines for community health boards seeking to increase citizen participation have emerged from research in the fields of health promotion and health development (Agnes, 1994; Bracht, 1991; Catano, 1994; Park, Brydon-Miller, Hall, & Jackson, 1993; Purdy et al., 1994; Rappaport, Swift, & Hess, 1984; Tandon, 1981; Wallerstein & Bernstein, 1994). An extensive review identified the following major factors that contributed to the effectiveness of community committees in health planning:

1) There was a motivated core membership consisting of existing community

leaders.

2) External staff were utilized as facilitators or resources, providing knowledge and guidance on research, leadership, conflict resolution and group facilitation.

3) A deliberate process involving dialogue, analysis, problem-solving, and ongoing reflection between members on the committee or board was essential.

4) There was a balance between action and reflection in order to prevent committee members from becoming frustrated or disinterested.

5) Legitimate power was bestowed upon a committee or board in order that actions could take place.

Health promotion literature also provided indicators of increased empowerment and community participation. They included: (a) projects became sustained with local funding, (b) programs for high risk populations demonstrated increased utilization and measurable behavioral changes in participants, (c) users volunteered to be on planning committees, and (d) structural changes that marked increased equality, i.e., women on councils or less caste domination.

The sources analyzed were written and submitted by project coordinators, professional consulting firms, or academic researchers. As documentation tended to focus on the evaluation of health promotion projects, further research is needed on the experiences of the participants and the specific actions of the committee (Flynn et al., 1994).

Empowering Experiences of Board Members

In order to comprehend the personal experiences of community board members the literature was consulted only to find a lack of attention to the concept of empowerment in relation to board governance or membership. The following information has been organized according to the personal and small group development nodes as depicted on the Empowerment Continuum constructed by RNABC (1992).

Personal. Cyril Houle (1989), an educator who has been studying and teaching about the functions of governing boards since 1935, noted that sociologists or psychologists have ignored the human side of board membership. They failed to penetrate the power structure, to discover the forces of self-interest and altruism that are balanced or to measure how these forces shift during the experience (Houle, 1989).

A participatory research project conducted in Quebec (Alary, 1990) reported the constant quest for personal development or growth was at the root of collective groups working to improve the system. Individuals who were aware of their own distinctiveness and aspirations became more sensitive to others. "People seek self-actualization while working to improve the common living conditions of the collective" (Alary, 1990, p. 11).

Board members required personal development before participating with the group (Agnes, 1994). This researcher conducted an analysis based on the final reports and evaluations of ten selected health promotion projects in the Atlantic Provinces. Individuals needed to build self-esteem, social consciousness, and motivation for collective action in order to have meaningful participation. Agnes (1994) recommended allowing time for the board members to express their views and providing leadership training for all members. Travel expenses, child care costs, and the use of clear language enabled some community members to attend committee meetings.

In an attempt to analyze why a number of board members remained passive during meetings Neysmith (1987) questioned whether these individuals were displaying the effect of constant inequalities or if it was merely a lack of experience causing discomfort in joining the group discussion. These members were women and/or tended to belong to minority groups. No attempt was made to study the personal experience of these members.

Past experiences have demonstrated that professionals on boards often dominated, especially after the initial planning stage was over (Hastings, 1983; O'Neill, 1992; Sidel & Sidel, 1984). Professionals tended to be goal oriented which caused tension for some group members (Agnes, 1994). To be accepted as an individual, with self-interests was a potential threat to health professionals. It challenged the traditional role in which the "expert" looked after the patient (Hunt, 1990).

Corcega (1992) called for research on how the group dynamics of community members and health care workers will change as they interact. The conflict between professionalism and democratization needs to be resolved. The connection that many professionals have with the conventional or scientific paradigm requires the detachment or aloofness they often display (Labonte, 1993a). The alternate paradigms or theories, such as community development, critical theory, or constructivism are converging to identify a reconceptualized professional role. Components include: (a) facilitating, (b) enabling, (c) being explicitly concerned with creating more equitable power relations, (d) sharing personal values statements, (e) seeking consensual decision-making, (f) "midwiving" a search for meaning, (g) being critically self-reflective, (h) displaying empathy, and (i) involving oneself as a "stakeholder" with a "claim" to the outcome (Labonte, 1993a).

Small group development. "Only in interacting with others do we gain those healthful characteristics essential to empowerment: control, capacity, coherence, and connectedness" (Labonte, 1993, p. 58). Houle (1989) described the board "spirit" as a powerful bonding between individuals, a sense of unity that drew them together. He listed qualities of outstanding spirited boards, including, clearly defined roles, a shared purpose, ability to resolve conflicts, and opportunities for all members to contribute. As reported by veteran trustees, the list also contained values, such as respect, trust, and commitment (Houle, 1989).

Undergoing the process of group development should be a priority when boards are initially formed (Labonte, 1993). Labonte claimed that a year is often needed to deal with group dynamics. "When you put pressure on people to get results quickly, you short-change the process, don't get results, and everyone becomes disheartened" (p. 59). Group safety, which is based on confidentiality and mutual respect allows members to practice skills for participation in a comfortable environment (Agnes, 1994). Measuring changes in the group process, such as the number of times individual members entered into the group discussion, demonstrates success in the beginning, rather than expecting immediate outcomes, such as a plan for services (Labonte, 1993).

In order to evaluate the strategy of joint planning, a qualitative study was conducted with members of a task group assigned to develop a health city plan for Liverpool, England (Costongs & Springett, 1997). To determine the effectiveness of intersectoral collaboration in health planning, the researchers explored the individual participants' subjective perceptions regarding the value of the group process. They concluded formal joint structures were not enough to guarantee that people successfully worked together and that the "arenas for dialogue" deserved more attention. Members claimed the process was more beneficial than the structure and recommended joint working be used as a strategy to implement the plan designed by the task group.

Houle (1989) placed the responsibility for guiding the group process on the chairperson of the board. A facilitator proved to be effective in aiding the group process and preventing domineering personalities to become established (Oakley, 1989; Piette, 1990). Also facilitators have been used at board retreats, enhancing the contribution of all members in self-appraisal (Wilson, 1989). In participatory research groups Alary (1990) used "animators" to assist the group in the analysis of intra and interactions. Community groups in B.C. requested facilitators to train the group members in the development of participatory leadership skills, enabling the members to pass these skills on to other community members (B.C. Healthy Communities Network, 1992).

The issue of the group working collectively before a participatory research project has only been touched upon in the literature. Case studies provided the most valuable insight, or rather hindsight, as most failed to recognize the significance of interpersonal relationships until the analysis or conclusion (Brydon-Miller, 1993; Chand & Soni, 1981; Maguire, 1987; Salazar, 1991). Argyris and Schon (1991) criticized this omission in qualitative research documentation. Reporting the situation before intervention allows the reader to judge if changes occurred due to the research process.

Critical Theory

Theory in participatory research. Eakin and McLean (1992) observed that "theory is often one of the first casualties of academic-community research collaboration" (p. s74). Earlier descriptions of participatory research emphasized equal relationships and the generation of knowledge for emancipation. Reasons cited for failure to provide a theoretical basis included: wishing to avoid an elitist division, the researcher considered it irrelevant for the participants, it would spark controversy, it did not fit the community's agenda, or there was a limited time frame (Brydon-Miller, 1993; Eakin & McLean, 1992; Maguire, 1987). A debate regarding the need for the researcher to impart theoretical knowledge to the group or to remain only as a resource for the collection and analysis of data was presented by Comstock and Fox (1993). They concluded the prominent role of the researcher was in the critique of analyses and the promotion of a theoretically guided political struggle. Allison and Rootman (1996) clearly state "the researcher should not be seen as a mere instrument of the community. Rather, attempts should be made to match the interests of researchers with research priorities as expressed by the various levels of community" (p. 339). This approach does not deny the researcher's intent to add to the theoretical understanding of a certain phenomenon. Collaboration between practitioners, community members and researchers has produced collective knowledge which leads to action and health promotion research (Boutilier, Mason, & Rootman, 1997).

Critical theory defined. There are several perspectives of critical theory deriving from different fields and researchers such as Habermas and Freire (Stevens & Hall, 1992). However the central assumptions are common providing a broad conceptualization. Seven assumptions of critical theory identified by Kincheloe and McLaren (1994) are:

1) All thought is fundamentally mediated by power relations that are social and historically constituted;

> 2) The facts can never be isolated from the domain of values or removed from some form of ideological inscription;
>
> 3) The relationship between concept and object and between signifier and signified is never stable and is often mediated by the social relations of capitalist production and consumption;
>
> 4) Language is central to the formation of subjectivity (conscious and unconscious awareness);
>
> 5) Certain groups in any society are privileged over others and, although the reasons for this privileging may vary widely, the oppression that characterizes contemporary societies is most forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable;
>
> 6) Oppression has many faces and that focusing on only one at the expense of others (e.g. class oppression versus racism) often elides the interconnections among them; and
>
> 7) Mainstream research practices are generally, although most often unwittingly, implicated in the reproduction of systems of class, race, and gender oppression (p. 139-140).

In order to change the prevailing ideology, the rationalism that upholds it must be critiqued. The fundamental tenet of critical theory is as follows:

> Informed by critique, conscientized persons engage in dialogue with one another and reflect critically upon their own situations with respect to oppressive environments. They take context-specific action to bring about social change based on this critical reflection and dialogue. This liberation process can be conceptualized as dialectical,

> in that action prompts further reflection and dialogue, which in turn generates renewed action (Stevens, 1989, p. 60).

It requires exploration of our histories leading to an awareness of factors that perpetuate the power structures. Exposing these unequal power relations and taking actions for liberation are the basis of critical theory.

The ideology of nursing that purports individualism, adaptation, coping, and self-care only perpetuates the oppression of people (Kendall, 1992). Nurses do not speak out against the roots of the problems they witness daily (Chopoorian, 1986). A framework for the future development of nurses consists of the cornerstones, equity, community involvement, and intersectoral cooperation (Maglacas, 1988). In order to accomplish this, nurses must overcome their distaste for politics and learn the agendas and priorities of those who influence public policy. Community health nursing depends on the recognition of social, environmental, and political aspects of the environment affecting health and the willingness to work for structural changes at the community level (Chalmers & Kristajanson, 1989; Stevens, 1992). Participating with communities in the unfolding of power structures, joining in consciousness-raising dialogue, and acting for change leads to empowerment for community health nurses (Stevens, 1992).

Though critical reflection for emancipation has not traditionally been taught in the academic preparation of nurses, it is coherent with nursing's value of holism (Stevens, 1992). Research on nursing education using a critical theoretical framework revealed that nurses were constrained by dominant forces and did not develop a collective sense of community (Hedin, 1986; MacDonald, 1992). By participating in small group dialogues, nurses were able to challenge their positivistic ideology and plan strategies for change

(MacDonald, 1992). Weaving reflection with action may resolve an ongoing concern in the discipline of nursing, the gap between theory and practice.

Two processes that critical theory builds upon are *participatory competence* and *communicative competence* (MacDonald, 1992). Participatory competence is the outcome of empowerment as described by Kieffer (1984). Defined as "the combination of attitudes, understandings, and abilities required to play a conscious and assertive role in the ongoing social construction of one's political environment" participatory competence is not viewed as an endpoint but a "continuing process of adult development" (p. 31).

Communicative competence is based on the shared values of trust, knowledge, and mutual support. Comprehension, understanding, as well as linguistic ability, contribute to the goal of communicative competence; genuine collaboration (MacDonald, 1992). Communicative competence leads to the "ideal speech situation" in which there is uncoerced, undistorted, and nonauthoritative communication. Language is no longer a vehicle for social control (Kendall, 1992).

Critical theorists are intent on moving beyond a purely intellectual world and connecting theory to action (Hedin, 1986). Research supporting critical theory described how the discovery of contradiction mobilizes the study participants. These contradictions were perceived to be an injustice in one's lived world, leading to a sense of personal violation (Kieffer, 1984). Paulo Freire developed a philosophy based on the application of educational methods that facilitate the discovery of these contradictions. His work was successful in liberating illiterate Brazilian peasants as they used their knowledge to critique on the oppressive forces in their lives (Freire, 1970).

Freire. In the 1970s Freire's pedagogy was welcomed into the United States as a method used in the literacy campaigns established during the era of the "war on poverty." However, as noted formerly in the literature review, the social change did not occur. Consciousness was raised but it did not lead to action. In order to survive, these community-based schools utilized federal funding, necessitating a refocusing from collective empowerment to individual growth (Heaney, 1989).

Freire's work emphasized the *conscientization* that occurs as a result of the discovery of oppressive factors and the knowledge that one has the right and ability to act these oppressors. *Conscientization* is defined as the level of awareness that enables people to perceive social, political, and economic contradictions and to conceive of ways to take action against oppressive contradictions (Stevens, 1989, pp. 59). Martin (1997) stated that the identification of contradictory issues is not enough to produce *conscientization*; it is the dialogue that ensues between people who are willing to act for emancipatory change that leads to a new joint level of consciousness. The process of *conscientization* is not an individual experience as it involves becoming a "subject" with others who are also struggling against oppression (Heaney, 1989).

"Solidarity" is a term Freire names for the act when one enters the situation of those persons whom have been unjustly dealt with and fights by their side in order to transform their reality. Factors that may oppress and restrict some health care providers from engaging such situations are their current employers and their professional regulatory acts. It may prove that for professionals, such as myself who are employed within the government sector, participating in a study grounded in critical theory, seeking solidarity, is too risky. Freire recognizes this and calls for us to commit “an act of love” (1970, p.35).

The language used by critical theorists, especially Freire, is filled with neologisms discouraging students from reading and understanding their works (Maguire, 1987). It is ironical the critical paradigm of research, that denounces the positivist paradigm for its domination of power and truth, is beset with terminology that is difficult to read, understand and place in one’s own context.

CHAPTER II

Methodology

Participatory Research

The ultimate aim of participatory research is to bring about a more just society (Park, 1993). It is a systematic approach to personal and social transformation through the development of a critical consciousness that challenges the domination of societal structures and relationships (Maguire, 1987). A researcher who chooses to do participatory research wishes to not only understand the world but also to change it (Harris, 1992). The researcher must acknowledge the political nature of her inquiry and clarify her stance. Objectivity means being aware and honest about how one's own beliefs and values will affect the research process (Lather, 1990).

Participatory research, which is used synonymously with participatory action research, has a double objective: to produce knowledge and action useful to a group or community and to promote empowerment through the process of producing that knowledge (Reason, 1994). A concern for the powerlessness created by dominant elements in societies, a valuing of people's knowledge and experience, and the genuine commitment to collaboration are listed as the necessary qualities for those who endeavor to do participatory research (Reason, 1994). Henderson (1995) argued for use of participatory research methodology in nursing inquiries as the separation between practice and research will fuse, directly benefiting the clients or participants.

Stringer (1996) rejected the need for participatory research to challenge the "oppressors" in our society. Through collaboration participatory research "seeks to link groups that are potentially in conflict so that they may attain viable, sustainable, and effective solutions to their common problems through dialogue and negotiation" (p. 19). Using Michael Foucault as a reference Stringer described how assumptions found in our language and every-day lives shape our understanding, concluding that participatory research is therefore a search for new meanings.

Participatory research incorporates three components, research, education, and action. Stringer (1996) simplified the process in cycles of look, think and act, which he termed the "basic routine." These components are interactive and cyclic as they combine to create an experiential methodology (Fals-Borda, 1991). In this aspect, the political dimension is acquired as the experience extends from the micro to the macro level. Throughout the process, the components are linked, based on the cycle of reflection, informed action, and changed reality (Smith, Pyrch & Lizardi, 1993). This learning cycle leads to praxis: a conscious integration of theory and practice.

The requirements of the participants chose the methods in participatory research and these needs may vary throughout the research process. This diversity discourages a prescriptive research design and impedes the consistency that outsiders may desire in order to analyze the potential application of this methodology. "The preferred way to communicate the practice of [participatory research] seems to be through the description of actual cases" (Reason, 1994, p. 329). The intent is not to generate and disseminate theory, but to communicate other perspectives and to illuminate uncovered distortions (Reason, 1994).

The case studies differ in the extent to which the researcher reported on the actual consciousness-raising the research process initiated. Some projects were concerned with evaluating the action leading to measurable changes (Stringer, 1996) as opposed to focussing on the new understandings that the participants acquired (Maguire, 1987).

The magnitude of these case studies varied greatly, from a small group inquiry to a third world development project (Chand & Soni, 1981; MacDonald, 1992), as did the outcomes. Whereas one town rallied against a corporation, another women's group dissolved following the exit of the researcher. Concrete action stemming from participatory research included lobbying for social policy changes or initiating a self-help group (Comstock & Fox, 1993; Maguire, 1987). The understanding that led to such strategies, a result of critical dialogue, was the essential element that defined emancipatory changes in the participants.

For example, a participatory research study involving a Healthy Community initiative described how low-income families perceived the need for accessible and affordable recreational facilities in their community (Abbott, Blair & Duncan, 1993). With the facilitation of a nurse researcher, they were able to investigate the availability of such facilities. What differentiates this case from many other projects was the purposeful attention to raising awareness of the participants and other community members regarding the surrounding issues. Interestingly, the group discovered there were affordable resources in place, which led to further reflection to determine why they were perceived as inaccessible. Being involved in the process resulted in suggestions to improve the access, and, most importantly, reduced the alienation that many of the low-income families felt.

Using the technique of facilitated dialogue to critique nursing theories in relation to practice, study groups of bedside nurses produced collective recommendations for the development of a critical nursing practice (MacDonald, 1992). The researcher analyzed the data independently and planned to use her material as justification for changes in the nursing education curriculum. This participatory research dissertation initiated a process, which the researcher terminated when her needs for obtaining theoretical data were met. The author noted that some individual group members did increase their awareness of the forces influencing the practice of bedside nursing but there was no further action taken.

A participatory research project, conducted in Nova Scotia, addressed the problem of nutritional inequities with women receiving low incomes (Travers, 1997). The participants discovered and acted against a situation they had previously accepted as a condition of their social status. Collectively challenging an oppressive organization was an empowering learning experience for all participants, including the researcher. The study, presented in chronological form, described the process with an analysis of the major themes. The researcher also provided a theoretical discussion in which she compared the experiences of the participants to the empowerment continuum.

Role of the Researcher

The main concern for participatory researchers who are under the constraints of academic obligations, such as thesis work, is the loss of control that comes from a research process that responds to the questions arising from other participants. A clear problem statement, research plan, and method of analysis are often not available before conducting the research. Time schedules are unpredictable. Research submitted for grading credits one investigator only, discouraging true collaboration. "Participatory research is time consuming, demanding, and troublesome" (Maguire, 1987, p. 198).

Alary (1990) and Maguire (1987) found their positions to be difficult, as they were required to be facilitator, educator, and researcher. The above researchers recommended additional training for the researcher's role in participatory research.

The initial entry period into an unfamiliar community must be planned for in the research design. Suspicions and tensions must be worked out before any collaboration is possible (Perkins & Wandersman, 1990). Rural communities may be cautious about interacting with professionals or researchers from urban centres. One way to overcome this orientation period is to do research in one's own community (Dalhousie Association of Graduate Students, 1988). Two case studies (Comstock & Fox, 1993; Maguire, 1987) presented interesting observations regarding how easily student researchers were accepted by communities in which they had chosen to conduct participatory research. The concept of "student" may be less threatening to the established power structures.

The initial phase of a participatory research project is one of establishing the relationship between the researcher and the community members involved with the project. Fals-Borda (1991) called it "breaking up the . . . subject/object binomial" believing this step necessary to obtain authentic participation (p. 153). The researcher must be willing to be part of the struggle of the people (Parks, 1993). Reinharz (1990) commented that skills needed to conduct qualitative research were not highly valued in the world of traditional research. These were often the skills of women and others without power and included, "the ability to form relationships of trust with people, the ability to listen carefully, and good verbal and writing skills" (p. 299). In two case studies (Brydon-Miller, 1993; Maguire, 1987) the researchers felt that entering the community was a major step, and the separation between researcher and participants was never fully bridged. Other studies reported that the role of the researcher remained detached, purposefully, as the researcher planned to eventually exit (Perkins & Wandersman, 1990).

Greenwood (1994) warned researchers that many "norms" may be protective, albeit distorted and an amount of psychosocial unease may be precipitated if these representations are challenged. This may be quite disruptive in a heterogeneous group with individuals possessing various levels of power. Any attempts to deconstruct power, however unequal, may be unpleasant. A useful metaphor that Greenwood drew is that of the "causal onion . . . peeling them can bring tears to the eyes" (1994, p. 17).

Understanding the research process, making sense of the technical knowledge, organizing the information, and documenting the analysis usually are the responsibilities of the researcher at the beginning of the project. However, the long-range plans should include sharing the above skills with the group, acting as a resource person rather than an organizer. Success is defined as the community collectively investigates problems without relying on external experts (Comstock & Fox, 1993).

Fals-Borda (1991) and Alary (1990) have described the participatory researcher's role as an "animator." The animator is a socially conscious individual who has the ability to stimulate self-reflection and social analysis in groups. As the group develops and establishes mutual trust the animator promotes leadership from within the group members.

In preparation for the role of researcher, using participatory research methodology, during the past year I completed training and education in communication skills and group facilitation. My experience in Public Health provided additional training in adult education and counseling.

Community Health Boards in Nova Scotia

Interestingly, the role predicted for the Community Health Board (CHB) has evolved over the past three years. The original document that outlined reform in Nova Scotia, "Nova Scotia's Blueprint for Health System Reform" included mental health, continuing care, public health, and addiction services as being partially determined by the CHB (Minister's Action Committee on Health System Reform, 1994). The CHBs were to be responsible for planning, coordinating, and authorizing the funding of all primary health care services, such as outpatient clinics, nutrition programs, well-baby clinics and health education services (Nova Scotia Department of Health, 1995). The CHBs were not to deliver services or employ health care providers (N.S. Task Force on Primary Health Care, 1994). The functions of the CHB remained obscure as people tried to interpret the role of the appointed Regional Health Boards, Bill 95 (1994), and the role of the Department of Health Systems Reform Branch (Nova Scotia Department of Health, 1995). In the period from November 1994 to the present, the activities involving the Digby and Area CHB, the Digby community, the Western Regional Health Board (WRHB) and the Department of Health have been chronicled (See Appendix C).

In tracking the Department of Health's publications, the CHB was seen to be less instrumental in the actual responsibility of providing primary health care services as time went on. A document issued April 1996 stated "they will assess local health needs, develop plans to coordinate primary health care, and identify ways to improve the overall health of the community" (N.S. Department of Health, April 1996, p. 6).

The Western Regional Health Board has instructed the CHBs to submit a community health plan to the regional board. "By feeding into the Regional Health Plan, your community health plan will help the regional Health Board and the Department of Health use resources effectively at the local, regional, and provincial levels" (N.S. Department of Health, 1997, p. 5). The emphasis is on the provision of a plan to a larger decision-making body, which reduces the CHB to the position of being an advisory council.

This thesis was conceived on the premise that community development is the foundation of health reform and "CHBs should also be the driving force behind community development" (Minister's Action Committee on Health System Reform, 1994, p. 28). The orientation binder presented to new CHB members described the responsibility of CHBs in "fostering community development that encourages people to actively participate in local health planning" (N.S. Department of Health, 1996).

The Nova Scotia CHB membership includes health professionals. This tactic has failed in past local health councils, resulting in the recommendation that health professionals representing agencies be prohibited from becoming board members (Piette, 1990). British Columbia's health plan refused to allow professionals to participate on boards if they were employed by any agency governed by the board, thereby excluding the majority of health care providers (B.C. Ministry of Health, 1994).

Setting

The site chosen for this research project was an English speaking rural Southwestern Nova Scotian community that had initiated a community health board. I based the criterion for selection on my familiarity with the culture of this area therefore easing my entry and acceptance in to the field.

The Digby and Area Community Health Board represents Digby town and municipality. This involves a population of about 11,540 with about 80% of the population living in the rural areas. The high levels of unemployment average 15.4% and 17.2% of families are considered low income (Nova Scotia Department of Finance, Statistics Division, 1996). With the reduction in the number of fishing vessels and the closure of the Canadian Forces Base, Cornwallis, the population has declined. According to the census of 1991, the rate fell 6% in the previous five years. Digby General Hospital has undergone extensive changes in the past ten years. It no longer provides full surgical, obstetrical or intensive care services, currently acting as a 28 bed primary level community health hospital with 24-hour emergency services.

Originally, I had rejected the notion of conducting this project with the Digby CHB, as Digby was the area that I lived and worked in. Throughout the course of this study, I was the Clinical Site Manager of the Digby General Hospital. I based the original research proposal on the notion of working with a neighbouring community, a direction I supported until I began the actual project. Through ongoing participation with the Digby and Area Community Health Board Steering Committee, while waiting for the board formation, I entered the field and established a relationship based on my role as a researcher. After consultations with my thesis committee members, administrative staff of the Western Regional Health Board, other participatory researchers and members of the Digby and Area Community Health Board I decided to work with the CHB in Digby. The issues raised by doing research in one's own community are further discussed in this chapter and in Chapter 5.

Participants

The Digby and Area Community Health Board. The 15 members of the Digby and Area CHB were volunteers that responded to an advertisement mailed to every household in the catchment population. After an orientation meeting held October 30, 1996, only 16 people were willing to serve on the CHB. One person was asked to remain an alternate. Geographically, the membership is representative. The 15 members include nine females, five health care providers, and six retirees. The ages range from 35 to over 70, with the average age being around 53. All members had previous experience as community volunteers.

The researcher. In order to produce honest research it is necessary for the researcher to locate herself, by acknowledging her values and assumptions (Kirby & McKenna, 1989). My experience as a Public Health nurse practicing in a low-socioeconomic rural Nova Scotian community provided a contrast to the competitive, fast-paced childhood that urban Vancouver afforded me. I welcomed the slower lifestyle but what I mistook for contentment I soon recognized as apathy and hopelessness. It was ingrained through generations and people did not expect more. I was surprised at how the majority never questioned physicians, constantly denounced teachers or politicians, but never attempted to do anything constructive. Reliance on the government's social system was common, seemingly considered a right. Despite this dependence, the people of the rural community have many strengths, including a strong commitment to family.

A lack of appreciation for the abilities of other community members, especially those who demonstrate powerlessness by passively or violently accepting their fate, is evident in many situations. My hope was that a local health planning board would become aware of the imbalance of power, thus promoting the contributions of all community members.

One's position in society creates an assumption on the part of many other people that one interacts with. I believe this to be especially true in rural neighbourhoods as we have the opportunity to know the small number of citizens. Our society perpetuates the assumptions, which can prevent equality in relationships. I have simplified and emphasized this principle found in critical theory, as it was an essential factor in the perception of "who I am" and did influence my role with the CHB. Throughout the time of this project, I was the Clinical Site Manager at the Digby General Hospital and my employer was the Western Regional Health Board. The CHB members spoke freely about the local and regional health care system in my presence and denied any sense of conflict when I questioned their comfort. I may have felt the role tension more so than they did, as they accepted me as an active participant in their discussions that challenged the WRHB's direction. At all times I felt welcomed by the CHB members and privileged to be part of their development. However, I was always very conscious about the perception of positional power that the role of hospital administrator may carry.

Preparation and Entry

My thesis committee accepted the research proposal in August 1995. Unfortunately, the CHBs were not established until December 1996. This necessitated postponing the project, resulting in a slightly compacted timeframe. The interim period between the proposal approval and the actual implementation was spent with the Digby and Area Community Health Board Steering Committee. Though it was not a purposeful tactic, I had entered the field.

The steering committee received very little direction from the WRHB or the

Department of Health. This resulted in long hours of dialogue in which they created their own direction. The chairperson of the steering committee recognized the value of the discussions (N. Jeffrey, personal communication, October 30, 1996).

Between September 1995 and August 1996 the steering committee arranged several poorly attended public meetings, spoke on the media, attended meetings of other groups, participated in a community needs assessment and sent two newsletters to every household in the Digby town and municipality. They also met with the two neighbouring CHBs to agree upon the boundaries. This action resulted in two additional joint public meetings with the Clare and Annapolis citizens. The goal of the steering committee was to increase the public's interest in and support of the CHB. In August 1996, the committee achieved the goal and they began to plan for the selection of the permanent CHB members.

On August 15 1996, the same day planned for circulating the posters requesting CHB volunteers, there was a news release from the newly appointed Minister of Health, placing the establishment of CHBs on hold. Overheads displaying a series of statements issued from the Minister's office in bullet form were presented to the various steering committees in the Western region. One of the bullets contained the following:

> There is no question as to the commitment to local input. The 8-point mandate as it relates to primary care planning at the community level will remain unchanged. It is <u>not</u> certain however that the CHB structure, as proposed, is the best approach to ensuring a local level of participation and achieving necessary accountability for health care decision making in a regionalized and decentralized health care system. (N.S. Department of Health, August 27, 1996).

The established community health boards or the steering committees in the Western region were deflated and angry. The volunteers had devoted time and energy to a cause they supported. On August 21 1996 the Western Region's CEO contacted the 11 steering committees and instructed them to proceed. The Western Region was prepared to develop the CHB structure without provincial legislature.

This background information is detailed in the preparation for this research as it sets the political climate under which the CHBs grew. By the time the project was underway the integrity of the process was somewhat flawed.

Time Frame and Schedule

Recognizing that participatory research is unpredictable, a general schedule was required to establish some guidelines and communicate the expected time frames to the CHB and the thesis committee (See Table 1). The period of interaction originally planned with the CHB was one year. This allowed for two sets of interviews, approximately six to eight months apart, with attendance at board meetings, as approved by the community health board, during the period of the study. I requested a period of 30 - 45 minutes, following the first set of interviews, at a CHB meeting for the dissemination, validation, and discussion of the results.

In participatory research, the steps normally delineated in a research proposal are fused. Creating and collecting data or knowledge is ongoing, as is analysis and problem construction. Wallerstein and Bernstein (1988) have simplified the empowerment education strategy designed by Paulo Freire into three stages: (a) listening, (b) participatory dialogue, and, (c) action or envisioning changes. These steps provide an outline for this study design.

Listening

The listening stage is multifaceted in that the researcher listened to the views of the participants in their personal interviews and their dialogue with each other, as well as the considering the context. The participants were also listening to their community members and to the environment. This process unearthed the felt needs or issues of the community

Interviews. In many of the participatory research case studies reviewed in the literature, researchers began with personal interviews building rapport and encouraging the interviewees to self reflect. A one-to-one interview may increase a person's self-confidence, if the researcher shares in the value of the interviewee's experience. The perception that one's contribution is meaningful may be the incentive needed to encourage participation. The most effective method to develop the rapport and trust is through a conversation, rather than an interview guide. The interviewer must be prepared to express some of her or his own personality and listen to concerns that the interviewee feels are important.

The interviews were all approximately two hours long and took place in a variety of locations, at times mutually convenient for the researcher and participant. I held the majority of the interviews at the CHB members' private homes, which provided comfort and privacy. With consent from the participants, I audiotaped the interviews. The initial interview included demographics, such as sex, age, and occupation from most of the participants.

Table 1.

Time Schedule

Time (months)	Activities	Data collected
1-2 months Listening	Individual CHB member interviews. Attending meetings.	Transcripts Themes identified. Codifications developed.
2-6 months Participatory dialogues	Presentation to CHB. Facilitate dialogue. Identify mutual research questions.	Observation notes. Minutes from meetings. Visual aids developed for CHB. Journal. CHB resources
6-8 months Action or envisioning change	Participate in CHB activities. Final interviews	Meeting notes Journal Records of activities Compiled interview results
8-12 months	Report/record to CHB Thesis finished	Record of CHB activities.

As the conversations focused on the concepts of empowerment and participation, the situations were specific for each interviewee, although a pattern was followed (See Appendix D). I developed the questions based on observations, literature, and my experience in relation to the context of the CHB.

I planned the interviews using a dialogical approach. "The researcher and the participants share control of the process whereby knowledge and understanding are generated through conversation that is rooted in the participants' personal histories and horizons" (MacDonald, 1992, p. 86). Though I shared the selection of discussion topics, I provided the stimulus necessary for interviewees to identify and evaluate the validity of their assumptions. Using critical questioning, I challenged the common beliefs, thus promoting reflection. The interview started with open-ended questions regarding personal experiences of the Community Health Board member that described empowerment or meaningful participation. The purpose was to identify the assumptions underlying and continue to question in a manner that engaged the participant in an exploration of meaning. In my research plan, I envisioned the reflective cycle with a resulting "ah-ha" for each interviewee (Feather & Labonte, 1995).

Engaging the interviewees in dialogue was not always possible in these initial interviews. Often, a critical question resulted in interviewees asserting their perception more emphatically. Occasionally, I found it necessary to disclose a personal experience in order to encourage reflection. Sometimes, I became so absorbed in the stories the interviewees told that I neglected the interview guide. Always, I felt a connection as we openly acknowledged our mutual goal in furthering the CHB and ultimately the community.

Spradley (1979) described a rapport process that develops in ethnographic interviews. The stages identified were apprehension, exploration, cooperation and participation. Working together for a common vision expedited the progress through these stages in the interviews between the CHB members and myself. Several themes consistently emerged in all of the interviews and I did validate and analyze these themes with CHB members in the subsequent interviews, after the interview rapport process had advanced to the cooperative or participatory stage.

Kvale (1996) described the need to ensure transcription validity. I transcribed the tapes myself following each interview, adding contextual notes when applicable. This procedure ensured consistency and accuracy. I typed the interviews verbatim excluding long passages that were irrelevant. Transcripts were returned to the interviewees and they were asked to call me if I misunderstood any of their comments or if they would object to me placing excerpts of their transcript in the context of my report.

I conducted the second set of interviews with the same Community Health Board members approximately seven months following the first interviews. Two members had left the CHB due to other commitments and one member was not available during the time of the second interviews. The questions focused on the major theme of "making a difference" and explored how each member experienced the dialogical process that led to the joint CHB vision. I also asked each person was how the collective vision and values supported their personal values. As the purpose of this interview was to gather specific information, the majority of the questions were direct (See Appendix E). I took notes rather than audio taping the interview as three of the informants requested telephone interviews. I compiled the answers to these questions and disseminated the results were to each member.

The written recordings of the CHB sessions I facilitated and the participant observation notes produced data. I wrote the salient points stemming from the dialogue and group activities in a simple handout form and distributed it to all CHB members within two weeks of each meeting. Group discussions were not audio taped as I had originally planned due to poor sound quality. In addition, the CHB members intertwined their business into the discussions, which created a concern regarding confidentiality.

As listening is ongoing, I kept a personal journal to record experiences, observations and impressions. Rodgers and Cowles (1993) labeled such data collection as *personal response documentation.* The authors recommended compulsive recording and suggested establishing classifications of contextual, methodological, and analytical documentation. Rather than dividing the journal entries into the three classifications I preferred to first write in a narrative form and then highlight the categories.

Participatory dialogues

The process of "decoding" involves analyzing the issue, through dialogue, moving beyond the personal meaning to a social analysis. Wallerstein and Bernstein (1988) provide a five-point strategy for facilitators to use during discussions of the codifications.

> People are asked to: (1) describe what they see and feel, (2) as a group define the problem, (3) share similar experiences from their lives, (4) question why this problem exists, (5) develop action plans to address the problem (Wallerstein & Bernstein, 1988, p. 383)

Stringer (1996) described the “basic routine” and provided a “cookbook” to aid the process of interpretation. The steps are very similar to the Wallerstein and Bernstein strategy delineated above yet neglect to include the personal emotive involvement that is intrinsic to *conscientization.* He drew his references from the work of constructivists such as, Dension, Guba and Lincoln. Labonte (1993b) distinguished between the paradigms of constructivist and critical theory by the political nature inherent in critical theory. Constructivists seek to build a consensual understanding of our natural lives while dissensus in a critical perspective may create an emancipatory learning opportunity. For community development or participatory action to occur, the research method must not stop at a common understanding but must proceed to motivating the participants to act on the inconsistencies they discern.

The dialogue took place at two meetings. The CHB planned the first meeting after identifying their need to explore their values and establish a collective vision and invited me to facilitate this session using the themes I extracted from the individual interview data. The plan for the six hour meeting encompassed the steps delineated by Wallerstein & Bernstein, (1988) and included extensive time for reflections. The CHB arranged the second meeting in order to enact their vision. Dialogue continued throughout the meeting as they worked to produce a community newsletter.

Action or Envisioning Changes

The "problem-posing" stage appropriately describes this stage, as usually there are no clear solutions to act on (Wallerstein & Bernstein, 1988). Discussing new visions, expressing hope, logically exploring alternatives are all positive changes. If participants recognize small changes, a deeper cycle of reflection occurs, enabling people to collectively address greater obstacles (Wallerstein & Bernstein, 1988). The researcher can facilitate this process with critical questioning, placing some responsibility on the participants to act, helping identify the strengths and reinforcing their sense of mastery.

In my role I contributed by suggesting a framework to display their themes, facilitated small group activities that encouraged further discussion and interpretation, and compiled the flipchart lists in order to produce a written record. I then did the computer layout of their newsletter mailed to every household in the area.

Data analysis

I analyzed the data from the interviews to determine the major issues or themes. These themes represented the "codes" or "codifications" Freire described in his pedagogy. The analysis leading to the discernment of the themes was similar to the procedure of chunking categories that constitutes the first steps of grounded theory. However accuracy and depth was not of primary importance as the purpose was to provide a nuclear issue that will be further analyzed, or "decoded" by the group. Common themes arose from personal stories or histories involving the community, rather than from reflections. The technique of creating "generative themes" as described in detail by Freire (1970) and Coover, Deacon, Esser, and Moore (1985) was not employed as originally planned. A previous workshop held for the CHB members had received the criticism of having too many “games.” The “generative theme” codifications are often presented as plays, pictures or stories and I sensed the CHB was not interested in time-consuming activities imposed from an external source.

My original plan was as follows: A community health board session would be allotted to the exploration of themes and the resulting discussion would be analyzed for (a) confirmation and expansion of themes presented by the researcher, (b) group *critique* of the themes leading to *conscientization*, and (c) any other outcomes. Additional themes identified by the participants would "fan" out from the initial issue.

The CHB did not support the steps I designed. The Presentation of the Findings captures the changes in the process. The flexibility necessary to incorporate the agenda of all participants into the project was essential. In retrospect, the intent of the research study, which was to promote an understanding of empowerment and participation through dialogue and critique did occur. However I did not drive the dialogical exchange and it may have taken place regardless of the participatory research study.

Initially I envisioned a theoretical data analysis occurring with the CHB members. On a practical level, this did happen as the CHB members explored the themes relevant to their purpose. The group analyzed the themes from the interviews at least twice as their individual perceptions of these themes related to a common vision. The themes focused on by the CHB were the concrete categories, such as resources, community involvement, health and community development

Maguire's (1987) account of her participatory research project with vulnerable women noted that the women did not learn about doing research. Maguire has published a book in which there is extensive theoretical analysis by the researcher based on her own experience in the study. The majority of the case studies reviewed in the literature also included a theoretical analysis of the research process by the researcher in the documentation. Yet few of the textbooks outlining the method of participatory research recognize or place this component of analysis in the method (Stringer, 1996; University of British Columbia, Institute of Health Promotion Research, 1995). Throughout the research process, I found myself analyzing the data in comparison to my worldview and the theories that I have been exposed to in my academic background. The challenge was to weave my personal analysis in the presentation of the findings without seeming to "betray" the CHB process. I focused the themes on the concepts of empowerment and participation. The overall representation of "making a difference" surfaced from the interviews and remained relevant throughout the process. Another theme "doing for" was inherent in several of the contradictions articulated in the dialogue regarding the role of services and programs in promoting health.

The results of the CHB meeting, in which the analysis of the themes occurred, were typed and returned to the CHB members. An additional meeting further explored the expanded themes or issues, resulting in action. I also recorded this meeting and issued printed copies to all CHB members. In turn, they distributed the issues they had researched, analyzed and agreed on by consensus to the community for validation.

After the second set of interviews, I compiled the results of that questionnaire, hoping to present them at the last meeting I attended. However, the members had a busy agenda with deadlines requiring attention. I have included my impression of that final meeting in my presentation of the findings.

Validity

In qualitative research the question of validity is commonly addressed by verifying that the interpretation by the researcher coheres with the experience and understanding of the group (Heron, 1988). Kincheloe and McLaren (1994) rejected the notion of validity, arguing that trustworthiness is more appropriate in critical research. One criterion of trustworthiness is the credibility of the research in portraying the picture accurately. This study continuously sought participant comments throughout the process.

This research project did not presume to produce knowledge that is generalizable to other situations and contexts unless the participants, themselves, underwent changes to their cognitive process, enabling them to transfer this insight to new contexts. Viewing validity in this light is captured in Lather's definition of catalytic validity: "Catalytic validity points to the degree to which research moves those it studies to understand the world and the way it is shaped in order for them to transform it" (cited in Kincheloe & McLaren, 1994). Self-understanding and self-determination affirm validity.

Throughout the process, I shared the findings and interpretations with colleagues, friends, and other community members. Other participants did the same as they sought to confirm the issues they had identified with other community members. The CHB members validated the vision statement and identified issues but they were unable to elicit the community input they sought. We recognized that silence might, at times, be considered affirmation, as waiting for consensus may be paralyzing. The final interview questions provided an indication of the agreement between all individual participants and the joint vision that we had developed.

The continuing integration and comparison of literature, other research, and reports from other sources pertaining to the topic or its social and political context increased the accuracy of the our interpretations. The CHB members received reports, articles and attended meetings with other neighbouring CHB members. Sharing experiences was a form of validation, especially as we discovered through informal communication that other CHBs were undergoing similar vision-building processes.

Validating my theoretical analysis at the board level was not successful in that it evoked little "special" consideration. The CHB members reviewed my personal diagrams and themes with the same interest displayed for each other member's ideas. In fact, I experienced the results of overcoming one of the contradictions that our culture normally supports. In establishing equality, I lost my position as an "expert." I did not receive any indication that others disagreed with my thoughts, moreover, my points did contribute to the collective views that created the CHB vision, but there was no interest in conducting a theoretical discussion.

The Report

Producing the research report was my responsibility, as an academic requirement. If the central purpose of participatory research is to benefit the participants, then should participants directly benefit from the report? Hearing that some of her group felt betrayed upon reading her report surprised Brydon-Miller (1993). She included her personal theoretical analysis in the documentation, resulting in the description of the participants in language unfamiliar to them. The participants took exception to being portrayed as objects.

Originally, I intended to write a thesis that would be available to, and readable by the CHB members. I considered Brydon-Miller's story of the participants' reaction to her report and vowed to prevent such a representation. Unrealistically I believed the written thesis would benefit all the participants and I would have the CHB members review the document before its final review. I planned to write the report concurrently. This did not happen. Instead, there was a trail of journal entries, CHB notes and the compiled handouts prepared for the CHB. CHB members received ongoing records of our proceedings and they have been satisfied with the amount of documentation. Two members responded to my offer to share my thesis. After submitting my thesis to the university, I will organize the notes and handouts into a readable form of documentation for the CHB.

Miles and Huberman (1994) advised researchers to determine which type of audience will read the report, noting that often more than one report is necessary. In reality, my written thesis will not directly benefit the other research participants. It is written for an academic audience, intending to infuse theory and past research findings into the thesis.

Including actual quotes from participants enhances the validity. Kirby and McKenna (1989) recommended weaving the voices of the participants in with that of the researcher. The participants should be able to recognize themselves in the report. As board members may also recognize each other, I received permission from the participants before including any quotes from the interviews in the report.

Protection of Participant/Ethical Considerations

A letter from myself, along with a project outline, was circulated to all members before a meeting in which the terms were discussed. (See Appendixes F and G). I attended the meeting and received unanimous approval from the board members. There were few questions asked.

All members granting individual interviews signed consent forms (Appendix H). The consent form addressed areas such as purpose of the study, participant expectations, potential benefits, freedom to withdraw or refusal to answer any questions and confidentiality. There were no perceived health risks. Approval was received from the Human Ethics Review Committee, Faculty of Graduate Studies, Dalhousie University, the Western Regional Health Board, the Nova Scotia Department of Health Systems Reform Branch, and the principle researcher of the Heart Health project currently under way in the Western Region.

I assigned a code number to each audiotaped interview and erased the tapes after I completed the transcription and generation of themes. These themes were common issues identified by the participants and could not be linked to individuals. The omission of names in the research report does not ensure anonymity, as participants may recognize traits, demographic attributes, even patterns of language that distinguish individual members. However, confidentiality has been maintained.

The report has ethical considerations. As the participants came to know each other, anonymity was not possible among the board members, making the report a potentially sensitive matter. The nature of several discussions was political and opinions were encouraged. When deciding whether to include details, especially direct quotes I often had to weigh the use of such information versus the potential harm.

CHAPTER III

Presentation of Findings

Participation and Empowerment: Individual Perceptions

Listening

Conducting individual interviews prior to attending group meetings was beneficial in three aspects: they provided data for the theme identification, they encouraged CHB members to explore their own perceptions regarding the concepts of participation and empowerment, and they fostered rapport between each CHB member and myself. The last point was especially relevant in a small community, as people tend to know *about* each other rather than know each other. In establishing rapport, we were able to "test" our assumptions, removing the barriers that our status in the community may have created.

The questions focusing on the concepts of participation and empowerment in relation to the community's health and the role of the CHB resulted in the formation of "generative" themes. Generative themes are representations of "complex experiences that are charged with political significance and are likely to generate considerable discussion and analysis" (Heaney, 1989, p. 9).

Freire (1973) wrote of the contradictions that arose in people's stories, acting as catalysts for dialogue. The themes or codifications he described to illustrate this point were derived from his work in teaching oppressed individuals in developing societies, such as illiterate peasants in Brazil. As with Maguire's (1987) research with women that suffered personal abuse, the participants' reality served as the contradiction against the principles of equity and justice.

The conversation began with questioning the CHB members about their own community activities. I then asked them to consider their personal "empowering" experiences and relate them to community participation and the anticipated role of the CHB in promoting the same. "In Freirean terms, they could begin naming their reality" (Maguire, 1987, p. 134). Maguire (1987) described interviews based on dialogue as a means of encouraging interviewees to reflect on the "whys" of their lives. Maguire's research was conducted with oppressed women, based on the understanding of factors leading to personal empowerment. The CHB members freely articulated their understandings of the issues, the problems and possible solutions relating to community participation. It became a social analysis as they compared their reality, their perceptions regarding other citizens' circumstances and their understanding of conditions that foster health.

The CHB members represented people who had experienced the process of empowerment. As individuals they displayed quite similar understandings of community involvement, and all had confidence in their ability to contribute to the health of their community. There were few glaring contradictions arising from the interviews.

As I continued my conversations with the individual CHB members, I realized the first cycle of reflection was my own. It was humbling to find my own assumptions were in need of "deconstruction." As individuals, the members demonstrated their insight and awareness regarding the strengths of their community and the potential for the community to address the root determinants of health. I had assumed that only health promotion "experts" knew about the determinants of health.

The generative themes were identified and prepared in a format to present to the CHB in order to initiate dialogue. In order for participatory research to have economy in conduct and reporting, the data is presented as the agreements and disagreements that arise from multiple sources in each reflective cycle (Dick, 1996). In the presentation of findings I have grouped the themes derived from the individual interview data as they relate to the research questions originally proposed. Under each heading, I summarized the agreements and disagreements that arose between the CHB members' interview data.

Participation.

A central theme soon emerged from every personal account of "participation." The stories people choose to tell included the aspect of a "felt" contribution. These were positive, successful experiences occurring at individual, interpersonal or even political levels. I labeled this theme "making a difference."

Participants identified the concept of participation from three perspectives, personally, in relationships and at the community level. Personally, members described situations where they participated in activities that provided them with skills or knowledge that enabled them to act on their own behalf. One member explained how he researched the local interagency in order to use it as a resource. "That is when I decided it might be a good idea to get into it and participating more deeply and learning everything I could find."

Helping others provided personal satisfaction for several CHB members. Comments such as, "I like to visit and talk to older people who get lonely and take them something I have made" represented "making a difference" on an individual level. Several of the CHB members recognized the benefit of a one-to-one interaction as a strategy for increasing community involvement by members. Participating with other people formed the basis of healthy relationships, as was noted by this CHB member.

> I used to be a big believer in programs, setups and I am not saying these should not be done, but I think most of what works, or at least we have seen work at the centre is the relationships.

A rural environment was appreciated as a factor that promoted relationships and encouraged participation. "I think with the rural community you have more caring people because there are not so many of you and they are interested in you and your health and well-being", was a statement that expressed the sentiment echoed by one half of the respondents.

Every respondent identified factors negatively affecting relationships. They included poor self-esteem, severed family ties and the expectation to be handed everything. Comments such as "I think what we have is a 'me' generation" or "The people need to learn to put back into the system instead of always just taking out of the system" were expressed by several members.

Stories about participation also demonstrated the leadership abilities of the CHB members in organizing community groups and activities. All of the CHB members had at least one successful experience as a group leader, organizer or facilitator. When members were asked why people from "vulnerable" populations were not on the community health board, they indicated the need for a wider representation by statements such as, "Right now everybody is a volunteer and maybe when our term is up they can look at ensuring that all these segments are represented." When probed further as to how people experiencing personal powerlessness would achieve a sense of "making a difference" by participating on the CHB, only one member related this question to her own struggle for participatory competence. Another member alluded to the need for people to feel they have the ability to contribute before they are able to participate on a community board by saying, "I hope in the future the CHB will help people know that they can have a say no matter what their background is and in the future they will want to be on the board."

Many CHB members expressed their frustration with the low numbers of people participating in community activities. Activities mentioned included recreational, educational and political events. They directed their frustration at both the citizens and the established bureaucratic system. In answer to a question pertaining to the reasons why the public does not become involved in community matters, the replies included dependence on social programs or services, discrimination, lack of interest, apathy and mistrust. One CHB member said: "Part of it is the mistrust, like obviously the fishermen now mistrust the government."

Empowerment

The members readily understood the word "participation." However, the term "empowerment" led to a mutual fumbling with the definition, which seemed to restrain the response. After attempting it in three interviews, I discarded the label and asked interviewees to expand on their stories in order to extract the defining characteristics of "empowerment." I sensed the feelings of accomplishment as the CHB members described overcoming an initial challenge or struggle in the following comments: "We work really hard at developing relationships and we do it!" "It was hard to get it started . . . . The group was a success but we no longer needed that support."

Kieffer (1984) in his study of personal empowerment, found that success created a desire or determination to do more, increasing the participatory competence of people. The histories recounted by several CHB members reflected their growing obligation to their community. "Successful in that I was able to get it going, yes, and to see the younger ones have the same experiences as I did . . . that was the beginning of my volunteering in Digby."

Exploring a concept that defies a universally accepted definition poses the risk of the researcher assuming a standard meaning and applying it to the voiced experiences of the participants. All of the CHB members demonstrated qualities of self-determination, self-confidence, critical thinking and the perceived ability to "make a difference." These participatory competencies indicated an internal sense that agreed with my definition of personal empowerment. Yet, when I asked for specific circumstances leading to this sense of power most interviewees were unable to provide a direct answer.

Without the identification of a clear personal empowering transpiration, there could not be an application of such an experience to a social analysis. The data from the interviews did not provide a common understanding of the concept of empowerment. Generally, it was difficult to discuss power as an isolated concept. It may have been unrealistic to expect people who have a long history of participatory successes to envision a condition of personal powerlessness. It also may have been threatening, as these community leaders may have been required to acknowledge that they potentially were part of the problem in propagating inequity in the community.

The majority of the CHB members interviewed were able to articulate their perception of the potential power that communities could unleash if they became organized. Comments included the following:

> "People are power, so consequently if all the people say this is the way we want our system to run the government has to listen to us."
>
> "We blame whoever is in the elected office and use them as an excuse not to do anything . . . any changes are going to be made, then we are the individuals who are going to make them."

The discussions surrounding programs, services and education safely addressed the concept of empowerment. There was a dissensus between CHB members in their beliefs of the social system's affect on public participation and empowerment. They further identified these contradictions in the dialogue session and eventually shared an understanding. The common understanding led to the agreement on the primary values from which their vision stemmed. Building the capacity and increasing a sense of control within individuals and the community were the articulated values. Throughout the research study these values were never named "empowerment."

Health care services. The discussions that originated with the examination of health care services or programs accented the dichotomy between security and dependence. Some members were angry as they condemned the downsizing that took place at the Digby General Hospital several years ago. They were very concerned that the future may bring further reductions, evidenced by the following statement: "We have thought about leaving, only recently. Health and the facilities we no longer have are playing a role in that . . . . I just no longer feel secure in this community." Another CHB member commented:

> The reform was a great vision but there was nothing put in place before it went ahead. People are left feeling hopeless . . . .It is really scary and obviously people are going to suffer in the short term. Hopefully in the long term it will not be as bad.

The notion that "reform" represented reductions in health care services was repeated in several of the interviews. This respondent had observed the following reactions:

> I hear that there is anger with the way institutional cut-backs have affected them. They are scared, fearful and they don't have the tools to take the place of the services and the people they have been used to. They have no other replacement.

However later in the interview she expanded her position with the following comment:

> If we don't get panicked by the changes, I see them as being positive. The inevitable will take place and people will become more responsible and knowledgeable. They will mature and start doing what they should have been doing all along.

One CHB member disagreed with the need to protect the health care services observing, "People are saying there is no doctor at outpatients. And I say, 'Well, you probably didn't have to go anyway.'"

Several CHB members referred to the current home care services negatively in their discussions of programs. In order for citizens to acquire information and tools so that they can claim more responsibility for their health, changes in relationships with health care providers are necessary. The community should determine home care and complementary health care needs by involving the citizens in the planning. One member claimed that unqualified caregivers were being assigned to ill people while another noted that the seniors still felt as if they were on their own and unable to cope. He suggested a daily visiting program.

Programs and education. Some respondents viewed educational or service programs as the answer to problems such as teen pregnancies, drug abuse or unemployment, while others viewed them as resources to be utilized after determining the solutions. These defining criteria represented the contrapositions that led to dialogue. Quotes from CHB members that indicated the need for more programs included the following:

"We need a program of some kind to make that person realize they have a problem."

"But there should be more out there for them. Not only the seniors but the children, the young, the teenagers . . . .Where are these kids going to go if there are no activities for them?"

"Kentville and Yarmouth have programs, but maybe we could get more in this area."

Other CHB members dissented stating, "The problem is that there have been too many programs and people are dependent on them" and "I don't think the kids know how to organize themselves today."

CHB members identified the risk of social programs in creating a dependency in citizens. Relying on social programs destroyed the fellowship that arose when neighbours or families cared for each other. Most of them believed that citizenry was adversely affected by the present social programs.

Members viewed education as a strategy that would increase people's ability to participate or shoulder more responsibility for their own health. Several CHB members stated that just providing information was not enough, as there had to be values, such as respect, sharing, and self esteem incorporated into the learning experience. They identified health professionals as one source of information, from which the public could benefit. One CHB member cynically noted that it was easier to prescribe a pill than it was to sit down and teach someone, especially if that individual was not well educated.

Promoting Community Development

All of the CHB members were familiar with the term community development. Questions or probes that sought their perceptions regarding the CHB's ability to promote community development were generally answered with ideas reflecting the notion of community mobilization and increased public involvement. Members expressed the need of the Digby community to regain a sense of local control. How to achieve this sense of control was considered somewhat problematic.

Though the exact role and function of the CHB was unclear to all members, most echoed the sentiment that, individually, they were going to promote a healthy community. They spoke of being role models, communicating their values, and demonstrating their appreciation of fellow community members. One of their biggest challenges was to increase community involvement. Several members described their success in expanding community participation by issuing personal invitations, as illustrated by this comment:

> We found that once it got underway that people started to say, "Oh I can do that". And it has really worked itself out to help the community. People need to be encouraged, as there are not the things provided that there used to be . . . . We don't have any trouble getting people to help with things, like the meals. I find that it is a way not only to involve the drop-in centre but also to involve other people. You call them for help.

The CHB members expressed a desire to form a collective voice. Some identified the need to increase their confidence in order to speak out. Building their collective strength and establishing legitimacy in the community would be a slow process. Several members stated they were prepared to wait for a two to three year period before they were really accepted and functioning as a decision-making body. One member stated, "I have learned not to see any results fast. Even if the government backs down and does not recognize community health boards, I am still going to stick around. I'll become an activist."

Most of the members recognized the urgency in establishing a legitimate position and a trusting relationship within the community. How to achieve a presence in the community was not clear, as indicated in the following:

> I guess just being there is how it will work. After we get our pictures published people will be able to stop us on the street . . . . That is where we will impact . . . . If we are visible in the community and people will come to talk to us we can help them. But they need to know us as people before they will do that.

The CHB members sought legitimacy from the community rather than the province. The legislation for the regulation of community health boards denied in August 1996 by the Minister of Health was not considered a handicap. The commitment to the community rather than governing bodies is in line with the results of the survey conducted on regional board members by Lomas, Woods, and Veenstra (1996). There were virtually no statements indicating a need to be accountable to the WRHB or the Department of Health. Instead, several CHB members identified the need for the WRHB to support and shift control to the CHB.

Government. There was a general sense of mistrust in the CHB members' regard of the government. They described it as being too big, too bureaucratic and too full of rhetoric. One person clearly stated the CHB was being deliberately set up to fail and another commented on the possibility that CHBs would be scapegoats if community development failed to happen. The WRHB was linked to the government. Comments opposing government's interference included the following:

> I am trying very hard to be positive in thinking that they have chosen us to do a job and they will let us do it. I don't care if we have their support as long as they don't tell us we can't do what needs to be done. If they cut us loose and it's sink or swim then we will swim.

In summary, the generative themes representing participation, "making a difference," and empowerment, a local sense of control and capacity, revealed a high level of agreement between all the CHB members. It was startling to discover such coherence in their perceptions of accountability to the community, mistrust of the government and the mutual desire to work as a team.

The membership of the CHB consisted of five health care providers, all employed in various health sectors in the community. Participation on the CHB was strictly on a volunteer basis and there was no recognition that members were representing their profession or employer. Only one person was employed in acute care, and the majority of her work was conducted with ambulatory clients. Interestingly, with the exception of this one person there had been no expression of interest towards the CHB by hospital nurses or other personnel, despite holding the CHB meetings at the hospital.

There were no discernible differences in the responses in the individual interviews from the health care professionals compared to other people except in the use of technical language. Their understanding of empowerment and participation was congruent with other CHB members. I also did not witness the domination of the health professionals in the discussions or decision-making at the CHB meetings.

The other themes, which gave rise to tangible examples, such as programs, services or education, indicated some areas of disagreement among the CHB members as to the affect of these services upon the health of citizens. Some members described the need for additional programs but neglected to say why. I sensed that, to some members, services and programs, especially medical, represented security, status or even control. Five of the interviewees believed that the government decision-makers unjustly treat rural communities, as evidenced by the recent losses in health care services. Yet, conversely, four other CHB members blamed programs and services for the creation of dependence and apathy in many of the citizens of Digby. With the exception of emergency medical services, the programs described as being desirable in this community addressed issues of social, emotional or physical well being. Examples included smoking cessation, fitness programs, and family counseling.

The literature voiced a fear that it may be as difficult for citizens as for doctors to shift from health care provision to health promotion (Marchand, Durocher, & Tousignant, 1996). This concern was shared by one CHB member who said, "I think the biggest obstacle is getting the CHB beyond sickness care. I suspect that is what people are going to respond to." The interview data did not support this supposition. Shinyei (1997) interviewed six members of community health boards in the Western Region of Nova

Scotia and found five people understood health reform as being compatible with Nova Scotia's Blueprint for Health System Reform. Only one member linked health reform to hospital reduction.

Freire (1973), Maguire (1987) and Travers (1997) described how the researcher initially collected information from the other research participants in order to learn about the participants' worldview. A "learned powerlessness" shaped their subjects' reality. The CHB members did not represent a similar population. My findings indicated they were all "empowered" at the personal level, and, individually, they were able to reflect beyond their personal situations to a social level. It became a challenge to rethink how the Freirean educative process could benefit this group of people. My journal entries during the period of interviewing and analyzing the data indicated my confusion. I repeatedly asked, "Is this participatory research?" I was the only person who appeared to learning at this point. The CHB members did not display an interest in my results although they did consent to my request for permission to present the themes to them during one of their regular board meetings.

Before I was able to facilitate the planned session, an incident occurred that presented an opportunity for a "reflective cycle." As it contributed to the research cycle, I have included it in my narrative.

Learning From Action

I planned an educative session based on a facilitated discussion of the themes. The objectives of this dialogical session determined solely by myself, were to share common views regarding participation and empowerment, challenge some of the disagreements that arose in the generative themes and begin to critique the current health care system in order to identify barriers that must be overcome. I based the format on the five-point strategy (Wallerstein & Bernstein, 1988) described in Chapter II using "making a difference" as the generative theme representing participation. Fanning out from the interview data were the "codes" or contradictions, under headings such as, who we are, what we do, what we value, what we said about government, services, programs or education and how can we make a difference.

The first step was to obtain consensual agreement from the CHB members on the "making a difference" theme. Not only would this validate our mutual understanding but also it would define the level of participation that the CHB was reaching for. When the CHB members compared the current status of the health of their community citizens, the effects of societal systems and the goal to increase the level of participation they would start to identify areas that require changing. My journal entry of March 10, 1997 described the following:

> There I was, with the perfect presentation, clear, simple and thought provoking. It should have led to a round of dialogue that would enable the CHB, with their heightened awareness, to develop and embrace the concepts of empowerment and participation. I began to talk and saw some of the members taking notes during my overhead display. I wanted to lay the background before leaving them with the conflicting issues. As I neared the highlight of my presentation, in walked Dr. Ross.

I wrote the journal entry with irony as I realized that the CHB members did not have a desire to explore their understanding of participation at this time, regardless of Dr. Ross's visit. They were prepared to listen, even take notes, but unless an issue arising from my presentation connected their learning objectives to mine, the process I hoped to initiate would not have "made a difference" to the CHB. At this point I was transmitting my knowledge or "banking education" (Freire, 1970).

Dr. Ross had requested an audience with the CHB in order to apprise them of a possible withdrawal of 24 hour physician coverage for the emergency unit at the Digby General Hospital. The rural physicians were finding it unreasonable to commit to the time demands without an alternate source of remuneration. He explained that with adequate payment for their services the physicians would able to take time off, rest and provide a higher quality of patient care.

Dialogue. After Dr. Ross spoke to the CHB and left, dialogue arose. CHB members had different opinions on the issues of physician payment and practice and freely challenged each other. Their diverging viewpoints informed each other and I witnessed a thorough analysis of the complex situation. This real life situation exposed the contradictions that had surfaced in the interviews. The CHB members identified systemic factors that they could not control. These included the employment status of physicians, fee-for-service incentives, the physicians' role as gatekeepers to the medical system and the fact that without a physician on-call the emergency unit in their community hospital would close. Factors that could be addressed with local physicians stemmed from the CHB's hope that physicians would work with them in order to increase the ability of people to participate in their own health or medical care.

I was very conscious of my employment position and refrained from adding to the discussion. I did provide facts regarding utilization of the service when requested. In addition to focussing on the crisis, they brainstormed for alternate ways to address this problem in order to bring about improved relationships with the local physicians. They concluded that, given the sensitive political nature, and the immediate need for a resolution, they supported the demands of the physicians. They also wished to have a long-term plan to review how physicians practice in the community.

Action. The CHB members were active, if not instrumental, in the organization of a community protest publicized in the media. It attracted the attention of the WRHB and the Department of Health. Within a week, a settlement providing hourly wages for physicians working in the Digby General Hospital emergency department was implemented. However, one-half of the local physicians still refused to be on-call.

The CHB chairperson, in an informal conversation, informed me that the CEO of the WRHB had indicated the action of the CHB in regards to the physician issue was inappropriate. The CHB chairperson had also received a letter clearly stating the provincial level of government dealt with matters of physician payment. The chairperson disagreed with the WRHB's position, stating it had proved the community could mobilize around an issue and it demonstrated the government's response to the "squeaky wheel." Following the acceptance of the physician payment scheme there had been no further plans to improve the quality of physician and community interactions. Individual board members asked physicians meet with them, but the physicians had refused. As one CHB member quipped "When they say it ain't the money, it's the money." Another member was indignant, claiming, "They [the physicians] just used us."

The CHB members demonstrated their ability to dialogue on the issues, act and reflect on the consequences following. They were able to critique the medical practice of the local physicians in relation to their goal of increasing the public's capacity to be involved in their own medical care. However, I questioned how many "outsiders" would assume the CHB had, as expected, focussed all their energy on preserving an acute medical service.

The CHB met on April 14, 1997. The minutes of this meeting refer only briefly to the physician emergency service. The CHB reviewed several reports from subcommittees who had completed various "needs assessments." Two people representing a community health centre also made a presentation.

Following the reports and presentation, the board discussed how they should judge and respond to requests from community groups. A separate workshop, other than their regular business meeting, might be helpful in establishing a common framework from which to view the gathered material. They determined the themes I had quickly distributed as a printed handout to them on March 10 1997 were representative of their values. The CHB asked me to facilitate a workshop planned for Saturday May 10 1997 using the themes as a starting point in the development of a collective vision. Research questions developed for this workshop were:

1. How do we, as the Digby and Area Community Health Board envision a healthy community?
2. How do we translate this model into a vision statement that will guide our actions?
3. What are the health issues in our community?
4. How do we address these issues using the vision statement as a framework?

Participation and Empowerment: A Collective Understanding

The CHB members, in a pre-workshop survey clearly indicated they wanted action to stem from this meeting. They were inpatient, tired of rhetoric and "white binders" from the Department of Health, Health Systems Reform Branch. In order assist the CHBs in developing their community health plan, a series of 11 workbooks were issued with instructions to fill out the forms. One workbook provided guidelines for developing the values and vision of a CHB.

Stringer (1996) labeled this the "think" component of participatory research and described it in the following:

> The task of the research facilitator in this phase of the research process is to interpret and render understandable the problematic experiences being considered. Interpretation builds on description through conceptual frameworks--definitions and frameworks of meaning--that enable participants to make better sense of their experiences. It utilizes experience-near concepts drawn from people's day-to-day lives (rather than, e.g., theoretical concepts from the behavioral sciences) to clarify and untangle meanings and to help individuals illuminate and organize their experiences (p. 81).

I found it difficult to apply Stringer's rational and techniques to the participants I was working with. They understood their experiences and did not require me to "untangle" them. I displayed the values reported by the CHB members in the interviews, added to them as instructed until the CHB members agreed on the central values by consensus. I was confident in the validation of these values, having heard them repeatedly in the formal interviews and in casual conversations. The values included a local sense of control, community responsibility, trust, respect, relationships, caring, pride, commitment, and increased community participation. The central issue, as identified by the CHB members, was increasing community involvement. Though members had been issued my portrayal of participation as "making a difference" they did not consider it to be a defining characteristic. They did not oppose it, but it just did not serve other people's theoretical representations as well as it did my own. At this point, we carried individual images of participation and empowerment. The purpose of the first workshop exercise was to identify our personal vision of a community that fosters the participation and empowerment of its citizens and then to collaborate as a group in order to create a collective model.

The CHB members, individually, sketched their "utopia." We defined this as a community that fostered the values put forth by the CHB. The members formed small groups; each one produced a joint graphic representation of "utopia" (See Appendix I). Though I did not present the interview themes to the CHB again they did appear in the diagrams and explanations created by the groups.

Dialogue

Dialogue was easily facilitated as we critiqued the contradictions between reality and the ideal healthy community. The disagreements I unearthed in the individual interviews surfaced as programs, services and education were identified in the community models. The contradictory assumptions those individual CHB members stated became topics leading to dialogical exchanges. I recorded the following dialectical interaction.

A: We do not need any more government programs.

B: We deserve to have the same services as <name of place>. We are taxpayers.

A: What good is a program if no one comes. We have different needs than <name of place>.

B: I understand that but why should we have to do without funding?

A: I am not saying we do without funding--just that we decide where the money is being spent.

B: O.K. I see that. I just don't want us to keep giving stuff away. Sometimes when we don't take what they offer, we get nothing.

The common agreement resulting from this discussion was that they required resources, such as funding, but only if it was part of their solution. Without the dialogue, these two CHB members may have maintained two different views regarding government programs. The CHB rejected government programs that created dependence in individuals or controlled the community.

Relating the concepts to health. During this period I began to see "doing for" emerge as a theoretical representation. Several times during that day I heard the phrase, "If we don't get this done, they will come and 'do it for' us". The CHB agreed the strength of the community had to come from within. The distinction between programs or services that enabled communities or individuals to "do it" themselves became a focal point in the critical analysis. The CHB interpreted their understanding of "empowerment" as the building of strengths that abound in the Digby area and achieving a local sense of control. A healthy community represented one that encouraged the citizens to be involved and respected the contributions of the citizens. They described how small successes would spur other positive changes. Statements that described a healthy community were listed under the heading "Essential Elements" and included the following:

1. Individuals and community are strong, capable of making decisions.
2. Services, programs and government funding are resources.

3. Resources are NOT the drivers; the individual or community has the capacity to determine their needs.
4. The CHB's role is to help build these capacities and help find resources that support that development.
5. Healthy policies.
6. Caring neighbours.
7. Involving present organizations.
8. Increased community spirit.
9. Increased community pride (Digby & Area Community Health Board Workshop May 10, 1997).

We pursued the vision through the process of critical analysis and dialogue for over an hour. At times, it seemed we were going around in circles, as we tried to produce a vision statement from the "sentimental rhetoric" that the above words connoted. I sensed some members were getting discouraged, the dialogue had abated; yet, the common understanding was still too vague. We needed a "theme" that represented our vision and incorporated our critical consciousness of the process of community development.

One member spoke up and reeled off the following statement. "To promote a healthy community through the development of the required resources and the encouragement of community involvement." The statement was dissected and applied to our understanding of a strong community. This group of words represented our conscientization. The phrases in the statement were defined as follows:

"To Promote" - The Digby and Area Community Health Board's role is to facilitate, to support the development of our community, including human resources, services, programs and facilities, thus enabling us to address or deal with the issues that impact on our health.

" a Healthy Community" - a community that is working together to deal with the issues that affect our health.

"Through the Development of the Required" - building those resources determined to be most effective and efficient

"Resources" - facilities, services, buildings, people, neighbours, programs, education, elected government representatives, etc. - All are tools or means that enable individuals, groups and the community to strengthen, and build the capacity to deal with their health issues.

"Encouragement of Community Involvement" - People need to feel their contribution will make a difference in their own lives and the lives of other community members. To be actively involved, people must be part of the problem-solving process.

Following the discovery of this vision statement there was a sense of elation and a release of energy from within the group. All members eagerly discussed how they could enact the statement. They reviewed and reframed issues that had arisen at previous meetings in comparison to the new vision. Past disagreements now converged with the collective understanding. The CHB members expressed confidence in the direction that they were taking. In 30 minutes, they had outlined their action plan.

The Digby and Area CHB focussed on the meaning of participation to individuals and then discussed how they would foster a community that valued the contribution of its citizens. Perhaps in a small community it is easier to conceptualize how changes would affect the people as we could easily put names on the faces and relate to the stories. The CHB related health to capacity building, recognizing that their first challenge was how to increase involvement of people in decisions that would affect their own lives. I jotted down a two-line conversation in my notes that did not capture my attention until I was completing my analysis of the finished research study. One CHB member had commented, "The healthiest choices need to be the easiest choices" while another CHB replied, "I don't even think some people are able to make choices."

I found it difficult to articulate my reaction to the workshop's outcome. My journal reflects my excitement and I noted that I finally felt as if my research was "making a difference." However, I did not capture, in words, the emotional wave that came over me as I shared the vision with these people. I sensed the dedication, commitment and felt the collective strength.

One of my personal goals had been to explore the concepts of participation and empowerment. Members freely discussed community participation, defining its role in improving the health of their community, analyzing the status of community involvement against the optimum and seeking suggestions to increase participation.

We did not name the concept of empowerment in the joint analysis. Instead many CHB members indicated a healthy community promoted citizens to "do it for" themselves, supported people in their struggles and shared in their successes. The dialogue revealed an understanding and desire to advance the elements of the empowerment process, as I defined it. Underlying the verbal exchanges, I sensed an attitude of optimism and hope.

I achieved the goal of initiating dialogue that led to an increased critical consciousness for the participants. Focussing on the disagreements in the individual perceptions of CHB members regarding the effects of programs, services and education provided an application of the strategy of Wallerstein and Bernstein (1988), as outlined in the research methodology. Participants initially focussed on their personal experiences with health programs, comparing these experiences to statements based on other peoples' assumptions. The dialectics carried the dialogue to a general critique of the current health care system, resulting in the identification of actions that could influence the health system. The CHB distinguished between actions that could be initiated at the local level and responses required at the policy making level.

Action

The CHB members planned another meeting for June 9 1997 in order to compile their information and assess the health issues of the community. The vision was again validated and the values identified at the workshop were listed on a flipchart.

The Department of Health workbooks depicted a process for the collection and analysis of information that would illuminate the community health issues. The CHB rejected the process as they had conducted extensive community consultation over the past two years. They also opted not to comply with the prescribed workbook format.

The health issues identified in previous meetings were verified through a brainstorming session. Information from other sources, such as past needs assessments, was used to check the issues for accuracy and agreement. There was a consensus from the CHB members that the issues were inclusive. A CHB member noted that some of the root causes of ill health were the antithesis of several of the stated values. In turn, enacting the vision would address these determinants of health.

Disagreements that created an opportunity for dialogue at this June 9 meeting centered not on the health issues but on the rights of the CHB members to represent the community. Some members, especially those who had been on the steering committee previously, claimed there had been ample opportunity for public input, while others expressed some hesitation. How could they ensure the citizens of the Digby area agreed with the CHB's plan to address these issues? Though not all members concurred with the need to consult the community they decided the citizens required information and access to the CHB in case other community members had responses.

A group of CHB members created the newsletter at our following meeting. They simply described the role of the CHB in relation to regional health planning, listed the issues and included the names and home telephone numbers of all the CHB members. They extended an invitation for people to call any of the CHB members. The back of the newsletter contained several questions and the public was encouraged to answer the questions and drop off the sheets at one of three central points. I helped by laying out the newsletter on my computer and printing the master copy for them. Every household in the Digby area received a copy of the newsletter in the mail (see Appendix J).

The Research Process: Did it Benefit the Participants?

The purpose of my final questionnaire was to gather information for my use in the evaluation and completion of my thesis. The results validated the vision and reinforced the commitment by this group of individuals to promote community development.

The members all stated they were satisfied with their personal contribution towards the vision, and agreed that the values were reflective of their individual beliefs. However one member stated he did not think the vision espoused the common thinking of the citizens, especially the seniors.

Three people responded to the question regarding changes in their understanding of community participation by using the term "doing for." One person commented that she now was beginning to understand "doing for people is not making them healthier." These answers were surprising as I had not shared my "do it for" representation with anyone. Two other members stated they were now aware of "capacity building" or "building on what we have."

All members identified ways they personally would promote the vision. I interpreted this as their perceived ability to advance community empowerment and participation. The statements included activities such as share the vision with other citizens, act as a role model, and continue to be active on the CHB and personally invite friends to be involved. In the first interviews the members expressed uncertainty regarding their individual role as a CHB member and questioned how they could contribute to the group. This uncertainty has receded as the CHB members all answered the final interview questions without hesitation and with confidence.

I did have one disconcerting finding. Out of 12 responses to the question regarding perceived barriers to the achievement of the vision, eight CHB members strongly conveyed their fear that the WRHB or the Department of Health would interfere in the process of community development. Possible examples of interference described by the CHB members included, demanding regional conformity, limiting community innovation, restricting CHB decision-making, and emphasizing the completion of tasks or projects rather than appreciating the process.

At the time of the first set of individual interviews, eight months ago, there were three CHB members who firmly stated they would disengage from the CHB if they did not witness certain results. I sought additional comments from these three individuals, as they were still active in the CHB without having obtained their desired outcomes. I asked each one separately, at the time of the final interview, why they continued to participate. The replies were spontaneous and genuine: the dedication and commitment of their fellow board members had fueled their hope and optimism. However, one person did caution me that she soon would need a sign of support from the WRHB.

I also asked five members, informally, following the last interview, what was their impression of the May 9 1997 workshop? All five had shared my sense of a common understanding, almost a group "bonding" that arose after the vision was articulated. One person called it "the big ah-ha." Another observed it was "pretty intense" while someone else remembered feeling "quite low and all of a sudden things just took off."

I presented a handout of the compiled result to the CHB members at their meeting of August 26 1997. There was no discussion, but I was not disappointed as they had a busy agenda, beginning with a presentation from a community-based organization that provided services to pregnant women with low incomes. Before attending the meeting the presenter was provided with the CHB's vision statement and a list of values and community health issues. The CHB requested that she direct her talk to the means her organization had to address the issues and contribute to the vision. The CHB was not focussing on what others could "do for" their community, rather they wanted to hear how others would facilitate the development of the Digby citizens. For example, the presenter described how several of their salaried caseworkers had been previous clients.

The WRHB assigned the CHBs the onerous responsibility of developing a community health plan. From the plan would stem a "project" for which funding had been assured. I listened to the CHB members discuss how the latest events were at cross-purposes to their vision. In order to complete the assignment the WRHB hired "assistants" for the CHBs. The qualifications for this job included a Masters degree in Health Education. The CHB members openly acknowledged their sense of inadequacy, as an "expert" was now required to determine the needs of their community. One member commented, "we are only puppets on a string."

At this meeting members proceeded to complete their action plan and set timelines. They had established a process, facilitating meetings in the community and connecting various groups that were contributing positively to the identified health issues. Originally this process was their plan, but now they implemented it as a means to consult the community in order to create their plan and project. Community participation may be decreased if consultation is the process rather than collective action (Martin, 1997). At the time of this last meeting, several CHB members confided that they were confused as to what the plan would be and how it would be implemented.

Defining Community Participation and Empowerment

The findings, as presented above, address the research questions only if we share a uniform definition of the concepts of participation and empowerment. I established my own definition of participation and was confident that it represented the concept in each of the initial individual interviews. I defined participation as purposeful involvement in an activity that was perceived as "making a difference" in one's own life or the lives of others. Community participation was the community's capability for fostering such meaningful involvement for the citizens.

The definition of empowerment remained elusive throughout the study. Participants even acted out their impression of empowerment by pointing to their own body and saying, "You know, it comes from here." How could I capture that definition? I have defined community empowerment as the capacity of a community to define its own problems, solutions and to act on them. That does not preclude the need for resources. It is through a local sense of control and self-determination that citizens will find participation meaningful.

The CHB members, individually, comprehended the concepts of participation and empowerment similarly. Their understanding of health related to issues of community development and not to a perceived need for increased sickness cares services. They all identified the need to develop the assets of their community, including the citizenry. In the group dialogue, they learned that this was a collective goal, which served to strengthen their personal vision and determination. They demonstrated the ability to critically analyze situations, act and then reflect on the outcomes, creating experiential learning cycles, in order to increase their understanding of community development. The vision statement represented their collective understanding of empowerment and participation in relation to the health of the community.

The nine months in which I worked with the CHB members was a learning and growing period for them. They were relative strangers who had come together to serve on a government sponsored board with an unclear purpose. During that time they became aware of specific factors that promote or block community development. The answers to the final questionnaire indicated they had gained commitment as a group and an increased consciousness of the need to establish their authority and gain some local control. However they still did not have a clear position on how, or even if, they were able to influence the public's perception regarding the value of community participation and capacity building. The provincial regulatory legislation withheld in August 1996 prevented the CHBs from having an official position of authority in Nova Scotia's healthcare system. Though some of the members negated the need for the government to give them formal power, this omission may have contributed to the confusion regarding the CHB's role in health planning and community development.

CHAPTER IV

Discussion

Chapter III presented the findings as a chronicle of the research process. The narrative described how the CHB members and myself, as the researcher, came to understand the relationships between the concepts of empowerment, participation and community development. Heeding the recommendation from Dick (1996), I focussed on interpreting the agreements and disagreements that arose from the reflective cycles that emerged during the participatory research process. The following discussion extends our understanding and situates it in relation to the literature, past research and current trends in health. As such it serves to validate our experiences, providing further questions to explore.

Though the intent of participatory research is not to generate theory I view my world as a "researcher," in that I tend to test my daily experiences against theoretical suppositions. In order to reduce the hidden bias of the researcher I developed a graphical representation of the conceptual framework in which I organized the findings and data from other sources for the purpose of discussion (See Figure 1).

Without the framework, which highlights the concepts I wished to not explore but also to promote, the project may have been overwhelming. The framework prevented me from neglecting the political aspect of participatory research. This is a significant point and is expounded in the discussion on the role of theory.

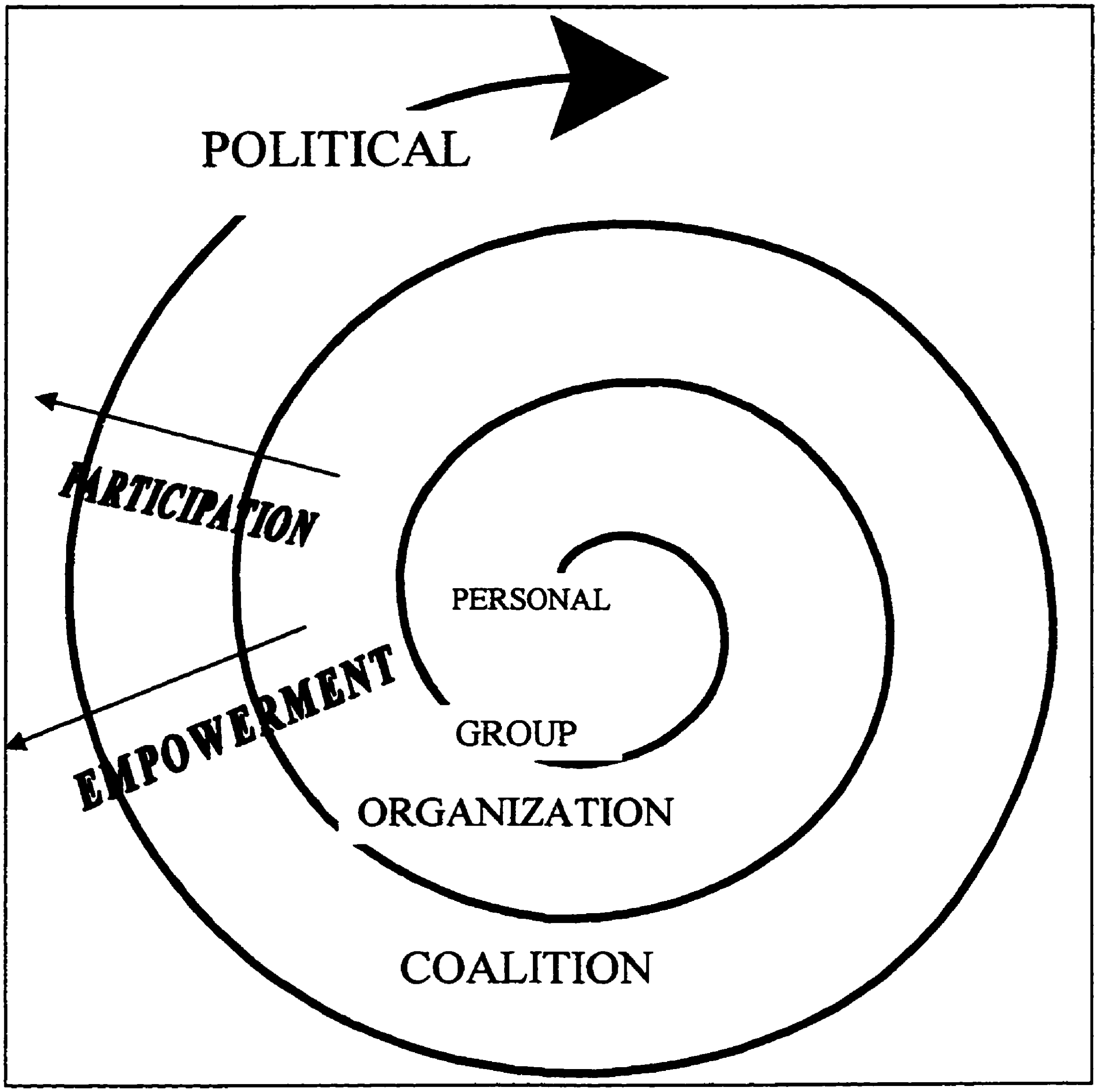


Figure 1. Graphical representation of the theoretical framework.

Participatory Research Methodology

Participatory research methodology represented a methodological praxis for me as it incorporated the aspects of theory, practice and personal honesty that I felt compelled to follow. I struggled with the dilemma of instilling all three of the above components into a thesis that met academic research standards, clearly narrated the process and truthfully portrayed how we, as research participants, came to understand the concepts of empowerment and participation. Two issues that remained especially problematic throughout the research study were the role of the researcher and the role of theory. The discussion on the role of theory is located at the end of this chapter, as it was only towards the end of the research process that the relevance of theory was clarified.

Role of the Researcher

Entering the field was a gradual process, starting with my affiliation with the Digby and Area Community Health Steering Committee. Although I was a member of the steering committee, I was not a member of the CHB. The CHB accepted me a researcher and my role as a member did not become solidified until the time we agreed on the vision. Adler and Adler (1987) explored the membership roles of researchers who immerse themselves in their field of study. They concluded that in striving to have equal status with the subjects or "going native," the complete-member-researcher (CMR) role is complex, sensitive and open to role conflicts. They described how the researcher might initially be detached from the community members but, as the project progresses, the researcher becomes involved to the point where she includes her personal changes as part of the phenomena studied. My journal notes traced this shift, demonstrated by the use of "we" as a pronoun to describe the CHB members and I. Before the May 9 workshop, I wrote "we" infrequently, whereas following that day I became very comfortable using it.

The CHB's criticism of the health system divided my loyalties, for I am concurrently a researcher, a member and a health care professional. Adler and Adler described the phenomena of conflict between two roles, member and researcher in the following passage:

> [Her] research experience was fraught by such "conflicts of consciousness." On one hand she felt the need to remain somewhat of a detached, objective and neutral observer in her research role. Yet her membership role demanded active commitment and involvement . . . . She felt as if she was betraying the movement through her dual commitment. The issue of betrayal was one she could not shake, and that came back to haunt her in her relations with members (Adler & Adler, 1987, p. 74).

The above quote affirmed my feelings of guilt and divided loyalties. I felt uneasy during the period that I compared the outcomes of our research with literature and theories. I trusted the integrity of the actual research process. The members validated the findings, but somehow applying those findings to theoretical "language" felt like a violation. I questioned my right to create my own theoretical conjecture. These emotional feeling were shared by other field researchers as evidenced in the following passage:

> She experienced a profound sense of betrayal. CMRs have such a strong commitment to and self-identification with the group they study that they have an especially hard time portraying them in the light of the detached analyst. They do not want to reveal the members' secrets and foibles, to hurt them in any way, or (most especially) to

show them that they thought of them in any way other than the way members think. Nearly all of these, though, must be done if the CMR is to write a theoretical analysis. The final road, then, is particularly difficult for the CMR (Adler & Adler, 1987, p. 80-81).

Research Questions

The research questions listed in Chapter I were determined prior to the initiation of the study. I based the questions on my interests and a perceived gap in knowledge regarding the development of people and communities. The methodology was chosen due to my personal need to contribute, to "make a difference," other than advancing theoretical knowledge. Establishing a research question before initiating participatory research was the first contradiction I encountered. Approaching a group of individuals with a request to study how they came to understand empowerment and participation did not create a participatory research study. By remaining responsive and flexible, I was able to incorporate my research questions into the query submitted by the CHB. After the CHB asked me to facilitate their own understanding and articulation of the elements that lead to community capacity building, the research became "participatory" and I sensed that my project did "make a difference."

I informed the CHB my research purpose and the questions that I sought to explore at our initial encounter and throughout the process members expressed a polite interest in my academic progress. However, their research questions were the focus of our participatory inquiry. Fortunately, the process of defining their values and vision led to their understanding of empowerment and participation as concepts integral to community development. Posing specific research questions before entering a contract with research participants was taking a risk. I also feared that my contribution as to the direction of the research process might be viewed as a form of manipulation in order to ensure my questions were addressed.

Participation and Empowerment

Participation

In conversations, before the workshop that led to the vision statement, the CHB members used the word "involvement" to indicate a presence. For example, in reference to a public meeting, poorly attended by community members, one person from the CHB said, "There was no community involvement." Another CHB member described the crowd that appeared at the protest against the withdrawal of physician services as a sign that the community did want to be involved. These statements demonstrated the careless use of the word "involvement." After reflecting on their own participatory experiences, all the CHB members articulated their understanding of participation.

The interview data analysis indicated that people considered participation as a positive experience when they personally contributed to an activity, another person's well-being or their own life. The vision defined "involved" as "people feeling their contribution was making a difference." All members enthusiastically agreed that "encouraging community involvement" was a primary focus in the improvement of health in their community. Yet exactly how this would be measured was not discussed during the meetings I attended. The literature also tended to promote the concept of participation without considering the how "participation" will be evidenced.

The exact role of the CHB, as a driver of the process of community development must be determined by the Department of Health, the WRHB and the CHBs and then clearly communicated throughout the province. The concept of participation takes on a completely different meaning in a model which delimits the CHB as a structure merely representing local communities in the operation of planning regional primary care services. In this role, the definition of participation becomes public consultation and input.

Abelson and Lomas (1996) coined the expression "voice" or "choice" to represent the levels of participation they were presenting. In an article regarding the process of public participation in the Ontario District Health Councils, they concluded that the public was content to have a "voice" and strategies for service planning should concentrate on designing public input processes.

If promoting "choice" is to be the goal of the CHB, their strategy must bring into focus the experience of individual participation. Unless an individual consciously makes the decision whether or not to be involved, there remains powerlessness or coercion. The issue is not measured by numbers in attendance, but by personal perceptions regarding choices and the anticipated outcomes. The essential element is the individual's perception of choice, control and ability to contribute.

At the visioning workshop there was a conversation based on how the CHB members would invite other people in the community to participate in various activities. There was an agreement that the CHB members could personally act as mentors for those people who lacked the skills and confidence to join. They spoke of widening the circle through personal connections. One member said, "We have to ask people how they each want to participate. Some just like to donate money and crafts. But even with that they want you to personally let them know how things are going." This member understood how different citizens may construct their "participation" and appreciated the diversity. Another CHB member devised his strategy for gathering participants. "I'll just act helpless and then after they do the job, I'll tell them how wonderful they did."

Freire defines a "subject" as a human that has "the capacity to adapt oneself to reality *plus* the critical capacity to make choices and to transform that reality. [A person becomes an 'object' when he] loses his ability to make choices and is subjected to the choices of others, to the extent that his decisions are no longer his own because they result from external prescriptions" (Freire, 1973, p. 4).

Personal Empowerment

The rapport established between the individual CHB members and myself during the one-to-one interviews was invaluable in securing a trusting relationship. The dialogue at this stage centered on who we were and how our worldviews converged on the community. In a small community, our social positions or occupational status represented a "code" that required deconstruction. The interpersonal skills acquired from my nursing practice were helpful at this stage of the process.

The interview data produced few disagreements among the participants related to the concepts of empowerment and participation. All CHB members had developed a level of individual participatory competence. Their experiences affirmed the RNABC's empowerment continuum (1992) and the validated the results of Kieffer (1984) and Lord and McFarlow (1990).

Most members of the CHB recognized empowerment as a fundament of health. They identified components of the concept such as overcoming a challenge, feeling successful and acknowledging the sense of achievement. Comments such as this one, " It seemed like I was able to help someone now, whereas two years ago someone got me to go to a meeting" illustrated the developmental nature of empowerment. Other members compared their own experiences with the health issues found in the community, noting "There are some my age who would want to figure out how we get these younger ones that have got the children . . . and do the things we did with our kids. We never had any money but we had a good time and it was wholesome." If empowerment is a conscious process that we enter voluntarily then primary to empowerment is the concept of participation.

The cohesion of the respondents' perception of empowerment and participation as essential elements of community development was unexpected to me. I reflected on my reaction and chastised myself. Why had I imagined, just because I had spent days researching the concepts of empowerment and participation, that I was an expert? It was because of our common understanding that the research questions determined by the CHB converged on the concepts I had selected to study.

<u>Promoting the understanding of personal empowerment.</u> A discussion took place at one meeting after someone suggested enlisting a youth to be on the CHB, in order to ensure representation. The use of dialogue as a method to critically reflect on the meaning of representation and tokenism allowed the CHB members to explore the whole issue of their membership. The members understood how individuals require personal empowerment before participating in groups: to do otherwise may only reinforce their perception of powerlessness (Travers, 1997). Instead of "plucking" an individual student, the board established links to several youth organizations and student councils. In this example, I facilitated the discussion, providing information I had gathered in my

research. The fact that I presented such knowledge led to further reflection on the propriety of offering "expertise."

Professionals and empowerment. Labonte (1987) described the need for professionals to develop an empowering practice in which they regard their "clients" as fellow community members, as people capable of making their own judgements. "Developmental casework" is the term used to indicate that not only are individuals supported when they need help but they are also linked to other individuals or groups that will continue to increase their growth. This requires that people providing the personal care consciously direct their interactions towards capacity building and the promotion of natural support networks. The need to care for individuals, yet build towards mutual support was recognized by the following CHB member:

> I have worked with Alzheimer's for years but I know there are some out there who haven't. There is a lady in <name> who really is getting anxious and she is afraid she is going to have to put her Mom in a home and she doesn't want to. I said to her, 'When you are getting really frustrated, give me a call and I will come out and give you a break' . . . . I would like to see an Alzheimer group out there in <name>.

The CHB is in a position to uncover and nurture these natural networks. They are the links to resources, often unrecognized or appreciated in this unique community. For example, one member observed:

> This foodbank, I think it is alright but still I know people that would give up parcels of land in the summer and somebody would plow it up so that people in groups could plant something and it would mean everybody, even the kids working again too. These young people don't know anything about growing.

Statements such as the one above were often voiced but quickly disregarded. People in the community assume that the "experts" have investigated such simple ideas and there is a good reason why it will not work. One CHB was discouraged, saying:

> We all have good ideas and some of them don't even cost anything but every time you have a good suggestion and go through the channels to reach the head, the head says, "Oh no we can't do that or it has been tried or if it has been done it has not been done well enough for us to be aware of."

John McKnight (1994) accused professionals, under the guise of "good intention" of destroying the natural associations that build a community. His theory of community capacity building claimed that service provision is a large industry dependent on the needs or problems of others to flourish. After describing two community initiatives, which he has been instrumental in facilitating, he commented:

> I worry over and over that even the saying of what we're saying will be heard by people who are managers and experts in systems, and that it will be quantified, systemized, administered, and all we will have done is guided the way for them to finally colonize more of the everyday life of community folks (p. 26).

Such a statement indicated an assumption no less disempowering than other stereotypes that serve to classify individuals. The notion that he must "guard" his secret for capacity building only served to perpetuate the us/them division that must be overcome. Participating in a critical analysis with my fellow community members compelled me to assess the distribution of power in the health care system as well as in the community. Learning about these forces *with* the CHB dispelled the myth that I was an expert.

We encountered confusion regarding the benefits or harm of professionals and services in relation to citizen health in the interview data and in the dialogue. There were clear opposing opinions expressed. The dialogue focusing on these contradictions led to an understanding that professionals, services and education are necessary, *as resources.* Services, or the lack of, were viewed as part of the solution not the problem. Reframing issues related to health care service cutbacks in this light provided CHB members with a sense of control, eliminating some of the panic that surfaced each time a rumour circulated. Members were able to pause and critically say, "OK, what was that program doing for us anyway?"

Whereas John McKnight implied that health care providers should be restricted in the services they administer in communities, Labonte inserted them as vital links in the development of a community. Before they were able to participate in the development of their community, professionals had to become personally empowered (Labonte, 1987). The CHB members decided to forge connections with the professionals in the Digby area, especially the physicians. One CHB member suggested a strategy that would inform the physicians how much the community valued them. Not all members were prepared to grant physicians such a position of privilege. One CHB member stated, "I think everyone can be volunteers, professionals included. I think everyone can give a small fraction of their time to make this a better community." Several members tried to arrange to meet with individual physicians but there was no reciprocal interest from the physicians.

The arguments put forth by McKnight and Labonte failed to isolate and highlight the heart of personal empowerment and the essential role of people who carry the image of an "expert." In Freire's portrayal of the people's struggle against oppression, he clearly identified factors that continued to manipulate or "domesticate" people. One such factor was the care provider who assumed recipients of the services were "objects." In "extending" expert knowledge without providing an opportunity for dialogue, the care provider was declaring the ignorance of the recipients (Freire, 1973). Therefore, the "professional" or "expert" can best foster the capacity of other individuals through personal dialogue *with* them, ideally in a position of *solidarity*.

Freire's language is reminiscent of peasant rebellions, which dissuades the application to our current Canadian health care system. However his conception of oppressors also being dehumanized may well illustrate the status some health care professionals, especially physicians, have been assigned. Freire postulated that dehumanization of oppressors occurs as they develop the conviction that *having* is a condition of *being* and consequently they no longer *are*, they merely *have*. "As the oppressed, fighting to be human, take away the oppressors' power to dominate and suppress, they restore to the oppressors the humanity they had lost in the exercise of oppression" (Freire, 1970, p. 42).

Freire defended the essentiality of dialogue despite protests claiming it was too time consuming, there were few successes and the oppressed lacked the ability to enter into dialogue. In his argument, Freire examined the societal structures that discouraged dialogical interactions and he linked the critical consciousness arising from dialogue to action based on changing these structures. Freire incorporated the perceptions of personal empowerment and group conscientization, as he described the process leading to civil reform. In this light, his theory parallels the empowerment continuum.

Group Conscientization

The empowerment continuum (RNABC, 1992) represents a linear relationship between the personal to political action "nodes" as does the "spiral" that I designed. The CHB came together and began as a community organization. The final questionnaire demonstrated a high level of agreement as to the benefit of the dialogue session in raising their awareness of each other and developing their collective vision. The community organization looks outward, identifying the causes of suffering and acting as a group to challenge those causes, while a small group nurtures the soul, turning inward to support the participants. Responses from three CHB members credited the connection to their fellow board members as a force that sustained their participation. This would support the notion that small group development did occur.

There were published reports available, illustrating the potential for group conscientization in oppressed populations (Freire, 1973; Maguire, 1987; Travers, 1997). The focus was on developing the critical consciousness of individuals as they learned to support each other. Travers described a group of women, who were dependent on government social assistance, that worked together in order to transform aspects of their world by becoming critically aware of social factors that impacted on their nutritional choices. She described this process as consciousness-raising that began with the experience of oppression. Maguire noted that conscientization was on her agenda, but not on those of her participants, female victims of domestic violence. Though the group of battered women that Maguire studied with benefited from the dialogue and developed a greater awareness of the causes of their own problems, they did not gain a structural analysis.

The population I worked with did not resemble an oppressed sector. They were vibrant, well-informed leaders in the community. They volunteered to participate in the CHB, confident they were able to contribute to the health of the community. Research published on community leaders undergoing further empowering experiences is rare. As I carried out various unsuccessful literature searches, I questioned whether researchers only conducted participatory research with disenfranchised groups. The reports I did locate indicated the participants came to together to research and act on a specific cause, such as an environmental concern (Comstock & Fox, 1993) or to research and act on issues regarding their profession (Labonte, 1993b). There was a lack of published participatory research studies in Canada and those that were available contained few descriptions of the process, as they focused on the outcomes (University of British Columbia, Institute of Health Promotion Research, 1995). If outcomes measure success, would a vision statement be our sole achievement?

There were problems translating Freire's model of popular or empowerment education to a situation where the subjects were not themselves in oppressive situations and the power struggles in society were hidden or more subtle than are those in the underdeveloped nations, such as Brazil. Labonte (1990) proposed that the North American cultural myths of classlessness and individualism prevent the simple identification of, and action against dominating forces. Labonte suggested that Freire's educative strategy "offers instead the opportunity for relatively alienated 'individuals' to redevelop a sense of collectivity. This sense of collectivity, in turn, is viewed as an essential step in the re-creation of communal value" (Labonte, 1990, p. 65).

The CHB benefited from the collective understanding towards their role and their vision. However the experience of this group extended into conscientization with the realization that citizens and communities have the right to determine their own needs. Applying Friere's terminology to a specific example, some CHB members came to understand that health care consumers have the right to be subjects in their relationships with professionals and agencies. Though the CHB did not represent an oppressed group they dispelled a common myth that several members held.

Community Organization

Analyzing the experience of the CHB as a group and community organization, in relation to my empowerment spiral and in comparison to the other information, created another reflective cycle. As a group, the Digby and Area Community Health Board demonstrated the criteria indicative of a spirited board (Houle, 1989). At the initial meetings, those CHB members previously on the steering committee were able to guide the others as they explored their own objectives and converged on the collective vision. As an observer, I was aware of a communicative culture that respected each individual's history but was mindful of the addressing the community as a whole. Freire (1973) identified cultural synthesis as a process that is required before groups can undergo conscientization. Cultural synthesis is achieved when people learn from, and appreciate each other's diversity and then agree on common goals on which to collectively act. It is compared to the process a small group undergoes as it evolves from a self-help group to a community organization.

The processes of empowerment and conscientization can result in groups acquiring an awareness of the forces that oppress them and the power to transform them. If these processes are to be encouraged in a reforming health care system then the CHB's response to the physician issue in Digby was a positive factor in their development. From that experience came a reflective cycle in which their understanding of at least four political structures was enhanced. The CHB critically explored the relationships between the elected provincial government, the Western Regional Health Board, the Nova Scotia Medical Society and the citizens of the Digby area following the protest. That analysis contributed to their identification of the need for a framework to guide some of their decisions, ensuring the CHB supports resources that add to the capacity of the community

The cycle that resulted in the vision clearly demonstrated the CHB's desire to build on the capacity of the people. As a group, they perceived their own capacity as being increased. This strengthened their resistance to restraining forces. I could not locate a description or even a story that portrayed what conscientization feels like. Does is just slowly build or was it the big "ah-ha" that the CHB members and myself experienced on the day of the workshop? It was at this point on the empowerment spiral that the CHB started to resist the instructions coming down the bureaucratic channels. Indeed, the Chairperson of the Digby and Area CHB shrugged off his reprimand from the WRHB administration following the CHB's involvement with the physician protest. The CHB members refused to comply with the procedures for completing the workbooks, and asked if they could have the funds instead of the "assistant." When they were bound to accept the assistant, they quickly organized their meetings without waiting for her. The chairperson told me that he challenged the WRHB on several issues at the last regional meeting and during a coffee break at the meeting, other CHB chairpersons thanked the Digby representative for expressing his thoughts. They too shared these concerns but were reluctant to voice them.

Labonte (1993a) captured a consternation shared by people advocating for systemic transformation. We should not confuse "participation in a bureaucratic process with participation in a social change process. Bureaucratic processes are inherently conservatizing, and the higher one goes in complex organizations the greater is the imperative to ensure that controversy is avoided, rather than created" (p. 65). The tension between the CHB's commitment to the citizens of their community and the protocols determined by the WRHB was growing. In August 1997 one CHB member predicated, "The next six months are going to make it or break it."

Coalition Building and Advocacy

The CHB discussed forming intersectoral working groups to initially address the health issues in their community, using a broad, loosely defined approach that would encourage public dialogue and critique. However, the provincial government had set aside monies for community health initiatives and a project proposal was soon required in order to qualify for funding this year. At the last meeting I attended, the members were very busy drafting their schedule for consulting representatives from various community groups. The emphasis appeared to be on collecting and compiling the information for submitting the plan to the WRHB.

Again drawing from the essays of Labonte (1993a) there are discernible characteristics of coalitions that define their intent. Institution-created coalitions are really an extension of community-based programming while community group coalitions usually arise from the community in reaction to a critical issue. Community group coalitions tend to seek a resolution in a manner that creates a power-over situation. Institution-created coalitions serve to coordinate and integrate services. As such, they perpetuate the current power relationships. Labonte described an often-neglected element in coalition building as the small group process that must take place between the representatives from separate community groups.

The CHB does have the potential for organizing groups within the community in order to take a stand on public policy issues. The extent to which they will challenge the social and political structures would depend on the community support and the WRHB's determination to retain control. CHB members displayed an awareness of the political forces, mistrust of the government and a sense of commitment to the community. Two of the most empowering features they possess are their recognized collective strength and their volunteer status. In one discussion concerning the CHB taking a position on an issue not favoured by the WRHB, one CHB member voiced, "What do we have to loose?"

Coalitions have been the founders of many Healthy Community projects. Based on the design of WHO's Healthy Cities promotion, the Canadian Healthy Communities Project, introduced in 1986, was source of funding that enabled communities to organize coalitions to plan, propose and implement projects that would demonstrate improved health in their community. Canadian Public Health agencies offered workshops and facilitation across Canada in order to encourage community groups to organize and apply for the funding. Local governments were expected to drive the process and provide the commitment to sustain projects. Participation was voluntary and the only city east of Quebec to engage in this program was Dartmouth, Nova Scotia (Poel & Pym, 1994).

Hoffman (1994) identified three models of community organizing: social planning, community development and social action. Social planning represents the intersectoral cooperation resulting from institutional-created coalitions. Hoffman credited the majority of Canada's Healthy Community projects for reaching beyond their mandated social planning role to endorsing community development. However, he noted that the relationships between some of the community committees and the Canadian Public Health Association became strained when there was a strong community development initiative, possible due to the Association's perceived loss of control.

Currently many Healthy Community projects continue to operate. British Columbia and Ontario appear to be the leaders, having incorporated the Healthy Community program under their provincial realm of health services.

In southwestern British Columbia a partnership between the University of British Columbia and the City of Richmond has resulted in a city wide urban planning project that is looking at indexes of "ecological carrying capacity" and "social caring capacity" (Hancock, 1996). "What makes this of more than academic interest is that the City of Richmond is now attempting to take these concepts and apply them in the development of planning guidelines and in the process of decision-making on planning applications" (p. 72).

In Toronto, the Healthy City Office, established in 1989, has a citywide mandate to pursue its three principal themes, namely equity, economy and environment. It is a political structure that is directed by a steering committee with representatives from a number of different government departments as well as community members. "One example of the way in which it does this [address the themes] is to present an annual series of awards (called "The Neighbourlies"), to community organizations that have shown leadership and initiative in the three areas" (Hancock, 1996, p.72).

I reviewed reports about Healthy Community projects across Canada. I also considered the missions of the two provinces that do have a central office or clearinghouse for their provincial projects. The B.C. Healthy Communities defines its role as a liaison between communities and other government boards, whereas the Ontario role includes community "animation" and facilitating healthy public policy establishment (British Columbia Healthy Communities, 1997; Ontario Healthy Communities Coalition. 1997). However, the community projects described by each of these provincial groups were very similar in their scope. Without a clear understanding of the intent of these projects, it is impossible to systematically analyze the qualitative data.

After collecting the above information, and reading the literature, I compared my understanding of Healthy Communities to the "spiral of empowerment." Do these coalitions address the concepts of empowerment and participation? One Healthy City project in England studied the effects of a new heating system in a housing tenement on the residents' health and levels of satisfaction with their housing. There was a positive correlation (Green 1996). Did the residents contribute to this project? Alternately, did a government department "do it for" them? Does it matter as long as the indicators demonstrated improved "health" status?

Poland (1996) observed that the emphasis has been on quantitative indicators as a means of evaluating Healthy City projects and suggested that, in order to address social inequities, a critical social perspective be included in the criteria for evaluation. The author provides examples of the political implications and the potential for uncovering inequities. "A participatory form of critical pedagogy might generate a context in which participants (ourselves and others) are challenged to explore the assumptions brought to the table and influencing daily practice" (p.242). Poland then cited a national project in which health promotion practitioners participating in small groups, told stories and critically analyzed these stories using a dialogical approach (Feather & Labonte, 1995). Having been a participant in that study myself, I refute the claim that it was an "empowering" experience. There was no group process and I was uncomfortable sharing my story, for the purpose of critique, with strange individuals. Resources advocating the use of participatory research as a tool for evaluation of Healthy Community initiatives (Poland, 1996), or as a measure of community empowerment (Israel et al., 1994), fail to provide concrete examples of how their suggestions will be operationalized.

Coalitions can be instrumental in advocating for changes in public policies. The trend has been for government to provide various entry points in the political system for submissions or expressions of concern relating to policy development. Rather than enhancing the effectiveness of coalition lobbying, the many task forces or commissions serve as a consultative process, thereby dissipating activist energies (Labonte, 1990). Papers presented at a health promotion symposium stated concerns about the evaluation of public policies. "Specific policies affect public behavior, but their health impact is difficult to assess [and] effectiveness evaluations have hidden assumptions" (Edwards, 1996, p. 27). We need "the development of better tools for health impact assessment, especially ones which take equity into consideration and incorporate the experience of people at the receiving end of policies" (Whitehead, 1996, p. 30).

A community empowerment model defies the "power-over" situations that may result when coalitions demand actions without long range planning. "A community empowerment model transcends hierarchical, patriarchal, coercive, or violent conceptualizations of power and challenges the assumption that power is a zero-sum commodity, that is increasing the power of one community, organization, or individual implies decreasing the power of another" (Israel et al., 1994, p. 154). To portray an "empowered" community as one without power struggles is misleading. One aspect that added to the lack of support for the Australian Health and Social Welfare Councils was their inability to represent the various voices of dissent in the community. To do so was viewed as criticism against the government (Baum et al., 1997). An empowered community is one based on the principles of democracy, opposing views are encouraged but common values are shared. Expressing disagreements may foster dialogue and lead to some consensual agreements. This, in turn, may lead to political action.

Political Action

A general interpretation of political action could be the support or stance emerging from a larger, more diverse population, based on shared values rather than a single issue. Political action may imply nothing less then a coup to overthrow the current government to some citizens, discouraging any involvement in "politics." If one follows the philosophy of Paulo Freire, such a radical action would represent "power over" and oppression would remain (1970). Oppressors only achieve equality when they are in concert *with* the people struggling for freedom. The forces that prevent individuals from actively participating in their own determination and alienating them from their "community" are the antithesis of democracy. Political action then should be based on the promotion of the values that lead to democratic participation for all citizens.

After World War II labour unions and other activist organizations accepted a guaranteed social security system in exchange for the support of a large bureaucratic government that controlled the majority of public policies. As the community welfare was essentially "taken care of" by the government, citizens centered their individual goals on collecting material goods and economic advantage (Heaney 1989).

The CHB members easily identified the societal contradictions influencing citizen participation and empowerment. The reliance on social programs necessitated passivity, in order to be cared for. A dependency on a diminished natural resource, fish, has led to poverty and hopelessness. Many victims of the lost fishing industry did not complete grade school and certainly have not had an opportunity to develop critical thinking. They were devastated, lacking the resources to explore other career options, and relied on government programs to provide their income.

The discussion that ensued after the threatened attempt by the physicians to cancel their services resulted in a critique of some of the well-established social hierarchy that was in this community. The CHB members identified how the accepted divisions in social status shaped an individual's health.

The culture of the Digby and area community sustained racial and geographic, as well as socioeconomic discrimination. This discrimination discouraged a number of members from participating. The CHB members blamed the capitalistic society for creating individualism, which disintegrated the community and spiritual fellowship.

The broad health issues identified by the CHB members contradicted the values displayed in their "utopias." These contradictions paralleled the three "P"s, policy, participation and political action, that have become representative of a proposed direction change for the Public Health Department in Ontario. The rational driving this departmental refocus was based on a list of research reports evidencing the effects of poverty and social class on health (Raphael, 1997). The following quote from the document, describing the growing detriments of social inequities, identifies how all classes are negatively affected.

> Increased economic inequality not only affects those on the bottom of the ladder but affects everyone, including those at the top. As a society begins to deteriorate, a result of increasing polarization and alienation, there is increasing lack of civility, decay in civil commitment and increased evidence of poor health. These may take the form of greater violence, increased risk behaviour, and increased crime. The rich begin to opt out of the public discourse. They send their children to private schools, lobby for two-tiered medical systems, hire security guards for their property and homes thereby heightening the move toward disintegration (Raphael, 1997, p. 5).

One CHB member in the initial interview noted the withdrawal of the "upper" class members from participating with community volunteer groups. She made the following comment:

> When I first came here physicians and teachers were active in community boards etc. It is tragic that they stay away because we have lost some of our natural leaders. Maybe the doctors do have to be made to feel as if they are vital and important to this community.

The comparisons between the factors affecting the health of citizens in the Digby and area community are congruent with those factors cited in the literature from the fields of adult education, health promotion and public health (Hancock, 1996: Heaney, 1989: Raphael, 1997). Such comparisons further reinforced the accuracy of the community health issues identified by the Digby and Area Community Health Board.

The CHB members frequently voiced their distrust for the government and its bureaucracy. They also acknowledged that distrust negatively affected citizen participation. They were not alone in their unease with placing confidence in the hierarchical structures that mold most public agencies but they did note that their optimism and hope for change was not commonly shared by other citizens.

In a recent on-line participatory research posting the author, Pablo Leal, described how organizations have appropriated the words "participation" and "empowerment," thereby rendering them as components of management theory. The main goal of management is to enable workers to effectively and efficiently achieve the mission of the employer. He reminded us that those concepts flowed from emancipatory teachers, such as Freire, and advised us not to loose sight of their real meaning.

His critique of two community development projects currently building industry in third world countries illustrated how people can be "culturally invaded" by agencies who use participation and empowerment as strategies to facilitate development of the industry. He also objected to "scaling up" of empowering projects as he maintained that participation is only possible at the human level. "So if participatory processes are to be truly emancipatory processes, they need to be articulated to the struggles for construction of meanings (and identities, for that matter), since power is also concerned with the control of cultural codes and thus, it is these struggles which re-interpret participatory democracy in civil society" (Pablo Leal, personal communication, August 27, 1997).

As I endeavored to organize the discourse from various documented political theories, I came across a resource that illustrated some of the irony between "formal" theory and how the CHB members perceived the concepts of participation and empowerment. The source was a series of workbooks designed to renew democratic citizenry. The phrase they used to capture the principle of democratic engagement was "making a difference" (National Commission for the Renewal of American Democracy, 1995).

As I expanded my reflections from personal empowerment to the political and social issues, I drew on the writings of philosophers, educators and researchers. Though the spiral guided me through the cycles, I always returned to the personal level to create my understanding. I constantly reverted to comments made by various CHB members in my attempts to integrate theory into meaning. Repeatedly I was struck by the insight these individuals brought to our discussions as they, too, were interpreting their personal understandings. In effect, the political is personal, as at the moment we shared that common vision we committed ourselves to collectively stand up for those values written on the flipchart. Yet, each of us constructed a personal meaning to that vision. The dialogue enabled us to work through the individual agreements and disagreements, coming to the common understanding.

The Role of Theory

Theory in Participatory Research

The literature on critical theory and participatory research presented contradictory applications of the theory. Literature describing the potential effects of critical inquiry on subject emancipation frequently does not contain explicit evidence to back up the presuppositions. In fact, Fay (1975) in his widely quoted reference book admitted that the critical theory was untested in the manner he proposed. Participatory research reports often neglected to apply the theory described in their literature review to the actual study. Some evaluation reports of projects that cited their objective was to improve health had no mention of theory at all. These reports prevented the reader from acquiring an understanding of the intent of these projects, and blocked the ability of the reader to critique the success of these "healthy" projects.

Is the lack of attention to theory in participatory research publications an attempt by the researcher to suppress the image of an "expert" researcher? Alternatively, was the theoretical intent of the study not conveyed to the participants in fear they may not agree with the theory? To deny the intent of a participatory research project is a form of manipulation by the researcher. The theory of the researcher would best serve the purpose of the critical inquiry if the researcher shared it with the participants. It would provide an opportunity for the participants to dialogue and "test" the researcher's theory against the participants' assumptions. I was surprised to find how closely my theoretical understanding of community development matched the individual interview respondents. The main difference was in the language that we chose to represent our images.

Research based on critical theory conveys a conscious intent to promote change. For such research to be participatory, the researcher must communicate this intent to the participants. I found that a simple statement such as "I would like us to work together to make things better" helped clarify my interest and commitment to the participants. Many of the theories in social science are about people, yet the terminology prohibits their communication. The terms created by Freire have been inserted in the language of health and education, resulting in the same potential for manipulation that befell health promotion discourse (Grace, 1991). Fay's (1975) description of activities required of a critical social scientist used technical language often connected with positivist research. I was unable to translate it to a denomination that would permit comparison to my own theory of critical inquiry. In effect, by presenting his theory in such unfriendly language the theorist had rendered it "anti-dialogical."

Blake Poland (1996) compared the various studies conducted, world wide, on the Healthy City or Healthy Community projects. He concluded that, while these projects were evaluated locally, there was a lack of systematic inquiry addressing effects of the Healthy Community movement towards the determinants of health at the macro level. Recognizing the political value-laden nature surrounding the choice of a universal theory or method, Poland suggested combining the generic questions based on the principles of the macro issues with local participatory research approaches. He recommended a local participatory research process that "encourages sustained reflection of assumptions, issues of power and so-forth (as per a critical social perspective . . .) and that assists in the development of conceptual models rooted in (and derived from) local practice" (p. 347).

Dr. Poland and several of his research colleagues have been meeting since 1993 in order to develop a framework in which to establish tools for local self-evaluations of healthy community projects. In that period they have been making presentations based on the proposals put forth in Poland's paper, along with approaching many practitioners involved in Healthy Community initiatives across Canada, seeking their input in the study design. At the time of writing this thesis, Dr. Poland was unaware of other participatory research studies conducted with local health councils (personal communication, September 29 1997).

Personal Theory

Theory is the understanding that consciously guides action. Freire claimed "We must have a clear and lucid grasp of our action (which implies a theory) whether we wish to or not" (p. 112). He alleged theory arose from a deliberate reflection regarding the purpose and the efficacy of our actions. This theory is a point of reference when making further choices. As such, theory development is a means mobilizing individuals to act as subjects in their own world. Theory also is a means of conceptualizing and communicating values. Dialogue provides a forum for discussion that challenges our personal theories, leading to an awareness of common values.

Without theory, there is no *intent.* When we are unaware of our intent, we risk becoming objects, as defined by Freire (1973). If we do not openly communicate our intent in our relationships with others, we risk being manipulative or oppressive. My understanding of the role theory was enlightening to me, as I no longer perceived restraint in my ability to express my own theories

The CHB's development of their values and vision was a method of identifying their conceptual framework. In this framework they placed the concepts of participation and community development and incorporated their theories of health, empowerment and capacity building.

Theories consist of concepts linked by propositions, which indicate the relationships of these concepts, and infer the outcomes of applying the theory to reality (Polit and Hungler, 1991). The CHB's vision or theory proposed that, by shifting to a social system where individuals and communities are respected as being capable of making their own decisions, eventually people would realize their actions "make a difference." Analyzing individual experiences of the CHB members, the board was able to identify negative and positive factors that validated its collective theory. This theory, in clarifying the CHB's understanding of the relationships between participation, local control, capacity building and health, communicated the *intent* of their actions. It allowed them to establish guidelines for future decision-making and action and it will enable ongoing evaluation.

During the period of my research, I had the opportunity to discuss my findings with chairpersons from two other CHBs in the Western Region. Both described how their CHBs had also developed a vision. However there had not been encouragement from the WRHB for the CHBs to share their visions. If the CHBs did discover that they all supported a common vision and the intent of their actions was clearly communicated, would their position as a political force be strengthened? Local theories may be the dots that connect to create the paradigm shift required to achieve a primary health care system.

CHAPTER V

Summary, Limitations, Implications and Conclusion

Summary

The purpose of this study was to explore and describe the experience of community health board members as they participated in health planning. The research questions stemmed from a lack of attention in past research as to how people, in the role of board members, came to understand the meaning of participation and empowerment in relation to the development of health in their community. The questions, themselves, failed to capture the intent of the research study which was implied in the choice of participatory research methodology and the use of critical theory as a conceptual framework. The researcher's role became one of participant and facilitator in the process of experiential learning that the community health board underwent in order to develop the critical awareness necessary to foster empowerment and citizen participation in their community.

Participatory research is a methodology that by its nature is open to the application of various methods of investigation. As it continues to gain popularity, especially in the research fields of adult education, sociology and health promotion, participatory research is becoming a term that is carelessly applied. Often there is a lack of clarity regarding the theoretical underpinning of participatory research methodology, presenting a contradiction of its own ideology. Whereas some researchers claimed that consciousness raising was a method of participatory research (Henderson, 1995), others were reluctant to assert any theoretical representations, fearing such action may be a form of domination (Maguire, 1987).

Fals-Borda (1991) described participatory research, with its cycles of research, reflection and action, as a spiral that increased the participants' sense of control and competence with each successful cycle. Rather than providing a summary by means of reducing the findings or discussion previously presented in Chapters III and IV, I have outlined the primary issues and new understandings that were illuminated during the reflective cycles.

Entering a participatory research study in order to fulfill an academic requirement is risky. I was fortunate in having the stability in my home and work that permitted the long wait before CHBs did become established. Though generally people were supportive of my research design and the group I proposed to study with, I did receive some words of caution. The project appeared to be unmanageable and difficult to operationalize. Perhaps the lack of a well-defined research plan was discomforting to persons aligned with positivistic research.

During the individual interviews, the CHB members freely shared their theories with me, although I did not name their understanding as a theory at that time. As I prepared the thesis document, I reread all of the interview data, recognizing how closely their interpretations of their personal experiences resembled some of the "labeled" theories that I had been taught in my undergraduate university education. One CHB member carefully outlined her understanding of the stages individuals must go through before they are able to change and I realized that some of my ingrained assumptions were faulty. For example, I had unconsciously believed that Lewin had invented the process of change and only those who attended institutions of higher learning could know about this theory.

I accepted that my assumptions regarding other peoples' understanding of the broad definition of health and societal factors affecting health were wrong. Initially this conscious acknowledgement provoked feelings of confusion and guilt. This cycle contributed to a personal transformation and a renewed appreciation for the capacities individuals and communities have. I learned so many interesting facets of peoples' histories that I developed a new respect for individual wisdom and other worldviews. At this time, I found the philosophy and writing of Paulo Freire (1970) particularly useful. After I interpreted his language and applied it to my present environment, my awareness of oppressive situations increased.

My role as a researcher, rather than a CHB member, maintained my position as an "outsider" until the dialogue session that led to the creation of the vision statement. The vision statement represented the culmination of the dialogue, the group conscientization and our personal understandings of empowerment and participation. Though the statement captured the collective theory, it failed to communicate the process we underwent to arrive at one sentence.

One aspect of the research project that I had not anticipated was the emotional connection that I made with the individual CHB members and the board as a whole. Perhaps, because I am surrounded by increasing cynicism and voiced negative expectations from other health care providers and consumers, I lost sight of the positive strengths that abound. While this experience renewed my faith in the abilities of citizens, it did create a practical dilemma as I began to resent and object to professional and bureaucratic actions that interfered with the CHB's development.

I planned to exit the field after nine months of working with the CHB in order to write the thesis and fulfill my academic obligations. Fortunately I did not physically leave the community and my friendship with the CHB members can continue. At this point, I am no longer attending meetings, but I still receive the CHB's meeting records. There is a formal link to the CHB through my position of employment, providing ongoing interactions. Perhaps there will be an opportunity for me to further this research with the CHB again in the future.

The stories, theories and dialogue I shared with the CHB members addressed my thesis questions. The research process, through the facilitation of dialogue, accounted for one aspect of how the CHB members came to understand, collectively, the concepts of participation and empowerment in relation to the health of individuals and their community. However, our worldview is constantly reshaping our understanding as we continuously experience new challenges. The research project only captured a snapshot of a life long learning process.

As a subject of my own research design I came to understand how the concepts of empowerment and participation relate to the process of community development and the health of the citizens in the Digby area. I clarified my personal theoretical representation of the above concepts in line with the empowerment continuum presented by RNABC (1992) and the spiral as suggested by Fals-Borda (1991). With each reflective cycle in the research process I became more confident that my theory communicated my beliefs and propositions. I welcomed the opportunity to introduce it to other people and encouraged their critiques.

The research process engaged the participants in dialogue that formed a critical analysis of our own theories and understanding. This analysis, the essence of participatory research methodology, extended our understanding to a level that transcended the assumptions we all held. Removing our preconceptions enabled us to become critically conscious of the factors preventing the generation of a healthy community. This new level of understanding also created a sense of discovery which strengthened the group's commitment.

Limitations

Participatory research methodology primarily benefits the participants rather than generating or testing theory. As such the reports are often in the form of a summarized case study. Though I did not require evidence of reliability or validity in participatory research reports, I found it useful to compare the various case studies in order to extract information that helped in the design of my research project. To aid in the comparison of this research study to other participatory research studies I have highlighted the characteristics that I found to be unique in this research.

The participants in this research study were individuals who had established their personal sense of empowerment. They had volunteered to be on the Digby and Area Community Health Board, as they were confident that they could contribute as community representatives. This population differed from those of most of the participatory research projects I reviewed. The majority of the studies indicated that the researcher elected to work with groups of disempowered individuals.

The CHB formed to fulfill a defined function within the organizational structure of a government system. This represents an "artificial" link in the empowerment continuum as these individuals came to together as a community organization. Most of the reported participatory research was conducted with people who came together as a group in order to act upon issues that personally affected all of the members. Commonly, these groups were located outside of the government bureaucracy.

I conducted the research in Digby, the community that I lived and worked in. This fact may have eased the field entry but it required conscious attention to dispelling any myths regarding my bias or "expertise." I was worried, initially, that the CHB would look to me for direction, but that did not happen. Being a member of the community added to the benefits of participatory research as it provided an opportunity to correct our assumptions regarding each other and establish an enduring partnership.

Being a novice researcher and conducting a research methodology not commonly used by graduate nursing students was ambitious. The rural location further distanced me from ongoing interactions and consultations with experienced researchers.

I initially planned for a period of 18 months to work as a participant with the CHB. However, the dormant period spent waiting for the formation of CHBs reduced the time I was able to allot to the fieldwork. An additional six months studying with the CHB would have added to the exploration of the CHB members' understanding of empowerment, participation and community development. As I concluded the research, the CHB members were just beginning to conceptualize how they would influence the health of their community.

The final limitation evolves around the ethical notion of confidentiality and censorship. In documenting the research process and preparing a written thesis there were examples, other than the excerpts I chose, from the CHB's discussions that may have provided a clearer illustration of the themes. I weighed the benefit of a graphic illustration against the harm of printing a sensitive or controversial conversation.

Implications

The wide scope of this research study uncovered many implications for action, education and research in order to promote and further the understanding of the concepts of empowerment and participation and the process of community development in relation to health. The most startling implication lies in the need for all people who are truly committed to shifting from our current "paternalistic" health care system to a primary health care system to recognize that this shift necessitates social change. This shift is mandated in the WHO's Primary Health Care Report, which emphasized that all people have the right to equality and the opportunity to participate in decisions concerning their lives (Martin, 1997). Health is purposeful. Therefore I have described a broad conceptualization of what the social change could resemble, followed by the implications that would stem from that idealization. I classified the salient points under the following: implications for professional practice, education, research and the future of Community Health Boards in Nova Scotia. Health care professionals are defined as people that have received specialized training, including a theoretical education, and they practice under a set of principles and regulations.

Implications for Social Change

I based the implications on the premise that health care practitioners support the goal of social change leading towards the establishment of primary health care. The definition of primary health care incorporates all aspects of a person's life (N.S. Department of Health, November 1996). The CHB members were provided with a broad definition of primary health care and a list of nine factors affecting health. The intent of primary health care was unclear: the intent being to reduce the social and economic inequalities that prevent all humans from becoming subjects in their own world.

The social inequalities are becoming one of the major influences in people's health, perhaps more so than economic inequalities alone (Raphael, 1997). The basis for this effect may be related to a sense of immobility within one's social sphere, the assumed rewards of our capitalistic society are too far from reach. This perceived lack of significance or control restricts voluntary participation, in effect, limiting the sense of "making a difference." These individuals retain a sense of incapacity that deflects external forces that attempt to educate or service them.

Rachlis and Kushner (1994) surveyed the Canadian Constitution, the Canada Health Act, and various provincial constitutions. They concluded that the most important core value that Canadians seek in health and health care is equity. The authors stated the present health care system does not reflect this value. Equal access to health care services is not synonymous with equal access to health. Despite the leadership Canada has demonstrated in the setting of health policies, there has been an inability to implement changes that significantly alter the status quo of the health care system. The current health care system serves powerful groups such as the medical profession, drug companies, hospitals, and private insurance companies. Rachlis and Kushner (1994) claimed that the present structure of the health care system prevents groups such as nurses, community agencies, health care institution employees and patients from becoming organized in order to challenge the dominant forces.

Also affecting the reform process are the factors of public ideologies and beliefs.

Ideologies are the core values we hold, such as equity, while beliefs are our understanding of how people have equal opportunities to participate in their own health decisions. Rachlis and Kushner noted that the public's beliefs are "somewhat out of synch with those expressed by the various Canadian commissions that have recommended fundamental health reform" (1994, p. 229).

Implications for Professional Practice

The majority of health care workers in Nova Scotia practice in bureaucratic institutions or agencies such as hospitals, home care agencies or public health agencies. Baumgart (1992) noted that there are inherent tensions arising when professionals educated to believe in a holistic, individualist approach are expected to practice under organizational policies and procedures that restrict this approach. The fact that these tensions become silenced or reduced to ineffectual "whining" has been compared to the oppression of nurses (Roberts, 1983). While acknowledging that political and policy level changes are necessary, the primary focus of this thesis is on the factors affecting participation and empowerment at the personal, group and organizational levels of a social change continuum.

Ironically, I found this section one of the most difficult to write. From my experience in exploring concepts related to health with the CHB members, I discovered some of my assumptions about other people's understanding to be incorrect. As I explored the implications of this research for professional practice, I found myself hesitating. I became aware that my understanding of the practices of other professionals is largely based on assumptions. I do not really understand how nurses experience their work yet I am a nurse manager. Nurses may verbalize their anger to me about lack of time to spend with patients but when I see that their actions do not reflect a patient focus, I discount their words. I have not created the opportunity for the nurses and myself to engage in a dialogue regarding the discrepancies I observe and they experience. Furthermore, in my political naiveté I cannot comprehend how large bodies of health professionals, such as nurses, have been unable to organize themselves in order to collectively promote an important vision of their profession.

The findings of this research indicated that the CHB members held common beliefs that did align with the direction of primary health care. When provided the opportunity, they discussed their common values, converging on a common vision. They also recognized that individually they contributed to the health of the community by personally establishing connections and inviting participation with other community members. As these findings oppose the statement that Rachlis and Kushner (1994) presented regarding public beliefs, is it reasonable to challenge the statements about the inability of repressed groups, such as nurses, to affect changes to the status quo?

Individually, as health care professionals we need to develop a reflective practice by identifying our own theories and reflecting upon our actions in order to determine the contradictions that disable an empowering practice. Nursing education provides the values, theory and skills necessary to support an empowering client interaction. A communication skill textbook used in a Canadian undergraduate nursing degree program described the helper-client interaction as being a relationship built upon collaboration in which both parties experience positive changes (Egan, 1994). Is the experience of professional-client interactions considered participatory? Do these experiences with our clients or peers lead to our professional sense of empowerment?

These questions arise from the intent to advance a process of personal empowerment for individuals that we interact with and ourselves. Such a process includes developing insight into one's own values, visioning one's own theories, understanding the internal barriers to change and developing a sense of self in relation to other human beings. From the reflective cycles that occurred during my interactions with the CHB members, I acquired a clarification of my own vision.

The Digby and Area CHB's vision depicted health professionals acting as resources used by individuals or the community. If we reframe our practice theories to align with the CHB's vision, then how does that affect our notions of control and professionalism? There is a balance between acting as a resource, representing a field that one has a high level of knowledge in, and creating the image of an "expert." The only way to overcome this is to develop a genuine respect for the knowledge that all human beings have and a genuine interest in what the knowledge imparted means to the recipient. Such a practice requires authentic participation by both parties. Clients require information presented in a problem-posing approach with an opportunity to share interpretations with the practitioner.

Labonte (1987) described an empowering professional practice as one that rests on the principles of the community's self-determination of problems and solutions. He warned that professionals, becoming frustrated by bureaucratic institutions have idealized communities, yet communities are often not organized, cohesive or empowered.

Baumgart (1992) acknowledged that primary health care is a philosophy that all nurses should aspire to. However, she restricted her example illustrating the application of a primary health care philosophy in practice, to public health nursing. I, too, have used public health nursing as a depiction of an "empowering" practice as it is a field that recognizes community development as part of its mandate. My personal background is grounded in the field of public health nursing and I am less likely to make unfounded assumptions. The challenge we must not loose sight of is the incorporation of a primary health care philosophy in the theories and actions of those health care professionals who practice in institutions.

Public Health nurses are in a position to promote personal and group development in the community. The public has accepted these nurses into their homes and this privilege allows nurses to develop trusting relationships with individuals who otherwise would be disenfranchised, unable to seek help. The nurse establishes a relationship with the intent to build a level of competency and the sense of self that would enable these individuals to interact with other individuals with similar interests. The nurse then can promote a link to support groups or social networks that would support their client.

In the practice of public health nursing there are opportunities to interact with community groups that share a common goal. For example, in Digby there was a group of women, including myself, as a public health nurse, which had been instrumental in founding the Well Women's Clinics. This group listened to women coming to the clinics and concluded there was a growing wealth of knowledge about women's health in this community. In order to facilitate a forum for the sharing of this information with each other and the public they established a location and a date, and provided the administrative tasks that such an event requires. The conditions that led to the voluntary participation of 18 groups included a personal invitation to each group by one member of the founding committee, and an indication that their participation would "make a difference." Eighteen displays were set up in the local Legion and representatives of each participating group or agency remained at the site for over six hours. There was often casual conversation between health professionals and members of the community that analyzed the health care system and its negative affect on the ability of women to participate in decisions relating to their health. Perhaps, if recognized, this group could collectively form to address women's health issues as a community coalition. Health care professionals, in their intent to reduce inequities in health, should be consciously aware of such opportunities to facilitate the organization of groups in response to health issues.

If, in our practice, we apply theories and assume they fit, we may be guilty of forming unjustified assumptions. Such is the case of oppression and nursing. As nurses became aware of the health care system's disempowering effect on their practice, they placed the blame on the system. Not only has this served to immobilize many staff nurses, but nurses who accept management positions, with the intent of facilitating change, may be viewed by their colleagues as representatives of the system and no longer a voice for nursing. Oppression theory labels nurses who enter the field of bureaucratic administration as "queen bees" claiming they take on the characteristics of the oppressors (Roberts, 1983). This division prevents the profession of nursing from establishing a collective voice at a level that may affect organizational change.

The current health care system is based on the concept of "cultural invasion" or paternalism. The employees of health service organizations have come to expect security in exchange for obedience and any threat of an impending change creates a perception of an unsafe working environment. If we shift to "cultural synthesis," an environment in which we honour diversity but work towards a common vision, it will necessitate reflecting on the contradictions between job security and a practice based on the value of human development. It is only through the establishment and continuation of dialogical relationships that nursing administrators and staff nurses will collectively develop a critical consciousness of the factors that oppose empowering practices. However, such a process requires a commitment of time and the willingness to share from all of the participants.

The findings of this research added to my understanding regarding team or committee meetings, routinely held in many health care organizations. Maintaining staff attendance and interest has always been difficult. Not surprisingly, the committees most poorly attended by staff are those that serve to handout information, elicit staff input, have little discussion and result in no action.

Health care professionals have sought to define their practice boundaries and establish their professional status. Even practitioners who aspire to "do" community development have attempted to create ownership of their specialized skills (Labonte, 1993b). Placing the practice of health promotion under the wing of one group of practitioners, rather than consider it as a principle for all to advance, has led to the bureaucratization of health promotion (Rachlis & Kushner, 1994). In the search for professional autonomy, have we not only perpetuated the individualism that thwarts social change? We need to refocus our energy on human social issues, looking outward, rather than inward. If health practitioners are accountable to, and accept the legitimacy of CHB, horizontal obligations will arise. The CHB may instill a collective vision and facilitate in the group development of representatives from various health care professions.

In our professional role, we have to seek opportunities to enter dialogue with our colleagues. By appreciating the knowledge and experiences of all health care professionals, we can learn from each other and collectively define our mutual understanding of health. This is a major implication, as my perception is that health care professionals have divergent interpretations of health as well as incongruent *intentions* of practice.

In summary, we have been unable, as health care professionals to shift the status quo of our health care system to a primary health care system. Forces currently dominating our system can be challenged if we collectively develop a critical consciousness of the assumptions that act as barriers. In order to initiate this process professionals must participate in interactions that foster mutual empowerment, with the *intent* to reduce social inequities and increase human subjectivity and mobility.

Implications for Education

Education is a process involving experiencing information through one's worldview rather than the "banking" of data. The goal of education is to provide individuals with the ability to use knowledge as a means for developing their capacity to critically analyze their reality, make choices, and act upon their decisions. For adult learners, this goal needs to be explicitly stated as most adults have been socialized to expect education to be transmitted to passive students.

Fostering the development of critical thinking in students is an educational standard in most modern school systems in Canada. The method to do so centres around the teacher encouraging students to question "why" (Brookfield, 1988). This research study indicated that, if education is to be emancipatory, the dialogue could not be restricted to students as the sole learners. Teachers must join in the process as mutual learners.

Heaney (1989) claimed that the field of adult education has been unable to forward the philosophy of Freire in the current political situation, which leaves the reader with a sense of pessimism. I would suggest that if the principles of Freire's communicative strategies were widely practiced, there would be a discernable change in the educative approach at all levels. I have become acutely aware of situations where I "extend" my knowledge in such a way that it can be viewed as "power over."

Professional education. One of the major tasks facing the education and "production" of health care professionals is the critique and "debunking" of the image certain professions portray. Some characteristics of a professional image include expertise, autonomy, independence and self-determination. All of these traits can be barriers in relationships that value equality and mutual learning. It becomes more difficult to address the myths of professionalism after one leaves the educational system as the public coverts the image. Students have the opportunity to engage in dialogue that will increase their understanding of societal expectations and increase their ability to resist conforming to the "image."

Health professionals, such as nurses are required to complete practicums. Often they are assigned to a preceptor, an experienced practitioner who is not an academic teacher. After completing their training session they return to the educational institution and recount the experience by way of a written report or verbal presentation. Such experiences are the grounds on which to critically analyze the structural and philosophical barriers that were perceived as contradictions to the theoretical framework under which the student planned to practice. A further means to expand this opportunity for dialogue would be to invite the preceptor to participate in the dialogue.

Students should be encouraged to develop their own theories for various phenomena in their lives, rather than accepting theories that are defined and labeled. After describing their own theory, they can compare it to a theory already formulated. Such a mechanism will bestow an appreciation for knowledge that all people create and it will further validate defined theories.

One barrier to change in the health care system is the autonomy of various health care professions. As many health care professionals receive their undergraduate education at a common university there is the opportunity to integrate their curricula, especially in subjects relating to social issues. Combine students from different professions, such as physicians and nurses, in study groups and assign participatory research projects. In collaboration, they learn about social perceptions with and from each other.

Continuing education. Rural locations have few opportunities for on-site continuing education programs as they lack the numbers of individuals practicing to justify the expense of transporting educational resources. Health care professionals must commonly travel to the urban centres to attend continuing educational sessions. The dimension of rural identity is relevant to this thesis in its consideration as an oppressive factor. Rural practitioners may assume they lack the experience and expertise of their urban counterparts, so when they do attend educational sessions in the cities they may be uncomfortable participating in discussions or posing questions. Organizers of professional continuing educational sessions must be sensitive to the diverse backgrounds of their learners, providing opportunities for the sharing of rural and urban experiences.

Distance and online educational programs are rapidly increasing the ease of accessing continuing and graduate education for health care professionals. Some programs include a mechanism for discussion, such as teleconferencing and online chatting, but other distance programs provide written or taped resources only. This study demonstrated the value of exchanging human dialogue, which leads me to question how a non-interactive distance program can advance critical consciousness in the students.

Graduate education. Graduate education is considered to be a formal undertaking by an individual that seeks to advance her professional status and personal abilities. Some people view it as a means to personally "get ahead." We should emphasize the increased ability to contribute to fields related to health rather than the personal scholarship that one has achieved.

Graduate students do conduct meaningful research studies that contribute to our knowledge and understanding. To be accessible, we must publish our research in journals read by students, professional colleagues and the population involved in the research study. The articles published in professional health care journals should be included in the bibliographies or reading lists of future students. An audience that would be valuable to reach is the public affected by CHBs. For example, I should submit articles stemming from this research to a public health journal and to a local publication, such as the WRHB newsletter or the local health centre's web page.

I observed during my graduate education, that the position of a student affords one the privilege of entering practical and social situations normally restricted to "authorized" persons only. Students carry a non-threatening image but are also often an undervalued source of education for practitioners.

Public education. The Digby and Area CHB appreciated the value of continuous learning and they identified the lack of regard that some members of their community have towards the process of education as a health issue. Their analysis of the theme of health education led to the conclusion that public education programs were best used as solutions to community determined problems. The Digby and Area CHB did not want the lack of programs to be their problems. How to develop health education in order to act as a resource for individuals or communities requires further exploration.

Implications for Research

The following implications address the process of conducting and disseminating research rather than the identification of further topics of which to investigate. In participatory research methodology, the topic is secondary to how the process benefits the participants.

Participatory research proved to be a methodology that permitted me to incorporate my personal values and my practice into the research process. It has resulted in benefits for my community, and myself, which extend beyond the research study. Yet there were barriers that almost derailed the process and there were supports that helped me back on track.

One barrier that I still attend to is my own lack of confidence in the role as a researcher. I feel alienated because my physical location is outside the urban and academic centres that house the majority of academic researchers. I miss the opportunities to enter dialogical encounters with research colleagues and often acquire my information from traditional sources such as written reports or large audience presentations. As such I learn from others but do not appreciate that I have something to contribute.

Another barrier was the inaccessibility of research studies to people "outside" of the affiliated learning institution. Maguire (1987) echoed this observation as she conducted searches for reported participatory research projects. A database listing graduate thesis topics and abstracts that is universally accessible would be possible now with electronic transmission. Using Internet discussion groups, it is possible to include distance students in such activities as student "thesis clubs." At this time, student discussion groups tend to post notices, not initiate debates. In an other electronic participatory research discussion group the postings usually are submitted by individuals that include their scholarly credentials and university affiliation. I was somewhat intimidated and lacked the confidence to insert my thoughts or observations.

I constructed the above barriers from my own perceptions. In lacking appreciation for my own knowledge and understanding, I risked paralysis. During a long dormant period in the research study, I received an invitation to participate in a research conference and that expression of interest sustained my thesis involvement for the next six months. Following my presentation in the urban centre, I offered to share my experiences at a local research symposium but the organizers said there was no interest in such an activity. We need to foster an appreciation for local knowledge and to dispel the aura that elevates formal research to a level where it defies critique.

All research is meaningful and by denying the significance of student research it will continue to remain hidden. Student participatory research studies have the potential to be another set of connecting dots if we develop horizontal support links and share our evolving understandings. We should celebrate our contribution by confidently publishing and publicizing our research.

I appreciated the opportunity to participate in a project that allowed me to promote my values. As a nurse, my practice fosters personal empowerment and interpersonal relationships and it was important to use a research methodology that advanced those strengths. I also wished to contribute to primary health care and the social shift necessary to reduce inequities. Part of the research design should include how this research will "make a difference" in the researcher's practice, profession or society.

Recommendations for future research. The whole issue surrounding the CHB development and the effect this structure has on the advancement of a primary health care system requires continued ongoing research. As it represents a historical phenomenon, not only should various research studies with differing approaches be encouraged, but also there needs to be a process for collecting and comparing these studies. I see this as a role that universities can assume, thereby assuring that student research does contribute to our understanding of social issues.

One issue that surfaced in several of the CHB discussions and in the literature is the notion of representativeness. The CHB members were empowered individuals that saw themselves representing and being accountable to the local citizens. Further research is needed to address whether the local citizens and health care professionals perceive the CHB as an accessible and representative body.

Continued research conducted with the Digby and Area Community Health Board would be valuable in determining if the process of conscientization continues between the CHB board members. Their ability to continue to base their decisions on their own vision also requires continued monitoring. It would be unfortunate to loose the opportunity to research and record actual factors that interfere with a community board that demonstrates the potential to contribute to the capacity building of their community.

Studies are needed to determine to what extent health care practitioners view their service as a resource to self-determined individuals and communities. How will this vision alter professional practices?

The CHB discussed, at length, the association between physicians and the issues relating to the health of the citizens in their community. Some of the questions they posed were rooted in the present status of the physicians as community members. For example, they asked, do physicians feel they are alienated from the community? Do they feel devalued? Do they respect local knowledge? A participatory research project with members of the CHB and the local physicians would be valuable in creating a common understanding of the contribution of the medical profession towards the capacity building process of their shared community. It may even initiate the freeing of the oppressors by the oppressed, a necessary action in order to realize reform (Freire, 1970).

Other research questions that surfaced during this research study were in response to my discovery that, often what I accepted to be a truth was, in fact, an untested assumption. Questions left unanswered include, how do professionals such as nurses understand the concepts of empowerment and participation? Can professional-client interactions be truly participatory? Do these experiences with clients or peers lead to a professional sense of empowerment? How do they relate these concepts to the health of their clients? What do the nurses perceive as barriers to the establishment of an empowering practice? How does a body of professionals envision challenging the current health care system in order to promote a system that creates equal opportunities for participation? This flood of questions would best be addressed by the use of participatory research methodology with groups of professionals, such as nurses. If we acknowledge that critical theory underpins participatory research methodology and base our research on the intent to promote equality in health then it is essential to create situations where the oppressed can freely engage in dialogue and be supported in their critique.

Implications for Community Health Boards

The Nova Scotia Department of Health has stated that Community Health Boards, "will assess local health needs, develop plans to coordinate primary health care and identify ways to improve the overall health of the community" (N.S. Department of Health, November 1996). Their role in promoting the social change required to achieve primary health care remains ambiguous. Historically government formed public councils have been unsuccessful in advancing social changes (Baum, Sanderson & Jolley, 1997; Geiger, 1984; Piette, 1990).

In this participatory research study conducted with the Digby and Area Community Health Board there were some positive aspects that could contribute to the health of the Digby area citizens. The CHB members demonstrated their collective commitment to the community. This was their primary obligation and took precedent before their accountability to the WRHB. Individually, the members theorized the relationships between participation and a local sense of control, human capacity, and health. These theories aligned with the direction sought for the development of a primary health care system. Collectively they constructed their vision and then identified barriers preventing their vision from becoming a reality. This process led to a shared critical awareness or conscientization, which served to strengthen their determination. Most importantly, this group of individuals trusts that their fellow members share the common values and vision.

Throughout the research process factors were identified that would support the CHB in its pursuit for community health. The CHB identified the need for legitimacy in the eyes of the community. CHBs requested having authority, with defined responsibility and resources to match, from the government but this had not yet occurred. The Digby and Area CHB planned to form intersectoral committees within the community in order to facility a broad response to the defined health issues. They discovered that people employed in other government departments, such as education or community services, were unaware of the presence of CHBs. As such, these people were not obliged to participate in the meetings and those that did, often appeared as volunteers with no authority to make decisions. Primary health care spans the fields of education, housing, environment, justice and community services, necessitating their participation in community health planning. How professionals practicing in the community will be accountable to the CHB is one aspect of the CHB's role that needs exploration.

The CHB members are volunteers. As volunteers they have chosen to participate, assuming their involvement will "make a difference" to the health of the citizens in their community. Another aspect of voluntariness is the freedom to make self-determined decisions. In a situation that requires lay people to make decisions that may affect the power and status of the elite, efforts must be made to ensure there are no manipulative or coercive constraints preventing the CHB members' voluntary decision-making (Yeo, 1996).

The CHB, at one point, complained that they were not receiving enough information from the WRHB. The CHB chairperson attended a monthly meeting that included all the chairpersons and a member of the WRHB executive. At that time news updates and printed handouts were provided along with some discussion. After one meeting, the Digby chairperson commented that there was no time to delve into some of issues. Other members of the Digby and Area CHB stated that they would like the opportunity to speak personally with members of the WRHB. The time required from the WRHB executive to provide ongoing education and dialogue for the 11 CHBs in the Western Region will be problematic.

I analyzed the relationship between the CHBs in the Western Region of Nova Scotia and the WRHB by comparing it to the empowerment continuum. I unearthed the following implications for coalition building and political action.

The WRHB has the opportunity to encourage the horizontal coalition building process by creating situations for the 11 CHBs to meet and discuss common issues without interference. At least two CHB chairpersons wished to share their visions among the other CHBs.

Political social action starts with the sharing of values and the building of a collective vision between the WRHB and the CHB representatives. It is this pluralism based on a commitment to the common vision that will support the unmanageable aspects that are intrinsic to community development. The WRHB can facilitate this commitment by demonstrating it is willing to learn from and respect the vision and values of the CHBs.

The histories that I reviewed in Chapter I implied that community councils have received little support from bureaucratic structures or government agencies (Baum, Sanderson, & Jolley, 1997; Geiger, 1984; MacDonald, 1994; O'Neill, 1992; Piette, 1990). There are no accounts of relationships between the levels of community and government that describe a process resembling ongoing dialogue. As these same histories indicated that the community councils were relatively ineffective in promoting community development, it may be surmised that working with the bureaucracy is a key factor in determining the success of local boards. The current level of mistrust and cynicism is so high in the CHB members that it will take time and commitment on the part of the WRHB in order to overcome the suspicions. Unless there is a process established that does foster dialogue and mutual learning the governing structure will continue to be perceived as dominating or manipulating.

I remain hopeful that there will be changes leading to a shift towards a system that promises greater opportunities for participation and empowering experiences. However, it would be naïve to ignore the following consideration. Even in the ideal dialogical situations there will be people who are unable to determine the contradictions that arise between their worldview and reality. If they do develop a critical awareness, but return in isolation to oppressive social environments, it is unlikely these individuals will choose to act against their dominating forces unless they are able to foresee options for their personal safety. We have to accept that people have deeply entrenched beliefs. To deconstruct their worldview without providing some alternate form of security will cause great discomfort and potentially increase their oppression.

Conclusion

Community Health Boards in Nova Scotia have been assigned to promote community development in a system that purports to be shifting to primary health care. A primary health care system engages citizens as subjects in the determination of their health. The concepts of empowerment and participation are intrinsic to community development. Their definitions demonstrate an intertwining or codependency, creating a process by which people improve their well being.

This empowerment process is a transformation, with a sharing of power, leading to the building of individual and community capacities. Participation in dialogue, resulting in critical thinking, reflection, and collective problem identification and solving leads to actions against the root causes that prevent health. Empowerment education or *conscientization*, as designed by Paulo Freire, combines critical reflection with action producing new levels of understanding, which challenge the dominating patterns. Social critical theory, in order to facilitate emancipation, uses dialogue as a method to allow people to understand how commonly held beliefs have distorted reality.

The Digby and Area Community Health Board members held common understandings of empowerment and participation, in relation to the health of their community, that were congruent with the philosophy of primary health care. Engaging in dialogue, the CHB members were able to unearth contradictions between their healthy "utopia" and the reality of health in their local community. As a group, they analyzed the factors affecting peoples' health, developing a vision that would guide their actions in a direction compatible with the healthy community they had created. They identified values and health issues pertaining to the Digby area. Ensuing actions included a strategy to increase community awareness and involvement in addressing the identified health issues.

The literature review revealed that research studies conducted in collaboration with community members often neglected to identify a theoretical basis for the research. Omitting a theoretical foundation hides the intent of the participatory research methodology and opposes the principles of critical theory.

We all hold theoretical representations that explain how we interpret our world. The ability to identify one's personal theory and the confidence to share it with others indicates empowerment. Participating in dialogue with other people regarding our theories leads to an understanding of our common values and a shared vision. Participatory research methodology provides the opportunity to advance this shared vision through the stages of research, reflection and action.

Participatory research methodology enabled me to explore my research questions and participate in the research process. During the reflective cycles arising from the participatory research process, I challenged and altered my own assumptions regarding the CHB members' understanding of health and the role of theory.

Appendix A

A Continuum of Empowering Strategies

X	X	X	X	X
Personal Empowerment	Small group Development	Community Organization	Coalition Advocacy	Political Action

PERSONAL EMPOWERMENT
- Developmental case-work
- Enhancing personal perceptions of control and power

SMALL GROUP DEVELOPMENT

- Improving social support
- Promoting personal behavior change

COMMUNITY ORGANIZATION

- Developing local actions on community-defined health issues
- Critical community/professional dialogue
- Raising conflict to the conscious level

COALITION ADVOCACY

- Lobbying for healthier public policies
- Achieving strategic consensus
- Collaboration and conflict resolution

POLITICAL ACTION

- Support for broad-based social movements
- Creating vision of sustainable, preferred future
- Enhancing participatory democracy

(RNABC, 1992)

Appendix B

The Empowerment Holosphere

(Labonte, 1993, p.55)

Appendix C

Chronicle of Digby and Area Community Health Board

June 1994 - August 1997

June 1994	Several groups involved in health issues got together to form the Digby and Area citizens for health Steering committee.
Fall 1994	Mary Jane Hampton presented the guidelines for establishing Steering Committees at a public meeting in Digby.
1995	Various public meetings were held through out the Digby area. The group became the Digby and Area Steering Committee. Meetings were held with the town and municipal councils and Victor Maddalena. Meetings were also held with the Annapolis and Clare Community groups in order to establish boundaries.
December 1995	Six thousand flyers were distributed by mail to all households within the proposed boundaries.
Spring 1996	Additional public meetings were held to emphasize the need public participation in health reform.
August 1996	CHB formation put on hold
September 1996	WRHB decides to go ahead
October 1996	Every household (6000) receives application form to volunteer to be on CHB.
November 1996	Fifteen members approved by the WRHB
December 9, 1996	Digby and Area Community Health Board has its first meeting.
January 13, 1997	Research Project presented at board meeting
January-February	Individual Interviews are conducted
March 1, 1997	Attended workshop on "Getting Started" with CHB
March 10, 1997	Presented themes at regular CHB meeting
May 9,1997	Facilitated workshop. Vision statement and values developed.
June 9, 1997	Working meeting to identify issues and action plan.
June	Newsletter mailed to 6000 households
July 11, 1997	Met to review responses from community, plan for next meeting
August 1-20	Final interviews conducted
August 26, 1997	Meeting to develop strategy to consult community in order to develop community health plan.
	Last questions and compiled answers returned to CHB.

Appendix D

Interview Guide *

1. *What* led you to become a Community Health Board member?
   What role do you play in the community? i.e., professional, community leader
   How have you participated in organizations in the past?

2. *Why* did you volunteer? What skills did you bring?
   What past events contributed to your confidence in your personal abilities?
   What satisfaction do you personally receive?

3. *So what* do you need to sustain your involvement in a structure such as the CHB?
   What are the positive factors?
   What are the negative factors?
   How will you know your contribution has been effective?

4. Community development is a process in which people take control of their lives and their community. It is grounded in the value of people learning, sharing, and working together to change their own conditions.
   What will be the CHB's role in supporting community development?
   What are the strengths of this community?
   What are the problems/barriers?

5. *How* do you think the CHB will be a positive/negative factor in supporting community development?
   What are the historical, political, and cultural contexts? Past successes? Level of participation/volunteerism? Level of control?
   What organizational structures will help? hinder?

6. *So what* do the issues discussed above mean to you as a board member?
   What experiences of your own can you build on?
   What barriers, preventing involvement, have you encountered?

*(Sample questions with sub-questions to encourage reflection. Further critical questioning will be specific to the topic of conversation).

Demographic Information
Sex____
Age____
Occupation__________________________

Appendix E

Final Interview Questions

1. Increasing community involvement or participation was identified in almost all of the original discussions between individual Community Health Board members and myself. Each member described their own community participation as involvement in activities where they were able to *make a difference* in their own lives, the life of another individual or in their community. Generally, these were described as positive experiences. How does this notion of participation affect your understanding of "the encouragement of community involvement" as is stated in the vision statement?

2. The vision/values were developed after a series of discussions that took place over a 6-month period. How did these discussions benefit you individually? The CHB as a group?

3. How does the vision statement support your own values?

4. Do you feel the major health issues in this community have been identified and listed?

5. Are you satisfied with the amount of input you personally had in the discussions?

6. How do you think you as an individual can contribute to achieving the vision of the CHB? What do you need to help you do this?

7. List conditions that may prevent the CHB from being able to follow its vision.

8. List conditions that will help the CHB follow its vision.

Appendix F

Letter of Introduction

My name is Lynda Casey. I am a graduate nursing student at Dalhousie University, the Clinical Site Manager at the Digby General Hospital, and a citizen of Digby, N. S. I am requesting the Digby and Area Community Health Board's consideration in allowing me to participate with the board and its members in a research study entitled, "Perceptions of Community Health Board Members Regarding Community Empowerment and Participation".

The purpose of this study is to explore your perceptions and experiences as a community health board member, in relation to central aspects of community development, such as the shift of control to the communities and the widening of public involvement. As I am also a member of a rural western Nova Scotian community and want to contribute to the success of the community health board I have chosen to use participatory research. The goal of this study is to benefit the participants, rather than generate information to be used elsewhere, though the final report will be submitted as a partial fulfillment of the requirements for the Degree of Masters of Nursing. Dr. Barbara Downe-Wamboldt, School of Nursing, Dalhousie University (494-2391) is the principle advisor.

This study is planned for a period of one year. Along with the defined interviews and corresponding group sessions described in the enclosed outline, I am seeking permission to attend regular board meetings and would be happy to help with research initiated by the board, such as a community needs assessment. I have skills in group facilitation, workshop presentations, adult learning, and communication techniques that I can share with the board members, if requested.

I would like the opportunity to attend a meeting for the purpose of explaining the study and answering any questions. This agreement does not obligate individual members to participate in the personal interviews.

Thank-you for considering to participate in this research project. Please feel free to contact me for further information at 245-2501 (work) or 245-5039 (home).

Appendix G

Participatory Research Study Outline

Each board member will be asked to participate in an interview, individually, at a convenient time and location. The interviews will take about 1 - 2 hours and will be audiotaped. Participants will be required to sign separate informed consent forms. The purpose of the interviews is to identify and discuss issues related to board members' personal experiences in participating in their community and their perceptions about the role and potential influence the community health board will have in promoting community development in health.

A second interview with each of the community health board members will be conducted 6 - 8 months following the first interview. This will allow for further exploration of the issues identified originally and for identification of changes in perceptions regarding these issues during the 6 -8 month time period.

After the completion of each of the two sets of individual interviews I am requesting approximately 30 minutes to be allocated at a community health board meeting in order to present the common issues that are repeated in the interviews. I would like permission to facilitate the discussion and exploration of these issues or themes. These sessions will be audiotaped, transcribed, after which the tapes will be erased. In order to ensure confidentiality, names and personal information from the interviews will not be presented to the group.

The report will be written concurrently throughout the study. In order to assure it is written accurately, ongoing feedback from the community health board members will be sought. Anyone requesting further information or detail please feel free to contact me at work or home. Thank you for participating in this study.

Lynda Casey, 245-5039 (Home) or 245-2501 (Work)
Thesis Supervisor, Dr. Barbara Downe-Wamboldt, Dalhousie University (494-2391)

Appendix H

Code No.____________

Consent to Participate in Personal Interview

I hereby consent to participate in a research study conducted by Lynda Casey, Master of Nursing Student of Dalhousie University entitled, "Perceptions of Community Health Board Members Regarding Community Empowerment and Participation". The nature of this study has been clearly explained and I have received an outline of the study process. I understand my responses will be audiotaped, typed, and the tape erased. I will be identified only as a code number. The interviews will last approximately 1 -2 hours and will be held at a time and location that is mutually convenient to the researcher and myself.

The purpose of the interview is to discuss my personal experiences in participating as a citizen and my perceptions regarding the community health board's role in influencing community development in health. There are no right or wrong answers. The intent is to have a conversation that is thought provoking, rather than strictly information gathering. I may benefit from the opportunity to discuss and explore issues with the researcher. General themes or problems in our community will be identified for group discussion with the community health board at a future meeting. Personal comments are kept confidential. I understand that excerpts from the interviews may be used in the report without any identifying information and I will have the opportunity to review the report before its final submission.

My participation is entirely voluntary. There are no perceived health risks due to my participation. I understand I can refuse to answer any questions I find uncomfortable. Furthermore, I clearly understand I may withdraw from this study anytime. If I have any concerns or questions I can Call Lynda Casey at 245-5039 after 5:00 p. m.

This consent was signed in the presence of the researcher and I received a copy.

____
Signature of Participant

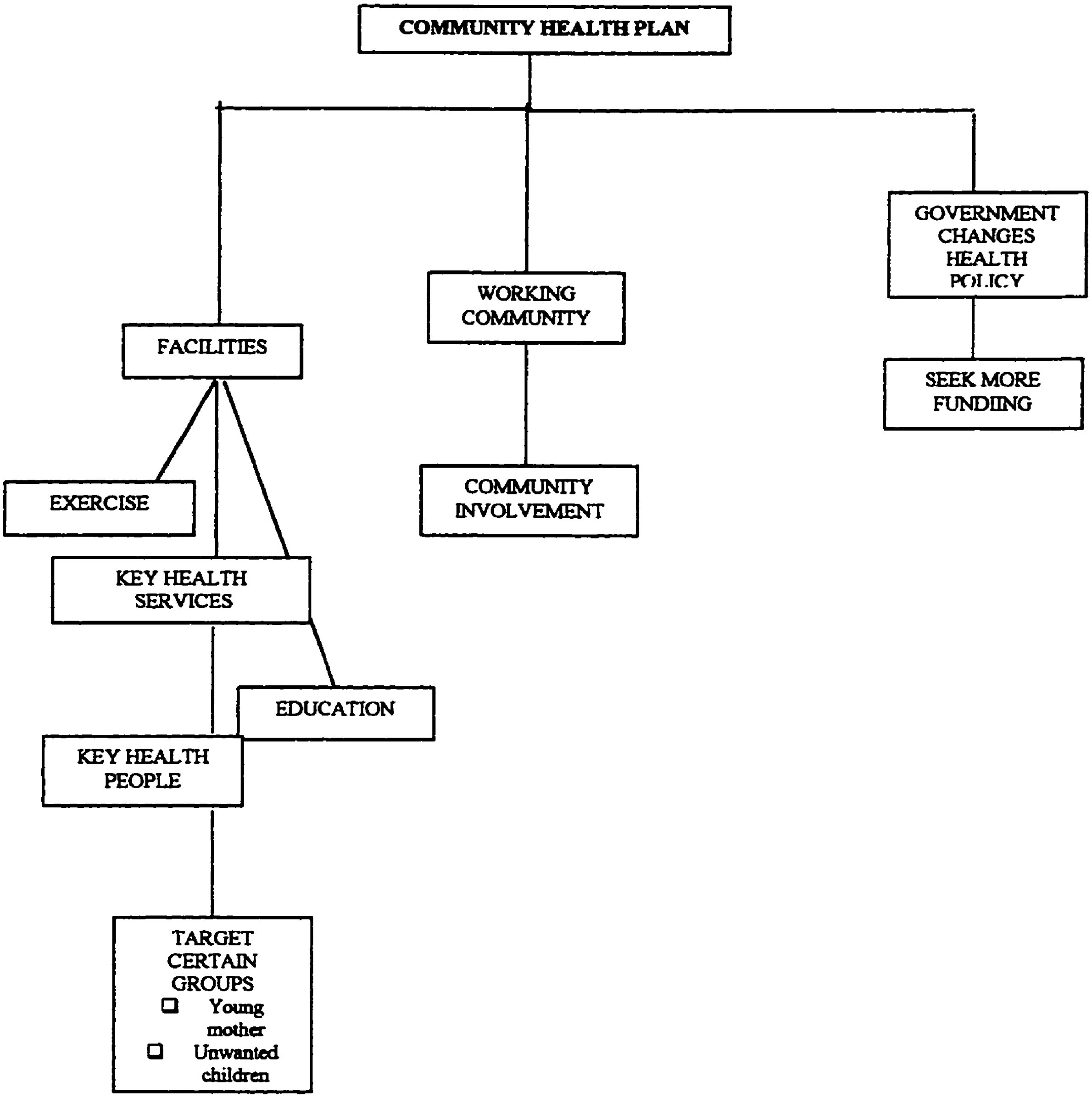
____
Lynda Casey

____
Date

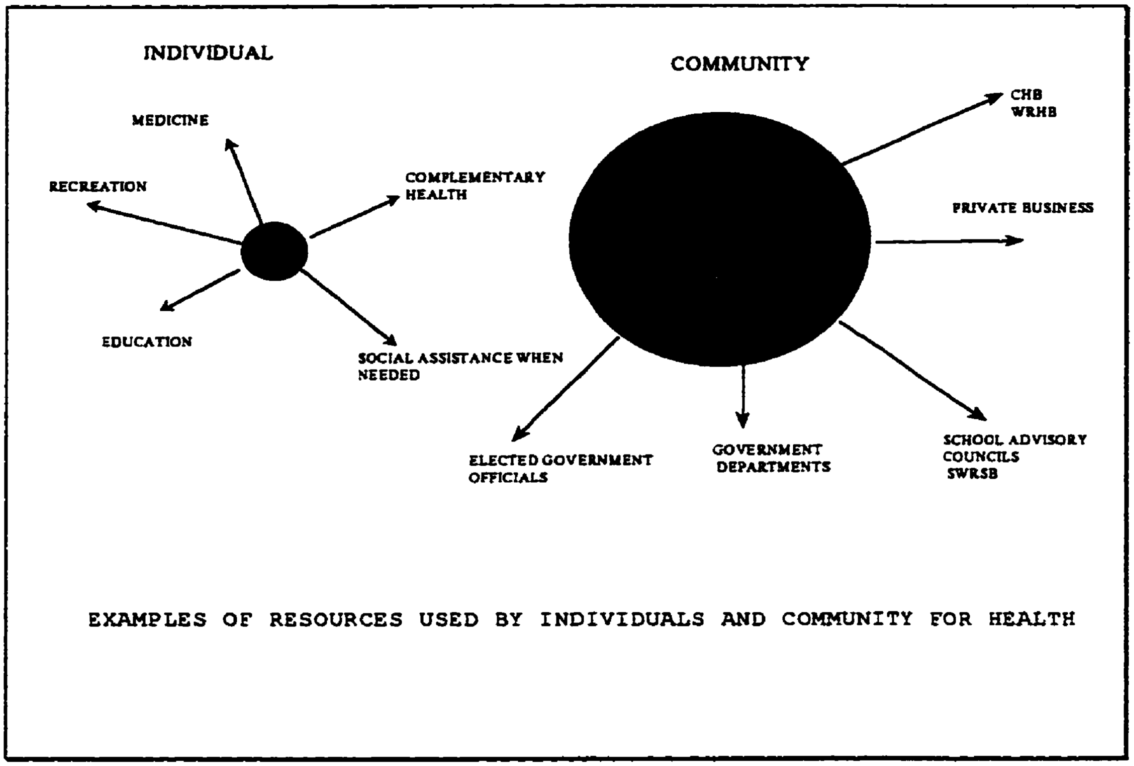
Thesis Supervisor: Dr. Barbara Downe-Wamboldt, School of Nursing, Dalhousie University (494-2391)

Appendix I

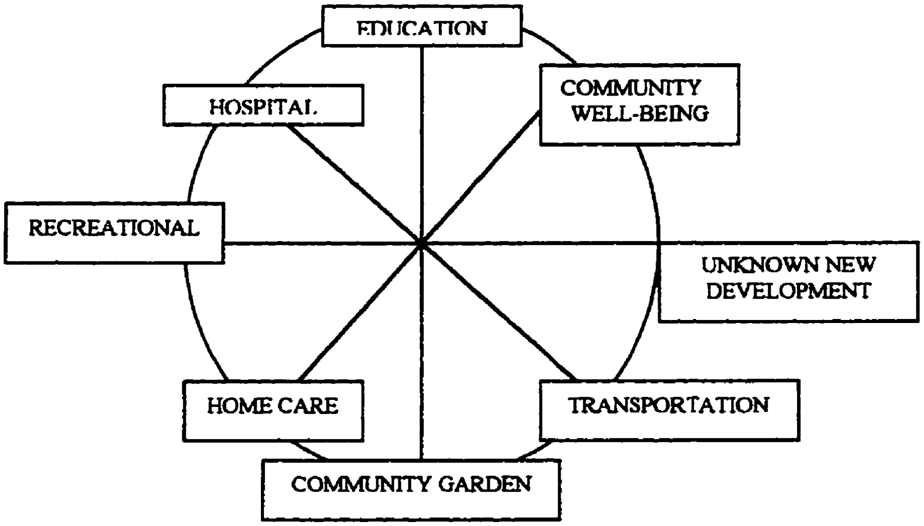
Diagrams of a Healthy Community



GROUP ONE



LYNDA'S MODEL (FROM INTERVIEWS)



GROUP TWO

Appendix J
Newsletter

DIGBY & AREA COMMUNITY HEALTH BOARD NEWSLETTER

JUNE 1997

The health system must be accessible and responsive to the needs of the people in the Western Region. The Western Regional Health Board, to be effective, must actively involve communities, through effective local Community Health Boards, in the development of a true regional health care system. By November 1997 Community Health Boards will take a lead role in regional health planning through the development of Community Health Plans.
(Western Regional Health Board, Strategic Plan 1997)

OVER THE PAST SEVERAL YEARS THE DIGBY & AREA COMMUNITY HEALTH BOARD AND THE DIGBY & AREA COMMUNITY HEALTH STEERING COMMITTEE HAVE BEEN LISTENING TO ***YOUR CONCERNS*** REGARDING THE HEALTH OF CITIZENS OF THE DIGBY AREA. THE ISSUES YOU HAVE DESCRIBED ARE LISTED AS FOLLOWS:

ISSUES THAT IMPACT ON OUR HEALTH

- ✓ Drugs, alcohol, smoking and gambling - addictions.
- ✓ low self-esteem, low expectations.
- ✓ poor education.
- ✓ unemployment.
- ✓ lack of strong family units.
- ✓ chronic diseases (e.g.. cancer, heart, lung and arthritis).
- ✓ depression.
- ✓ dependence on social programs, government and community leaders - expectation that someone will "look after" us.
- ✓ instability of our emergency/healthcare services.
- ✓ lack of social support - community does not look after its members.
- ✓ all of the above affecting our children - leading to problems such as teenage pregnancy and increased youth violence.

DO YOU AGREE? HOW CAN WE WORK TOGETHER TO OVERCOME THESE PROBLEMS? WE WANT YOUR IDEAS!! PLEASE ANSWER THE QUESTIONS ON THE OTHER SIDE OF THIS SHEET. ➡ ➡

DURING THE SUMMER WE WOULD LIKE TO <u>HEAR</u> FROM YOU. PLEASE <u>CALL</u> OR <u>TALK</u> TO US WHEN YOU SEE US. THE MEMBERS OF THE DIGBY & AREA COMMUNITY HEALTH BOARD ARE:

[redacted] [redacted]

What contributes most to good health and wellness in our community?

What contributes most to poor health and illness in our community?

What are the major health issues and concerns, now and in the future?

In order to improve health in our community, what are your recommendations?

You can contact us with your feedback or ideas in one of the following three ways:

- Call any member of the Community Health Board at the given number listed on the flip side of this letter.
- Drop off written comments at the front desk of the Digby General Hospital.
- Mail to: Digby & Area Community Health Board
  P.O. Box 1521
  Digby, NS B0V 1A0

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IMAGE EVALUATION
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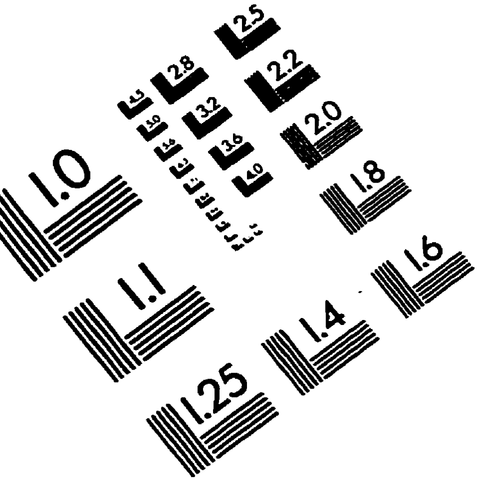

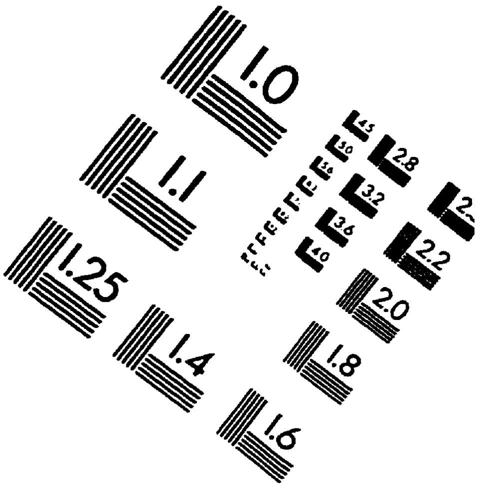

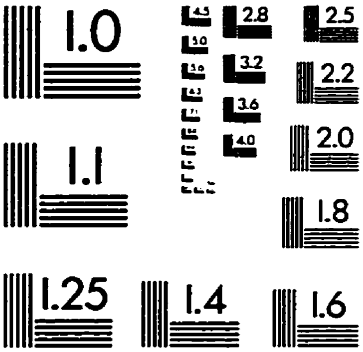

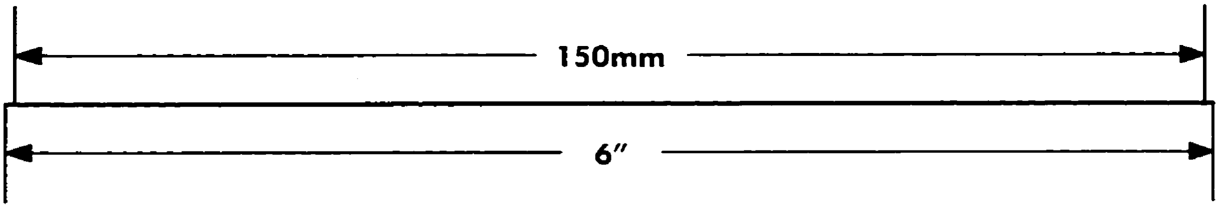

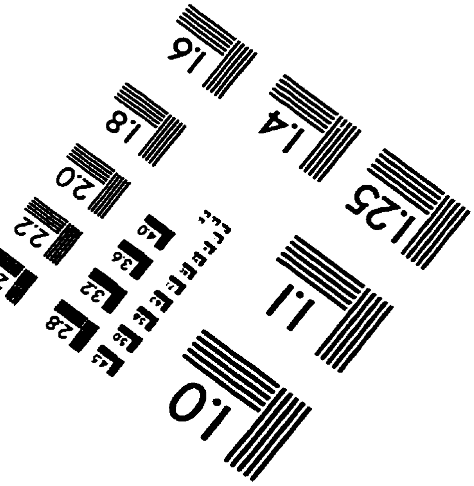

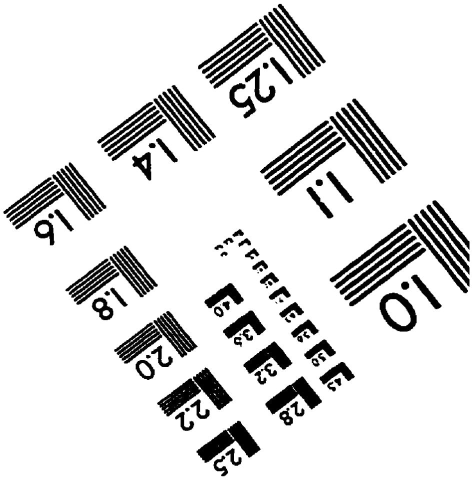

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