

WITHIN VULNERABILITY: UNDERSTANDING THE PRACTICES AND
EXPERIENCES OF ENHANCED HOME VISITING PUBLIC HEALTH NURSES
AND COMMUNITY HOME VISITORS

by

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DEDICATION

This dissertation is dedicated to all the public health nurses and community home visitors who shared with me their time, experiences and stories of commitment to enhanced home visiting. Some of these dedicated women participated in interviews across many miles. Without their support this research study would not have happened.

I also dedicate this research to Wayne, my partner in life who always believed in me and knew just what I needed to get through when my faith in myself was challenged throughout the journey.

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ABSTRACT

In Nova Scotia, a targeted Enhanced Home Visiting program began in 2002 as an enhancement to the universal healthy beginnings program for families requiring additional support at home with healthy child development. Public health nurses (PHNs) and community home visitors (CHVs) began working together in this program. There have been informative evaluations done of the EHV program however a deep understanding of the personal experiences of both CHVs and PHNs who work together to support mothers and families was not evident in the reports. The purpose of this qualitative research study was to explore how the Nova Scotia Enhanced Home Visiting program for marginalized mothers and their families was organized, delivered and experienced through the practices and experiences of PHNs and CHVs. Feminist post structuralism informed by discourse analysis was used to explore and examine PHNs and CHVs' personal experiences working in the EHV program. The ways in which their practices had been constructed and continued to be influenced by social and institutional discourses emerged within the data analysis. The social discourse on mothering layered within the social discourse of being part of a vulnerable population added an interesting understanding about gender and class. Six PHNs and eight CHVs participated in one on one in depth interviews. Four PHNs and six CHVs also attended a focus group where they responded to a presentation of the preliminary study findings. The findings of the study are focused on 1). Building relationships with mothers living within vulnerability 2). Communication in EHV practices within vulnerability 3). The unique practices of support for mothers living within vulnerability.

This research contributes to an understanding of the ways in which PHNs and CHVs' practices have been constructed and influenced by social and institutional discourses. The social discourse on mothering layered within the social discourse of being part of a vulnerable population added an interesting understanding about gender and class in this study.

LIST OF ABBREVIATIONS USED

CHV	Community Home Visitor
EHV	Enhanced Home Visiting
FPS	Feminist Post Structuralism
PHN	Public Health Nurse

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Chapter 1: Introduction

The health of mothers and that of their families is influenced primarily by the economic and social conditions they experience in their daily lives (Browne, Doane, Reimer, MacLeod, & McLellan, 2010; Raphael, Rainer, & Layton, 2011). Public Health Nurses (PHNs) have a historic tradition of home visiting that supports the health of the most marginalized families including mothers who have been affected by their economic and social conditions. In a Canadian study that included 32 PHNs, Browne et al. argue that while there is documented evidence that PHNs support the health of vulnerable families, it is difficult to find studies that focus on how PHNs do their supportive work.

Home visiting programs vary across Canada. However, currently, in Nova Scotia one home visiting program includes both PHNs and Community Home Visitors (CHVs) who work within the Nova Scotia enhanced home visiting program for families requiring extra support with their newborn at home until they reach 3 years of age (Kathy Inkpen, verbal communication, Nov. 2012). Changes to universal home visiting programs occurred in Nova Scotia in 2002 when CHVs were added to create a more targeted program that supported mothers and their families needing extra support parenting and promoting optimal development and health of their children at home as part of the Healthy Beginnings Enhanced Home Visiting Program (Healthy Beginnings Support Manual, 2013). Many of the mothers in the program are single mothers however other families in the program include those who have experienced difficult life circumstances that put extra burdens on a family caring for a new born baby. Examples of difficult circumstances include: geographic isolation from services; limited education; lack of

support from families, friends or community; personal experiences with mental health issues; and other unique burdens specific to a family where a need is identified by an in depth assessment (Healthy Beginnings Support Handbook). While the Enhanced home visiting program is inclusive of mothers and families who experience extra burdens that may impact their parenting of a new born it is important to understand the impact that economic conditions have on family experiences caring for a newborn. As one of the major determinants of health, low income, and in many cases poverty has a significant impact on families because of existing social circumstances families with extra burdens in the enhanced home visiting program are already experiencing. Mothers, especially those who are parenting on their own and who experience low incomes have the poorest health outcomes in Nova Scotia and across Canada and are directly affected by practices of CHVs and PHNs within the Healthy Beginnings Enhanced Home Visiting as participants in this public health program (Raphael, 2011; Verbal Communication, Kathy Inkpen, 2012; Suzanne Landry, 2013).

The work of PHNs requires them to understand the personal and social issues in health within the context of their practices with mothers and their families (Aston, 2008a; Aston, Meagher-Stewart, Sheppard-Lemoine, Vukic, & Chircop, 2006). Negotiating partnerships with families and in particular new mothers includes nurses' acknowledgement that mothering is constructed by discourses (Aston). In home visiting the nurse client relationship has been considered a major factor that supports the success of home visiting with mothers and families requiring extra support for diverse reasons (McNaughton, 2005). Currently relationships are developed among PHNs, CHVs,

mothers and their families as part of the Nova Scotia Enhanced Home Visiting Program (Healthy Beginnings Support Handbook, 2013). While there have been informative evaluations done of the Nova Scotia enhanced home visiting program, a deep understanding of the personal and social practices of both CHVs and PHNs that surround mothers and families is not evident in the reports.

Globally, attainment of the World Health Organization Millennium Development Goals by 2015 with a focus on universal access to relevant health care for all is desired as an outcome for 2015 (*The World Health Report 2005 Make every mother and child count*, 2005). The health of women and their children, and in particular mothers raising children by themselves while also experiencing low income are considered the most vulnerable population in the world, and this situation is not improving as quickly as hoped (World Health). Exclusion from access to relevant health services is considered a key determinant of inequity in health and a significant constraint to progress in maternal and child health (World Health Report). These gaps or inequities in health access must be better understood and addressed with a fundamental understanding of the direct link between poverty and the health of mothers and children (World Health Report). In 2010 world leaders at the G8 Summit held in Canada, made maternal and child health a moral and political agenda item to demonstrate each country's support in aiding the achievement of the Millennium Development Goals for 2015 with a specific focus on improving the health outcomes for mothers and children globally (UNICEF Canada, 2013).

In response to the identified need to support marginalized families such as mothers parenting on their own and experiencing burdens from low incomes, the Canadian Government established the federally funded Healthy Beginnings program with a focus on supporting the health of families with children up to 3 years of age. In Nova Scotia, an Enhanced Home Visiting program began in 2002 as an enhancement to the healthy beginnings program for families requiring additional support at home fostering healthy child development. The language used to describe families participating in the enhanced home visiting program includes, families experiencing extra burdens or facing challenges in life, at risk families and families experiencing a change in their capacity (Healthy Beginnings Support Manual, 2013). Due to the diversity of families involved in the enhanced home visiting program and the need to support unique needs of families a continuum of services is offered to support families in Nova Scotia and enhanced home visiting is one service offered.

PHNs have a long history of delivering universal home visiting programs like the healthy beginnings program in Nova Scotia and have also been part of the implementation of the targeted Enhanced Home Visiting Program. The language of universal and targeted is commonly used in association with home visiting (Olds, 1999). Universal refers to home visiting offered to all families who have a baby in Nova Scotia and this has been part of the practices of PHNs. Enhanced or targeted refers to home visiting offered to a specific population of families who have distinct needs such as those screened into the enhanced home visiting program in Nova Scotia (Healthy Beginnings Home Support Handbook). Also, within the literature there are examples of targeted

home visiting focused on first time mothers, teen mothers, and families with children with developmental delay (Armstrong, Fraser, Dadds, & Morris, 1999; Hedges, Simmes, Martinez, Linder, & Brown, 2005; Olds, 1999).

In Nova Scotia CHVs were added as the primary home supporters of families who were accepted into the enhanced home visiting program. The CHVs are given a structured training program that guides their practice with families. The addition of CHVs was an enhanced change in how the home practices were delivered when supporting Nova Scotia families with children up to 3 years of age (K. Inkpen, Personal Communication, Nov. 2012).

Given the changes in how mothers and their families are supported in their homes as part of the enhanced home visiting program since 2002, uncovering how relational practice roles of PHNs and CHVs are understood within the practices of enhanced home visiting can provide a deeper understanding of how this work constructs and supports the lives of the mothers and their families.

In Nova Scotia the enhanced home visiting program was internally evaluated (Personal communication, Suzanne Landry, July, 2013). I was able to review one evaluation report from District 9 which represented the largest population in the province. Upon review of the evaluation report of the Nova Scotia targeted Enhanced Home Visiting Program, in district 9, there appeared to be a gap in presenting a deep understanding of practices of PHNs and CHVs whose work constructed the participating families' enhanced home visiting experiences. In response to this gap, research targeted at understanding how the personal social, institutional and practices of CHVs and PHNs

constructs families' home visiting experiences has the potential to provide new evidence that has not already been uncovered when evaluating the home visiting programs.

Upon reflection of this Nova Scotia context, a number of questions emerge: Is it possible that the best evidence on PHN/ CHV practices and experiences has not been collected? Is it possible that evidence is invisible in practices that surround marginalized mothers and families in the enhanced home visiting? Could exploring the personal, social and institutional practices that surround marginalized mothers and their families create another way of understanding that uncovers a deeper understanding of the social construction of their lives? Could a theoretical analysis guided by feminist post-structuralism provide another way to create new knowledge that is not represented by Government Program Evaluations?

In summary, I suggest that there is a gap in understanding how PHNs and CHVs' personal and social practices support the health of marginalized mothers and their families who participate in the Nova Scotia Enhanced Home Visiting Program. After reviewing the recent enhanced home visiting evaluation report for District 9, it became evident that discourses that represent the personal, social and institutional practices and experiences of both CHVs and PHNs who support the health of mothers and their families is not visible (Research Power Inc., 2012; Kathy Inkpen, Personal communication, Nov. 2012; Young, Personal communication, Oct. 2012). These experiences are hidden for me in the report. The method of analysis used in the report focused on summarizing themes found within the transcriptions of focus groups and individual stories. While the data is very rich in descriptions of experiences, a deeper

analysis of the experiences represented by the discourses and the relationships between the discourses could uncover another dimension of understanding practices of both PHNs and CHVs and how their work together supports mothers and their families within an enhanced Home Visiting Program. A similar scenario exists in the literature where there are many studies on home visiting presented but few examine the personal, social and institutional practices of both PHNs and CHVs who work with marginalized mothers as part of an enhanced home visiting program. Further discussion of findings from the literature will be presented later.

I would further suggest that understanding the gap in both practice evaluation reports and the literature calls for research that guides a deeper understanding of the personal, social and institutional relational experiences and practices of PHNs and CHVs and how their work with marginalized mothers and their families who participate in the enhanced home visiting program is socially constructed.

New discursive representations of both PHNs and CHVs' practices can open up and create new knowledge and subjectivities about the practices that surround marginalized mother participants within enhanced home visiting in Nova Scotia.

Purpose

The purpose of this research was to explore how the Nova Scotia Enhanced Home Visiting program for marginalized mothers and their families was organized, delivered and experienced through the practices and experiences of PHNs and CHVs in Nova Scotia. This examination provided critical information about how practices and experiences of PHNs and CHVs were deeply rooted within personal, social and

institutional discourses that represented the enhanced home visiting program delivery. There is potential for this study to provide decision and policy makers with another way to understand the known, unspoken and hidden practices that support marginalized mothers and their family's health in the Nova Scotia Enhanced Home Visiting Program.

Guided by a feminist poststructuralist framework this inquiry revealed how power operated through discourse to create knowledge about the social and institutional construction of home visiting with marginalized mothers and families who experience difficult life circumstances such as: lack of access to services, limited education, lack of family, friend or community support, low incomes, mental health issues or other unique experiences that socially construct their health outcomes (Cheek, 1999; Mills, 2003; Rabinow, 1984; Weedon, 1987). Uncovering both positive and oppressive conceptualizations of power through the discourses of the participants created an opportunity to redesign alternate subjective positions (Cheek, Mills, & Weedon). Therefore, through the feminist poststructuralist lens our understanding of enhanced home visiting practices of PHNs and CHVs can guide changes in policies, knowledge, programming and practices of both professional and lay persons. This philosophical approach in this research inquiry promoted complex examination of how the social, historical and political factors influence the practices that support the health of mothers and families who are marginalized.

Research Questions

The questions guiding this research study were;

1. How are Enhanced Home Visiting services understood and experienced by PHNs?

2. How are Enhanced Home Visiting services understood and experienced by CHVs?
3. How are Enhanced Home Visiting services communicated between PHNs and CHVs?

Reflexivity

This study was influenced by my previous Masters in nursing thesis that explored the parenting experiences of low-income single mothers within the Halifax Regional Municipality and facilitated by the Department of Public Health. Conclusions from that thesis suggested the need to explore factors that support low-income single mother's parenting in more depth in further research (Sheppard-LeMoine, 2000). Since completing this study in 2000 I have been a university professor and taught a Caring for Families course with third year nursing students. In this course the social determinants of health are included in a framework to guide assessment and interpretation of the life contexts of diverse family types. Working with students has helped me to understand the diverse perceptions they have of mothers and families and their knowledge regarding the influence of contexts of day-to-day lives on families. When I share with them my research with low-income single mothers there is always at least one student who comes and talks with me about her situation and how grateful she was to hear her issues addressed to a class of nurses as she often hides what she experiences in life. Through exposing thousands of students to interviewing families in their homes and reflecting with the students in small groups about the complexity of families' lives my goal has been to promote a broader understanding of the needs of single mothers who experience economic hardships who have been marginalized in society related to how their lives have been socially constructed and often misunderstood.

As a past chair of an undergraduate curriculum committee for 7 years I was committed to ensuring the perspectives of social justice, primary health care, cultural diversity and accessible, relevant health care influenced how courses were decided upon in the BScN program. I quickly learned that faculty also require education on the contextual worlds of marginalized people like mothers who experience low incomes and how to bring the principles of primary health care, the determinants of health and equity to life in the teaching supporting students in hospital and community settings.

My earliest experiences in nursing were as a paediatric nurse and we worked from a strengths perspective with the families to ensure we understood what they brought to the relationship of caring for their child in collaboration with nursing and other professionals. I have found this has influenced who I am today as an educator and as a researcher. I believe it is critical when working with people who have been marginalized in society to find something that is a strength that they bring to the relationship and always acknowledge the strength. It has been my experience that this approach immediately opens up communication and I find it builds relationships of trust. For me, I believe that nursing education, research and practice traditionally have focused on problem identification and this approach was not the way I chose to create my nursing practice or research from the beginning of my career. Perhaps my early clinical experiences with families and children built my foundation but I think it goes back further to who I am as a person and what I believe creates constructive relationships among people.

Growing up in Industrial Cape Breton I was immersed in a working class culture my entire life and wealth was not dominant in my world but I always believed I could accomplish anything that I wanted with education and hard work. These values were instilled in me by my family, my community and my schools. I have believed since a young age that it is part of my responsibility as a citizen to share whatever resources I have with other citizens who may not be able to access what they need to survive. Role modelling of how to reach out to others in need surrounded me as I grew up in a one industry town where it was common to get involved when a community member needed help. Today these values remain part of who I am as a person and a professional. I see these values as one of the reasons for my sincere interest in the topic of this study as I truly believe we are a rich and prosperous country where relevant supports for all mothers and their family's needs to be understood so that they can receive access to needed and relevant services they require without having to ask. I sincerely believe we need to influence our world to stop focusing on problems and realize potential in everyone. I believe these early years still influence why I do what I do. I will be interested to see how participating in this research and uncovering how current enhanced home visiting practices support parenting experiences of families and marginalized mothers in Nova Scotia will influence my values and approaches to research, practice and education.

From my location as a novice mid-career researcher but expert educator and nurse who has worked for many years with mothers and children from diverse economic backgrounds I have always considered how I can influence social justice agendas of policy makers in health and government departments. Resisting the dominant societal

viewpoints which are oppressive to marginalized populations like families and mothers who experience economic hardship has been a dominant theme that runs throughout how and what I teach students, the type of research I like to be part of and how I interact with people at meetings or in my day-to-day life (Strega & Brown, 2005). However, I must acknowledge the position of power I do occupy as a middle class, educated woman and how my experiences with power and knowledge production through teaching in a university influences how I approach research and the participants of this proposed research study. The following example from Kimpson (2005) helped me to understand my position a little more clearly.

Kimpson (2005) struggled with power and how she was going to represent her work when doing graduate studies. She was searching for an anti-oppressive research methodology that supported exploring women's experiences, and one that connected her own experiences with marginality to her research. Feminist and critical perspectives helped her to understand how to include women who live on the margins in her research. As a disabled, academic woman, Kimpson experienced the life of a marginalized person and she related most to those women who had experienced similar power and cultural imbalances in their lives. During her research journey Kimpson chose a methodology called an autobiographical narrative approach to use so that she could honour her voice as a marginalized person in her research. Through self-reflection, Kimpson explored how she could use a feminist approach in her research where women's voices that were traditionally silenced in research could be heard. It took courage for Kimpson to choose her approach to research as she felt it was not accepted in the academic world as a

legitimate way of creating knowledge. Kimpson's experiences with choosing a research methodology approach represents for me the importance of the personal tone of research, and how difficult it can be for a researcher to remain true to the personal connection between being the researcher and the research. Like Kimpson, I have a personal and professional history that impacts my choice of research area, methodology and where I plan to participate in my research and I look forward to centering my reflexive journey throughout this research inquiry by engaging in reflection of my experiences and how they may change throughout the process.

Through this reflection I have come to realize how this research study has been part of my life work in a number of ways. Looking back to my experience in my masters, I considered how I have made contributions to this proposed area of research based upon my research with marginalized populations of mothers and their families. Throughout my academic career teaching I have advocated for the importance of home visiting experiences as a required clinical component of nursing curriculum. The concept of marginalization and the social determinants of health guided how I constructed both my course approach and the teaching strategies I used with students to expose them to other ways of understanding families and how society socially constructs family lives. Personally my strong working relationship with PHNs and the services they have offered within the province of Nova Scotia over the last 20 years has contributed to the questions I am interested in pursuing as I develop my program of research. Finally, I have been shaped by my previous involvement in a research study that examined the personal experiences, relationships and contextual meanings of empowering relations between

PHNs and mothers in Nova Scotia (Aston, Meagher-Stewart, Sheppard-LeMoine, Vukic & Chircop, 2006). Three PHNs and three mothers participated in this interpretive inquiry guided by feminist post structuralism (FPS). The role of power in the practices between PHNs and the mothers was a focus of the study and always intrigued me. Having the opportunity to work with a research team with this focus has influenced my research interests. Recommendations from this study suggest the need to do research examining PHN skills with diverse women from different contexts such as socioeconomic status, age, race or culture (Aston et al.). This study offered another examination of the practices and experiences (skills) of PHNs and CHVs as they worked with diverse mothers and families, some of whom were affected by diverse life circumstances and participated within relational experiences within the enhanced home visiting program. Thus answering the proposed research questions in this study offered another understanding that builds upon Aston's research with PHNs.

Chapter 2: Literature Review

The following literature review represents the main inter connected concepts of interest for this study. This section is not an exhaustive review of the concepts rather its focus was on the dominant discourses that influence societal understandings of motherhood, mothering, enhanced home visiting and the health of marginalized mothers and families. An emphasis on dominant discourses that represent these societal institutions, practices and the influence that FPS has on guiding understanding these concepts was also the focus of the review. Marginalization and its connection to the study will be discussed first.

Marginalization

Marginalization has been referenced as a concept that represents peoples' lives that have been shaped by inequity, injustice and exploitation (Strega & Brown, 2005). While there are multiple realities of people connected to how marginalization is understood, acknowledging how knowledge has been produced that has sustained marginalization is important to create supportive changes in the lives of marginalized people. In the documents that describe enhanced home visiting in Nova Scotia, families who participate are referred to as vulnerable, at risk, facing challenges, experiencing extra burdens and changes in their capacity (Healthy Beginnings Support Handbook, 2013). While these words are descriptive, Hall, Stevens, & Meleis, (1994) would suggest they are not inclusive of diverse people and their experiences. Rather, the words are more reflective of responses to the way society constructs marginalization in peoples' lives. Based upon the work of Hall et al., marginalization, for me, represents a societal

understanding of human responses to life versus individual responsibility for what happens in a person's life. The families and mothers who participated in this study were described as a marginalized group to reflect the societal construction of their parenting experiences as they participate within they enhanced home visiting program.

People who experience marginalization in their lives are vulnerable to health risks related to exposure to discrimination, environmental dangers, unmet basic needs, severe illness, trauma and restricted access to healthcare (Hall et al., 1994). Creating knowledge that reflects the impact of diverse experiences in creating human responses to health and illness in diverse contexts can be guided by the inclusive lens that marginalization offers (Im & Meleis, 1999). A description of marginalization follows and how it supports feminist post-structuralism and discourse analysis which guided the study design.

Marginalization has been defined as living on the periphery of society which also defines a persons' or groups' boundaries to social networks and their community as people who are excluded from taken for granted societal experiences due to their gender, race, economic oppression, political and cultural differences (Hall, Stevens, & Meleis, 1994). Oppression, alienation, stigmatization are other terms often associated with aspects of marginalization and represent a narrower subjective experience (Hall et al.). Marginalization on the other hand includes all of these terms. Marginalization as a concept promotes the ability to guide the inclusion of diversity in the development of knowledge and can shape research, theory and practice that affect diverse population health experiences (Hall et al.).

The method of discourse analysis as a deconstruction practice has been associated with post-structuralism as a way of reconsidering how accepted knowledge about marginalized peoples' lives have been constructed (Strega & Brown, 2005). The feminist research contribution to post-structuralism enhances the focus on the political and oppressive nature of research and the accepted, patriarchal knowledge it has created about women (Strega & Brown). Feminist research offers a lens to examine the connections between how and what knowledge is created and who is entitled to participate within the research process for the construction of knowledge. Thinking from the perspective of marginalization supports a feminist post structural perspective as both focus on a need to understand and include those experiences that have been silenced, hidden or not evident in the literature (Strega & Brown). As well, through seeking to reclaim and incorporate the personal and political contexts of knowledge construction, feminism fosters uncovering tensions within discourse through research processes that challenge the relations of domination and subordination that create marginalization for researchers as well (Strega & Brown, 2005). With this previous description in mind, I suggest considering how marginalization has regulated people to social positions that have less power within a group or society and what that has meant for their day-to-day life responses. I believe that the concept of marginalization supported the population of focus within this study and the overall goal of the research. That being, to uncover how the practices and experiences of both PHNs and CHVs were socially constructed as they support mothers and families who have been marginalized in society and are supported within the enhanced home visiting in Nova Scotia.

Motherhood/Mothering

Motherhood is referenced in the literature as a dominant societal institution where mothering practices and relations of mothering within society have both empowered and oppressed mothers in western societies (Short, 2005). As a result of patriarchal practices mothering has been problematized (Short). One of the concepts that helps build understanding about the power and oppression connection to motherhood includes understanding how the practices of mothering are embodied in the emotional and physical relations of mothering (Short). Another perspective is how mothering practices and related discourse and language can be re-created to resist oppression constructed by the dominant societal accepted understandings of motherhood (Short). Exploring the boundaries that exist between the practices of mothering and the way the societal institution of motherhood dictates how mothering should be socially constructed provides a deeper understanding of motherhood (Short).

To be a 'good and normal' mother, society has created accepted connections to diverse discourses. Short (2005) suggests that dominant discourses direct new mothers about how they are supposed to meet all of their child's needs including stimulation of their child's physical, emotional and mental development. Gavey (2011) described how societal structures such as institutions influence ways of thinking about how to be a good mother through the production of discursive acceptable practices found in health care practices such as well baby visits. These practices provide normalizing approaches that may then contribute to beliefs about right or wrong mothering practices to ensure healthy development of children. The intent of the practices within the Enhanced Home Visiting

Program in Nova Scotia is focusing on the strengths of mothers and families. However, mothers and families are screened into a program of family support based upon a score they attain on an assessment tool that then determines if they are at risk. This type of screening seems to contradict a strengths based approach (Pan-Canadian Inventory of Public Health Early Child Home Visiting, 2009).

New mothers are also bombarded with a reality of motherhood being the most glorious time of their life when they should feel the ultimate in self-actualization (Varcoe & Doane, 2007). This western ideology represents a neo liberal, individualistic influence where the discourse of motherhood has been influenced in such a way that mothers have decided what it is to be a good mother based upon the inferred norms of dominant societal discourses and practices (Varcoe & Doane). This way of thinking can be related to the Canadian enhanced home visiting programs which represents a government institution that has protocols, standards and programming objectives that structure how marginalized mothers should be supported in their parenting experiences and ultimately their mothering practices. As part of the Nova Scotia enhanced home visiting program, practices of the PHNs and CHVs support the home visiting of marginalized mothers who experience low income and other difficulties such as low education and mental health, and through exploration of these practices a further uncovering of social construction of mothering can occur.

A critical point to consider is the lack of societal recognition of the differences among mothers' discourses of motherhood and the lack of representation of their unique realities because of diverse structural, cultural and discursive contextual experiences

(Varcoe & Doane, 2007). Dominant societal discourses that represent the institution of motherhood and the practices of mothering need to be continuously examined to build understanding about different mothering experiences. For example marginalized mothers, who experience life contexts of poverty such as single mothers who experience low incomes, and other mothers who have diverse cultural experiences such as indigenous or first nation's mothers need to have their experiences represented in research (Short, 2005).

Through research that explores the less dominant ways of understanding motherhood and how it is structured in society, discourses of motherhood can create a new understanding of how motherhood and motherly practices are experienced by marginalized mothers and those who support and work within societal structures that direct mothering practices of marginalized populations of mothers. Part of the examination of mothering in this study focused on understanding the social location of marginalized mothers. The influence of institutions like the Nova Scotia enhanced home visiting program on the social construction of the practices and experiences of those who support the health of mothers emerged in the data.

The perspective that mothering is socially constructed and organized to meet the needs of capitalist patriarchy is supported by Rossiter's (1990) work. Guided by post structuralism, Rossiter's extensive research on mothering challenges a fixed meaning of mothering as she suggests that mothers "are constantly in the process of being formed and of producing forms themselves" (p.212). For Rossiter application of post structuralism to guide research studies facilitates understanding how subjectivity is

formed through structures of language and discourse that then influence societal thinking about the institution of motherhood and the practices of mothering. Discourses are historically created and evident in day-to-day living practices and actions of societal institutions (Rossiter). Post structuralism has an optimistic side as it supports the idea that multiple discourses can represent realities of mothers. Thinking from a poststructuralist viewpoint creates a questioning about whether the health of marginalized mothers is being understood in a way that reflects their reality or is there another reality (Rabinow, 1984).

When FPS guides research there is often a goal to identify the plurality of women's experiences and the contradictions of these experiences that are inconsistent and unique (Gavey, 1989, 2011). Through a shifting of the emphasis of the meaning of subjectivity to the context of power and practices that impact subjective experiences and the conscious and unconscious thoughts of an individual an understanding of mother's worlds can be uncovered. Through analysis of the discourses of motherhood and what shapes them, understanding can evolve as to how a mother's subjectivity is constructed in a particular way and understood in relation to the world surrounding her (Rossiter, 1990). Together, an analysis of the creation of subjectivity and discourses of motherhood and mothering has the potential to uncover how power operates in society that may be empowering or oppressive. In a study by Aston et al. (2006) the empowering practices of three Nova Scotia PHNs who worked with mothers in their home were uncovered. This pilot study was guided by FPS and revealed a deeper understanding of the empowering practices of PHNs while working with mothers in their homes. Feminists like Rossiter

embrace post structuralism for its ability to uncover the social nature of individual personal experiences and how they are shaped by societal politics. Also, through deconstruction of long held assumptions subversive in language, subjective understandings of how motherhood and mothering practices were constructed can be uncovered (Gavey).

Given that single mothers involved in the enhanced home visiting program with children up to 3 years of age is the population of focus in the study it was important to examine the concept of motherhood and the practices of mothering. Understanding how the Nova Scotia Enhanced Home Visiting supports the parenting and healthy child development practices of mothers and their families is an example of an exploration into the social construction of the practices supporting the mothers. The mothering theory offers a lens for understanding how patriarchal domination results when societal institutions direct how mothering should occur (Sawicki, 1991).

In this study, enhanced home visiting was identified as a program within a societal institution that directed how practices that supported mothers who were marginalized was organized in Nova Scotia. Exploring the experiences of CHVs and PHNs uncovered how their practices contributed to the construction of mothering for those who participated in the Enhanced Home Visiting program.

Home Visiting/Enhanced Home Visiting

This section is focused on the concepts of home visiting and enhanced home visiting by PHNs and CHVs that are organized within the Public Health Care System. These concepts represent the practices that support mothers and families who participate

in the Nova Scotia Enhanced Home Visiting program. In this section, literature will be explored that shaped accepted societal understandings of home visiting with a focus on those visiting programs that support marginalized mothers and families. The intent of this review is to present an analysis of the literature describing these concepts. Home visiting practices are positioned within broader societal discourses. Fundamental to this proposed study was understanding the competing views regarding how home visiting is practiced and experienced by PHNs and CHVs in Nova Scotia. Through a review of the literature, how home visiting has evolved based upon western philosophies to support mothers and families will be presented thus providing a deeper and clearer understanding of the Nova Scotia context of home visiting.

Another area considered when exploring the literature on home visiting was the way the discourses on motherhood interfaces with home practices. For example, in this study, a unique opportunity existed to understand how PHNs and CHVs' practices socially construct motherhood for those mothers who participate in the enhanced home visiting program.

The ideals of home visiting practices are situated within a wide range of influential discourses that are connected to health discourses and in particular public health discourse that guides home visiting programs. For example, program evaluation with outcome directed expectations guides how PHNs and CHVs are expected to meet the needs of families in their home visiting practices (Ammerman et al., 2007). The language and discourse surrounding the social construction of home visiting serves to

shape and influence PHNs and CHVs' practices, experiences and the meaning they assign to their experiences (Peckover, 2002).

Social discourses and inferred norms construct the practices of home visiting for PHNs, CHVs and mothers (Peckover, 2002). Home visiting is an experience that is constructed and shaped by interaction with social conditions that have a significant impact for PHNs, CHVs and the families they work with in visiting programs (Peckover). Building understanding about home visiting in relation to mothering is part of this literature review as both of these experiences are shaped by multiple social conditions that comprise the enhanced home visiting in Nova Scotia. This approach to the literature review will support understanding home visiting and its relationship to mother's and family's health that is supported by enhanced home visiting in Nova Scotia. The experiences and practices of PHNs and CHVs was the focus of this study's data collection and the literature reviewed represents the dominant views on home visiting that have contributed to these practices and experiences. Emerging in the literature were the discourses that influenced home visiting. These discourses contribute to a deeper understanding of what shapes practices of home visiting as well as what potential gaps in understanding may need further exploration. Such critical analysis of the literature on home visiting supported the purpose of the study and the methodological approach of feminist post-structuralism that will be discussed in the next section.

Images of home visiting are represented in the literature and are heavily influenced by the work of an American researcher and home visitor program developer David Olds since he began his work in 1977 (Jansson, Petersson, & Udén, 2001).

Acknowledgment of Olds' work is important as he promoted the impact of nursing practices and how they support the health of families and in particular first time mothers who experience low incomes and are teen mothers (Goodman, 2006). Home visiting as a concept needed further clarification according to Byrd (1995) as there was little definition about the main nursing interventions connected with home visiting practices. Byrd suggests that home visiting was often represented as an intuitive practice that needed to be explored in a way that could uncover and describe specific activities connected to home visiting. Byrd supports researchers such as Olds who built a program of research that blossomed into the Olds 'Model. Within this model, a home visitation approach is based upon a nurse family partnership that involved 20,000 mothers in 20 American states (Goodman). Evaluated rigorously, Olds' research provides evidence based data that documented the effectiveness of nurse's practices in supporting first time mothers with young children experiencing low incomes. Three successive randomized controlled trials make up Olds' research in the area of home visiting by nurses in the United States. Home visiting has been a main strategy of Public Health to prevent problems and promote health and well-being of pregnant women and parents of young children from the 1900s up until the 1970s in the United States (Goodman). Funding was cut in the 1970s and 1980s to support home visiting due to a lack of evidence that this type of public health programming was effective (Goodman, 2006; Olds, 1999). One of the main reasons suggested by Olds for lack of valid evidence included, use of research designs that did not rule out threats to validity of conclusions that were made regarding the effectiveness of programs. Olds supports randomized controlled trials as offering the

best evidence as this type of study design ensured objective measurement based upon the significance of statistical results between a control and experimental group of participants. This perspective of what and how best evidence should support the effectiveness of a home visiting program proved to be a powerful argument that funders and government agencies supported (Goodman). Olds concluded that most of the early studies on home visiting results could not be trusted as evaluation of visiting programs was not done as well designed research studies. For Olds, his research strategies were funded starting in 1977 with the Elmira trial with a sample of 400 White women in a semi-rural area. The focus of this study was on modifying risks for poor outcomes of pregnancy that also included dysfunctional care giving and compromised maternal life course. The clinical activities with mothers that the nurses were required to implement were theoretically based (Olds). In the mid-1980s results of the Elmira study were published and the home visiting by nurses resulted in improvement in all of the risk areas. Olds also conducted an economic evaluation of the program that indicated that the cost of the program was recovered among families experiencing low-income by the time each child turned four. As a result of the Elmira study, policy advisory bodies began recommending increased levels of funding for preventative home visiting services for low income pregnant women. While Olds was urged to disseminate the program to other communities, the research team felt they needed to see the impact of the program in other settings and with different populations. As a result of this felt need for increased validity evidence, the study was replicated in Memphis, Tennessee with an African American population and similar corresponding effects were documented. An example of the

effects in Memphis included decreased incidence of hypertensive disorders in pregnancy, hospitalizations of child injuries and ingestions decreased by 80% in the first 2 years of life, fewer pregnancies of mothers by their child's second birthday and greater spacing between pregnancies. In 1993, Olds and his research team did a follow up of the long term effects of the Elmira program and they concluded that the effects of the program were sustained for 15 years. While Olds and his research team attracted the attention of politicians, decision makers and local community leaders he was under pressure to consider altering his home visiting program to include paraprofessionals. Olds was dedicated to nurses as the most effective professional to implement home visiting and he believed he had the data to support this rationale. Other home visiting programs were being implemented based upon the Olds' Model that were modified to include paraprofessionals during the 1990s. Home visiting programs had grown rapidly over 20 years and it was estimated that at least a half a million American children were enrolled in six large home visiting programs. Olds was one program with five of the six using paraprofessionals (Goodman). Evaluation data of these types of programs had mixed results of their effectiveness. As a result, Olds felt pressure to gather more data through another randomized controlled trial where the research design included a third group of mothers visited by paraprofessionals with high school education. Olds chose Denver and 735 first time mothers were randomly assigned to one of three groups, a control group who received no visits, a nurse visited group and a para professional visited group. There were important differences between the nurse visited mothers and those who did not receive visits. There was a higher incidence of mothers who received visits re-entering

the workforce. Also, the mothers receiving visits had fewer pregnancies and children born to mothers with psychological vulnerability developed better language skills and had better behavioural control when they were age 2 and 4. When the para professional visited mothers were compared to the control group there was very little difference. The mothers visited by the para professionals had improved interaction with their children and some reduction in psychological distress and these were the only measureable differences found. With all of these results from the three randomized controlled studies Olds' confidence in his program was solidified and he was ready to make the program grow (Goodman). Janet Reno, the U. S. Attorney General in 1996, approached Olds to be involved in a long term prevention program involving six cities with only seed money of \$25,000. A non-profit foundation resulted called Invest in Kids and in 1999 a \$10 million grant was received to reach 100 communities and 10,000 families. Growth of this nature required new approaches and as a result the Nurse-Family partnership was incorporated and a president and Chief Executive Officer were hired to lead the work guided by a business plan. Twelve hundred additional nurses were hired to support the growing work in 38 states and involving 34,000 families (Goodman, 2006). In the United Kingdom in the past year approximately 6,000 health visitors (PHNs) were hired as part of the same type of nurse family partnership program (Personal Communication, M. Aston, 2013).

In an extensive review of visiting practices of PHNs, researchers summarized critical issues related to home visiting and they suggest that randomized control trials conducted in Elmira, New York and Memphis, Tennessee demonstrated that home

visiting by nurses reduced the number of hospital visits for children over the age of 2, decreased maternal and youth arrests significantly and reduced youth running away from home. Nurses who visit families in their homes are more successful than CHVs at sustaining family participation in home visiting practices (O'Brien & Baca, 1997; Olds et al., 2007; Reiter, 2005).

With training, para professionals or CHVs, as they are also called have been shown to be effective when they are supported and supervised by nurses (Bull, McCormick, Swann, & Mulvihill, 2004). Other studies suggest that nurses who deliver home visiting programs versus para professionals (CHVs) have better outcomes in improving child mother interactions while also supporting improved health outcomes in the areas of parental mental health and attainment of healthy child development skills (Duggan et al., 2004; Reiter, 2005). However, Olds, who is a pioneer in home visiting practice's research, maintains that nurses have highly effective outcomes in home visiting practice he also acknowledges that nurses may not be enough to sustain home visiting effectiveness because more research is needed to evaluate their effectiveness (Olds, 1999). It has been suggested that there is a need to focus future studies on who (CHVs or nurses) is more effective in attaining the outcomes outlined by home visiting programs and what type of families successfully meet program outcomes (Bull et al., 2004; Reiter, 2005). Also, exploring the differences between CHVs and PHN's practices and how the combined efforts of PHNs and lay home visors together affect outcomes of their practices has also been suggested as a focus for future research.

When reviewing the literature there is an obvious debate that exists regarding the best approach to home visiting (Ammerman et al., 2007; Olds, 1999). But, there is agreement that home visiting is a core function in early prevention of family health issues. One issue identified by Olds was the lack of evidence based data available to evaluate home visiting programs. Ammerman et al. suggest using a web based system to manage the large volume of data that results from evaluation and monitoring of multisite home visitation programs such as the one they implemented called Every Child Succeeds (ECS) in south western Ohio and northern Kentucky. Through the collection of useful data by an efficient, valid approach, Ammerman et al. suggest that home visiting experiences and the strategies used to support families will be identified efficiently and then able to promote larger scale prevention programs with families. Also, the authors note that those collecting the data will have a streamlined approach to follow where specific questions prompt short answers that support the defined outcomes of the program. Based upon the Nurse Family Partnership Home Visiting Program of Olds, and Daro and Harding's program called Visitation Healthy Families America, ECS was a third major home visitation program established using both nurses and para professionals to promote family health with an initial emphasis on preventing child abuse and neglect. The program expanded to provide a range of services to support the general health and development of young children. Ammerman et al. committed resources to create a business model approach to program evaluation based upon Continuous Quality Improvement (CQI) that is consistently used in the business and manufacturing industries. While I agree that there is a need for evaluation of home visiting programs, I

suggest there is also a need to explore multiple ways of understanding the experiences and practices that are part of home visiting that may get missed with well-planned evaluation strategies that Olds and Ammerman et al. reference. Woodman (2007) notes that Olds himself has acknowledged the importance of not missing important unplanned nurse home visiting experiences and practices with families that can occur outside the carefully planned program evaluation strategies like those that Olds and Ammerman use in monitoring the effectiveness of their home visiting programs.

Various home visiting programs exist that support diverse family needs. In the literature, summaries of their effectiveness are found as I have previously discussed. Hedges, Simmes, Martinez, Linder, and Brown (2005) share an evaluation of a Welcome Home Baby Program (WHB) from northern San Diego, California that focused on the well-being of first time mothers during their baby's first year of life. The authors suggest that underserved populations are often targeted for support through home visiting. The goal of the WHB was to include all first time mothers as they believed there was a need among the mothers due to shortened hospital stays where follow up dates were not always set up before discharge from hospital and illness in babies is not always recognized during the short hospital stays. Also the authors note that tired moms may not realize what support they need until they are in their own homes and on their own to care for a new baby (Hedges et al). The WHB utilized professional and para professional home visitors. Objectives were developed to guide evaluation of the effectiveness of the approaches used in the home visiting. Case management guided the evaluation approaches and clinical pathways determined the expected outcomes and what supports

were given to new mothers. Costs were associated with each clinical pathway. While the article suggests the effectiveness of the home visiting based upon the program objectives there were no descriptions of how the professional and para professional home visitors worked with the new mothers. The focus in the article was instead on the clinical pathways and how they can provide evidence to inform health care decisions and decrease health care delivery variances and costs. While this study does represent a different way of delivering universal home visiting through describing the program structures and outcomes, the processes involving the visitors are not clearly evident.

In response to the previously described visiting program, Kitzman, Cole, Yoos, and Olds(1995) would suggest the importance of qualitative research studies to build knowledge about how programs are successful in supporting families. The authors go on to use the work of Olds in the Elmira New York randomized controlled trials as their reference point, when they suggest a need to have another way to interpret data from home visiting program evaluations. In their study, Kitzman et al. provide detailed protocols to home visitors based upon elements that were essential to the Olds home visiting program called the Nurse Family Partnership. Focused on African American families in Memphis, Tennessee the researchers worked with a community advisory committee to ensure the program activities they used would be supportive of families in the local area. Nurses were encouraged to establish nurse family relationships where unique needs of families were acknowledged and supported through creative, family specific program activities that may not have been part of the home visiting program designed by Olds. Seventeen nurses who were all baccalaureate prepared were the study

participants and they describe the challenges they experienced during home visits. While many descriptions of challenges are summarized in the article, a deeper understanding of what the challenges mean for nurse's practice and their experiences with the families was not evident. True to the theories guiding the Olds' model, the descriptions used to summarize the nurses experiences implementing the program focus on how to change or influence the behaviours of families. While this qualitative study represents an attempt to understand the challenges of nurses implementing the Olds' home visiting program I found it remained focused on how to change families versus understanding nurse and families' practices and experiences as they participate in a home visiting program.

Internationally, home visiting programs are widespread in Australia. A randomized controlled trial of nurse home visiting with 'vulnerable' families (defined by the study) with newborns is presented by Armstrong et al. (1998). An evaluation of the impact of home visiting programs with targeted families who had a child with a developmental delay was the focus of one Australian study (Armstrong). Early intervention programs were started in Australia and overseas to prevent the impact of environmental risk factors that affect children. A range of intervention programs were offered that included families with defined characteristics. The families of focus presented high risk experiences such as, domestic violence, sole parenthood, parental ambivalence toward a child, history of childhood abuse, financial stress, unstable housing, lack of social support, decreased parental mental health, drug or alcohol use by the parents and accidental injury of a child. The study result suggests that targeted health delivery in the home through visiting with vulnerable families is acceptable to the

families. The conclusions of the study are based upon a 63% participation of mothers in completing a risk assessment questionnaire. Also, the study results suggest that the greater the vulnerability of the families the more likely the family would consent to a home delivered program that supported the health of a mother and an infant. An important result from this study was the identification of how circumstances that vulnerable families experience prevents them from accessing well child health care and this also leads to inequitable poor health outcomes that children born into adverse circumstances experience (Armstrong).

Many examples of reviews of home visiting are represented by a meta-analysis that focused on the review of American home visiting programs for families with young children (Sweet & Appelbaum, 2004). A Canadian systematic review that explored the effectiveness of home visiting as a delivery strategy for PHN interventions in the prenatal and post-natal period provides valuable information on literature up to 1993 then from 1995–1998 (Ciliska, Mastrilli, Ploeg, Hayward, Brunton, & Underwood, 2001). Another Canadian systematic review by Wade et al. (1999) focused on studies examining the effectiveness of lay /peer/ para professional home visiting on the health outcomes of children 0-6 and mothers. Wade et al. reviewed 344 articles but she found only 86 were relevant to her review. In addition to suggesting more longitudinal studies that followed home visiting throughout the development of a child, Wade et al. also suggested a need for more qualitative studies that documented the experiences of lay / peer / para professional home visitors to more fully understand the home visiting practices. In the U.S.A. Caldera et al. (2007). reviewed the impact of a state-wide home visiting program

on parenting and on child health and development. In this review, Caldera et al. assessed a voluntary, paraprofessional home visiting program and how it promoted the child health development and maternal parenting knowledge development and the change in attitudes and behaviours of the parents. The study results suggest that targeted home visiting by para professionals improved some aspects of parenting, child development and child behaviour but not child health. Chaffin (2004) presents a question as to whether it was time to rethink healthy start programs for families and how they are delivered.

Olds and others have had a great influence over western home visiting practices. Looking with fresh eyes at how home visiting practices have been socially constructed requires understanding other ideas that contribute as well. For example, I would suggest that embedded within the literature is the idea of liberal capitalism that is often in the background of western practices (Varcoe & Doane, 2007). In Canada, for example, liberal capitalism influences the norms for home visiting that have been created and organized within the social and economic context of Canadian government budgets that decide and direct what programs need to be supported (Raphael, 2011). Statistics Canada also plays a role in defining family structures and needs regionally across the country which then determines who and what programming will be supported financially (Raphael).

Theory has also influenced the accepted nurse client relationship that best supports home visiting for at risk families (McNaughton, 1998). Nursing theorists' models such as Peplau have been applied to home visiting programs (McNaughton). Solution focused approaches to prenatal and early childhood home visiting have also

been explored for their effectiveness to promote family self-efficacy in Olds' randomized controlled trials in New York, Tennessee and Colorado. Based upon a health promotion model by Pender, the solution focused approach supports home visiting that builds relationships with families based upon the strengths of the families versus their problems with an overall goal of building new behaviours that support clients (O'Brien & Baca, 1996). A solution focused approach was not considered a common practice of nurses according to O'Brien and Baca so workshops were offered for nurses to build expertise in this approach before implementing the Olds model with families. Para professional home visitors were not included in the training as it was noted that they did not have the professional knowledge foundation in establishing therapeutic relationships. However, separate training was provided to para professionals to increase their therapeutic relationship skills but solution focused approaches were not included in the training.

Due to the impact of early home visiting programs on child development they have been a recent focus of attention in Canada (*Pan-Canadian Inventory of Public Health Early Child Home Visiting*, 2009). Early home visiting programs are offered in every province and territory in Canada but there are differences and similarities in how they are delivered. The National Collaborating Center for the Determinants of Health (NCCDH) conducted a pan Canadian review of public health early child home visiting to demonstrate the effectiveness of this type of programming to “improve health equity and health outcomes of children and their families” (NCCDH, 2009,p.5). Early childhood refers to the time from prenatal up until a child is 8 years of age (Irwin, Hertzman, & Siddiqi, 2007). Through an environmental scan that involved telephone interviews a

comprehensive inventory of Canadian early child home visiting programs was created that represents diverse types of programs, who delivers the programs, types of assessment tools used, and variation in evaluation of the programs and many cases where there was no evident evaluation.

The NCCDH also learned that different language is used across the country to represent the descriptions of the programs. Dominant programs that are implemented in Canada to support home visiting include, Growing Great Kids which is based on an American curriculum with a focus on a strengths based home visiting strategy and it has specific modules to guide the program; Healthy Families Americas program that was developed to reduce child abuse in America, Invest in Kids , a parenting program in Canada with a goal of transforming Canadian parenting; Nurse-Family partnership approach based on the work of David Olds' 30 years of evidence from randomized control trials that support vulnerable parents with a focus on low income first time pregnant teenage mothers; and Triple-P Positive Parenting program that originates in Australia with a focus on diversity, socio economics and family structures. In addition to diverse types of programs offered there is a variety of assessment tools used to screen families in or out of programs (NCCDH). There has been a suggestion by the NCCDH that due to the diversity of programming in place across Canada to support families it is difficult to share approaches across provinces. The language used to explain ways of delivering programs requires translation before sharing and this contributes to an inability to share approaches from region to region in Canada.

When tracking the evolution of home visiting, a movement that occurred in the 1990s to address the needs of at risk populations through targeted programs was based upon a bio-medical model of evidenced based practice (Estabrooks, 1998; Hall & White, 2005; Olds, 1999). As a result of this evidence, public health nursing practice was affected and thorough family needs assessments carried out by PHNs were decreased. At one time these types of assessments had been a core aspect of their practice. Throughout these times the health of marginalized mothers and others did not improve and inequities in health became more obvious (Ashton & Seymour, 1988; Government of Canada Public Health Agency of Canada, 2001; Raphael et al., 2011).

The Centre of Excellence for Early Childhood Development has evaluated home visiting programs with mixed reviews (Wade & Fordham, 2005). Indicators of programs that resulted in positive outcomes included those targeting at risk families and children based upon a structured curriculum that utilized trained visitors and those using nurses had the most positive effect on maternal and child health outcomes. Wade and Fordham suggest that more research is needed to get evidence that supports how to improve the home visiting programs.

Other studies focus on the economic benefit of targeted home visiting by using language such as high yield investment in strong families by home visiting programs which is reflective of a health economics focus of public health practices (Powell, 2010). In the United States where Medicaid is the provider of health services for those who do not have money to pay, some state governments evaluate home visiting based upon the cost benefits of a program. For example, if a program yields an overall goal of reducing

health inequities by providing the most cost effective program at the same time then it is assessed as effective. In these examples from the United States the professionals who evaluate the programs are often accountants or economists who are concerned with distributing financial resources equitably versus determining how the home visiting is understood and delivered to families (Powell). A theme I found in the literature that runs through home visiting programs in Canada are their roots are often in American programs that are based upon a different type of health system. For example Erkel, Moore, and Michel (2004) assessed rural home visiting programs designed to support at risk mothers for poor pregnancy outcomes using community workers within a case management system. The indicators of successful outcomes were measured by how cost effective the program was at decreasing health disparities for the mothers. Once again the language used to describe the effectiveness is rooted in economics and not how the women are supported in their health.

One qualitative, descriptive, interpretive study by Heaman, Chalmers, Woodgate, and Brown (2006) in Manitoba identified themes and issues that 24 PHNs and 14 CHVs identified in their experiences working in the Baby First home visiting program in Manitoba. The researchers in this Manitoba study focused on training needs, how to retain visitors, program delivery issues and family enrolment. Another study by the same group of Manitoba researchers evaluated the relationships among participants in the home visiting program that included PHNs, CHVs, and parents. Both of these studies provide valuable information on their program but understanding how the practices of CHVs and PHNs impact the families was not clear (Heaman et al., 2006). An Australian

study by Kemp, Anderson, Travaglia, and Harris (2002) presents evidence that sustained nurse home visiting in early childhood with vulnerable families requires high level nurse competencies versus lay home visitor skills to have successful outcomes with the families. In the literature there are a few studies that support the idea that positive health outcomes result when early home visiting is carried out by PHNs. (Ciliska, Mastrilli, Ploeg, Hayward, Brunton,& Underwood, 2001) completed an extensive review of early home visiting literature and suggests that evidence supports the positive impact of nurses on improved health outcomes for families.

In Ontario, Jack et al. (2012) made significant research contributions to implementing and evaluating the Nurse Family Partnership program (NFP) in Ontario based upon the work of Olds (1999). This research has contributed to understanding how to implement the NFP in a Canadian context and they have made extensive and thorough recommendations as to strategies they have found to support positive outcomes for mothers and children (Jack et al).

In Nova Scotia, enhanced home visiting was added to the existing Universal Healthy Beginnings Home Visiting program in 2002 to further enhance in home support for those families experiencing circumstances that create additional burdens for families during the early days of a baby's birth up until age 3 (Healthy Beginnings Support Manual, 2013). Circumstances such as low income, geographic location, age of a parent, limited education and support have been identified within the Nova Scotia enhanced home visiting program as contributing to increased family burden that impacts their ability to support the best outcomes for their child's health and developmental needs. An

initial screening tool is administered to all postpartum mothers to identify mothers/families who may experience challenges caring for their newborn. This assessment usually occurs within the hospital upon delivery of a baby but it can also occur when there is an initial visit to a home after a baby is born (Kathy Inkpen, Personal communication, Nov., 2012). If the family is identified as requiring additional support a more in depth assessment is done to assist PHNs to determine what services could be offered to build upon family strengths and further support the best development of their child. If families agree to participate, the enhanced home visiting can be offered for up to 3 years but at a minimum, the visiting is offered up until the child is 4 months old. The enhanced home visiting has been described as offering an individualized family visiting approach that has defined criteria with a focus on parenting support, fostering healthy parent-child relationships, promoting optimal childhood development and providing linkages for families with resources that best support healthy outcomes for the family (Healthy Beginnings Support Manual). Up until 2002, PHNs did the entire home visiting in Nova Scotia. With the enhancement to home visiting in 2002, CHVs who are also referred to as CHVs, were also included as part of enhanced home visiting practices. The home visitors' practice is described as being assistive to families through helping them to set and achieve goals while providing information on parenting, development of children and other outside services they may want to access (Healthy Beginnings Support Manual). Home visitors also act as advocates for families if unique needs arise during the visiting. A linear logic model is used to guide evaluation of the program and the outcomes. It is acknowledged by the authors of the home visiting support manual that the

logic model presents a simplified view of the work of the enhanced home visiting as the process of home visiting is an integrated activity that involves many more people and activities that the model does fully describe.

Standards guide expectations for public health practices, activities and desired program outcomes in Nova Scotia (Healthy Beginnings Support Manual, 2013). In Canada, core functions for public health have been integrated into public health work such as home visiting. As a result of this coordination between federal and provincial mandates of public health, the enhanced home visiting reflects the core public health functions of surveillance, population health assessment, health protection, health promotion and disease/injury prevention (Healthy Beginnings Support Manual). Through program evaluation and surveillance activities, healthy beginnings enhanced home visiting practice decisions are made. Essential knowledge and skills are part of the expected core competencies that support the practices of public health. As a result of this competency requirement, core training for home visitors is based upon Invest in Kids and Great Kids Inc. Core curriculum (Healthy Beginnings Support Handbook). Ongoing monitoring of how these programs make a difference for families is a requirement to maintain public health standards (Healthy Beginnings Support Handbook; Suzanne Landry, Personal Communication, July 2013).

The Nova Scotia Enhanced Home Visiting program has been evaluated consistently and a recent evaluation was done to measure whether standards and objectives have been met (Suzanne Landry, Personal Communication, 2013). While there are positive outcomes noted in the report about improvement in supports for at risk

families (language of public health) it is difficult to identify differences between CHVs and PHNs practices and experiences and how they support marginalized mothers and families.

One method of analysis used in the evaluation approach focused on summarizing themes found within transcriptions of focus groups and individual stories of all involved with home visiting. While the qualitative data is rich and provides context for how home visiting occurs and is understood by those participating, I would suggest that this proposed study offers an analysis of the experiences of PHNs and CHVs that will go deeper into understanding through discourse analysis the relations of power that are socially constructed in the social, institutional and cultural experiences and practices of PHNs and CHVs within the Nova Scotia Enhanced Home Visiting Program.

The literature reviewed and previously discussed, personal communications with public health directors, managers, a provincial program coordinator and a PHN suggests that this study's focus on understanding both PHNs and CHVs' practices and experiences, within a feminist poststructuralist theoretical framework has not been done in Nova Scotia. Everyone I met with have supported the proposed study as coming at a critical time with new protocols for public health being implemented and changes to the enhanced home visiting that were pilot tested in the fall of 2013. Those participating in the study had the opportunity to share their experiences and practices within a changing home visiting program (Kim Barro, Suzanne Landry, & Linda Young, Personal Communication, July 2013).

As has been previously noted, marginalized mothers who experience the burdens of low incomes also experience poor health outcomes that have not improved since the 1980s (Raphael et al., 2011). I question whether data is being collected that reflects the best practices that support the health of marginalized mothers. Work to revise the protocols that guide outcome measures for health practices in Nova Scotia occurred during this study. Included within this work was a focus on how at risk populations (public health language) are supported in reaching optimal health (Healthy Beginnings Support Manual). The details of these protocols had not been released, however one can assume the results will influence the structures of programs that support all marginalized populations in Nova Scotia in the future (Linda Young, Sheila Sears, & Kathy Inkpen, Personal Communication, Nov. 2012). Given the invisibility of mother's health, I am left to question if practices needed to support marginalized 'at risk' mothers and their families experiencing the burdens of low incomes will be evident in their recommendations.

Within the structures and practices guiding home visiting for marginalized 'at risk' mothers experiencing low income there has been extensive evaluations of some Canadian programs and not others (*Pan-Canadian Inventory of Public Health Early Child Home Visiting*, 2009). I would suggest that there is an obvious gap in understanding the experiences of CHVs and PHNs who support mothers and their children in the enhanced home visiting program. Is it possible that how the structures and processes are evaluated in Canada regarding support for parents programs have missed the invisible experiences, practices and perspectives of those working closest with the

families who participate in the home visiting programs? Within this literature view I have presented the diversity of home visiting that occurs worldwide with an emphasis on the dominant contributors of the United States of America, Australia, the United Kingdom, and Canada. I outlined that evaluation is part of some of these programs but not all have it included. Within the literature, program evaluations predominantly come from the United States perspective where cost effectiveness is a focus of their health care system. It is evident from the literature that different language is used to describe program evaluation and the majority are guided by a bio medical approach based upon collection of evidence as is apparent in reference to randomized control trials approaches, the health economics of public health practices, and an evaluation of consistent focus on whether program outcomes versus objectives were met.

During an environmental scan I completed across Nova Scotia during October and November of 2012, directors and a manager of public health, with extensive experience with home visiting and evaluation of programs, suggested the need to look at the practices of CHVs and PHNs who support the health of mothers and their families who participate in the Enhanced Home Visiting program. These experienced public health professionals reflected that this type of research can further the understanding of how PHNs and CHVs' practices impact the families who participate in the home visiting program, and as a result home visitors may more clearly understand how to offer support. I have found one researcher from the United Kingdom named Dr. Sue Peckover who used a research approach that offers a way to uncover a deeper understanding of the practices of both PHNs and home visitors who work within enhanced home visiting.

Peckover (2002) offers an approach to knowledge construction in regard to home visiting practices in the United Kingdom that I have not found frequently in the literature. In a qualitative study involving interviews of 24 health visitors (PHNs) and 16 women who were victims of domestic violence, Peckover examined the health visitor's practices in relation to women's experiences of domestic violence. Through focusing on the theoretical understandings that arose in her study Peckover's findings offer another way of considering practices and experiences of PHNs. Guided by the theoretical framework of FPS with an application of Foucault's notion of disciplinary power, Peckover's findings represent how women discursively described being engaged in home visiting disciplinary practices. The discourse reflected how the women saw themselves as good mothers and how they felt constructed as objects and subjects because of the health visitors' gaze. Also, the women's discourse demonstrated a resistance to the disciplinary practices of home visiting. The health visitor's (PHNs) discourse provided an understanding of how they interpreted and applied disciplinary power in their home visiting work. Peckover suggests that her research findings further support the need for health visitors to understand how to develop their home visiting practices based upon understanding what differences and tensions exist between lay, professional and sociological perspectives of home visiting. Peckover notes that there was little empirical work done developing the ideas found in her research within the context of British home visiting. I would suggest that the same can be said about the Nova Scotia context. While Peckover found a number of studies that focused on application of Foucault's notion of disciplinary power to analyze nursing practice there was limited research on disciplinary

power that facilitated furthering the understanding of these practices. Foucault's theoretical perspectives provided a critical lens for Peckover's research and are useful for the study I am proposing with its focus on understanding the practices and experiences of nurses and CHVs who work within the Nova Scotia Enhanced Home Visiting Program. Aston et al. (2006) did a pilot study in a similar way to Peckover where they examined the empowering relationships of PHNs when they worked with mothers in their homes. Guided by FPS Aston et al., like Peckover wanted to understand at a deeper level the practices of PHNs and the role that power has in the practices.

Through universal access to mothers, British health visitors (PHNs) have historically been in a role of policing families with young children (Abbott & Sapsford, 1990). While mothers often had no choice but to accept this type of surveillance of their mothering they did not always accept it as a wanted support (Mayall & Foster, 1989). Peckover suggests that the knowledge base that provided the guidance for health visitors' practices had been developed based upon discourse normalized by middle class and patriarchal perspectives. Feminist post-structuralism was selected by Peckover for guiding data analysis as it supported her study's purpose of understanding how power was exercised between mothers and health visitors through discourse examples of mothers and home visitors 'practices and experiences. Peckover's research uncovered both the policing and supportive roles of health visitors and discourse that creates health visitors and mothers through the power that exists in their relationships.

In summary, Peckover's research supports a need to understand the practices of home visitors (PHNs) who are engaged in home visiting. Through furthering this

understanding of how the visitors' roles have been socially constructed the complex relationship between mothers and home visitors' (PHNs) practices can be more deeply understood.

Another analysis of the previous study by Peckover (2003) highlighted how feminist perspective provided insight into the professional knowledge base that guides British home visitors' (PHNs) practices. Feminist work has increased the visibility of issues that women and children experience in their lives such as domestic violence (Peckover). The importance of a feminist perspective in furthering the understanding of the gendered perspectives of power relations that underlie domestic violence was suggested by Peckover. In her research, Peckover notes that British health visitors provide universal services to families with young children with a primary focus on health and social well-being. With a feminist perspective facilitating understanding and informing the practices of health visitors (PHNs), Peckover suggests that issues such as domestic violence would be understood in a way that provides legitimacy to the issue and thus elicit more attention from those who support health visitor's practices.

Until recently, there have been few feminist, qualitative studies that provide a contribution to the knowledge base that guides the practices and experiences of PHNs and CHVs who work within an enhanced home visiting framework like the one offered in Nova Scotia. There is a need to explore and understand the practices and experiences of PHNs and CHVs' practices to build further understanding of how they construct mothering (Peckover).

Understanding the knowledge base that informs the practices and experiences of professional and CHVs and how power is exercised within the relationships with families has been a focus of Peckover's research (Peckover, 2002, 2003, 2009). Guided by feminist post-structuralism, Peckover's research approach provides relevant strategies for my proposed study.

I suggest that through exploring the practices and experiences of CHVs (CHVs) and PHNs, with marginalized mothers and families who experience the burden of low incomes and other unique experiences, and participate in the enhanced home visiting in Nova Scotia a new way of understanding will occur that can influence ways of informing policy and programming decisions that support these mothers and families in the future. Cheek (1999) suggests that post structural approaches lend themselves to supporting research that seeks to represent acted, written or spoken health care practices. For Cheek, these health care practices become the data and the focus of the study's analysis. The enhanced home visiting practices of PHNs and CHVs represent health care practices designed to support all mothers and their families reach optimal health, however, I suggest that the health care practices needed to support marginalized mothers and families are not understood deeply enough.

Contexts Impacting Health Experiences of Marginalized Mothers

As many of the mothers who participate in the enhanced home visiting program are marginalized due to being mothers who are raising children alone and experience the burden of low incomes, this section provides a social context of their experiences.

Globally, it has been estimated that there are 1.5 billion poor people in the world and 70% are female with mothers raising children on their own experience a disproportionate poverty burden (International Congress of Nursing [ICN], 2005). Poverty is a major determinant of poor health as it impacts where people live, what they eat, the education they receive and how children's development is supported (Public Health Agency of Canada, 2006). Since mothers raising children on their own experience poverty at a significantly higher rate than others then it is reasonable to assume that they will experience poorer health. There has been national acknowledgement that inequality influences the majority of Canadian mother's lives who are parenting alone and experience the burdens of low incomes, and there is a need to understand the influencers of the mother's lives (Nova Scotia Advisory Council on the Status of Women).

Within the health literature there are references to victim blaming which diverts attention away from the societal, systemic influences that create contexts for the emergence of poor health in marginalized groups like mothers parenting on their own and their families (Reid, 2004; Sherwin, 1998). Associated closely with poverty is exclusion which is an equally important determinant of health (Hayward & Colman, 2003). Marginalized mothers who experience the burden of low incomes have been excluded historically through under representation in government decision making, research and through limited access to resources (Hayward & Colman). Vulnerability is yet another term used to describe groups in society who are at an increased risk of being socially excluded and low-income single mothers and children have a prominent place within this

group (Colman). Characteristics of vulnerability include low-income, poor housing, working and living in dangerous locations, lack of support, food insecurity and lack of control over one's life (Hayward & Colman).

A recent Canadian, qualitative, longitudinal study provides an illustrated example of social exclusion and vulnerability through a lack of recognition for and interaction with marginalized mothers who parent alone as legitimate contributors to an accurate description of their lives (Gurstein & Vilches, 2010). This study involved in depth interviews from 2004–2006, with 17, poor, single mothers (study language) every 6 months over a 3-year period on the east side of Vancouver, Canada. As a result of their study, Gurstein and Vilches, recommend the need to redefine a just city to be more inclusive of all people's participation. Part of this inclusiveness requires engaged citizenship of the most marginalized in communities such as mothers who experience low incomes. The authors provide qualitative examples of the life contexts of the participants which illustrated the mother's ability to deal with vulnerable situations despite their life constraints (Gurstein & Vilches). Themes that were identified in the study included the mother's constant navigation of housing and food provision, bureaucratic interactions and childcare and volunteer activity to meet their childcare demands (Gurstein & Vilches). However, despite the constant survival activities of the mothers, the researchers suggest there remains a lack of recognition and understanding of the mother's needs and what resources are needed to support their life experiences with low income (Gurstein & Vilches). The researchers believe the government needs to be more than a provider of

social assistance who monitors what the mothers feed their children, how they parent and with whom they interact.

Browne et al. (2010), a group of Canadian researchers have done extensive research with Canadian single mothers on social assistance and they identified them as having much higher risk of poor health status. Historically, researchers have devoted more attention to the causes and adverse effects of single parenting than examining what difficulties single mothers experience as they raise children alone (Mcbride-Murry, Bynum, Brody, Willert, & Stephens, 2001). Economically disadvantaged women (study language) experience higher incidences of breast cancer, coronary heart disease and psychological distress (Caron, Latimer, & Tousignant, 2007; Fleury, Keller, & Murdaugh, 2000; Vickberg, 2008). It is not a new discovery that, globally it is known that, marginalized mothers who live with the burdens of low incomes and poverty experience poor health outcomes. In the 1930s social ecologists identified the negative health outcomes of low income on populations (Caron et al). However, 80 years later, mothers parenting on their own who experience low incomes continue to experience poor health outcomes (Raphael et al., 2011).

Critics have suggested the idea that traditional health promotion focuses on programs and interventions that place responsibility for health on individual women and suggest it hasn't worked well at promoting healthy outcomes in vulnerable populations (Reid, Pederson, & Dupere, 2007). From their standpoint, the biomedical, psychological and behavioural models have dominated and provided the theoretical background for health promotion work and as a result inequities in women's health have not been

appropriately addressed (Reid-Pederson & Dupere). A feminist philosophy supports building knowledge from the experiences of women in the lives and places where they live versus a traditional health promotion model that often disempowers and oppresses women. Applying an intersectoral theory to health promotion strategies is another way to focus interventions on social structures and processes and their interrelated power relationships. Arriving at this point requires acting on a macro system determinant of health such as poverty (Reid-Pederson & Dupere). Globally and in Canada, the social determinants of health have been identified as fundamental influences in eliminating health inequities (Raphael, 2011). Foundational support for the role of the determinants of health in promoting the health of Canadians can be traced back to the policy work represented in the Ottawa Charter for Health Promotion (WHO, 1986). Health promotion interventions need to reflect the complex interactions of factors that women who are marginalized experience daily (Timmerman, 2007). Social inequities result when mothers who are marginalized experience life situations that are significantly influenced by their poverty experiences and poor health outcomes often result (Raphael, 2011). Research needs to be designed in ways that ensures voices are heard that can influence how potential inequities are understood in society. In the past, health and its determinants were influenced by a positivist science perspective with an emphasis on valuing quantitative methods to build knowledge and evidence (Raphael et al., 2006). As well, with a focus on the determinants of health in Canada and globally there was a movement away from blaming individuals for their life situations to more closely examining the

impact of societal structures on a person's health (Mikkonen & Raphael, 2010; Raphael et al., 2006).

It was proposed that this study had the potential to provide a deeper understanding of the practices of both PHNs and CHVs and how they navigate the systems in their environment to achieve equitable health access for marginalized mothers and families who participate in the enhanced home visiting program.

Also, uncovering how power was experienced in the lives of mothers who were marginalized through health supporting practices directed by the institution of public health was a focus in this study.

Reflexivity

As I reflect on my own mothering experiences, I see myself as a strong woman and a mother who has raised two intelligent, loving, kind and capable children. I am not sure how I would feel about myself as a mother had my children had a different outcome. I think my love and pride would remain but I could also experience great disappointment and a sense of loss if I was hoping for another outcome that did not occur. I take great pride in my accomplishments as a mother. I don't feel guilt that I was a working mother throughout the 24 years since I birthed my first child. I had worked hard to achieve my education and it gave me control over my life to some degree regarding my financial stability and it had been reinforced at a young age that education was my way to freedom. Growing up in industrial Cape Breton has shaped the depths of who I am as a woman and a mother. My experiences from a young age fostered a self-pride in contributing to my community and society so that I left the world a better place. These values and beliefs

were part of how “I was raised up” as is often heard in Cape Breton. Much like the anthem of Cape Breton Island, “We rise again in the faces of our children,” the words represent the social construction of the passion Cape Bretoners have to raise their children and leave a legacy in the world through them regardless of the obstacles. The feelings this song evokes is something I can relate to and they represent my contributions as a woman and mother but also how many mothers may feel when raising their children. In my proposed research there is potential to provide a new way to represent understanding the practices that construct mothering for those mothers who participate in the Enhanced Home Visiting Program as they raise their children. Feminist post-structuralism provides the possibility of understanding the construction of mothering through the lyrics of their life song that has not had the opportunity to be sung or maybe not yet composed.

Through my life experiences I have been sensitive to issues mothers experience due to what gets constructed around a person through no choice of their own. For example, I understand what it is like to be labelled for where I lived and who I went to school with, however I did not experience this awareness until I left the safety of my working class, multicultural community to attend high school. I quickly learned not to tell others where I was from as I saw their negative responses. Now, I recognize the richness of my early experiences and how they have fostered me to be the woman and mother I am today. My understanding of difference has been socially constructed through real experiences. I don't need to read a book to understand how it feels to be controlled by a context that was beyond my choice. I lived it, breathed it and loved it

until I felt like I was labelled and then I understood the impact of marginalization and oppression at a personal level through experiences with others through their reminders that where we lived was not as good as other parts of town. These experiences did not discourage me; instead it created a self-determination of agency to show the world what I had to offer. It was because of the life examples of strong mothers and female teachers in my life that I found the agency to move outside my subjective position and feel empowered to seek the possibilities. I felt that I had the strength to succeed. My own mother was orphaned at 2 years of age when her mother died suddenly. Her father moved her to her grandmother's farm where she was raised by her and her mother's sister. These mothers were also strong, independent women who ran a farm and did many other types of work like being a teacher and postmaster and taking care of the accounting for the church. These mothers were respected in their rural community for being able to take care of important jobs that need to be done. However my own mother had health problems that created difficulties for her mothering but the strong women who surrounded her supported her mothering of me which created a strong bond between myself and my great Aunt who was a surrogate figure for me in many ways.

Constructions of motherhood vary (Varcoe & Doane, 2007). My interest in the social construction of mothering practices can be traced back to the strong mothers who were in my life while growing up in a multicultural centre of Nova Scotia called Whitney Pier. Strong mothers that represented diverse cultures from, Italy, Ukraine, Poland, Russia, Scotland, England, France Israel, Bahamas, West Indies and Africa surrounded me because someone in their family history came to work at the Steel Plant. It was

through the social construction of mothering within the microcosm of the industrial centre of Cape Breton Island that my desire to understand more began. It was the mothers who kept the cultures alive for the children as they were first and second generation immigrants. When we played on the streets of Whitney Pier under the clouds of iron ore spewing from the Steel Plant stacks, it was mothers who daily carried out their practices of mothering through nurturing, raising children, socializing within the community and maintaining relations with churches, synagogues, groups, schools and politics. Yes, politics, it was well known to get elected in Whitney Pier meant engaging mothers in your campaign in some way to ensure you got their vote from their respective women's groups. Was it the mothers' choice to live their mothering in this way? It is difficult to say as many were articulate and able to also run small corner store businesses but their main focus was always on the education for the children. It was common for me to have the same question asked of me by Marcie (Ukrainian), Toots (Ukrainian), Angeline (Italian), Hannah (Jewish), Alice (Irish), Katie (Scottish), and Miss Arthur (African)—“How are you doing in school?” For these mothers, a major role of their mothering was to influence the next generation through supporting education of the neighbourhood child. Also, their mothering practices included sharing food and inviting the community to be part of their church or synagogue activity. As a child I quickly learned the schedule of activities in all the halls throughout the Pier as they were free and there was always a snack, a drink usually tea with milk and sugar and someone willing to have a conversation. These experiences represent a collective nature of mothering that influenced the roles the mothers in Whitney Pier adopted. They are not representative of

a western model of an individualized and problematized approach to mothering (Porter, Short, & O'Reilly, 2005).

I believe it is important as a feminist researcher to reflect on my personal location and my experiences and how they may influence my understanding of the social construction of mothering. At an early age I saw the strength of mothers. Like Rossiter (1990), if I have been shaped by the mothering practices that resulted from a dominant patriarchal society within the context of a one industry town, I feel compelled to ask myself, how do I understand mothering practices? For me, "normal" understandings of mothering have been constructed through a lens of diverse culture, the need to work and the power of community support to raise children. Now, I realize, the many strong mothers I had the privilege to have in my life and these experiences with their practices of mothering helps me to understand motherhood from that perspective of social construction of strength, purpose and directed intent.

I did not feel I had limitations in life until I left the security of strong mothers. I was not aware of any oppression the mothers in my community experienced because of their different races, culture, language, and working class incomes because everyone was treated with the same respect. How the mothers fought for their children and their education became apparent to me as I grew older. Some of us were informally adopted by mothers who knew our mother or another mother needed help with the practices of mothering due to stress, health concerns or other reasons. These women were mothers that shaped who I am as a mother, woman and researcher. Each of these women shared a common social construction of mothering because of where and how they lived in

Whitney Pier. They also represent the plurality and uniqueness of mothering practices when other contexts such as culture, race and community contributes to the social construction of mothering. Some of the mothers were strong, opinionated, quiet, hardworking, and respectful; all were fighters for experiences to construct a new reality for their children that created choices. From a feminist perspective, these women of the Pier represent how the personal is political and how sharing in raising children within the context of community may be a non-traditional way of mothering but it reflects the community involvement in the social construction of mothering (Lather, 1991; Reinhartz, 1992; Varcoe & Doane, 2007).

In sharing my personal experiences I wanted to provide a context for understanding what might construct my understanding of mothering practices. I recognize that as a researcher I play an active role in constructing the reality or norm that I am also trying to explore (Cheek, 1999).

The fuel for my motivation to understand the practices that surround mothers who participate within the Nova Scotia Enhanced Home Visiting Program comes from what has socially constructed me as a woman, mother, academic and researcher. Uncovering practices that surround mothers can create awareness and resistance through new ways of understanding the hegemonic power within discourse that constructs mothering practices (Cheek, 1999). Feminist post-structuralism's theoretical underpinnings focus on understanding subjectivity, power and discourse that forms practices (Cheek, 1999; Weedon, 1993). This theoretical lens has the potential to uncover new ways of

understanding the social construction of services and practices of PHNs and CHVs that create mothering.

Chapter 3: Methodology

To understand the theoretical orientation of the study this chapter provides the evolution of FPS and what it represents and why I chose it as a philosophical approach and methodology that guided the inquiry. The contributions of post-structuralism, Michel Foucault (French philosopher), feminism and FPS provide the structure for this chapter.

Post-structuralism

While developing my understanding of post structuralism I found it useful to explore the connections among postmodern theory, structuralism and post structuralism. From my extensive review of books and literature it is clear to me that the terms post structuralism and post modernism are used interchangeably to mean the same thing. In this section I will begin with a presentation of post modernism, followed by structuralism and post structuralism.

Post modernism has many definitions and it is difficult to summarize but I will highlight the key points that resonated with me and helped build my understanding of this philosophical way of thinking. As a school of thought, post modernism was initially used to describe how artists and architects expressed themselves in their paintings and style of buildings beginning in the 1960s and up until the 1990s (Ward, 1997). While it began in the art world, post modernism played a dominant role in influencing societal thinking by creating a world view that has been used by academics and philosophers for over 40 years (Ward).

Lyotard, a French philosopher played a major role in influencing this era of thinking through his suggestion that there is not one common way to understand the accepted beliefs and foundations of knowledge in society. In other words Lyotard challenged the idea of one total truth with one meaning and he went a step farther to suggest a need to understand how knowledge becomes translated into language (Cheek, 1999). In some ways I would suggest that post modernism was a mini revolution in the development of thinking. This revolution created scepticism about how people's lives were organized and controlled by structures that became accepted as power and guided the organization of day-to-day societal life and ultimately how reality is represented (Cheek ,Ward, 1997).

Structuralism influenced how postmodern thought developed by shifting the focus from what texts mean to understanding how texts got their meaning (Ward, 1997). Structuralists focus on the stability of societal systems and structures and accepted norms. When thinking from a structuralist perspective it seems realistic to question if language can ever be transparent and represent reality as the language becomes accepted as a norm over time. As a result realities are constructed through language. This construction creates relationships among meanings in language. Thus, as a result, connections with societal structures become the accepted or norm view of society and are the essence of a structuralist world view.

Poststructuralists accept the tenets of structuralism but include other ways of understanding structures and practices in society such as the influences of political theory, philosophy, and critique of existing literature, structuralism and feminism.

Jacques Derrida, another French philosopher, was a post structuralist who is often referenced in the literature. He deconstructed texts through discourse analysis as a method to “dig up hidden suppressions and exclusions upon which texts are constructed” (Ward, p. 34). Post Structuralists acknowledge the power behind words in society and deconstruction is a necessary approach for their analysis work in research.

In summary, post structuralists focus on the instability of societal structures and systems and look for gaps in the way meanings of day-to-day life are produced in society. There are similarities among the post structuralists of Lyotard, Derrida, and Foucault. In this research study the thinking of Foucault will guide the study as his work on analyzing the relations of power in knowledge development can provide a guideline for uncovering and understanding the relations of power among the practices and experiences of PHNs, CHVs, and mothers in the enhanced home visiting program.

Foucault

Foucault was a French philosopher who did not label himself as a particular type of thinker but he is referred to consistently in the literature as a poststructuralist. Sawicki (1991) suggests that Foucault “was not developing a theory of truth or rationality, but rather analyzing the relations of power and knowledge that underpin certain understandings of truth and rationality” (p. 5). For Foucault it was important to understand how theory of society, history and power produce domination over people (Foucault, 1967, 1998; Martin, 1988; Sheridan, 1980). Foucault’s life work focused on societal institutions and how they controlled people’s lives through the power they exerted over people through monitoring and surveillance activities. Understanding how

the societal political structures influenced the institutional practices and the lack of neutrality and independence within societal institutions were critical areas that Foucault examined. Throughout his life as a prolific writer of books Foucault focused his work in the areas of psychiatry, clinic medicine, prison systems, sexuality and the human sciences,

Foucault is recognized for his concern with how accepted societal knowledge creation is related to power and he suggests that people's understanding of their personal view of self is produced by the institutions that surround them. Foucault would support the view that a person is socially constructed by those institutions that surround their day-to-day life which creates a lack of individual consciousness (Foucault, 1963, 1972a, 1988). I will not attempt to cover all the diverse areas that Foucault has influenced. Instead the focus of my presentation of Foucault is on understanding the role of the concepts of discourse, power and subjectivity throughout his work and how these concepts have been linked with feminism to create a feminist poststructuralist philosophy that will guide this study. Understanding the history of thought systems and knowledge production was a goal of Foucault's life work (Cooper, 1981). Also, pushing for analysis of institutions and what they were based upon informed new ways of doing things for Foucault so that a change in accepted societal, institutional practices could occur.

Foucault wrote about the subtle, unspoken language behind the accepted dominant medical truths in his work in clinics. Foucault's in depth analysis of modern medicine and its related dominant discourse with his questioning of who is the object of the discourse led to his passion for deconstructing discourse that organized individuals'

experiences in hospitals and health care experiences (Foucault, 1963). Intentionally, Foucault wanted to shake up what was accepted to be true in society and while he did not focus on women's experiences he successfully engaged some feminists as they could see ways to apply his philosophy with their approach to studying women's experiences (Cheek, 1999; Weedon, 1993). Through challenging societal assumptions about reality and truth Foucault pushes us to also consider the causes and effects of life experiences and the concept of agency in people's lives to make decisions, change and create a new way of experiencing the world (Butler, 2005, 1990a, 1990b, 1994). Foucault deconstructed power structures of society through examination of institutional practices. For example, Foucault supported the importance of understanding societal patriarchy and capitalism and the subsequent power these contexts exert on people in the prison system. The structure of the prison system practices represents a societal institution that controls and dominates people in such a way that the institution treats a group of people as subordinate and they are made to feel less powerful. It was Foucault's approach to analyzing accepted patriarchal power relations such as those in the prison system that pushed feminists to consider using his work to support their existing approaches to understanding power relations among women (Foucault, 1991; Lather, 1991; Scott, 1994).

Through his examination of how clinics worked within health care practices, Foucault connected clinic approaches towards people directly to a disease based health care model. Through the clinics and the type of medical gaze they created, the body began to be viewed within a medical scientific framework. Thus, the body became

objectified and subject to the technology of medicine and science (Foucault, 1963; Sawicki, 1991).

Bio Power is a concept associated with Foucault's thinking where he suggests that institutions such as public health operate as a form of bio power in society as they regulate programs that are assigned to populations based upon criteria that are often defined by government agencies (Burchell, Gordon, & Miller, 1991; Cheek, 1999). This regulatory power is often hidden behind government policies. Foucault goes on to suggest that bio power supports capitalism as it creates an avenue where the bio politics can be applied to such processes as health to the extent that "it is the target of state interventions and the object of study in demography, public health agencies, health economics and so forth" (Sawicki, p. 68). One of the main foci of Foucault's work is to "locate the processes through which women's bodies were controlled through a set of discourses and practices governing both the individual's body and their health, education and welfare of the population, namely the discourses of Bio power" (Sawicki, p.67).

Governmentality is another concept that Foucault developed through his examination of power and knowledge related to the state (Cheek, 1999). For Foucault, government represented the programs, strategies, approaches that authority in society used to shape what a population believed and how they conducted themselves as citizens and thus they became both a subject and an object of the government. Within this frame of reference, governmentality and its related power are often subtle and it is associated with regimes that create individuals who are impacted by discourses of power (Cheek, Foucault, 1982). The Nova Scotia Enhanced Home Visiting program is an example of

governmentality and bio power in action where a program was developed with guiding principles, a defined curriculum and approaches to parenting supports and early childhood development as a target population with the overall goal of maintaining the health of children in Nova Scotia (*Pan-Canadian Inventory of Public Health Early Child Home Visiting*, 2009; Kathy Inkpen, Personal communication, Nov. 2012).

Feminist Connection and Foucault

Feminists ground the experiences of power relations in women's experiences however; Foucault provided a way for feminists to analyze the structures that oppress women such as commonly held societal practices and the institutions that control the practices and how they have sought to understand gendered power. I see Foucault as supporting feminist research by providing another philosophical perspective when studying oppression of women. I would also suggest that Foucault challenges feminists in ways that some may not like and there are feminists who critique Foucault as coming from a male perspective and say he does not understand the perspective of women's experiences (Sawicki, 1991). There are others who suggest Foucault was neutral in his approach to examining societal experiences and practices and he did not focus on women for that reason (Mills, 2003). I suggest that Foucault created tensions among feminists as to whether they were doing enough to understand the oppressions of women's lives. He did not judge women's experiences in society; instead he sought to understand how power worked in people's lives and was evident in the discursive descriptions of those experiences. As well, Foucault suggests that oppressed people can resist the oppression and change through a reconstructed way of describing what has been a commonly

accepted way of describing their practices of their day-to-day reality within the world. In other words Foucault suggests that marginalized people can resist dominant discourse and practices if their voices are heard.

Research has been one of the institutions which have shaped what knowledge has been produced and shared with society about mothers. Patriarchal privilege has maintained male values, perpetuated sexism and supported male domination in the research world (hooks, 2000). Feminist researchers believe in action and make deliberate attempts to use their research to create change, raise consciousness and influence oppression. Feminist philosophy does not support searching for knowledge without considering a political goal (Gardner, 2006). As a major influence in and contributor to nursing research since the 1980s, feminism has become accepted for its relevance and fit to support nursing research questions (Im, 2013). When reviewing the number of feminist studies in Pub Med, Im documents that 584 articles were retrieved when the words “nursing” and “feminism” were used in the search approach. In her pragmatic way of trying to understand how feminism guides research Im suggests that acknowledging the complexities of women’s experiences has become strength of contemporary, current feminist research approaches. For example, Im suggests that the evolution of the feminist movement over the last 20 years has been transformed to include diverse philosophical perspectives such as discourse, post-structuralism, critical theory, liberalism, hermeneutics, phenomenology, existentialism and cultural studies to name a few (Im). Feminist researchers over time have combined philosophical perspectives to create ways of guiding studies and furthering the understanding of the complex experiences of women

living in a global world and not only a western world. The diverse evolution of feminist thinking has created feminist research based upon varying definitions and inclusion of non-feminist philosophers like Foucault. The combining of philosophies is created by feminist researchers who see a way to disclose women's experiences through the support of another perspective that together with feminist perspectives provides a way towards deeper understanding and possible action for change (Butler, 1994; Meleis & Im, 1999).

For Butler

That feminism has always thought about questions of life and death means that feminism has always, to some extent and in some way, been philosophical. That it asks how we organize life, how we accord it value, how we safeguard it against violence, how we compel the world and its institution, to inhabit new values, means that its philosophical pursuits are in some sense at one with the aim of social transformation (1994, p.2).

When I consider Butler's definition of feminism I can see why some feminist researchers embraced Foucault's perspectives. Foucault wanted to uncover how knowledge and its related power is created in society and becomes accepted as the norm. Through uncovering how societal structures contribute to creation of power relations, Foucault believed action through change could occur. For me, I would suggest that Foucault supports a definition of feminism that Butler refers to, one where philosophical pursuits of research are to contribute to social transformation that can also transform what is accepted in society as the norm or accepted knowledge and relations of power.

Feminist research is created in different ways and it has made valuable contributions to the world of health care and nursing practices. The everyday world as problematic is an international feminist reference text which challenges the health care world that consistently focuses on problems (Smith, 1990). Reference to power imbalances within institutions is real according to Smith and is experienced by those who work within institutions of health care, universities and communities. Traditionally, nurses have witnessed firsthand the hierarchical structures of power which control the amount of autonomy health professionals experience with the exception of physicians who have traditionally been regarded as the most powerful. This is changing, because of people like Smith and nurse researchers who have been challenging hegemonic gender biases that have limited the availability of power to others outside of a physician role. Exposure of the inequity and marginalization of large numbers of women in health professions has taken over 100 years. It is obvious that the power imbalances are related to gender.

Dorothy Smith is a feminist ethnographer whose research focuses on power imbalances within institutions. Even though her work is based in institutions her philosophy of how to approach research can be transferred to work with vulnerable and marginalized populations like mothers who experience low incomes. Because of her questions and perseverance to influence change in institutions Smith has contributed to creating 'other ways of thinking' and understanding how people experience and interact with institutions. The influence of her feminist philosophy is evident through her inclusion of participant's experiences of their world, in their words versus a sociological

anthropologist who observes, takes field notes and names what a person's experiences are without asking. Smith suggests inclusion of feminist ways of doing research which includes borrowing from an array of feminist approaches as she believes that one approach is not enough to truly understand and represent the complex life contexts that marginalized mother's experience (Harding, 1987; Olesen, 2005). Feminist researchers have struggled with understanding the many interpretations of research methodologies. These struggles result in new ways of doing research that can make a difference through the changes that are made in society (Reinharz, 1992; Stacey, 1991).

Feminism is multi paradigmatic with gender playing a major role in organizing what shapes and influences life conditions (Lather, 1991). A major goal of feminist research is to make visible those female experiences that were hidden and as a result, create a more equal representation of their experiences to the world (Lather). Feminists suggest that their research should be useful for women and influence positive changes in their lives (Wuest & Merritt-Gray, 2002). A major underlying assumption of feminist, qualitative theory is it is dialectical and committed to action that changes the world in some way that helps the life situations of vulnerable people (Olsen, 2005). Feminism places the social construction of gender as a central goal. Qualitative methodologies seek to understand people's lives and their personal interpretations versus quantitative methodologies where predicting future reoccurring behaviours is a primary goal (Denzin & Lincoln, 2000). Qualitative researchers think from an interaction perspective and explore what are the structures influencing people's lives while integrating their own experiences during the research process (Denzin & Lincoln).

Mothers who experience low income and struggle to meet daily needs are by virtue of being female are part of a group who experience oppression and marginalization (Sherwin, 1992). Feminism offers a conscious raising approach to understanding the economic, political and social inequities they experience which shapes their marginalization (Sherwin, 1992). In this proposed research study, PHNs and CHVs will be participants as they work with marginalized mothers who are participants of the enhanced home visiting program. Little is documented about how Nova Scotia PHNs and CHVs together support the mothers who participate in the enhanced home visiting program (Linda Young, Personal Communication, July 16, 2013). This proposed study will be guided by feminist post-structuralism to uncover an understanding of the practices and experiences of PHNs and CHVs who work with marginalized mothers and families who participate in the enhanced home visiting program.

Feminist Post-structuralism

This section presents an overview of feminist post-structuralism as a theoretical framework and how when applied, it can facilitate understanding the practices of PHNs and CHVs who participate within the Enhanced Home Visiting Program in Nova Scotia. Its purpose is to provide the reader with the theoretical and philosophical underpinnings of the framework, which as a lens of inquiry can also contribute to understanding the social construction of mothering within my research.

I have organized this section in several parts. First, I will briefly discuss feminist post-structuralism to provide a context for the discussion and analysis. The social construction of mothering will be discussed next. Feminist poststructuralist perspectives

will be woven through the discussion as a way to facilitate understanding how it can contribute to uncovering the social construction of mothering in my proposed research. The final section will discuss how the theoretical framework of feminist post-structuralism can be applied to understand and advance the services and practices of PHNs and CHVs in their relationships with mothers and families. By providing an overview of the social construction of mothering within the context of feminist post-structuralism I believe there is potential to strengthen the understanding of the contributions that feminist post-structuralism can make to understand the services and practices of PHNs and CHVs within the relationships they create with mothers and families.

The philosophical underpinnings of feminism and post-structuralism create the theoretical framework of Feminist Post-structuralism (Cheek, 1999; Weedon, 1993). Complex practices within health care require theoretical approaches that can uncover the deeply rooted understandings that craft practices and services such as those within the Enhanced Home Visiting Program in Nova Scotia (Foucault, 1998; Hekman, 1996; Udod, 2008). Feminist post-structuralism challenges assumptions about what is understood to be every day and potentially hegemonic practices within health care practices (Aston, Price, Kirk, & Penney, 2011; Cheek, 1999; Foucault, 1980; Gavey, 1989, 2011; Weedon, 1993). Assumptions that are dominant within societal practices are based upon scientific knowledge where reasons for practices are steeped in biological, socially and institutionally constructed discourses. Gender, how governments justify decisions about policies and programs, and the search in societies for the highest level of human capacity

have been shaped by dominant discourses or world views through relations of power. Feminist post-structuralism supports understanding and examining the structures that regulate and affect practices and services such as home visiting (Weedon, 1993). Through the practices of PHNs and CHVs, their decision making, the services and practices they provide related to enhanced home visiting are negotiated as a form of power relations. Feminist post-structuralism suggests that established meanings that are part of common societal regulation of others does not need to be taken-for-granted as the only normative assumption about health care practices (Ward, 1997; Weedon, 1993). As a framework, feminist post-structuralism can be applied to diverse social practices and facilitate uncovering meanings, values and relations of power that control practices which are defined as those activities that people engage in during their day-to-day lives. In the case of PHNs and CHVs, their work day as well as their personal experiences (Cheek, 1999; Powers, 2001; Weedon, 1993). Subjectivity, discourse and power are facilitators of accepted societal meanings, values and relations of power that exist within practices. Feminist post-structuralism as a theoretical framework addresses where the meaning, values and relations of power originate, who benefits from them, how they have maintained their power and asks the question “is there a way to shape a new understanding of the structure in control” (Cheek, 1999; Powers, 2001; Weedon, 1993).

Language development and what it represents is historically, socially and politically based and it contextualizes meanings of commonly held beliefs, assumptions and norms (Foucault, 1980, 1998; Weedon, 1993). Meanings are assigned to people’s experiences and objects through various ways of using language. The repeated practices

and patterns of language create effects that are called discursive practices or discourse by feminist poststructuralists (Cheek, 1999; Weedon, 1993). In western thought, language and meaning are predominantly built on dichotomous relations that have been built within relations of power. Words such as primary health care, primordial prevention and health outcomes are used to describe accepted normative practices in public health. In this research it will be important to understand what these words mean for PHNs and CHVs as they practice under the influence of this language. Their perspectives will add to understanding how this language contributes to their practices and experiences.

Discourse is an important concept within feminist Post-structuralism (Cheek, 1999; Weedon, 1993). It is through discourse that power is actualized in the realities of our words, thoughts and actions. The same can be said about enhanced home visiting practices that are represented by a particular discourse that has related meanings and actions (Cheek, 1999; Weedon, 1993). The actions get taken up in practice routine, thus becoming the accepted norms, regulated by institutional structures and societal settings perpetuated by patriarchal norms. The accepted norms then define people's subjective identities and who they believe they are to become in society (Butler, 1990a, 1990b, 1994, 2005). At times these identities are oppressive and it is difficult for people to feel the power to redefine them or move away from the influence that power has over defining the identities (Butler, 1990a, 1990b, 1994, 2005; Foucault, 1998). I would suggest that this proposed study provides an opportunity to explore alternative messages that support mothers' potential to define themselves and create their personal way of being.

A similar situation exists within mothering that is represented in society by a dominant discourse that I will discuss in the next section on the social construction of mothering. Feminist post-structuralism provides a framework that can guide an examination of accepted discourses and how have they have been created with the possibility for change (Cheek, 1999; Powers, 2001; Weedon, 1993).

The Social Construction of Mothering: What Can Feminist Post-structuralism Offer?

Motherhood is a complex societal institution that is subjectively created through the dominant discourses that represents mothering in society (Short, 2005; Varcoe & Doane, 2007). Feminist poststructuralists would suggest that to be a mother is not “natural” or neutral due to the subjective nature of the construction of mothering practices through the discourse that is assigned to them by society (Rossiter, 1990; Varcoe & Doane, 2007). The constitution of the roles of mothers related to their subjective position are strategic and the result of power relations (Porter, Short, & O’Reilly, 2005; Rabinow, 1984; Sawicki, 1991). Gendered and feminized, mothers are strategically placed to regulate and sustain the normative practices of mothering and the family (Foucault, 1998). A major role placed on mothers is that of caregiver and guardian of health with an expectation to influence the health practices within the family with attention to children (Hekman, 1996; Porter et al., 2005; Rossiter, 1990; Short, 2005; Varcoe & Doane, 2007). The dominant hegemonic discourse creates a stereotype that at risk mothers (authors language) are ineffective to manage their children and their mothering support gets transferred to experts such as PHNs and CHVs who have a

dominant focus on parenting support (O'Brien & Baca, 1997; Olds, 1999, 2002; Olds et al., 2007; Rossiter, 1990; Short, 2005; Varcoe & Doane, 2007). Referred to as scientific mothering, it positions control in the hands of experts who tell mothers how to raise their children (Rossiter, 1990). PHNs have also been viewed stereotypically as health care professionals who monitor and survey mothering practices and this has created a negative type of perspective surrounding surveillance practices. This position is in contrast to the actual work of PHNs and CHVs who focus on the strengths of mothers daily in their practices with mothers in enhanced home visiting programs as demonstrated in research by Aston (2008) when she looked at the practices of PHNs in Nova Scotia. Supporting mothering is a central focus of the services and practices of PHNs and CHVs within the Enhanced Home Visiting Program in Nova Scotia (Research Power Inc., 2012). Is it support however, or is it scientific mothering? Feminist Post-structuralism offers a theoretical framework to deconstruct and understand this and other ways that mothering is socially constructed for those who participate in the Enhanced Home Visiting Program.

Dominant societal discourses construct multiple meanings of mothers through media, culture, class and society in general (Cheek, 1999; Short, 2005; Weedon, 1993). Language through discourse and ritualized discursive practices socially construct a mother's life experiences and those of her families and ultimately affect mothers' practices to either conform or resist mainstream expectations of mothering (Foucault, 1998; Rossiter, 1990; Short, 2005). Language expressions of mothering practices are often taken-for-granted in society as the way mothering should be (O'Reilly & Porter, 2005). As a result of these expressions, accepted patterns of how to behave as a good and

appropriate mother are socially constructed by society (Short, 2005; Weedon, 1993). Mothers may take on subjective positions in their mothering role related to social expectations and lack of choice. For example, some mothers work and others stay at home with their children. With each of these unique constructions of mothering roles there are related expectations of how a mother should act out the role (Short, 2005; Varcoe & Doane, 2007). To change the ways that mothers are represented requires understanding the social and institutional construction as well as the cultural organization of mothering and the related social images presented of mothers and their concrete subjective experiences (Rossiter, 1990). Moments of agreement or tensions where similar and different discourses meet may come out in this research as well. The theoretical underpinnings of feminist post-structuralism supports ways of understanding the social construction of the subjective experiences of mothers in their diverse roles. “Understanding the social construction of mothering is essential to an ability to resist knowledge about mothers, knowledge created by abstractions, which control women through individualism and biologism” (Rossiter, 1990, p. 17). To understand the creation of this dominant and socially constructed knowledge about mothering requires analyzing and understanding the practices that comprise day-to-day lives of mothers. We may learn that women have struggled to follow the norm.

When certain practices related to mothering become accepted as normative societal practices and accepted and expected knowledge, how the language associated with mothering practices become ‘common sense’, embedded, unquestioned, and accepted as ‘the way’ or the ‘truth’. The type of representation of mothering often goes

unexamined (Scott, 1994). Through analysis to understand the social construction of mothering, critical questions are encouraged about how mothering practices have come to be understood in a certain way (Varcoe & Doane, 2007). In the proposed study, I suggest that the mothers in the Nova Scotia Enhanced Home Visiting Program have been socially constructed. For example, PHNs and CHVs are in a relationship with the mothers and families. As a result of the relationship between PHNs, CHVs and mothers/families construction of roles results. In the proposed study how the relationship is negotiated and developed between PHNs, CHVs, and mothers will be explored. Motherhood has been described as a societal institution where mothering ideologies create women's choices about how they act out the mothering roles (Porter et al., 2005; Short, 2005).

Motherhood elicits images of the ideal mother and what good mothering looks like (Porter et al., 2005). For many in society mothering is viewed and has become accepted as an instinctual, biological function role that should come naturally and is easily fulfilled by women (Rossiter, 1990). If women do not fit into this role naturally, society judges them as failures. Porter suggests that motherhood and its related practices of mothering reflect and are influenced by the cultural, economic and societal contexts that mothers interact with throughout their day-to-day experiences.

As was previously discussed, mothering practices include caretaker, which may take her away from the economic world of work (Short, 2005). The history of women doing unpaid work can be linked to many theories however the biological connection of mothers to their babies is dominant in the literature (Foucault, 1972, 1982). For example, the maternal infant attachment theory supports the natural biology of women to attach to

their babies through breast feeding and care for their baby's needs. As a result, mothers feel pressure to be with their babies and perform the related practices of mothering as part of this socially constructed 'natural role' that begins when a mother births a baby (Rossiter, 1990). Through the deconstruction of how mothering produces a woman, Rossiter's research represents her personal crisis regarding feminism and mothering related to her experiences as a new mother (Rossiter, 1990). A self-identified feminist, Rossiter writes about how she first believed feminism was focused on equal rights for women in society. However, when she interviewed new mothers about their mothering experiences, she redefined feminism to incorporate a new awareness as a feminist. After completing her research process, Rossiter redefined feminism as "an exploration of the complexity of gendered subjectivity" (Rossiter, 1990). She came to realize that she could not ignore her social context and how her life experiences were shaped by what was outside of her. The twist in this example is Rossiter's realization that her experiences were made to seem like she had control over her choices, rather, capitalism was constructing her experiences (Lather, 1991). Rossiter chose to stay home and was privileged to have this choice due to economic circumstances to raise her children and while reflecting on her choice she wondered whether it was due to a hidden pressure she felt to be the good mother as society defined mothering. This reason did not fit, as Rossiter's experiences made her feel that her babies were attached to her for nutrition and soothing through breastfeeding and overall comforting and she felt she was the best person for the job. These experiences of biological, bodily attachment to her babies scared Rossiter as a feminist as she had very strong beliefs that patriarchal society

controlled women through their bodies and she wondered if this was happening to her and did she have a choice to control her own body (Rossiter, 1990).

Upon completion of her research, Rossiter did not see mothering and feminism in opposition to each other. Rather, she recognized the silent lives many mothers live throughout their mothering experiences as a result of trying to do the right things a good mother would naturally do. The pressure from patriarchal society around the expectations of good mothering creates a silence among mothers as they don't want to say nor do the wrong thing in relation to how they mother and what type of women they become because of mothering (Rossiter, 1990; Short, 2005; Weedon, 1993). Mothers may fear speaking up and being ignored or not recognized. Understanding the experiences of PHNs and CHVs guided by a feminist poststructuralist lens may create an awareness of their influence on mothering practices and identify another layer of power that mothers choose to relate to within the home visiting experiences. Both Peckover (2002, 2003, 2009) and Aston(2006) carried out research studies guided by a feminist poststructuralist lens to understand the relationships of PHN and mothers that involved home visiting practices in the United Kingdom and Canada. Both researchers emphasized the need to understand the power that is part of these relationships.

Rossiter's approach to understanding the social construction of mothering resonates with me as I prepare to explore and understand the enhanced home visiting practices of PHNs and CHVs that occur in the day-to-day experiences of mothers and their families. Understanding the social construction of mothering requires uncovering the practices that shape the construction of mothers' day-to-day experiences. PHNs and

CHVs can describe their practices and social relations that they believe shape and organize how the Enhanced Home Visiting Program contributes to the world of mothers and their families. I acknowledge that the mothers have a perspective as well but for this study the understanding of the practices that surround them was the focus from the perspective of the PHNs and CHVs. Discourse analysis enabled the social and institutional construction of the practices of PHNs and CHVs to become visible.

Women as mothers live lives of contradictory practices resulting from societal patriarchal control over information that gets presented to mothers in diverse ways (Cheek, 1999; Hekman, 1996; Lather, 1991). For example, through programming like the Enhanced Home Visiting Program mothers are taught how to care for babies, how to breastfeed and how to parent young children with the ultimate goal of raising civically minded citizens that support the goals of the state (Browne, Doane, Reimer, MacLeod, & McLellan, 2010; Cheek, 1999; Rossiter, 1990; Short, 2005). As a result of programming, language becomes part of the dominant practices that are related to mothering delivered by PHNs and CHVs. Natural childbirth, equal parenting, breastfeeding on demand are common language associated with a dominant health discourse on normal mothering in North America (Hartsock, 1990; Varcoe & Doane, 2007). If a mother chooses not to breastfeed she may be seen as resisting, opposing or disagreeing with the dominant support that is available through public health and therefore she may feel guilt for not mothering the way she is expected to (Browne et al., 2010; Scott, 1992). Some mothers are labelled as vulnerable or high- risk due to issues of economic insecurity, mental health issues or other reasons that are deemed to put children at risk for harm and their

knowledge may be dismissed or ignored (Browne et al., 2010; Olds, 1999, 2002). The language associated with these vulnerable situations directs what part of the public health institution will support mothering practices and how this support will be implemented. However, if the expected mothering practices are understood differently by mothers due to their personal location and look different than how they are predominantly defined by the public health institution and society, mothers may quickly see themselves as being judged as to their abilities to be a good, normal mother (Foucault, 1998; Rabinow, Faubion, & Hurley, 2000; Rossiter, 1990).

“The importance of understanding the construction of the concept of mothering is to also understand how mothering works to continuously construct the concept woman” (Rossiter, 1990, p. 15). In other words, invisibility may operate in society’s construction of motherhood as a hidden patriarchal structure. Women construct mothering but the same can be said for mothering as it reproduces or constructs the concept of woman and how it gets defined in society.

Feminist Post-structuralism: Understanding and Advancing Services and Practices

Critics have suggested that feminist poststructuralist approaches to research are esoteric and are not able to contribute value to health care practices (Cheek, 1999). Since the deliverables from research are predominantly focused on strategies, best practice models and improving cost effectiveness of programs, feminist poststructuralist approaches are often critiqued as not providing deliverables. Cheek would contend that “If we are only interested in improving what is, it may well be that we will never explore what might be” (Cheek, 1999, p.10). Poststructuralist approaches do not focus on such

things as cost benefit analysis. However, they do provide a way to conceptualize new or creative ways of influencing how health is delivered through services and practices, and how attitudes about health are shaped (Cheek, 1999).

Health related practices such as home visiting can be theorized by the theoretical underpinnings of feminist post-structuralism (Crowe, 2005; Fairclough & Wodak, 1997; Fairclough, 2003; Gavey, 1989, 2011; Powers, 2001; Weedon, 1993). This approach to theorizing practices and services guides understanding how power operates within discourse to construct the services and practices of PHNs and CHVs (Cooper, 1981; Foucault, 1963, 1998). Discursive practices that have created knowledge about how home visiting services are delivered will be uncovered. Understanding the contradictions within the discursive representations provides an opportunity to advance practices and services in a new way thus resisting what has always been the practice or service (Gavey, 1989, 2011; Hekman, 1996). Examples illustrating how feminist post-structuralism can foster understanding and advancing the practices and services of PHNs and CHVs will be provided next. For example through identifying conflict, tensions or even positive practices moments can occur where we stop, question and think about possibilities for change or possibilities for continuing what we are doing.

Mothering is in front of PHNs and CHVs every day through their practice responsibilities within the Enhanced Home Visiting Program in Nova Scotia (Aston, 2011; Browne et al., 2010; Olds, 1999, 2002). Mothers may feel guilt for being part of health services and practices that focuses on supporting parenting another life skill development when raising children (Browne et al., 2010). Mothers are often blamed by

society if something goes wrong when raising children (O'Reilly & Porter, 2005; Varcoe & Doane, 2007). Many mothers understand how to mother based upon societal representations of mothering and their subjective position as a mother (O'Reilly & Porter, 2005). Tensions can occur if mother's knowledge is not in agreement with PHNs and CHVs mothering knowledge (Mills, 2003).

Conflicted feelings in mothers about their ability to be a good mother is socially constructed (Porter et al., 2005; Short, 2005). An example of these conflicted feelings and how mothering is individualized and problematized in western culture is found in a discussion of bonding experiences of mothers with their infants (Aston, 2008; Porter et al., 2005). Mothers have had different experiences of mother infant bonding however a dominant discourse of how bonding should take place controls mother's choices (Aston, 2008). Some mothers have felt the hegemonic health discourse of bonding has put additional pressure on them to bond quickly and in a particular way (Aston). Nurses in the hospital monitor this bonding and record how bonding is going. As a result mothers feel pressure to bond because they have heard about it from health care providers and society in general. Due to the pressure they feel to bond in a natural way, mothers may feel something is wrong with them when they don't feel they have bonded (Aston). PHNs are aware of the social construction of mothering and how it is oppressive to mothers as they try to negotiate what they should and shouldn't do or what they want to do and what they don't want to do (Aston). PHNs, CHVs, and mothers are aware and feel the impact of Western discourse of mothering through pressures of stereotypes of how to mother. Health messages such as whether a mother should sleep with her baby or

not, create opportunities for negotiation between PHNs, CHVs, and mothers. As a result of negotiation, knowledge may be accepted or challenged by mothers. Understanding the PHNs and CHVs' position in negotiating these types of experiences and practices fits within a feminist poststructuralist framework as it provides a way to uncover tensions in practices of PHNs and CHVs with mothers in a way that creates understanding mothers experiences.

I can understand how PHNs and CHVs' practices could appear oppressive as they have had a dominant role in using surveillance activities through monitoring at risk mothers and correcting their mothering approaches (Browne et al., 2010; Foucault, 1998). Dominant roles like surveillance, have sustained institution's accepted knowledge about how practices and services are delivered within health care. The ruling apparatus controls the lives of citizens through surveillance which creates dominant ideological meanings of how people should be regulated (Cooper, 1981; Foucault, 1980). With feminist post-structuralism as a theoretical lens, the analysis of ideological meanings that regulate how mothering is interpreted and how practices and services that support mothering are constructed will be uncovered. PHNs and CHVs are women and mothers who have created their own ideological meanings of mothering that represents their personal and professional subjective positions. These personal realities influence and construct their discourse which may be reflected in the practices they share with mothers (Butler, 2005; Weedon, 1993). Feminist post-structuralism provides a theoretical way of understanding how the practices of the PHNs and CHVs within the context of the Enhanced Home

Visiting Program have been constructed by their personal realities of life experiences and societal influences.

At times feminist post-structuralism can reveal resistance to accepted societal practices that are not questioned because they have become accepted as day-to-day routines (Foucault, 1988, 1991; Weedon, 1993). Feminist post-structuralism has been revealed as “promoting discourse which is rich in conflict and therefore rich with the promise of change” (Rossiter, 1990, p. 283). For example, PHNs and CHVs may create practices that are not part of the home visiting program’s curriculum that support the unique needs of mothers and their families that are not articulated within the program language of the Enhanced Home Visiting Program thereby challenging dominant social and institutional practices and beliefs that are oppressive to women and mothers (Suzanne Landry, Personal communication, 2013). Feminist post-structuralism provides an opportunity to reveal practices that fall outside of the regulated practices of the Enhanced Home Visiting Program and understand how this resistance to the regulated practices are developed (Arslanian-Engoren, 2002). In other words, feminist post-structuralism in this study has the potential to offer a deep understanding of existing practices within the Enhanced Home Visiting Program as well as explore other possibilities for change that are raised by PHNs and CHVs. Uncovering silenced discourses that represent resistance to dominant accepted practices that may be being practiced by PHNs and CHVs creates potential for change and action that enhances services and practises in new ways (Cheek, 1999; Weedon, 1993). The silenced discourse may represent another way to understand how to enhance mothering services and practices. A silenced discourse can

be identified by using the concepts from feminist post-structuralism that includes focusing on the beliefs, values, and practices of PHNs and CHVs that highlight what discourses they are using, creating, or challenging.

It is not unusual for tensions to exist within the delivery of health care practices (Arslanian-Engoren, 2002; Udod, 2008). Through my experiences of working with PHNs over the last 15 years I have heard about tensions that exist but are not shared openly. Understanding these tensions and how they influence the relationships between PHNs and CHVs and mothers can be revealed at a deeper level within the discourses that represent the experiences of PHN's and CHVs. Understanding multiple realities or ways of knowing is a principle supported by feminist post-structuralism (Cheek, 1999; Weedon, 1993). With this principle in mind, acceptance of diverse ways of experiencing practices is understood and no one is blamed for understanding in their unique way (Foucault, 1998; Weedon, 1993). For example, feminist post-structuralism provides a way to guide analysis of discourse that will consider such things as: how relationships between PHNs and CHVs are understood within the practices of enhanced home visiting; how are relationships understood between PHNs, CHVs and mothers/ families within the enhanced home visiting program.

Agency is a concept that provides opportunities for all involved in a relationship. Agency offers a way to shift the relations of power so that those who haven't been in control of power are provided with ways to feel empowered (Foucault, 1980; Hekman, 1996; Weedon, 1993). Power is relational and it is not meant to be understood in a linear way of cause and effect where victims are blamed for their life circumstances (Foucault,

1980; Weedon, 1993). Together, PHNs, CHVs and mothers have the ability to negotiate power and agency with mothers through their sharing of relations of power in their interaction practices they use to support mothers (Aston, 2002; Foucault, 1980; Weedon, 1993). Agency facilitates people's ability to be interactive in sharing their experiences while also encouraging their self-reflection and conscious attention to challenge their own social location (Aston, 2002; Foucault, 1991; Scott, 1992). PHNs, CHVs and mothers have a similar agency within themselves to make choices about how they facilitate power relations when they interact together. Through this other way of understanding how to shift power relations with mothers, PHNs and CHVs can reflect about their practice approaches and how they encourage mothers to share the power through their interactions. Feminist post-structuralism as a theoretical lens has the capacity to guide understanding PHNs and CHVs' approaches and strategies used when working interactionally in their relationships with mothers. Also how the social construction of mothering emerges within the discourse of their relations of power experiences can be uncovered (Powers, 2001; Scott, 1994). Revealing the silenced experiences of power relations that occur within the relationships has the potential to create new understandings that challenge accepted practices and promote change.

Feminist post-structuralism guided by Butler (2005); Gavey(1989, 2011) & Weedon(1993) provided a theoretical way to question how and what was offered to mothers to support them through EHV practices. PHNs and CHVs expressed both resistance and acceptance to practices of home visiting in this study. Aston (2008) also identified moments of resistance by PHNs to accepted institutional practices of home

visiting. Understanding why and how PHNs and CHVs practice in different ways emerged in this research. Through hearing different experiences of PHNs and CHVs, the goal was not to pass judgement as to whether one way was right or wrong, instead this research allowed me to see the variety of choices there are for practices within enhanced home visiting. Using discourse analysis within a feminist poststructuralist framework guided by Cheek (1999) & Weedon(1993) provided a way of analyzing the social construction of mothering beyond looking only at their behaviours. Instead, understanding how mothering has been socially constructed through the practices of PHNs and CHVs provided a deeper understanding of the silenced ways that shape and construct home visiting. At the same time, the ways that EHV practices were renegotiated reflected the unique ways that PHNs and CHVs supported mothers living within vulnerability.

Conclusion and Summary

Feminist post-structuralism is a theoretical framework that guides understanding the practices of PHNs and CHVs within the context of understanding how mothering is socially constructed. Mothering has been described as complex and socially constructed through the power of discourse that creates accepted discursive practices that represent mothers multiple realities (Varcoe & Doane, 2007; Weedon, 1993). Understanding what and how discourses are constructing mothering within their subjective positions contributes to new understandings for PHNs and CHVs to understand how their practices and services contribute to the discourse (Varcoe & Doane).

Feminist post-structuralism provided a lens to understand the social construction of mothering that creates a relationship dance between PHNs, CHVs and mothers within the Enhanced Home Visiting Program in Nova Scotia. Meaningful relationships between PHNs, CHVs, and mothers require understanding what practices and experiences support these relationships. Thinking deeply about how the services and practices of PHNs and CHVs support marginalized mothers and families can be facilitated by a feminist poststructuralist framework.

Feminist post-structuralism guided by Cheek (1999) and Weedon (1993) provided a way to theorize about the multiplicity of practices in the world that can be contradictory to each other while needing to be responsive to mothers. When contradictions occur there is an opportunity to critically question the practise and reconstruct an alternate subjectivity. In this research, understanding the practices of PHNs and CHVs offers new ways of understanding how to practice with mothers living within vulnerability. Also practices were uncovered that may not be fully understood and require further research.

“No step in the dance of being created/creating ourselves is done independently” (Rossiter, 1990, p.283). For PHNs, CHVs and mothers their dance will continue. They may critique their choice of dance steps, but through reflection there is potential to create reflective practitioners and practice where subjective positions and how they are created and understood will always be open to challenge within a feminist poststructuralist framework.

An underlying principle of all feminist theory is that politics exists between men and women in society and as a result relations of power are experienced between men

and women (Weedon, 1987). Second wave feminism of the 1960s to the 1980s worked to raise the consciousness of how societal power through patriarchal domination created oppression in women's lives which began an acceptance of Foucault's work in combination with feminist philosophy that created the feminist post structuralist approach to research (Cheek, 1999; Porter et al., 2005; Weedon, 1993). It is apparent to me why feminists were drawn to Foucault's work as he focused on the meaning behind knowing how accepted patriarchal knowledge results from the effects of power in society.

Lather (1991) suggests that feminism combined with Foucault's philosophy pushes feminist thinking beyond only a gender lens focus to include how knowledge is socially constructed as the focus of a research inquiry. From a perspective of social construction there is potential to shape consciousness, societal institutions and understand how power and privilege are distributed within society. For feminists like Lather, the absence, invisibility and distorted representations of female experiences needs to end to improve women's social position in society. As a result of feminist approaches to research, studies focused more on meaning and patterns versus control and prediction of outcomes that are represented within traditional, positivist paradigms research approaches (Lather). Accepted, societal, institutional practices and relations result in direct power being applied to diverse contexts of women's lives including how they mother or raise a family, work outside their home, get an education or how they participate in their communities day-to-day activities. Weedon (1987) suggests that FPS provides a framework to guide research that explores and critiques accepted societal power relations found within institutions and among individuals who make decisions that support

institutions. Weedon pushes us to try to understand how the established meanings and values that are a fundamental part of societal institutions and practices create a subjective experience with a related discourse that influences power within relationships. Feminist perspectives add a critical dimension to post structuralist analysis as it pushes us to consider how societal structures and thinking has been historically oppressive to women in society (Weedon).

For Gavey (2011) a goal of FPS is to deconstruct dominant oppressive knowledge so as to shake up, disrupt or displace oppressive knowledge that translated into accepted societal practices. In this proposed study, the health care practices represented by the Nova Scotia Enhanced Home Visiting Program support the health of marginalized mothers and families and will be explored. It is not my intention to judge these practices but to understand how they are experienced by PHNs and CHVs who support the health of marginalized mothers who experience low incomes. Both feminist and maternal scholars who support the health of mothers acknowledge the importance of understanding how power is represented in the lives of mothers (Porter & Short O'Reilley, 2005). The enhanced home visiting practices represent power in the lives of mothers who participate in a government lead program to receive extra support to parent in a way that supports healthy child development (NCCDH, 2009).

FPS offers a conceptual foundation for feminist research and practice as a way of building understanding about women's experiences with a focus on the relationships among language, subjectivity, social organization(processes) and institutions that create power relations within women's day-to-day realities (Weedon, 1987).Discourse analysis

is a method that supports a feminist post structuralist approach to research and will be used in this study and explored later in the chapter.

This section presents a discussion of the relations of power from the perspectives of Foucault and feminists that include Butler, Scott, Cheek, and Weedon within the context of discourse analysis. Its purpose is to assist the reader to appreciate Foucauldian and Feminist ways of understanding and challenging mainstay definitions of power and how these alternative perspectives can support understanding for this study of the personal, social, and institutional practices of PHNs and CHVs who work within the Nova Scotia Enhanced Home Visiting Program. I have organized the section into several parts. First, I will briefly discuss the connection between relations of power and discourse analysis. The relations of power through its roots in Foucault will be discussed next as a necessary lens for understanding how these perspectives challenge mainstream definitions of power while attending to how they also provide a way to understand personal, social and institutional practices. The final section will discuss how the perspectives presented in the chapter will guide a critical analysis of PHNs and CHVs' experiences within the Enhanced Home Visiting Program in Nova Scotia.

Discourse Analysis and Relations of Power

“Discourse refers to a way of thinking about and understanding a topic through language, which creates a social definition and knowing of the subject” (Aston, Price, Kirk, & Penney, 2011, p. 1189). Discourse analysis provides a way to uncover how language in the form of words is used, politicized and positioned within historical and social contexts to represent dominant voices (Cheek, 1999; Fairclough, 2003;

Fairclough&Wodak, 1997; Mills, 2003; Powers, 2001). Discourse analysis also examines who speaks and who does not and whether disagreement is present (Cheek). There are many styles of discourse analysis and it has been suggested there may be as many as 57 different approaches to discourse analysis (Powers, 2001). In my proposed research the use of feminist post-structuralism will guide discourse analysis. This approach to discourse analysis is influenced by the philosophical and theoretical work of Foucault and feminists that includes Butler, Scott, Cheek, and Weedon. Foucault (1972, 1980, & 1982) suggests that discourse analysis provides a way to theorize power relations and the effects of power through the tools of language, discourse and the related practices of discourse in action. The overall goal of discourse analysis is to explore the relationship between hegemonic power structures in the social world and how it creates discourse (Mills, 2003). The resulting discourses will not provide answers to the research questions but have the potential to influence new ways of understanding and therefore potentially influencing change in the practices of PHNs and CHVs who work within the Enhanced Home Visiting Program. Within discourse analysis, researchers are not looking for a positivist interpretation of phenomena where identifying cause and effects is the goal. Instead the focus of the research is on how the understanding of the experiences were created(Crowe, 2005).

Through discourse analysis we see that power exists everywhere, at any time and touches everyone not only those who exercise power but also those who are controlled by the power of others (Foucault, 1972b, 1980, 1982; Gavey, 1989, 2011). Foucault suggests that through discourses that are associated with activities and actions, power is

created, sustained, and perpetuated as part of life's existence and it is an unavoidable life experience. Thus, this perspective represents what Foucault called discursive practices (Cooper, 1981). For example, Foucault was interested in showing how relations within society formed discourse. Whether it was demonstrating the relations between the political economy and biology or wealth analysis and natural history, Foucault consistently analysed how political practices formed discourses (Cooper). Foucault provides an example from the Napoleonic period of how military practices become the accepted norm if they were supported by an acknowledged power structure. He uses the armies of that time period as an example and how they developed medical control by adopting medical discourse that originated from a doctor and thus created the norm of legitimizing, sustaining and perpetuating doctor's control over decision making related to medical practices. When peace time came, the medical discourse that had been accepted as the norm during wartime was transferred to the institution of public health where medical doctors were given the decision making powers (Cooper). This example from Foucault's work represents for me the power of discourse to create knowledge and accepted normalizing practices that although may have originated in distant historical times, but nevertheless remain active in current societal institutions. Often unchallenged, this notion of Foucaudian type of power becomes engrained in the fabric of our daily practices, often taken for granted without question.

The connections between power and discourse were explored in this study through analysis of the discursive practices shared by PHNs and CHVs based upon their day-to-day personal experiences and practices. Given that FPS in this study is based

upon Foucault and feminist scholars of Butler, Scott, Cheek, and Weedon it is important to understand what shapes these perspectives as they will guide the discourse analysis. Foucault's perspectives on relations of power and how they can be used to understand the personal, social and institutional practices uncovered in the proposed research will be presented first followed by feminist perspectives.

Foucault and Relations of Power

Discourse analysis informed by Foucauldian philosophy emphasizes the need to understand the dynamics of power that is inherently part of all discourse (Foucault, 1972b, 1980, 1982, 1998; Powers, 2001). Foucault has been referenced as being an outrageous historian as he was not considered like others who spent their time producing arguments or developing theories about what is rational thought (Sawicki, 1991; Weedon, 1993). Rather, Foucault sought to understand and analyse the relationship between power and knowledge that shapes and influences how truth and rational thought are understood in society through language and discourse. Foucault believed that people held onto truths or accepted societal norms which then constructed their subjective experiences and behaviours (Porter, Short, & O'Reilley, 2005). For Foucault, knowledge production is connected to power through discourse and how it represents multiple realities (Butler, 2005; Cheek, 1999; Weedon, 1993).

Foucault has made valuable contributions to nursing practice. Nursing researchers have applied his perspectives of power relations in research to create new ways of understanding nursing practices that had been accepted as the norm (Arslanian-Engoren, 2002; Udod, 2008). Foucault provides a theoretical lens that supports an

understanding of the contexts of the relations of power (Gavey, 2011; Ward, 1997). An example of this is found in the exploration by Udod where she applied Foucault's perspective on knowledge production to understand the diverse ways nurses work place experiences were shaped by power relations. In her exploration of nurse empowerment, Udod comprehensively examined how the relations of power are commonly played out within the practices of nurses. Through application of the Foucaudian concepts of panopticism where people are constantly being observed and disciplinary power Udod illustrated the subtle forms of power that structure the practices of nurses daily (Cheek & Rudge, 1994; Udod, 2008).

As a post structuralist, Foucault did not define power concretely; however, his observations in prisons, hospitals, legal systems and society generally guided his perspectives and understanding of power, and the power relations that result (Foucault, 1963, 1988, 1991). For Foucault, no one owns power in a relationship or a particular situation that has a set of actions, reactions and effects (Foucault, 1982). Having a strategy regarding how to respond to power is important as it will always exist (Foucault, 1982). As a result of this perpetual existence of power there is a need to understand power and work with it and not focus energy on eliminating power (Cheek & Porter, 1997). There is a productive side to power when resistance to power results (Foucault, 1972; Weedon, 1987). For example, when nurses speak up or confront someone regarding an issue, power is being exercised and Foucault would support this as being constructive. Understanding the operations and relations of power in contexts or situations supports those who resist the nature of authority being unquestionable (Cheek,

1999; Porter et al., 2005). Foucault's work helps to understand and make visible the constant routines that maintain the ability of power to operate within day-to-day practices of nurses at a micro level (Udod, 2008). Within the experiences of PHNs and CHVs, Foucault would suggest that power operates at a micro level through their routines within their day-to-day practices (Foucault, 1980). Understanding how power is experienced in the everyday practices, roles and structures of PHNs and CHVs who support marginalized mothers and families in the Enhanced Home Visiting Program in Nova Scotia will be understood guided by Foucault's perspectives. Differences of power within and between PHNs and CHVs will also become clearer.

Metaphors illustrate Foucault's representation of relations of power throughout his work. An example is represented in the term panopticon which Foucault used after he studied the prison and asylum systems (Cheek, 1999; Foucault, 1963, 1991). Through these experiences he discovered the way prisoners and patients were observed by guards and nurses. In both scenarios, there is an observation centre where prisoners and patients are constantly under an observer's gaze. This approach to controlling others through constant surveillance maintains alertness in individuals that they are being watched and also sustains an invisible power relationship. As a direct result of panopticism, power works in a way that creates compliance and self-discipline in individuals to the point that people unconsciously become subjects and objects as they stop consciously thinking about how they are acting in relation to the power (Cheek, 1999; Foucault, 1977). Disciplinary techniques of power within structures or institutions in society are internalized as rules and result in nurses or others such as CHVs behaving in an

acceptable way for the institution. As a direct result of this disciplinary power “ the issues of power in contemporary healthcare organizations focuses not on the legitimacy of power or on the abilities of the nurse, but on the myriad of practices and discourses that govern action, not only prohibitively but also creatively and productively” (Udod, 2008, p. 83). While public health practices do not traditionally take place in hospitals there are surveillance practices experienced which represent hierarchical observation or “gazing” by those at the top of an institutional hierarchy that observe those below them (Cheek & Rudge, 1994; Foucault, 1991). For example, PHNs and CHVs are required to submit reports of their interventions with families who participate in programs like the Enhanced Home Visiting Program in Nova Scotia (K. Inkpen, Personal communication, Nov. 2012). PHNs and CHVs, like hospital based nurses are subject to the “gaze” of each other in their relationships with mothers, families, and managers of their respective programs. Also they could be interacting with other professionals, para professionals and lay people who are also involved with the work of supporting families. The regulated health care environment in Nova Scotia expects PHNs and CHVs to document their practices on designated forms to meet standards and evaluation protocols regulated by program guidelines and government (K. Inkpen, Personal communication, Nov. 2012). Nurses contribute to maintaining the surveillance and power within the health care system through their adherence to the accepted norms, standards and practices of the institution (Udod, 2008). Resistance to power is acknowledged as an important aspect within the relations of power (Foucault, 1980; Weedon, 1993). It is through resistance to accepted power structures that new ways of understanding relations of power is created

and new practices can result (Foucault, 1980). Social institutions and their related practices such as the institution of health care and its related practices have created a specific discourse that has been constructed in the language and social practices (Weedon, 1993). Language creates a place for conflicting and competing meanings to be produced. In other words language creates the meaning of these practices for society (Powers, 2001).

When reviewing and reading the volumes of material that Foucault has created and the responses from many to his work, different words sometimes represent his ideas (Cooper, 1981; Foucault, 1963, 1967, 1972, 1980, 1982, 1988, 1998; Rabinow, 1984; Rabinow, Faubion, & Hurley, 2000). Regardless, it is clear that Foucauldian analysis has the potential to "illuminate how relations of power act to construct nurse's knowledge and how nurses govern their own practice" (Udod, 2008, p. 86). Foucault challenges thinkers to re consider the relations of power and how it is socially constructed through discourse. Foucault would suggest that discourse is power in society and represents political interests of those in search of power. Personal political interests of those with certain kinds of power create discursive frameworks that allow ways of dominant and ultimately acceptable thinking while other ways are excluded (Powers, 2001). Discourse determines who can speak when, what authority their discourse represents and whose voice is listened to. As well discourse determines who is excluded from speaking. For Foucault, knowledge production is directly connected to power through discourse and how it represents multiple realities (Foucault).

Feminists and Relations of Power

Foucault's perspectives on relations of power created a crisis for some feminists (Scott, 1994). Some feminist scholars were divided about accepting Foucault's poststructuralist analysis of perspectives on power as it did not account for the differences of gender relations with respect to power (Weedon, 1993). Feminists supported a perspective that the subordination of women in society had been based upon the patriarchal power men have exerted over women in society (Butler, 1990a, 1990b, 1994). Feminists who embraced Foucault's perspective on the relations of power extended their analysis of power to relations in women's lives. With the influence of Foucault, feminists did not focus only on the emancipation of women from the control of men. Instead, feminists began to include an analysis of power in women's lives that considered diverse contexts. Foucault's work on the relations of power through discourse analysis was extended by feminists beyond a focus on only gender differences to include how power is understood in society in relation to marginalized and underrepresented social groups due to race or class (Rossiter, 1990). "Foucault's work offers feminists contextualization of experiences and an analysis of its constitution and ideological power" (Weedon, 1987, p. 125).

Much of feminist work, before Foucault's post structuralist influences was consumed with how women were victimized by patriarchal society (Scott, 1994). While this position remains an important context to understand, Foucault's support of multiple subjectivities or realities versus one reality pushed feminists to consider subjectivity from a position other than gender. Foucault offered feminists to consider other ways of

understanding how power works within relations. Feminist critique of Foucault also focused on his view that subjectivity is created by relations of power and his perspective lacked identified norms to structure his way of thinking and how to use his thinking to guide analysis of experiences. Hartsock, (1990) contends that Foucault denies the possibility that increased knowledge of patriarchal power leads to freedom from oppression. For Hartsock, feminists have worked for the emancipation of women from power and Foucault's work suggests that power will always exist and we need to understand how it operates to create change through the self-agency within people to create new ways of relating to power. Feminists were critical of Foucault's position that power could be both productive and oppressive (Sawicki, 1991). Hartsock believes that Foucault reduces people to effects of power relations and victims of power through discipline. For me, Hartsock's position lacks attention to Foucault's acknowledgement that resistance is part of the relations of power and people are not always victims.

Scott (1994) suggests that feminists acknowledged that difference exists within society; however something was missing in their approach to furthering this understanding. Feminists began to recognize a need to understand the inner functioning of how experiences are created relationally to try and understand how power plays a role. The work of Foucault helped feminists to examine how through discourse, subjects were positioned in society and their experiences were produced (Scott). "It is not individuals who have experiences, but subjects who are constituted through experiences" (Scott, 1994, p. 22).

When Foucault was embraced by feminists, relations of power from a feminist perspective were recreated to emphasize the influence of social power, social relations, social frameworks and social meanings (Weedon, 1993). Also, how capitalistic societies shape the power relations that in turn structure cultural and educational institutions is acknowledged. Wanting to understand and challenge what existing social frameworks influence social meanings through the practices and values that become accepted in society as the norm, brought Foucault and feminists together to create feminist post-structuralism (Weedon, 1993). Through examination of social construction through discourse analysis, feminists and Foucault have created a way of uncovering complex relations of power that shape subjective realities (Varcoe & Doane, 2007).

Understanding power and its relationship to patriarchy's construction of women's experiences in society has been a dominant role of feminism for hundreds of years (Strega & Brown, 2005). Foucault's work did not focus on the power relations between men and women and some would say he was gender neutral in how he approached his work. However, feminist researchers applied Foucault's perspectives on power to women's experiences. Feminists suggest that there are many theories of power. However feminists contend that consistent themes throughout the descriptions of the phenomena of power are the structures that create the power have been predominantly created by men to benefit men (Powers, 2001).

Feminists and Foucault together, would suggest that practices and experiences of PHNs and CHVs who work within the enhanced home visiting program in Nova Scotia are connected to values, beliefs and practices that have been socially constructed by

society, institutions and individuals. These practices may be understood similarly or differently by PHNs and CHVs. Relations of power, based upon Foucault and feminist perspectives can be uncovered in taken for granted practices through discursive representations of PHNs and CHVs' experiences working within the Enhanced Home Visiting Program in Nova Scotia.

Relations of Power Applied to Analysis of Experiences

I have presented the underlying perspectives and theoretical underpinnings of Foucault and feminist approaches to defining relations of power that challenge accepted societal definitions. Together, the theoretical underpinnings of Foucault and feminists shape the methodology of FPS which will guide the proposed research study. Analysis guided by feminist post-structuralism, focuses on understanding how relations of power can be used to understand personal, social and institutional discourse found in experiences. In the following section I will discuss how relations of power as a key concept in discourse analysis will help guide analysis of the experiences of PHNs and CHVs practicing in the Enhanced Home Visiting Program in Nova Scotia.

Enhanced home visiting has a long history as women's work due to its focus on mothering, healthy baby, child and family development (Bull et al., 2004; Heaman et al., 2006; O'Brien & Baca, 1997; Olds, 1999; Olds, Henderson, & Eckenrode, 2002; *Pan-Canadian Inventory of Public Health Early Child Home Visiting*, 2009). Feminist and Foucault perspectives support analysis of the practices of enhanced home visiting through a gendered, power relations lens. Nursing practices like enhanced home visiting have been traditionally controlled by health institutions such as public health (Ciliska et al.,

2001; Cooper, 1981; Udod, 2008). By reframing how the subjective experiences of PHNs and CHVs are constituted, experiences are examined as not naturally occurring (Scott, 1994; Weedon, 1993). Instead, experience is thought to be created in discourse through patterns of language and one truth does not describe the experiences of PHNs and CHVs. These experiences also include relations with mothers and families in home visiting programs and the related discourse that represents how practices occur or do not occur. With Feminist and Foucaudian influences attention to what social, historical or political factors are creating relational experiences is a focus (Cheek, 1999; Ward, 1997; Weedon, 1987). In other words, how does professional subjectivity shape the practices between PHNs, CHVs and mothers and families? Critical questioning of these experiences provides a way to reflect on the professional subjectivities that are working within the discursive representations while also examining the relationships. Analyzing experiences in this way pushes examination of why and how practices occur and how relations of power are influencing the experiences (Powers, 2001; Rabinow et al., 2000).

Feminists have a long history of examining how female experiences of power are different from men as a result of patriarchal domination (Butler, 1994; Weedon, 1993). As has been previously discussed, Foucault provided another way for feminists to consider how gender and sex are created through discourse and discursive practices thus examining the politics of power (Foucault, 1998; Weedon, 1993). I provided an example of this earlier when I discussed how motherhood is socially constructed and how discourse shapes the practices that professionals, lay professionals and institutions take on to constitute and perpetuate the roles of mothers in society. Mothering practices

through the social construction of motherhood remains grounded in how gender is understood (Reinharz, 1992; Rossiter, 1990; Smith, 1990; Varcoe & Doane, 2007). Through the creation of a particular health discourse that focuses on providing expert services surrounding mothers and families, such as enhanced home visiting, discursive practices are standardized with the intent of controlling and regulating a certain understanding and knowledge related to the experiences and practices of enhanced home visiting (Wade & Fordham, 2005). Feminists and Foucault would recognize the power at work in the discourse and discursive practices that are operating to maintain and shape the identities of PHNs and CHVs' practices. Through analyzing how these practices have come to exist and the political, social and historical contexts influencing them, an understanding of how social and power relations operate within the practice will be uncovered (Weedon, 1993). The goal of understanding practices and uncovering the relations of power at work is not meant to devalue the practices or label them as good or bad but instead the goal is to understand the experiences within a broader framework of patriarchal and other hegemonic power relations (Weedon). Power relations occur at all levels in society (Foucault, 1980; Hekman, 1996; Lather, 1991). The power relations among those involved in the Enhanced Home Visiting Program as part of the institution of public health will become apparent through the experiences of PHNs and CHVs and how the institution of public health differentiates between the experiences of PHNs compared to CHVs. As Foucault (1998) suggests, people have self-power that is shaped by their position in society based upon their identity due to race, sexual orientation, ability, spirituality, their work status and through their relationships with others. With

this in mind, understanding how power constitutes public health practices will be examined as part of the analysis of the experiences of PHNs and CHVs working within the Enhanced Home Visiting Program through analysis of the personal, social and institutional relations of power.

In this research study, PHNs (PHNs) and CHVs (CHVs) shared their experiences within the Enhanced Home Visiting Program that was shaped by their professional practice experiences as employees of public health and as citizens within society. The personal experiences of PHNs and CHVs related to their work with mothers and between each other also played a role. Interview questions helped participants focus on their personal experiences related to their work with mothers and each other. An additional dimension of the analysis was uncovering how subjectivity and agency informed the context for PHNs and CHVs' roles and accountabilities within the institutional structure of public health (Butler, 2005; Scott, 1992). I introduced subjectivity earlier in the discussion. Subjectivity supports the idea that individuals have personal life experiences and their social location is informed by their values, beliefs and their personal interpretations of these experiences (Cheek, 1999; Weedon, 1993). By supporting the participants to share their experiences their beliefs, values and personal experiences emerged in the interviews. PHNs and CHVs subjective experiences can add a dimension of contextualization where their unique understandings of experiences within the enhanced home visiting program has an opportunity to be revealed within their discourse.

The concept of agency refers to a person's ability to have control in their life and make changes (Weedon, 1993). Agency has been linked closely to relations of power

within a person's personal experiences of how they react to power. Feminists and Foucault value people as experts of their own lives and the descriptions they share in research about their experiences are considered credible, thoughtful sources of data (Aston et al., 2011; Butler, 1994; Weedon, 1993). Self-reflexive and aware of their position in society, people recognize oppression that surrounds them in societal structures and ideologies however they may not share their impressions for fear of being judged. Analysis of experiences can reveal how relations of power may be oppressive in some circumstances within discourse through patterns of language that represents how it has been assigned meaning in lives (Cheek, 1999; Powers, 2001). Through their own agency people have the ability to question how oppression is understood in their personal situation through reflecting on their experiences. Understanding the relations of power and its potential oppressive effects within the practices and experiences of the Enhanced Home Visiting Program can challenge existing practices (Cheek, 1999; Weedon, 1993).

Another example of agency can be understood within the concept of surveillance. Nurses have experienced surveillance in their practice and power over nurses has resulted in self-surveillance and self-discipline by nurses (Cooper, 1981; Foucault, 1988; Udod, 2008). This type of inherent disciplinary power influences individual behaviours to a point where people might obey authority such as institutional policies unconditionally or they may challenge it in other ways and be considered non-compliant or present themselves in other ways. Certain practices become accepted as the norm and are practiced without questioning and become the reality for practitioners. Foucault suggests that this type of power can be productive and economical for institutions managing

nurses and lay professionals as people self-manage how they are supposed to act within their institutions. Foucault further contends that this type of relational power can push people to initiate their internal agency by resisting these surveillance power structures and create new ways of responding. This example of agency as a dimension of relations of power supports the self-reflexive nature people have within themselves to reflect upon their experiences and create new ways of understanding and responding to their experiences when power is exerted on them. Through theorizing the constitution of agency and the experiences that define it, hegemonic ideologies that have shaped PHNs and CHVs' practice experiences can be examined and challenged within the analysis to further understanding. For example, the analysis of the discourse can be guided by questions such as: What has maintained the dominant discursive stances in regard to surveillance practices among PHNs and CHVs?; What discourses are prevalent in describing agency at work in the practices of PHNs and CHVs?; What discourses exist in relation to home visiting practices and agency of PHNs and CHVs?; What are the inter-relational politics between PHNs and CHVs?; How are dominant discourses are maintained by PHNs and CHVs within their experiences?

Discourses represent relations of power by shaping identities that create people's understanding of themselves as reflected in the beliefs and actions that people present to the social world through interactions (Butler, 2005; Foucault, 1998; Weedon, 1993). Enhanced home visiting by PHNs and CHVs has played a dominant role in supporting marginalized mothers and families within the Public Health Care system in Nova Scotia (Aston, 2011; *Pan-Canadian Inventory of Public Health Early Child Home Visiting*,

2009; Research Power Inc., 2012). Dominant discourses that are produced within the enhanced home visiting program create effects that can shape knowledge and understandings that impact practices of PHNs and CHVs, the context of mothers and families' lives, and the structures (institutions) of the public health system. Within the analysis, understanding how the power of dominant discourses within the Enhanced Home Visiting Program has created knowledge that has become accepted within society and influences how Enhanced Home Visiting practices are regulated will be examined. Considering this representation of power by discourse, other questions that could guide analysis of the personal, social and institutional practices of the PHNs and CHVs could include: What are the effects and implications of the personal, social and institutional practices of PHNs?; What are the effects and implications of the personal, social and institutional practices of CHVs?; What discourses exist that represent how PHNs and CHVs relate to mothers and families?; How do these discourses support or hinder services for mothers in the EHV program?

Evidence based practices are accepted common language within health care and the practice of nursing (Estabrooks, 1998). These practices are based upon positivist and constructivist paradigms predominantly. Decision makers within institutions such as public health look to evidence to direct how practices such as promoting health of mothers, children and families in home visiting programs should be organized (*Pan-Canadian Inventory of Public Health Early Child Home Visiting*, 2009; Research Power Inc., 2012). Relations of power are connected to these decisions as knowledge from the evidence is used to organize and direct effective practices. Based upon the evidence,

programs are created that PHNs and CHVs are expected to apply in their day-to-day work. This is an example of relations of power at work through application of dominant accepted language that creates knowledge and impacts the worlds of people personally and socially through institutional power. The PHNs and CHVs are affected by this example of power in their expected implementation of evidenced based practice. Compliance to guidelines based upon evidence based knowledge influences government programming and creates normative standards for practices of PHNs and CHVs (Estabrooks, 1998). Also, professional subjectivity develops based upon the evidence as experts in their fields contribute to discourse that influences their personal knowledge development and the evolution of hegemonic ideology (Foucault, 1980, 1998). In other words, within the Enhanced Home Visiting Program, PHNs and CHVs are expected to accept how they need to practice as it is based upon evidence approved by institutional power. Through their acceptance of the institutional power that directs their practices, PHNs perpetuate how the program functions. When PHNs and CHVs do not accept mandated practices and institutional beliefs new knowledge and practices may result. As a direct result of the influence of evidence on institutional power, practices of PHNs and CHVs are created and controlled. Through discourse analysis there is an opportunity to understand how and what has constructed these practices and continues to recreate them (Foucault & Weedon, 1993). Some might say that discourse analysis goes beyond understanding and knowledge formation through its ability to promote understanding and politicized unearthing that leads to action and change.

I experienced an example of this type of institutional power when I attended a public health meeting of professionals, decision makers, stakeholders and lay professionals in Nova Scotia. One of the CHVs spoke about using the correct language in family assessments. She emphasized that the associated paperwork with the assessment was very important for monitoring the families and mothers so that they could justify why they were in the program. This person demonstrated how she supported the practices she was being asked to do by the institutional power. As well she expressed her concern about the paper work and what the impact of not doing it correctly had on families but she accepted that it needed to be done. This person's sharing demonstrated a tension between how she was expected to practice by the institution and how she was personally considering another way to practice. When I reflect on this experience and consider practices broadly, I recognize how this proposed research can provide an opportunity to reveal and understand how tensions may exist between how PHNs and CHVs are expected to practice versus their unique ways of practicing that are not acknowledged.

The Enhanced Home Visiting Program in Nova Scotia began in 2002 as an addition to the healthy beginnings program of early home visiting (Pan Canadian Inventory, 2009). Up until this point only PHNs did home visiting (K. Inkpen and L. Young, Personal communication, Nov. 2012). Foucault and feminist (Feminist Post-structuralism) perspectives provide an analysis approach that has the ability to uncover invisible practices of PHNs and CHVs like possible silenced tensions within relations of power (Cheek, 1999; Weedon, 1993). As well, this analysis approach does not encourage

identification of someone to blame as I mentioned earlier, instead, discourse analysis provides a way to understand tensions within relations of power through discourse and how it represents realities (Aston et al., 2011; Foucault, 1972; Gavey, 2011; Weedon, 1993). Within discourse, the thoughts, feelings, responses and relations of PHNs and CHVs informed by personal, social and institutional beliefs and practices will be uncovered and provide a way to understand how the relations of power are constructed within the Enhanced Home Visiting Program in Nova Scotia. Also, how PHNs and CHVs navigate their relationships and roles in the Enhanced Home Visiting program may be uncovered within the discourse.

Foucault and feminist perspectives represent philosophies that do not argue what or how we should understand the issues and practices of PHNs and CHVs within the Enhanced Home Visiting Program; rather how have we come to know and understand it in certain ways while excluding other interpretations (Aston, 2011; Aston et al., 2011; Gavey, 2011; Weedon, 1993). The effects of these practices are also revealed within this analysis of the discourse that represents relations of power.

Analysis of the practices of PHNs and CHVs revealed relations of power that conceptualize hegemonic understanding of the accepted, unquestioned knowledge that regulates activities and actions of PHNs and CHVs as part of the Enhanced Home Visiting Program (Butler, 1994; Cheek, 1999; Cooper, 1981; Fairclough, 2003; Gavey, 2011). While it must be acknowledged that relations of power contributed to analysis of practices of the PHNs and CHVs, the silenced discourses revealed relations of power within the enhanced home visiting practices. A focus on understanding how and why the

silenced discourses were not shared revealed a new way of understanding relations of power and its effect on enhanced home visiting practices. “Discourse analysis offers a way to understand the complex relations that created the polar relations in the first place” (Aston et al., 2011).

Conclusion and Summary

In this section I have discussed how Foucault and feminist perspectives on relations of power within discourse analysis provide a way of understanding personal, social and institutional practices while challenging mainstream power definitions. A further exploration of how relations of power through discourse analysis can guide critical analysis of PHNs and CHVs’ experiences within the Enhanced Home Visiting Program in Nova Scotia was presented.

PHNs and CHVs who work within the Enhanced Home Visiting Program in Nova Scotia have unique experiences that are represented in different ways depending upon their subjective experiences. Through application of Foucault and feminist positions on relations of power, the everyday practices of PHNs and CHVs will be critically analysed discursively. Discourse analysis is more than describing texts that result from research methods such as interviews (Cheek, 1999). The process of discourse analysis is in and of itself a critical and reflexive analysis of texts and reveals how language represents personal, social and institutional practices. In other words how the discourse is politicized is a result of analysis (Cheek). Foucault talks about the effects discourse has on revealing relations of power (Weedon, 1993). For example, one effect the discourse can reveal is how the personal, social and institutional practices of the Enhanced Home

Visiting Program constructs the relationships between PHNs and CHVs as colleagues. Also, the relationship between PHNs, CHVs and the mothers and families will reveal how those relationships are constructed through relations of power. Foucault and feminists offer a framework that can facilitate uncovering those silent discourses of relations of power related to day-to-day practices that haven't been shared. In other words, taken for granted discourse that has become embedded in accepted hegemonic practices may reveal itself in another way through a sharing of personal experiences from PHNs and CHVs.

Critical analysis, though the use of discourse analysis, framed by Foucault and feminist perspectives on the relations of power will involve a complex interrogation of the discursive practices shared by participants based upon their personal experiences. Dimensions that influence the relations of power have been presented throughout this paper and they provide a lens of critical analysis that will magnify how practices have been shaped by personal, social and institutional practices though discourse and represented as the accepted knowledge. "Discourse analysis involves the careful reading of texts (e.g., Transcripts of conversations or interviews, or existent documents or records, or even more general social practices), with a view to discerning discursive patterns of meanings, contradictions, and inconsistencies" (Gavey, 1989). There is no one formula or recipe for this approach to critical analysis. However, discourse plays a main role in the analysis and has the power to reveal details in language that creates new ways of understanding accepted practices of PHNs and CHVs who work within the Enhanced Home Visiting Program in Nova Scotia. Resistance by PHNs and CHVs to

contradictions in the discourse may result in new ways of practicing through understanding and questioning how their practices support mothers and families.

Examination of discourses that have sustained the understanding of home visiting are a critical elements in the proposed study's research process (Cheek, 1999). A review of PHNs and CHVs' early enhanced home visiting literature does not present an understanding of the discourses that represent the relations between the two different visitors' practices and experiences while working with mothers in the Nova Scotia Enhanced Home Visiting Program. This feminist post structuralist study will explore the practices and experiences that support the health of low income single mothers who participate in the Nova Scotia Enhanced Home Visiting Program (Hall & Stevens, 1991; Reinharz, 1992).

In a feminist poststructuralist study the researcher reproduces discourse from participants' stories that can provide new ways of thinking about practices. Texts provide examples of discourse from the study's participants. Discourse analysis is a set of methods that focuses on the social context of language and how it functions in relation to structures of power. Within the complexities of power relations, discourses that result from the study do not provide definitive answers to problems but can facilitate action that leads to societal changes and new ways of practicing (Mills, 2003).

Chapter 4: Methods: Data Collection

Selecting the methods that support data collection strategies ultimately lies with the researcher who makes the decision based upon the purpose of the research study, the methodology guiding the inquiry and what approaches support answering the research questions (Denzin & Lincoln, 2000).

The research design for this study was a qualitative inquiry guided by a feminist poststructuralist theoretical framework. I participated in two methods of data collection that supported furthering the understanding of discourse, subjectivity, agency and power relations in the practices of PHNs and CHVs while supporting the health of mothers who participate in the enhanced home visiting program (Aston et al., 2011; Butler, 1990a, 2005; Cheek, 1999; Foucault, 1980; Powers, 2001; Scott, 1994). Method one included one on one interviews with 8 CHVs and 6 PHNs. This data collection strategy facilitated access to personal, social, relational and institutional discourses that represented the enhanced home visiting practices of PHNs and CHVs. Method two included one focus group with the participants after the data has been analyzed. The preliminary study findings were presented to the participants for their input in a focus group. I presented a summary of the main themes to 6 CHVs and 4 PHNs. The participants agreed that the preliminary study findings represented the messages they wanted to share. The PHNs and CHVs were given the choice of having a separate focus group for PHNs and one for CHVs. They chose to have one focus group together.

Participants/Sampling

Purposeful sampling was used in this inquiry through recruitment of participants who were willing to share their experiences as PHNs and CHVs. The initial access to the research process in this study was through the support of the Capital District Health Authority director of public health's office. Meetings were then arranged with PHNs and CHVs through the director and managers in public health within the Capital District Health Authority. A letter of introduction about the study was sent to directors and managers describing the background of the study (Appendix A). Public Health sent a letter of introduction about the study (Appendix B), to family resource centers on my behalf requesting CHVs as participants.

Feminist researchers often choose purposeful sampling of participants for their research versus random sampling approaches (Denzin & Lincoln, 2000). This approach involves seeking out "groups, settings, and individuals where and for whom the processes being studied are most likely to occur" (Denzin & Lincoln, 2000 p. 370; Gillis & Jackson, 2002).

Scott (1992) suggests that the experiences of research participants in a feminist post structuralist inquiry form the discourse that builds understanding and uncovers new knowledge. Participants were recruited based upon the following inclusion criteria: PHNs and CHVs who supported mothers as part of the Nova Scotia Enhanced Home Visiting Program for at least 6 months (to ensure the participants had practice experiences to reflect upon).

In accordance with the methodology used to guide this study, I decided that demographic information about the participants would not be collected. I trusted that each of the participants personal information would emerge in the data based upon what they believed was important to share about themselves during the interviews.

Interviews/Setting

One on one interviewing facilitates hearing the personal experiences of study participants in their own words (Reinharz, 1992). Feminist, qualitative research supports representing participant's perspectives through interviewing with resulting experiences that have been liberating for both the researcher and the participants (DeVault & Gross, 2007). Interviews have fostered consciousness raising through open ended approaches where marginalized people have been able to share their experiences in explicit ways without being interrupted as they share their experiences (Reinharz, 1987). Interviewing from a feminist perspective involves listening to the participants experiences from their perspective and in their own words so as to understand their experiences. There are various types of interviewing but for a feminist, qualitative researcher it is important that the conversation between the researcher and the interviewee is done in a collaborative way of creating knowledge (DeVault & Gross, 2006). Reflexive awareness is maintained by the researcher which includes acknowledging to participants that the interview is a complex encounter where deep rooted feelings of identity, power, culture and constructions of feelings similar or different shape the interview experience (DeVault & Gross).

The setting for the interviews were chosen by the PHNs and CHVs. All of the interviews except two, took place in a private, confidential space at a family resource center for the CHVs and at the public health offices for the PHNs. Two interviews were done using a technology called Black Board Learn on the computer and through remote internet access. This involved one PHN and one CHV who agreed to this method. As the interviewer I was at a distance from the participants. A Dalhousie University technician set up the technology over the phone with both participants who were each in a private office. Once the technology was working the interviewer and the participants were alone in their offices but the interview was through the internet connected to Black Board Learn at Dalhousie University. It was like doing an interview over the phone. Black Board Learn has the built in capability to record the interview as the interviewer and interviewee speak through a set of headphones with a microphone connected to the computer.

These approaches support feminist qualitative research principles of ensuring participants feel comfortable during the research process (Guba & Lincoln, 2000). Open ended in depth interviews guided the data collection facilitated by a semi structured interview guide (Appendix D) which was adapted as the interview evolved and individual participants at times shared experiences that influenced the course of the interview. Since “the open ended interview apparently offers the opportunity for an authentic gaze into the soul of another” (Silverman, 2000, p. 821), this approach to interviewing addresses the complexity of listening to the participant’s experiences, and the need for the interviewer to be fully engaged and actively processing what is being said (DeVault & Gross). As a result of the information shared by the participants, the interviewer’s thinking may be

affected in a way that leads the interview on a detour that cannot be predicted or planned prior to the interview experience.

Interviews were scheduled for 60–90 minutes at a location and time agreed upon by the participants and myself. All interviews were recorded and then transcribed verbatim. Participants had the choice of being audio/video taped remotely using the Dalhousie University system called Black Board Learn. Transcription was done by a professional transcriptionist who has done this type of work before and understands the necessity for confidentiality. A confidentiality sheet for the transcriptionist was provided and signed (Appendix G).

Focus Groups

A focus group provided the participants the opportunity to revisit the analysis of data from the one on one interviews and verify what they shared was represented in the analysis. A letter of information (Appendix E) provided details describing the focus group.

The preliminary study findings were presented to the participants for their input in a focus group. I presented a summary of the main themes to 6 CHVs and 4 PHNs. My supervisor also participated in the focus group as the note taker. The participants agreed that the preliminary study findings represented the messages they wanted to share, The PHNs and CHVs were given the choice of having a separate focus group for PHNs and one for CHVs. They chose to have one focus group together.

In addition to hand written summary notes of the focus group it was also audio recorded and transcribed by a professional transcriptionist who signed the confidentiality

sheet (Appendix G). The summary of the focus group findings are included in the upcoming finding chapters.

Timeline

The study data collection began in January, 2014 and was completed in October, 2014 with the focus group. Data analysis of the participant interviews began concurrently to the data collection approach of one on one interviews. Subsequent data analysis occurred following the completion of the data collection and took an additional 6 months. The total time for the study was 16 months including data analysis before and after completion of the focus group.

Reflexive Journaling

Reflexivity has been a holistic practice of feminist researchers and a process that occurs throughout the research study and prior to and upon entering the field (Hesse-Biber & Piatelli, 2007). This process encourages the researcher to acknowledge their own personal and cultural biases that they bring to the research process. From a feminist perspective the acknowledgement of the subjectivity the researcher brings to the research fosters inclusion of their humanness and promotes their ability to build knowledge that challenges power in society (Olesen, 2005). It is appropriate for researchers who practice reflexively to share their own experiences with participants if it is relevant to the interview. Another dimension of reflexivity that results is the co-creation of knowledge that evolves between the researcher and the participants back and forth sharing throughout the interview (Hesse-Biber & Piatelli).

To support reflexivity, journaling by the researcher throughout the research process facilitates self-awareness of what they bring to the research and how they interpret their relationships with those they interact with throughout the study. The researcher may also share their interpretations with the participants to validate what they have heard from them. In this study, journaling will be maintained by the researcher as a form of self-reflection that may become part of the analysis upon completion of the interviews (Reinharz, 1992).

I did journal throughout this process for my own self-reflection on my experiences. Within my journaling I wrote about the research process and things I learned about methodological issues. Personal reflections, observations, impressions about the interviews and focus group, how I felt meetings went with everyone involved in the research and how I felt about the quality of the interview. I was focused on what I was learning from the PHNs and CHVs and my impressions about the meaning of what they shared.

Methods of Data Analysis: Discourse Analysis

Discourse analysis is a set of methods that focuses on the social, historic and institutional context of language and structure of statements, terms, categories and beliefs and how language functions in relation to structures of power (Hekman, 1996).

Institutions, according to Foucault have created objective knowledge that is accepted in society as a truth or accepted norm. Even when the truths are challenged, the challengers are often silenced (Rabinow, Faubion & Hurley 2000). For poststructuralists writing is not seen as neutral, or the truth, instead how and what words are used to create meaning

is the emphasis of analysis (Butler, 1992, 2005; Cheek, 1999, Scott, 1992). The influences of society, politics and history are evident in constructing realities that have been translated and transmitted through written words. In other words the recognition of the power behind words guides a feminist post structuralist approach to analysis of data.

Language, practices, beliefs and values are concepts that provide a framework to understand the practices and personal experiences of PHNs and CHVs who work within the Nova Scotia Enhanced Home Visiting Program. To understand, or interpret the PHNs and CHVs' experiences multiple discourses are connected to their experiences. Discourse analysis provides a frame to understand personal, social and institutional constructions of a participant's personal experience. The concepts of language, beliefs, values, practices, subjectivity, agency and relations of power are all included in a comprehensive analysis. Post structuralists do not support the idea that language represents a transparent presentation of a person's day-to-day reality (Gavey, 2011). Instead, post structuralists suggest that subjectivity is socially constructed and language has hidden meanings and influences.

There is not one way to approach discourse analysis however Foucaudian concepts and feminist perspective provided a guide for analyzing the discursive representations of the practices and experiences of PHNs and CHVs who work with marginalized mothers and families who participate within the Nova Scotia Enhanced Home Visiting Program (Cheek, 1999).

A first step in discourse analysis in this study included reading each of the transcripts of the interviews many times and discussing what I was seeing in the texts

with my supervisor. I searched for moments when the PHNs and CHVs talked about how they understood their practices, what they valued and believed about their practices, how they negotiated relations of power in their practices, what their practices and experiences meant to them. This searching was done by identifying key words, groupings of words and themes that reoccur about a particular focus on the language, practices, beliefs and values that framed an experience or practice of PHNs and CHVs (Butler, 1992, Cheek, 1999, Gavey, 1989; Scott, 1992). I began by thoroughly analysing individual interviews first, then I looked for patterns in the data among all of the participants. Once themes and patterns were identified I questioned what they represented by asking how meaning was developed throughout the discourse and how was the meaning produced?

Throughout the discourse analysis I was guided by my supervisor, Dr. Megan Aston who has extensive expertise in this method of analyzing data. We were in touch frequently via phone or in person sharing back and forth our individual impression of what was emerging in the data. As a novice, I recommend working closely with an expert when learning how to apply FPS.

Another important focus during the analysis was examining what was missing in the discourse (Cheek). Analysis of language guided by a post structuralist framework facilitates understanding how social relations develop and work in the practices and experiences of PHNs and CHVs. Also, how institutions are organized emerged in spoken words and cultural practices (Scott). Questions that guided the analysis of discourse in this study included; how have some meanings emerged as normative? What do the processes reveal about how power is constituted and operational? How do meanings

change? Post structuralists insist that words and texts have no fixed or intrinsic meanings and they are not transparent (Scott).

For feminist researchers, focus on gaps in what participants share during an interview or what is absent in women's words, influences data analysis approaches to be considered to get at the meaning that lies beyond the explicit discourses (DeVault & Gross, 2007). Thematic analysis is part of the initial and ongoing activity of discourse analysis that provides opportunities to identify what is implicit and explicit in the participant's discourses. For this study, discourse analysis was guided by Foucaudian and feminist principles to ensure the experiences and practices of PHNs and CHVs were understood and heard from their perspective (Olesen, 2000). Thematic analysis is the "search for common threads that extend throughout an entire interview or set of interviews" (Morse & Field, 1996, p.139). Identifying themes is an inductive approach where analysis moves from the specific to general and then the particular and it is a common approach used by qualitative researchers. The common threads were organized according to themes that emerged from the words of the PHNs and CHVs and then the themes were grouped together to identify the dominant discourses (Denzin & Lincoln, 2000). After each individual interview was understood, all interviews were compared for possible themes and differences. The themes were presented in the language of the participants. Finally, cross checking with the literature was done to find support for the identified themes, tensions or the implicit meanings behind the words, language, and discourses that were shared (Olesen, 2000). I identified the themes throughout the analysis and color-coded them to keep me from getting confused with the large amount of

data I had. More than once I reorganized the themes and my color-coding. I enjoyed the process of the analysis but I believe it requires focused attention and immersion in the data to adequately see emerging patterns and themes.

Discourse analysis has grown in popularity however the approaches used are varied (McCloskey, 2008). The research questions within discourse analysis usually have an emphasis on social problems, and focus on how processes and discourses are constructed and created, how a problem was created, how discourse is constructed and usually the focus is on social problems or processes (Crowe, 2005; Van Dijk, 1997). Sample size is not definitive as researchers using this approach acknowledge that patterns can occur in a small sample and they are not sure until they start to deconstruct the language that occurs. Usually researchers continue interviewing until they stop hearing different types of discourse. Interviews are the main elements in data collection in discourse analysis and have been described previously. Transcription involves not only audio taping and transcribing the tapes verbatim but also the linguistic features heard in the interviews such as how descriptions are offered, how people respond and how they understand. This is a high level of analysis that is going on in addition to the words, language and discourse that is examined (Fairclough, 2003; Fairclough & Wodak, 1997). Analysis within discourse analysis has been described by Fairclough as having three steps: describe the text, interpret the interaction between the producers and interpreters of the text and examine how social practices are explained in the texts. Validation of data is a critical component of discourse analysis and involves member checking by having participants review what the analysis is saying and having them determine if it represents

what they experienced. This validation was done in this study by presenting the preliminary study findings to the participants in a focus group. They all agreed that the findings represented the messages they wanted to share in their interviews. The final report of the discourse analysis involves using actual excerpts of the data along with interpretation and is an in depth approach to analyzing data and is time consuming (McCloskey). Verbatim quotations add credibility to the analysis. In this study verbatim quotations are linked with every theme and help the data come alive.

Based upon the literature presented related to discourse analysis I approached the analysis of the large amount of data from the interview transcripts in phases. This was one way of handling the large amount of qualitative data. As Cheek (1999) suggests there is not one way to approach discourse analysis and there is a dimension of intuition involved with deciding on the best approach that works for the researcher and the study. It seemed reasonable to divide the analysis of the data into at least three phases. For me, phase one involved concurrent collection of data and analysis of the first four interviews involving both PHNs and CHVs. My feeling was upon completion of phase one I would have had an opportunity to work through one set of data analysis and then upon reflection I could then create new ways of approaching the next set of interviews or continue with the approaches I used in the first two interviews. Phase two involved two sets of interviews involving one each with a PHN and a CHV. The third and final phase involved one set of interviews with a PHN and a CHV. At the completion of this phase a decision was made regarding the data collected and the analysis up to that point with my supervisor. The next activity was to then look across all of the interviews to see what

emerged across the interviews, This part took a great deal of time as I sometimes got lost in my data but things became clearer as I kept myself immersed in the data and themes began to emerge. Lessons learned from each phase guided the next phase. These decisions were always made in consultation with my supervisor and I also brought the analysis findings back to my committee twice during the process for their input. They saw new things that I had not discovered in the data. Their input also added clarity to the meaning of the data because we had discussions where one person's ideas stimulated an idea in another person in the group. It was a very active and invigorating experience as a new researcher.

Recruitment of participants influenced how the phases were organized and how quickly I was able to get the interviews transcribed. One day I had a request to do 5 interviews. I had not predicted this would happen. The high volume meant I had to re-adjust my strategy so that I could have time to get the interviews transcribed and analyzed.

Texts from participant interviews were selected for analysis and represented their experiences and practices. Through examining and exposing the discourse of PHNs and CHVs who worked within the enhanced home visiting in Nova Scotia an in depth understanding and contextualizing of their experiences has resulted.

Discourse analysis provides a research approach that supports a nursing focus on social issues through examination of the personal, social and institutional factors that shape the processes that create the issues (McCloskey). Discourse analysis supported the

overall purpose of this study to understand the construction of the practices and experiences of PHNs and CHVs who work in EHV.

Ethical Considerations

Informed consent occurred prior to each individual interview and was witnessed by the principal investigator. A written copy of the consent form (Appendix C) was provided to each participant.

Ethical approval for this study was obtained from the Capital District Health Authority (CDHA) first. Upon ethical approval from CDHA, Dalhousie University Health Sciences Human Research Ethics granted approval of the study as there are reciprocal agreements between these two institutions recognizing each other's ethics approval processes. Ethical approval was sought from all participants through an informed consent process. While anonymity cannot be guaranteed, the participants were assured that their participation in the study, their personal information and other ways they might be identified would be kept confidential. The consent forms (Appendix C & F) were explained by the researcher and signed prior to participation in the interview and focus group. Pseudonyms were assigned to each participant by the researcher to ensure confidentiality throughout the study. Taped recordings were listened to by myself and the transcriptionist who also signed a confidentiality form. The raw audio files are kept in a locked cabinet. Audio files of interviews obtained through Black Board Learn which is offered by Dalhousie University were encrypted in a password protected environment on a computer where only the researcher has access.

It was reinforced by the participants that they could withdraw from the study up until one month after they had been interviewed and they could refuse to answer any questions at any time. As well, if the participants had any questions they needed answered throughout the research process they were encouraged to ask. All transcripts and written materials will be destroyed 5 years after the publication of the thesis as well as the audio tapes. Data will be kept in a locked filing cabinet that is secure and only accessible by the researcher. Those interested in the study and requiring additional information were able to contact the researcher by phone or e-mail.

Trustworthiness of the Data

Feminist, qualitative researchers address trustworthiness in different ways (Guba & Lincoln, 2000). The researcher must ensure trustworthiness and accuracy of the participant's experiences throughout the research process. A study's applicability, consistency and neutrality are assured when trustworthiness of the qualitative findings are established (Gillis & Jackson, 2002). The criteria for data analysis that ensured trustworthiness in this study were, credibility, dependability, confirmability and transferability (Gillis & Jackson). Credibility involves the researcher accurately representing what the participants shared when they were interviewed (Gillis & Jackson). Strategies to ensure there is credibility include member checking where participants read the analysis done by the researcher and then they are given the opportunity to edit until they believe their experiences are reflected accurately (Gillis & Jackson). In this study a focus group was held and the preliminary study findings were shared with the participants for them to validate. Field notes were kept in a journal format with my

impressions of my experiences within the research. This strategy provides accurate recollections of all events that have taken place and it supports credibility within this research study. Dependability refers to maintenance of quality throughout the research process. A strategy to ensure this happened included keeping records of the research process through careful documentation of the raw data and how it was generated. Also I recorded how decisions about analysis were made (Gillis & Jackson). In this study I consulted with my supervisor as I moved through the data collection and discourse analysis phase as she is an expert in discourse analysis. Confirmability ensures that the study's process can be followed by another researcher and can be done by having another researcher and the participants review the data collection, data analysis and agree with the identified themes post analysis (Gillis & Jackson). To ensure confirmability I discussed with my supervisor and committee members the research process I followed and sought their input as to whether I followed the proposed study's research process.

Transferability means considering how the data applies to other settings, contexts and groups (Gillis & Jackson). Strategies that I implemented to support this final criterion of trustworthiness included describing: the participant selection, the analysis techniques and the marginalized mothers' life contexts that may help in enhancing the study findings and provide suggestions for future research (Gillis & Jackson). I have also included direct quotations and detailed analyses throughout the presentation of Findings to ensure readers have access to a comprehensive discussion of my analysis.

Dissemination of Research Findings

A summary of the dissertation will be made available to all participants and anyone who wants to read the dissertation within the public health department and family resource centers. Also, any publications from the research will be sent to the participants. A copy of the thesis will be given to Dalhousie University School of Nursing. Presentation of the study findings will be done at conferences, workshops, in journal publications and through presentations at the Public Health Departments and Family Resource Centers who participate in the study.

Chapter 5: Building Relationships with Mothers Living within Vulnerability

“I care you know...and I care a lot about the moms that I’m working with...”

This chapter is about how PHNs and CHVs built their initial relationships with mothers living within vulnerability. All of the participants described the importance of taking the time to understand each mothers’ experience of living within vulnerability. They specifically focused on what living within vulnerability meant to them and how it informed their relationships with the mothers. Subsequently, PHN’s and CHV’s practices were guided by their professional and personal beliefs about what it meant to be a mother living within vulnerability. Their practices were also significantly influenced by institutional discourses and system changes. The three subthemes discussed in this chapter emerged early in all of the interviews as foundational for building the initial relationships with mothers living within vulnerability and they include (1) The relationship begins with a focus on vulnerability (2) Building personal power with mothers living within vulnerability, (3) Program changes affect vulnerability.

As the participants told their personal stories the application of discourse analysis provided a clear understanding of how their subject positions that had been constructed through institutional and social discourses positioned them in particular relations with mothers. By using the Foucauldian concept of power we can see how participants negotiated their relations of power between each other (PHNs and CHVs) and the mothers that then brought forth the main themes in this study. The EHV program perpetuated different discourses that PHNs and CHVs worked within in their

relationships with mothers living within vulnerability. For example social and institutional discourses about vulnerability and mothering emerged through the experiences shared by PHNs and CHVs who worked with mothers living within vulnerability.

The relationship begins with a focus on vulnerability

CHVs and PHNs were aware of the social and institutional discourses that constructed the meaning of mothering and vulnerability. In particular they gave examples of how mothers were labelled as vulnerable because of their unique needs. The meaning attached to 'vulnerable' situated this group of mothers to be stigmatized and stereotyped as 'at risk', 'less than' and 'needing help'. The word vulnerable was used most often in this study to describe the mothers but the phrase 'at risk' was also used to describe the mothers. While the word vulnerable was used to describe the mothers in this study PHNs and CHVs acknowledged very early in the interviews that the word created a tension for them as it represented a label. As one PHN Jasmine stated:

So I knew that area. But also more of the, I don't know if you want to call them vulnerable, high risk, however we're labeling them now.

Jasmine's example represented her belief that within the EHV program they were labeling the mothers as vulnerable because of the geographical area where the mothers lived. The 'we' that Jasmine referred to was the program of EHV and she suggested that the program influenced how the mothers were labeled. Another PHN Alexandria went a little further than Jasmine in what she believed vulnerable meant when she shared the following:

...It's a pretty big thing that in a very vulnerable timewell, I mean being a mom is isolating all the time. And there's a lot of that first year especially, there's so much going on and so many changes in your life that you can't plan for. That it's hard...being vulnerable...I mean a lot of our families are at risk. So they're vulnerable to mental health challenges, to not having enough food on the table, to being isolated and alone...

Jasmine believed that being a mother was a time in life when a mother was more vulnerable. But for the mothers in the EHV she suggested that they also have added vulnerability due to other issues such as mental health and providing day to day necessities of life that may be hard for mothers to access due to economic challenges.

PHN Amber also believed the mothering time in life contributed to increased vulnerability and expressed her understanding in the following:

It's a very vulnerable time especially for somebody that has a lot going on in their background. Has had somewhat of a sorted past. And has a new baby. So they're vulnerable in that they'll tell you these intimate things. Many of them aren't even telling their friends.

Amber added another dimension to what she believed vulnerable meant in the lives of mothers and how they shared intimate things with a PHN and not their friends. This way of understanding the intimate experiences of the mothers supports the situated privileged position that PHNs find themselves in due to their professional position that gives them access to the lives and personal information of the mothers living within vulnerability. PHNs' situated privilege can also be linked to the complex institutional discourses that

construct individual subject positions such as those held by PHNs and mothers living within vulnerability. Nursing practices can be understood within larger institutional and professional practices where professional privilege has the potential to support emancipatory nursing practices (MacDonnell, 2014). Amber's position of privilege was institutionally constructed by the public health care system. The positioning gave Amber the opportunity to practice in a certain way. She was able to enact her beliefs and question what she saw and most importantly negotiate her practices with mothers through her relations of power with them. Amber had a certain power based upon her subject position and she chose how she used it and thus she was in a privileged position. Amber and other PHNs and CHVs said they felt privileged in their relation with mothers in their homes. She recognized her position of privilege and how it affected her relation of power with the mother.

Understanding privilege is critical in building a discourse that overcomes injustices (Martins). Most times a person of privilege does not easily recognize their own privilege. Often privilege is invisible to those who experience it and disadvantages those who do not experience it (Martins). For example a white heterosexual male does not worry about walking by himself at night or worrying about the color of his skin when he goes to a job interview. Ignoring privilege perpetuates oppression of those who understand the feelings of living outside of privilege (Martins). PHNs and CHVs in this study worked with mothers living within vulnerability who did not experience a privileged position due to the labels and stereotypes that were attached to them. CHVs and PHNs recognized their privileged position in their relations with mothers living

within vulnerability. This awareness contributed to how they practiced with mothers living within vulnerability and built relationships based upon a deeper understanding of privilege.

Mothers living within vulnerability were always described by the PHNs and CHVs in a similar way with reference made to the population of mothers as is evident in the next comprehensive description of what it meant to PHN Amber's practice:

I work with mainly vulnerable populations. So populations with challenges with financial challenges, mental health challenges, who have been involved in the past or present with Community Services in terms of Children's Aid Society, clients with issues with addictions. I work with a big newcomer population just because of the district in which I work. And there's a large newcomer population. So I work with people who don't have large support systems, people who may have come from a past history of domestic violence or abuse in their childhood, and any people who may have had recent traumatic events in their lives, whether it be a death of loved one or a separation from their partner or kind of unexpected traumatic birth or traumatic pregnancy or women who have delivered babies preterm unexpectedly. So lots of different factors which would screen someone into the EHV program.

CHVs also shared other examples of their experiences working with mothers living within vulnerability in their practices. Tory CHV shared what vulnerable meant to her and what she believed about her understanding of it prior to becoming a CHV in the next excerpt:

Just people that have a lot of stresses in their life, you know, and a lot of barriers maybe to be optimum parents. . . . When you take the job, you understand the program and the curriculum and what it's about but I don't think you necessarily understand how vulnerable some of these families are. So it's been kind of I guess a social eye-opener. And not that I came from a high place. I was born in public housing. My mom was a single parent with 4 kids. It's kind of. . . it's where I came from. But then seeing it again as an adult and seeing the issues and the problems that people face, it's a real eye opener.

Tory's example shows how she understood what vulnerable meant based upon her personal experiences and what she believed was the purpose of her job. Tory also believed and valued how her practice experiences opened her eyes to the social dimension of vulnerability when she began to understand and then realized that mothers living within vulnerability was much more than she thought initially.

For another CHV Jade, she believed that the EHV program:

Plays a crucial role with our young mom population. It plays I think a different kind of role with families that may come into the program who are not necessarily in the younger age bracket but may be in the more vulnerable population. So they may be more isolated. They may be more isolated due to transportation, immigration, isolated from a social perspective, so the program is helping to build capacity among that population.

In Jade's example, her beliefs about vulnerability related to whether the mother was young or older but she valued the role that EHV played to support mothers living

within vulnerability. She believed that the isolation experiences of older mothers contributed to their vulnerability.

It is evident that the understanding of mothers living within vulnerability was constructed through different discourses that emerged through the experiences and practices of PHNs and CHVs in this study. It meant slightly different things to both PHNs and CHVs as evidenced in the experiences they shared. For example, although many PHNs and CHVs agreed that mothering in general created a vulnerable time in a woman's life, the majority also spoke about the importance of understanding vulnerability in a different way. This is an example of how the meaning of vulnerability shifted and changed depending on the context. Discourse analysis encourages paying close attention to the meaning of language and how beliefs and values construct practices (Cheek, 1999).

There are multiple ways that vulnerability affects a person's life and one is the stigma that often gets attached to a person when they are labeled by society (Butler, 2015; Varcoe & Doane, 2005). Definitions of who are vulnerable can be connected back to institutions such as the World Health Organization and the policies they create to guide how to help those living within vulnerability worldwide (WHO, 2015).

A feminist interpretation of vulnerability adds another dimension to consider and that is the possibility of the societal infrastructures failing to support mothers living within vulnerability (Butler, 2015). In her analysis of vulnerability, Butler suggested that societal economic infrastructures create experiences for vulnerable populations that they cannot overcome on their own. However, the exposure to vulnerability ignites a

resistance from the most vulnerable to overcome it through their relations with others and support networks (Butler). Thus, PHNs and CHVs were positioned to work with mothers experiencing vulnerability therefore it is crucial that we understand how they understand vulnerability. The actions for PHNs and CHVs were guided by the EHV program however, as we will see in later chapters they also challenged every day program practices because of their understandings of vulnerability.

Up to this early point in the analysis, descriptions of the PHN's and CHV's perceptions of what they believed vulnerable meant for mothers revealed their two dominant ways of understanding. One way was connected to the mothers as a population and how society saw them and labeled them as vulnerable that then influenced the construction of a societal institutional support infrastructure in the form of EHV. The mothers were labeled as vulnerable for reasons that were previously described such as where they lived and having issues of mental health, inaccessibility to food and social isolation.

Vulnerable is clearly a health label within the practices of PHNs and CHVs where they tried to apply it respectfully. Yet vulnerable can also have different social meanings that carry stigma. The meaning of the word vulnerable seemed to be constructed within two different discourses that emerged in the practices and experiences of the PHNs and CHVs. One discourse was constructed through the meaning connected to being a mother living within vulnerability because she was poor, single or lived in the wrong neighbourhood. A second discourse emerged constructed by the institution of public health that defined vulnerability based upon the social determinants of health such

as education, age, gender and economics. The emerging discourses support the importance for PHNs and CHVs to understand what stigma and stereotypes mean in the lives of mothers living within vulnerability. This understanding helps PHNs and CHVs to uncover a deeper meaning of vulnerability in the lives of mothers and supports them to construct practices that best support mothers. The next example shows how the meaning of vulnerability pushed PHNs and CHVs to practice in a certain way.

Relationships were central to the way PHNs and CHVs supported families in EHV and are discussed in detail in the next chapter. However, prior to sharing the professional way they built relationships the PHNs and CHVs began with their first personal interactions with mothers in EHV. The beliefs and values of PHNs and CHVs created a certain meaning about what living within vulnerability meant to them. This meaning in turn guided how PHNs and CHVs built the initial relationships in their practices with mothers living within vulnerability. They seemed to practice by focusing on positive empowering relationships. Because of their beliefs that mothers were living within vulnerability due to difficult circumstances they practiced in ways that challenged the social discourse that brought with it a different meaning of stigma and judgement.

Some of their personal interactions illustrated the commitment the PHNs and CHVs had for the mothers and how the interactions made them feel personally. For example, Hope was a (CHV) who talked personally about how she valued supporting mothers through her home visiting practices because she believed it was a way for her to give back. Support was a specific kind of practice for Hope based upon her beliefs and values. The public health discourse she worked within as part of the EHV program and

how she understood the discourse of vulnerability in the lives of mothers constructed her practices. Hope believed that she “got as much out of providing support to other people (mothers) as they got in receiving that support.” Thankfulness from the mothers for how Hope shared support in her practices with them in their mothering journey with their new baby was valued by Hope. She talked about the excitement of the mothers wanting to share with her

...something that their child did based on, you know, information shared or an activity they did the week before...

This type of response from a mother to Hope’s certain way of practicing support was an important part of the beginning relationship that pushed Hope to do more for the mothers. She described in the next example how she felt after her early interactions with mothers in the following way

...caused this fantastic wonderful warm fuzzy feeling in me because I feel like, you know, I've been successful. I've helped them and been able to give back to somebody who needed the support as much as I did way back when I was having my kids...

Hope believed that the ‘warm fuzzy’ feeling validated her work with mothers and supported her continued push to challenge the social and health care discourse that constructed situations for mothers living within vulnerability to feel judged and stigmatized. In ‘giving back’ Hope was constructing a practice discourse based upon her understanding of what she believed worked best in supporting mothers living within vulnerability. The way Hope supported mothers was also based upon her beliefs and

values about what she believed was an important part of her beginning relationships within her practices of EHV with mothers living within vulnerability. Because of Hope's personal experiences as a young mother living within vulnerability who needed support she valued and took pride in her responsibility to help other mothers who were also living within vulnerability. Hope's commitment to how she practiced because of the responses from the mothers was also shared by other CHVs and PHNs who recognized that many of the mothers did not need to let them into their lives. More examples of how PHNs and CHVs in their EHV practices challenged the ways that social and health care discourse constructed situations of stigmatization and judgement for mothers living within vulnerability is discussed in a later chapter.

Star, a CHV, in the next example talked about how she personally valued being part of the mother's lives who lived within vulnerability.

...It's just like because I feel privileged that you're letting me in. And then to continue letting me in makes me feel good.

The privilege that Star talks about is related to her belief that the mothers do not need to let her into their lives or their homes. Instead the very welcoming into their homes was something that Star valued. While Star does not express explicitly the relation of power that exists between her and the mother, her feelings of privilege may be related to her knowledge of her role as a CHV and that a relation of power does exist as soon as she enters the home. In that way the welcoming in by the mother is a privilege for Star and not a right. This way of expressing privilege is different from being privileged to confidential and personal information about a mother that many professionals experience

as part of their role in the health care system (Tapp, 2000). Star's example of being privileged draws attention to the private space that mothers have in their homes to mother and the EHV program as a societal structure accesses this private space and in some ways makes it a public space when PHN or CHV accesses their personal space. In this study EHV is a program that was constructed by a societal institution that constructed the practices of PHNs and CHVs to include home visiting. PHN's and CHV's positions of privilege were institutionally constructed by the Public Health Care System because of their role that allowed them to access the private spaces of mothers living within vulnerability. The position of privilege gave PHNs and CHVs the power to practice in a certain way. Star had a certain position of privilege based upon her subject position and she chose how to use it when she entered a mother's home. .

While each PHN and CHV described their personal relationship experiences using different words their emotion and genuine caring about the mothers and the interactions emerged. This current study represents both CHV's and PHN's experiences where similar responses occurred when they included a friendly approach in their interactions with mothers.

Two PHNs also described how they cared about their practices and how they valued the responses from mothers and how it made them feel. Pearl, a PHN said

...I mean it makes you feel pretty good when you have a good relationship with a client...

Jasmine a PHN also shared her personal feelings

I care you know. And I care a lot about the moms that I'm working with...

The previous examples from 2 CHVs and the 2 PHNs represent a type of relationship that all of them valued with the mothers. Aston et al. (2015) in their study on *The Power of Relationships* discussed how the concept of a PHN being a friend came up in their study with 16 PHNs who did postpartum visits. In addition to the idea that a PHN was sometimes seen to be friendly they were also viewed by the mothers as a professional who might judge them and who had power (Aston et al.). With the idea of power being part of the friendly relationships the friendly nature of the beginning relationship was part of the negotiation of power between the CHVs, PHNs and the mothers. Thus understanding the meaning of friendly in the relationships that CHVs and PHNs participated in was a way to negotiate their practice in a non-judgemental way with mothers who were often judged by society (Varcoe & Doane, 2007). The PHNs and CHVs in this study valued their beginning friendly relation with the mothers as they shared in the examples. The idea that being friendly was an effective way to promote positive relations between PHNs and mothers was presented as a type of practice based upon PHNs and CHVs' beliefs and values of mothers living within vulnerability. This practice approach created another way of interacting compared to a detached hierarchical, expert driven approach of relating with mothers (Aston et al.). Being friendly in relationships challenges a dominant social institutional view of friendly that has been understood as a soft or negative way to negotiate a relation in home visiting practices (Aston et al.). Thus to understand the personal, social and institutional experiences of PHNs and CHVs in EHV, FPS provided a lens and a way to analyze their discourse that

represented the idea of friendly as an approach that could facilitate positive interactions between PHNs and CHVs during their first personal experiences with mothers.

Summary

In this sub theme how PHNs and CHVs understood the concept of vulnerability and more specifically their beliefs and values about mothers living within vulnerability were examined. Interestingly, all of the PHNs and CHVs began their conversations with me by talking about the meaning of vulnerability within their practice. Their beliefs and values clearly informed their practices with the mothers living within vulnerability in very specific ways that included concerted efforts that avoided being judgemental, actions that were friendly. PHNs and CHVs were aware of the social discourses that constructed mothers living within vulnerability to be judged and stigmatized and attempted to shift the meaning of vulnerability and shift power relations through their practices. They were also practicing within a health discourse that had constructed the meaning of vulnerability to be a helpful construct that screened certain mothers into the EHV program.

Building personal power with mothers living within vulnerability

Most of the PHNs and CHVs believed in the potential personal power that mothers living within vulnerability had to believe in themselves despite the stigma and labeling they experienced as mothers living within vulnerability. In this sub theme how PHNs and CHVs, through their EHV practices, encouraged mothers to explore their personal power and construct new meanings in their lives are explored.

Examples of how PHNs and CHVs understood what it meant to be a mother living within vulnerability were previously presented. There was a concern among the PHNs and CHVs that the mothers were labeled because of their vulnerability through socially constructed discourses and this affected how they built relationships in their practices and gained trust very slowly in the beginning with the mothers. One CHV Jade described how living within vulnerability affected mothers and families to feel stigmatized in the following example:

They developed their life skills in terms of caring for themselves. They were on income assistance. They were completely isolated from any community activity. They would not access a food bank because of their own stigma and embarrassment. They would not come to the Family Resource Center at all....they were very aware of talk outside of their home about them as a family...with my support they started participating in parent child programs

The majority of CHVs and PHNs shared examples of how they supported the mothers to challenge oppressive relations in their lives. They recognized that there were expectations on them as to how they should work with mothers in EHV due to the institutional program they represented and the authority connected to their role as a PHN or a CHV. “The correct or accepted ways of acting and being in society as a mother represents the views of those in authority who have the power to enable how mothers are to be” (Cheek, 1999 p. 41). Thus there were expectations connected to the institutional authority of the EHV program and by extension the authority of the PHNs and CHVs. A relation of power existed between the PHNs, CHVs, the EHV program and the mothers.

PHNs and CHVs recognized their authority and created ways of negotiating this relation of power in non-hierarchical ways through how they worked with mothers living within vulnerability.

The following examples from CHVs and PHNS show how in their practices they worked with mothers to challenge oppressive relations in their lives through building the personal agency with mothers to make changes in their lives. The first example from CHV Sara focused on helping a mother to take a bus and enhance her accessibility to services beyond home visits. CHV Sara shared how she believed many mothers were uncomfortable taking the bus because of the following:

...it's like a status thing...that they don't want to have to take public transportation...

...so it's just anxiety about getting on the bus... and it doesn't help the moms that the bus drivers don't help them with their stroller and there isn't a place to put the stroller on the bus...

...She doesn't see how it is physically possible for her to get on the bus with 3 small children, and to be able to control them

Sara was excited to share her example of riding the bus as it represented an example of how social stigma deterred mothers from taking the bus with young children and how this experience created a tension for mothers in their day to day lives as it limited access to resources. Through supporting the mother to take the bus Sara demonstrated her belief in the mother that she had the personal power to challenge a hierarchical relation of power she had had initially with the transit system. Beliefs shared

by PHNs and CHVs about their roles in promoting mothers' personal power included the following descriptions:

PHN Amber shared her beliefs in the following example:

But now our successes are more in terms of seeing the client emerge as a confident kind of expert in their own life

Amber's words represent her belief in attempting to shift the negative hierarchical relations between herself and the mothers so that the focus was on creating an encouraging relation where the mother was the expert in her own life about her situation. For Amber when she facilitated empowerment with mothers in this way she believed she had been successful in her practices.

PHN Aggie described that she valued

...encouraging them (mothers) and supporting them through stepping outside their comfort zone to grow...

Aggie like Amber valued the growth in the mothers to be able to find their personal agency to change their lives and grow so that they could move away from the EHV program.

CHV Grace shared how she believed when the mothers moved on from EHV it was an example of empowerment in action in the lives of the mothers. Grace believed that it was important for families to be independent because when Grace moved on from her home visiting relationship with families she didn't intend to keep in touch with the families. Often after three years of being part of home visiting with the CHVs the families didn't want them to leave and they often said to Grace "What am I going to do?"

Grace's response had been that she would always be there for them and "If you ever have a question, if you ever have something come up, give me a call. You have my number." ... I just kind of put it out to them... and they do kind of come back and call." Grace believed that getting to this point in her relationship with a mother where she felt empowered to be on her own was her goal as a home visitor. Once again like the previous CHV and PHN examples, supporting the development of personal agency in the mothers so that they felt empowered to negotiate their life without a visitor was a goal of the majority of CHVs and PHNs and was represented in the practice examples and beliefs and values they shared.

The PHNs and CHVs attended to the hierarchical relation of power between themselves and the mothers in a variety of different ways in their practices to support the empowerment of the mothers. Sara's ability to take the bus was just one example of how a PHN was able to work with a mother to challenge the fear and stigma that Sara had felt about riding the bus. All of the practice examples from the PHNs and CHVs represent their compassion for supporting mothers to create their own changes in their lives through discovering the agency they have within themselves and working through the relations of power they had with a PHN or CHV within the EHV relationship practices. Understanding the personal, social and institutional experiences of PHNs and CHVs working in the EHV program uncovered similar beliefs among both the PHNs and CHVs. In their roles in EHV both the PHNs and CHNs subject position was to facilitate the personal power of the mothers to move on from the EHV program. However, the subject positions of both the PHN and the CHV was influenced by the authority they each had as

part of their role and how they interpreted this authority when making decisions about how to encourage mothers in certain ways in their practices.

All of the PHNs and CHVS shared examples from their practice of how they focused on assisting mothers to build personal power. Power within an FPS lens provides a way to see the dynamic, reciprocal nature of the relations between people and how context also influences the relation (Aston et al., 2011). Personal, social and institutional beliefs and practices inform how a person feels, thinks and responds to power (Foucault, 1982). Power structures relations between subjects and Weedon (1987) believed that power is a relation. Within nursing and medical practices health professionals have a position of power that is socially constructed through their position as an expert and their relation with a client (mother) as a novice. Nurses are known for facilitating empowering relations with clients by focusing on the client's expert knowledge in health situations (Aston et al.).

Summary

PHNs and CHVs in this study were aware of the existing hierarchical relations of power in their practices with mothers living within vulnerability and this created moments of tension. For example, the bus example with Sara showed a mother's power to express her beliefs through avoiding bus travel. The mother was aware of the situation and she demonstrated her power in the relationship to express her beliefs by avoiding the bus. However, Sara in her role as a CHV believed using the bus would open up more support for the mother and she negotiated the relation of power with the mother by challenging her to see the possibility of taking the bus and actively supporting her to try.

This approach used by Sara also supports Foucault's belief in people's agency to create change in their lives so that they are making decisions about how they want to live.

Sara's belief in the mother supported the mother to find her personal agency that pushed her to take the bus and move beyond her beliefs that were connected to her fears of being stigmatized by the bus travel. Foucault (1972b) was very concerned with how accepted societal knowledge creation is related to power and he suggested that people's understanding of their personal self or subject position, is created by people's interpretation of the institutional discourses that they work within in their daily lives.

Examining the way relationships are established between PHNs, CHVs and mothers living within vulnerability provides a new way of understanding how to construct practices that best support mothers living within vulnerability. The example about PHN Sara choosing to help a mother with taking a bus was a non-traditional practice. This practice was based upon Sara's beliefs about how she could best support the mother in a certain way given her experiences of feeling judged in the past around bus experiences.

Program changes affect vulnerability

In this sub theme CHVs and PHNs described their understanding of how their practices with mothers living within vulnerability were influenced by institutional/organizational changes. Previously in this chapter evidence was presented from all of the PHNs and CHVs about what they believed vulnerable meant to them and how they experienced it in their practices. The next example from PHN Opal reinforced how she believed vulnerability defined the EHV program provincially:

...I mean, you know, provincially I think the EHV program really was set for what I would classify as the more vulnerable client and, you know, clients that had particular needs that the curriculum that the EHV program was based on, Great Kids Inc., that curriculum could support the client in becoming the very best parent that they could be....

Opal's words further support her belief that vulnerability guided the choice of program that was selected and how it fit as the best support for a mother living within vulnerability. The quotation also demonstrates Opal's valuing of the fit and how programming was a big part of organizing how mothers living within vulnerability were supported in the EHV to become the best parent. Further analysis of Opal's beliefs uncovers the institutional presence in affecting how vulnerability was addressed in NS through what programs were chosen to direct the EHV practices of PHNs and CHVs. As a result of programing decisions that were made by the health institution of public health, PHNs and CHVs were expected to support vulnerability in their practices guided by a chosen program. This directed way of practicing within vulnerability and with a certain program created a relation of power where PHNs and CHVs were expected to identify mothers as vulnerable because that is who accessed the program. This way of understanding the power that vulnerability had in creating a relationship between the PHNs, CHVs and mothers supports a relation of power that was created between the institutional program of EHV, the practitioners and mothers. The relation of power was one where the institution because of its position within a hierarchical structure influenced decisions about programing and a binary relation of power was created between the

public health care institutional decision makers and the PHNs or CHVs. While programs do not have power over people, according to Foucault (1972b) institutional beliefs and practices make up a discourse that creates multiple moments in practices like EHV where relations of power may be hierarchical, oppressive, empowering or disempowering. Over time people had developed certain words, meanings, practices and beliefs that had been socially constructed and they were brought to the program. When changes occurred in how EHV was offered in NS, evidence emerged in this study's data analysis that there were tensions experienced by PHNS and CHVs due to how they believed the changes affected their practices. A further description of these program changes, and tensions are provided by PHNs and CHVs in the next section.

Two changes occurred that the majority of participants talked about. One change involved the elimination of the coordinator position for the EHV program. The person in this role had facilitated the communication between the PHNs and the CHVs as well as communicated with managers in Public Health and family resource centre supervisors. The other change was phasing out the universal 'Early' home visiting program and expand the targeted Enhance Home Visiting program.

CHV Hope discusses the latter in the following quote:

...Public health used to have an Enhanced Home Visiting team and an Early Team. And so now the 2 have been combined. So there's no specific Early Team where they deal with anybody who's not Enhanced Home Visiting kind of screened families. So those families, the early team families are the families who are less vulnerable. So there's less observable barriers for these folks to kind of

get through to be able to parent well... So I haven't really had a chance to meet any of those nurses who have been doing that work. So I don't know how they work. If they would work the same, if they would work different, if there are things that, you know, might benefit them to know about ... more vulnerable populations...

This CHV described how the two changes (loss of a coordinator and moving to only an EHV program) affected her but she seemed worried about how the new incoming PHNs who had not worked with mothers categorized as vulnerable would work in the program and what they knew about vulnerable populations. As a result of the second change, all PHNs would now work with mothers living within vulnerability and CHVs were expected to collaborate with up to 6 PHNs rather than continuing in an established relationship with 1 or 2 PHNs. As the organizational structure changed, tensions emerged for both PHNs and CHVs. From a practice point of view they were all concerned about lack of communication between PHNs and CHVs. This lack of communication in turn affected information exchange about clients and support for CHVs from PHNs. They were also concerned about the way the two changes were implemented. All PHNs and CHVs felt they were not consulted or included in any decisions related to the program changes that they believed significantly affected their practice with each other and in turn with the mothers.

The following examples represent the main tensions experienced by both the PHNs and CHVs when two program changes (loss of a coordinator and moving to only

one EHV program) were made in the organization: CHV Tory described the ‘secrecy’ she believed went on within the organization around programs in the following:

...we never really quite know what’s going on. Public health seems to have like this secrecy around it. Like it’s always kind of there’s something in the works and nobody really knows what it is...

Sara CHV shared her belief in the following example

the higher up people in Public Health, you know, that’s kind of where they’ve shifted kind of all of their focus and their energy, right, is that, you know, higher risk population

CHV Jade described how she felt when the coordinator position was eliminated by saying:

...we had a nurse who coordinated the healthy Beginnings program...I very much appreciated her support. I felt more connected to the whole program. So that support from Public health is gone...

PHN Pearl described her disappointment in the loss of the coordinator who helped her in her practice in the following way:

...I think that’s where we fall down on both ends from the EHV perspectives. The clients will transition over to the community home visitor, and then there’s really no formal structure in terms of how communication happens between the PHN and the CHV...

Pearl valued her relationship with the CHV and she believed that the public health care system changes affected her ability to communicate effectively. It was different from the

way she had communicated before the change. Also, Pearl expressed “fall down” as her belief that with the loss of the coordinator ‘we’ as in EHV could not effectively do the work the way it had been done before the program change. Hierarchies can be good and non-oppressive. For example the EHV coordinator provided a structure within EHV that coordinated and connected all parts of the practices of both PHNs and CHVs. There was a relation of power that occurred between the coordinator and the PHNs and CHVs. All of the evidence in this study provided by practice examples clearly demonstrated a positive relation of power where all PHNs and CHVs felt supported by this role. Another example from PHN Opal represents her experiences with the changes in the following:

...I feel that there’s a big disconnect because...and that ends up completely out of our hands, and that has been said district wide. I am not in chargeSo there is that disconnect...

Opal’s above example like Pearl reinforces her feeling that she had no control over what happened in EHV as a result of the program change and it left her feeling disconnected and not in charge. The hierarchical relation of power that Opal experienced where decisions were made about program delivery of EHV outside of her involvement positioned her in such a way as to create feelings of exclusion. Because of her subject position as a PHN she experienced the relation of power as ‘not being in charge’. There were other decision makers within public health who were positioned hierarchically in relation to Opal. Therefore, Opal was not invited to the decision making table. She was

part of the relation of power but not in the way that she wanted to be with the decision makers. She felt left out and expressed this in the following way 'I am not in charge'.

CHV Hope believed that it was difficult to navigate the organization and her practices because of

...several layers of challenge that go on with the EHV thing as a whole...all the organizational stuff....

Hope was referring to the program change to only an EHV program where all PHNs and CHVs worked in the one program. She went on to describe in detail in the next quote how she believed the change in the organizational structure affected her practices.

So things could be a little bit different because I might not be as likely to pick up the phone and call a nurse whose name I've never seen before, who I don't really know. I don't know their work style, that kind of thing

CHV Hope is referring to her belief that the change to one EHV program affected how she worked with PHNs. Hope valued the trusting relationship she had with PHNs prior to the program change and she valued how she knew them and how they practiced. The way she was supported by PHNs meant her practices were also supported. With the program change Hope was forced to work with new PHNs and she didn't know how they practiced and whether she could call them for support. Hope was left with unanswered questions about how she could work with these new PHNs with whom she had not established a relationship. New relations of power with the new PHNs were created for Hope as a result of the program change. Hope was unaware of what her position was in the relation and that created a tension for her in her practices due to her unknown position

in the relation of power with new PHNs. Hope's feelings were shared by most of the CHVs who had established relationships with PHNs and called them for support. For example if Hope had a challenge around how to support a breast feeding mother she picked up the phone and called a PHN with her questions. Or if CHVs were not sure about a resource for a mother they could pick up the phone and say to the PHN that they worked closely with:

You know, I thought about this resource to share with this mom but do you know of any other ones?

CHV Hope valued her working relationship with the same PHNs as part of her EHV program. With the public health care system institutional program change to only a targeted Enhanced Home Visiting all PHNs were added to the EHV program after the elimination of the universal early home visiting program. The change in the program came from the public health care system decision makers. Beliefs and practices about how PHNs and CHVs would work together inter professionally came from the public health care institution decision makers. CHVs and PHNs disagreed with the top down decision and this shift in their practices because their beliefs about how to practice together was different than what the decision makers put in place. The CHVs and PHNs beliefs and values were not considered in the decision making instead they were told what was expected of them. . This created a binary relation of power because the power was directed one way from the top down. Hope was left with questions about how she would re-negotiate her practices with the new PHNs that joined the targeted EHV program from the universal program called Early Home Visiting.

The institutional discourses that represented the changed public health care system program had been constructed by the authority or ‘higher ups’ as CHV Sara called them. Beliefs and practices within the structure regulated how services and programs for mothers living within vulnerability would offer support in the new structure through new home visiting practices. Certain practices were developed by the public health care system decision makers and within the dominant discourses of the system. The new practices that resulted from the change in the organization might have made Hope and the other home visitors feel that they had no control because of new rules, regulations and expectations. This lack of control was evident in the previously described tensions where PHN Opal felt excluded from contributing to decision making around EHV program changes. A lack of inclusion in decision making reflected Opal’s subject position and her role within a relation of power and how she seemed to have no control over the decision outcome. She was oppressed by how the relation of power between her and the hierarchical decision makers created a lack of opportunity for her input. However, Opal’s willingness to share this experience in the study interview demonstrated the power she had to share what she believed happened and this exposed how decisions were made about the way the EHV program was re structured. Her sharing demonstrated her resistance, courage and personal agency to influence another way of understanding the relation of power she experienced as a result of the institutional change. When considering this other way of interpreting Opal’s story, her lack of control in decision making pushed her to resist the secrecy surrounding the change by making visible the institutional practice decisions through sharing her story. Many of the PHNs and CHVs

raised concerns about the secrecy around program decisions, shifting the entire program focus to vulnerable or at risk populations, losing a formal communication structure between PHNs and CHVs, feeling disconnected in their practice, and unsure of what it would be like working with new colleagues.

All of the above examples from both PHNs and CHVs suggest that they did not believe that they had the agency to challenge the power of the 'structure' or 'program' that represented the organizational decision making power surrounding their practices. However, their expression of disappointment and frustration with the hierarchical power structure within their organization that made the change demonstrates their agency to react to the changes and challenge why these changes were made without their involvement at some level of the hierarchy within the organization. There is a clear hierarchical structure within the organization that controlled what the PHNs and CHVs knew about the organizational changes. A hierarchical relation of power is represented in the example from CHVs and PHNs. For example, Tory refers to the 'secrecy' that created a subject position for her of unknowing and a lack of power in her role to access information from the organizational structure that was controlling the flow of information to her about program changes. The words 'secrecy', 'lack of support' and 'feelings of disconnect' 'the higher ups' and 'completely out of our hands' also represents a relation of power between two different discourses within the EHV program that led to a feeling of devaluing by the PHNs and CHVs when they were not told about the changes in their practices. The hierarchical structure of the organization regulated the way decisions were made and because of the type of authority given to managers PHNs and CHVs were

positioned to negotiate relations of power in particular ways. Attempts made to have their voices heard or at least try to find out what was going on did not allow them to access certain types of information about program changes until after decisions were made. This approach to change in the organization was questioned by the PHNs and CHVs.

Summary

This sub theme demonstrated the importance of organizations considering how program changes are made and who is involved with decisions. The PHNs and CHVs shared many examples of how secret organizational decisions affected support for their practices and mothers living within vulnerability after the changes. Organizations need to consider the impact of their decisions when changing a support that was valued by practitioners like PHNs and CHVs and how to include them in institutional/organizational change decisions.

While it may appear that the PHNs and the CHVs had no power in their relationship with the organization and the decisions that were made, PHNs like Opal and Pearl and CHVs like Hope and Jade positioned themselves in a relation of power with the organization when they questioned how the institution was making decisions. All of the examples from the PHNs and the CHVs represent the agency they had within themselves to resist the organizations power through challenging what the organization had changed in the program and how it affected their practices with mothers living within vulnerability.

Conclusion

The experiences and practices of building relationships with mothers living within vulnerability was the main theme in this chapter. Three sub themes emerged in the analysis and included: 1). the relationship begins with a focus on vulnerability 2). Building personal power in mothers living within vulnerability 3). Program changes affect vulnerability.

The main findings discussed in this chapter focused on 1). The complex and different ways of understanding vulnerability in the lives of mothers who participated in the EHV program. PHNs and EHV's believed that understanding exactly what vulnerability meant in the lives of mothers was an essential starting point of their relationship in EHV and provided a foundation for building other practice strategies for working with mothers living within vulnerability. 2). Building personal power in mothers living within vulnerability occurred in the EHV practices through the way PHNs and CHVs facilitated empowering relations with mothers by focusing on the client's expert knowledge on what was best for them in their unique life situations. 3). Program change created tensions for PHNs and CHVs because it affected how they supported mothers living within vulnerability Based upon the experiences shared by the PHNs and CHVs, organizations and institutions can learn from the dramatic negative effects of making program changes in isolation from front line workers has on practices. A lesson for future organizations is present in the findings related to how implementing a program change may go smoother if the primary deliverers of the program feel included in the change decisions.

In this chapter the personal experiences of PHNs and CHVs were examined as their relationships in EHV changed due to program restructuring influenced by decisions within the public health care system. Relations of power and tensions were uncovered when program changes that support mothers living within vulnerability were implemented. Weedon (1993) suggests that the most powerful discourses are based in institutions. The many examples presented in this chapter demonstrate how relations of power are constructed through social and institutional beliefs, practices, language, words, meaning and ultimately experienced between practitioners such as CHVs, PHNs and managers. The PHN's and CHV's shared their experiences of how they were situated within the institutional discourse of the public health care system and how their relationships within the EHV program became accepted as a practice norm for them in EHV with mothers experiencing vulnerability.

A focus group was held with PHNs and CHVs where the study's preliminary findings were shared for validation with the participants. The focus group findings validated many of the same findings that emerged in the FPS analysis of the study data. For example, both PHNs and CHVs shared that the organizational change affected their practices as there was lack of clarity of what their new roles would be within the new program changes of moving to one targeted home visiting program. Also the PHNs and CHVs shared how they believed that the managers did not understand their practices as represented in the following example from one focus group participant "But I think managerially, they understand the structure of what you do but I don't think they understand the physicality of going into someone's home...the level of intimacy that a

home visitor develops.” This quote was shared in response to the feelings the participants had over the changes that were made without their input and their belief that the PHNs and CHVs had about the managers not understanding their practices and not including them in discussions about possible program changes before they were implemented. They also shared that they believed that the managers did not trust the PHNs and that also led to the secrecy surrounding decisions within the organization.

Governmentality is a concept that can help to uncover a deeper understanding of the social and institutional construction of societal practices (Cheek, 1999). Through examining power and knowledge construction in society by government programs, the way people’s beliefs and understanding of themselves as citizens is uncovered (Cheek; Foucault, 1972b). The relation of power related to governmentality is often subtle and hidden from citizens. In other words people are the subject and object of the government’s power. In this study mothers living within vulnerability were the subject of government decisions. They most likely had no idea what changes were happening within the EHV program and how the changes might affect them personally. Governmentality helps us to understand the hierarchical relation of power created between citizens and the government where citizens may not be aware of how the government’s institutional discourses are silently creating their day-to-day experiences as is the case with mothers in this study. Governmentality provides another lens to understand the government institutions and how their discourses socially construct a program and the related practices of EHV and ultimately mothers living within vulnerability.

Chapter 6: Communication in EHV Practices within Vulnerability

“...finding that little strength in the haystack...”

This chapter is about how communication practices were experienced by PHNs and CHVs within the EHV program with each other, managers and mothers/families. All of the PHNs and CHVs shared the type of communication practices they believed supported their EHV practices with mothers living within vulnerability. Communication practices were experienced both formally and informally. Both positive and negative experiences were shared.

Four sub themes emerged from the analysis of the PHNs and CHVs' communication stories 1) Reflective practice needs supportive communication 2) Behind the Scenes: formal and informal communication and 3) Building relationships through strengths based communication 4) Negotiating transitions of mothers/families from PHNs to CHVs.

Reflective practice needs supportive communication

All of the PHNs and CHVs spoke about the importance of reflecting with peers and or supervisors as part of their EHV practices. PHNs and CHVs spoke about the importance of reflecting on their daily or weekly home visiting practices that involved speaking directly with either a supervisor or colleague. This type of communication was a valued practice as it was a way for both PHNs and CHVs to have someone else listen to their experiences as they spent most of their practice time by themselves working in isolation with mothers living within vulnerability.

Some differences emerged between the way PHNs and CHVs experienced reflective practice. PHNs mainly talked about sharing their home visiting experiences with another colleague and there was no description of being required to reflect with a supervisor. CHVs talked about how they were required to meet with their supervisor at the Family Resource Center weekly where they reflected with their supervisor what they had experienced in their home visiting practices. It was a time for the supervisor to hear about the experiences and to supervise the CHV.

The following example represents how CHV Sara personally valued being supported through reflective communication with her supervisor and the PHN who was the coordinator of the EHV program. She believed that this way of communicating with her supervisor was a way of support for her and her practices.

Having one consistent coordinator that we could all go to, so someone that, you know, if I go to my supervisor who's there, you know, and she doesn't know how to support me, she can go to that one coordinator and get the support that she needs in order to be able to in turn give me the support and vice versa. That I can go to that person. So I guess that's what I valued the most.

Sara believed in and valued the interaction with her supervisor. As a CHV Sara was expected to meet with her supervisor weekly to share what she had done in her home visiting practices. Her supervisor's role was one of supervision of Sara's work indicating a hierarchical relation between Sara as a CHV in her role and her supervisor in her role. We can see how they negotiated power in a positive way. Sara was subjectively positioned in relation to her supervisor to 'report' to her, debrief and tell her how things

were going. Sara described this hierarchical relation as a positive experience. We can see that this particular negotiation of power was beneficial for both parties and it appears that Sara felt empowered and supported in her role as a CHV. Instead she valued her relation of power with her supervisor as a way of supporting her in her practices.

Sara also referred to another layer of power within the institution of public health that was represented by the EHV coordinator who was a PHN and worked for Public Health. The way Sara described her communication interactions shows that she and her supervisor had a different relationship with the coordinator and ultimately a different way of negotiating power. The PHN in this role worked for Public Health but she was not part of the Family Resource Center. Sara valued the coordinator position that she had experienced in her practice. She believed that everyone (PHNs and CHVs) communicating with one EHV co-ordinator was a positive thing. Sara believed in this as it resulted in everyone being able to support each other through sharing with one consistent support and that being the coordinator. Sara felt supported by the coordinator and described how she shared a non-hierarchical relation of power with the coordinator. She believed that the majority of CHVs and PHNs also experienced a positive and non-hierarchical relationship with the coordinator.

With the change in the program the relation of power changed and less support for each other resulted since there was no one to coordinate the relation of power among all who are involved with EHV. The PHNs and CHVs valued and believed the relation of power they had with the coordinator was a support that they respected and valued in their EHV practices. However, given the elimination of the position it appears that the relation

of power between the public health care system institution and the coordinator was hierarchical and it was not valued in the same way as it was by PHNs and CHVs.

Most of the participants shared examples of reflection as a type of communication they valued with peers, managers or supervisors. The PHNs and CHVs described similar and different roles of reflection in their practices. The following examples represent what other CHVs believed and valued about reflection in their practice. CHV Alexandria shared how reflection was part of communication in her practice in the following:

And even to have that space with a supervisor to just have kind of a non-judgemental debrief...sometimes you come out of a visit and you're like you're so overwhelmed...so she understands what home visiting is like...

CHV Tory valued how reflection with her supervisor was a way of communicating that supported her in her practice in the following way:

...breaking it down with your supervisor and going through it...being able to process it...you have to talk about things to process it...sometimes you just need to say it and put it in its place...

PHNs have a different scope of practice connected to their role where they are able to make decisions about their practice independently and they described reflection in a different way from CHVs. PHN Jasmine described her beliefs about reflection in her practice and in CHV's practices in the following description. The first quote represents what Jasmine valued and the second quote represents how Jasmine understood how reflection happened in CHVs practices.

...the need for self-reflection and being able to go back and have someone that you are able to have that conversation with...I know who my people are that I can go to and I would have a conversation with...

It is supposed to be scheduled...they're supposed to have regular supervision once a week and that opportunity to have that relationship...

PHN Aggie also described a collaborative way that she experienced reflection in her practice in the following example:

My managers, coordinator and practice lead, they're all really important to me. To feel supported, to feel they believe in me, sometimes affirmation helps as well. Like I show something and, you know, we can kind of celebrate some of those success stories. Having someone you can share things with because they're part of your team...I see the whole team approach as being really important...

While PHN Aggie reflected with her supervisor she did not describe a hierarchical relationship where her managers were supervising her, instead she used words like 'affirmation' 'team' 'celebrate successes' 'someone you can share with' that was a different tone from the CHVs who used the word 'supervisor' consistently and their use of the word supervisor represented the responsibility they had to their supervisor as their scope of practice did not allow them to make the same independent decisions like PHNs. The relation of power between the PHN and the person they reflected with seemed equal and represented more a sharing of information. CHVs were expected to discuss their practice with their supervisor weekly. In the practices of CHVs, reflection was regulated by the dominant health institutional discourse represented by the supervisor at the Family

Resource Centre. An obvious hierarchical relation of power between the CHV and their supervisor was established as an expectation from the institution regarding how the practices of the CHVs should be monitored. Foucault (1980) would suggest that the dominant societal structure that created reflection in the communication practices of CHVs also regulated how it was experienced by CHVs during their weekly reflections. While the CHVs described reflection as part of their communication practices differently from PHNs, they believed that they benefitted from the reflection in similar ways to PHNs.

CHVs like Tory described reflection in a different way as they were required to reflect with their supervisor weekly and report what they did in their EHV practice. This approach to reflection, while appreciated by CHVs created a hierarchy that then led to participants experiencing a relation of power in particular ways and ultimately an expectation of how reflection happened in their practice that was different from expectations of PHNs. A hierarchical structure surrounded CHVs where they were expected to reflect with their supervisor. PHNs were not required to reflect with a supervisor. They chose to reflect with peers.

Summary

The importance of reflection in EHV practice was an expressed need for CHVs and PHNs. They believed they needed someone to talk to about the positive and negative experiences in a confidential way with someone who understood their practices. CHVs and PHNs worked with vulnerable families daily and they experienced some difficult situations by themselves in isolation from other colleagues. CHVs and PHNs believed

and valued the input from their supervisor, coordinator or peer. As one CHV stated earlier in the study, she had no idea how mothers living within vulnerability would be until she started working with them. Reflection provided PHNs and CHVs with a way to talk about their experiences with vulnerability and consider how they practiced and learned from another other ways that they could work mothers living within vulnerability. Given the independent way that CHVs and PHNs worked in EHV, reflection provided a link with others who were working in the program. Losing this in their practice put more burden on them to re-negotiate a way to continue reflecting with someone and in some cases with no one.

Behind the Scenes: Formal and informal communication

In this sub theme CHVs and PHNs expressed other ways they communicated in their practices that were different from reflection. Considered one of the most important aspects of practice for all nurses historically, studying communication is a foundational part of the majority of nursing curriculum worldwide. Similar philosophies create the best ways to communicate with clients (individuals, communities, families) based upon models that have been developed from practice and research evidence (Aston et al., 2011; Wright & Leahy, 2013).

CHV Sara shared her personal feelings and beliefs about communication generally in her practice and expressed her belief that she had ‘valuable information’ to share with her supervisor in their weekly supervision meetings at the family resource center. Sara valued having input into conversations with her supervisor where she felt that she was being acknowledged for what she could offer to the conversation. In the

following example Sara described how she believed communication was experienced in her practice with PHNs and her supervisor or other persons with authority in her practice and what it meant to her personally.

I don't know, like I mean I think that it wouldn't even have to be like a one-on-one situation. You know, like even in like a group setting as like all of home visitors. Like you know, this is what we're thinking. What do you think of that, kind of thing? Or you know, this is a tool that we're going to use to try to assess families. Can you look at it and see if it's something that... I mean we're the people that work with these moms, day in and day out. If I don't think she's going to answer the question, she's not going to answer the question. And I'm not being cocky or anything like that but it's the way that it is. So I mean we do have a lot of really valuable information that they could use, to learn which way or which direction they should go.

Sara expressed how she felt she wasn't being heard within the hierarchical structure of the EHV program. There seemed to be more than just wanting to be valued in Sara's previous description. She seemed to believe that there was a hierarchy when she said "we do have a lot of really valuable information that they could use..." Sara's tone seemed a bit defensive when she said "I'm not being cocky..." yet she was clearly concerned that she and other CHVs, the people "doing the work", were not being heard and their value to the conversations was hidden. She clearly had identified a moment of tension within the relationship between PHNs, supervisors, others in authority and CHVs.

Sara did not believe that she was invited to participate in important conversations that affected her practices and this created a hierarchical relation of power between herself and decision makers. How she chose to negotiate this relation of power with others was through sharing information with people like PHNs and her supervisor who she saw as experts. Sara challenged the imbalance of power, or the dismissal of her knowledge by indicating that PHNs and supervisors might have a lack of knowledge that she and other CHVs could add to because they (CHVs) were the ones who were primarily working with the mothers. She was challenging the everyday practices that were socially accepted that seemingly positioned her supervisor to have more power and authority whereby the voices of CHVs were not always included. This appeared to have been partially created structurally through the removal of a coordinator and loss of team meetings. CHVs felt heard when they had a coordinator. The obvious hierarchy between CHVs and PHNs or supervisors created a situation for the majority of CHVs to feel excluded and not valued.

The process of communication can be formal or informal. Informal might bring into play socially assumed hierarchies between those who have more or less education and status. The hierarchy that Sara described seems to be collegial where there was ongoing supportive negotiating between CHVs and PHNs who worked within the EHV program.

In Sara's next example she suggested ways to facilitate improved communication among all regardless of their position in the hierarchical structure that she describes as "top to bottom".

And then to have really strong communication between everyone, like from top to bottom within the whole program. So manager, PHNs, supervisors here, executive director, kind of us as home visitors. So that we actually felt like we were a team... So I think that's kind of the most important thing, so team building things. So training where the nurses were in the same training as the home visitors, and the managers were usually the ones that were putting the training on... where we all learn together as a group and kind of to help to build that one-on-one relationship with the different people within the organization. You know, that's all kind of gone away. That's not important anymore or a priority maybe. I don't know what the right word is. But I think that we're really missing that.

Sara was talking about the non-hierarchical relation of power she had experienced among all involved with the EHV program prior to program changes. Sara valued a relation of power where there was a shared power relation and she believed this approach to a relation of power promoted team building and shared learning. Also, through this nonhierarchical relation with others she believed that her subject position was not seen as less than anyone else in the EHV program. Instead Sara believed this way of relating built positive relationships within the organization and that was seen as a positive experience for Sara. CHV Sara clearly stated that she did not feel that they were a team anymore as a result of losing their coordinator and moving to only an EHV program This is an important finding for decision makers to be aware of when they make program changes to the EHV program and do not involve front line workers in the decision making

Another CHV Tory expressed how she valued the coordinator role as well and believed she communicated with PHNs in the following example:

...so the PHN is one part...we have to link together to make the whole puzzle for families right, otherwise it doesn't work.... So again it is the communication with PHNs. The coordinator was a great support...

CHV Coral described how she understood her role in communicating with PHNs:

...our role is different than a public health nurse...a public health nurse used to come to our center on a regular basis.....just seeing them more often....

PHNs talked about what they valued in their practice with CHVs. Based upon the next examples that PHNs shared, their communication with CHVs was built upon their relationship.

The following PHNs referred to what they valued as a foundation for their communication with CHVs:

PHN Jasmine: I value my relationship with CHVs.

PHN Amber: I like as much as possible to promote partnership between us...

PHN Pearl: level of power too that comes from the fact that our relationship with the Resource Centre is on a contractual basis so there's that kind of position of power too...in that we hold the control to say here is your funding for the next year...

PHN Jasmine and PHN Amber shared how they believed that the relationship or partnership contributed to communication between PHNs and CHVs. PHN Pearl's example highlights her belief that a binary relation of power existed between Public

Health and Family Resources Centers because of funding. This in turn affected the institutional and personal relationships between PHNs and CHVs. A hierarchical relationship was established through the contract structure where public health contracted EHV out to family resource centers. This arrangement created a relation of power that suggested that the institution of public health was in a hierarchical relation of power with the family resource centers. This relation of power affected expectations about how communication patterns were created between PHNs and CHVs through the coordinator role that liaised between public health and the resource centers. With the loss of the role CHVs were concerned about how the relation of power between public health and the resource centers might change. At the time of the study CHVs were not clear about how the communication was going to change.

CHV Sara's previous example seemed to represent a similar belief to PHN Pearl that a hierarchy existed in the organization and there was a need to bring all levels of the hierarchy together to build a team. Sara talked about a tension that existed in her organization around 'learning together' not being a 'priority anymore' but it had been in the past and she valued that type of coming together that was a way of communicating. Sara said it would be important to bring people together around a learning activity 'to help build one on one relationships with different people'.

When examining the words used by PHNs and CHVs in their communication experiences such as 'top to bottom', 'team', 'learn together', 'missing', 'relationship', 'level of power', 'position of power', 'who controls', and 'contract structure' they were describing doing things in a relation of power through their work of communication in

their practice. They were negotiating within a relation of power within the EHV program team. They challenged the binary relation of power or the top down approach of decision making. This new way of decision making made them feel left out of a team that had in the past worked well together and had strong communication that supported them in their practices. The relation of power created between decision makers and team members by program changes affected the communication within the team. With the coordinating structure gone from the EHV practices, CHV Sara's descriptions of her beliefs about decision making represented a loss she felt as a member of a team. Sara experienced a binary relation of power where decisions were made for her not with her.

In regard to the CHVs and PHNs communication experiences, Foucault's philosophical way of thinking provides a way to uncover how people work through power in their work. In the experiences of communication, PHNs and CHVs shared in the previous examples how they worked through the relations of power connected to their communication practices and the impact of an institutional program change on these experiences. Both PHNs and CHVs believed in and valued reflection. However, this was lost from, their practices when the coordinator position was eliminated.

After analyzing how PHNs and CHVs personally viewed their development of self, Foucault would suggest that the communication practices of PHNs and CHVs were created by the practices constructed within the health care institution represented by Public Health that played a dominant role in constructing their view of self in relation to their communication practices (Weedon, 1993; Foucault, 1992b)

Foucault believed in pushing for a deeper understanding of how institutions were constructed through relations of power based on particular beliefs, values and practices. This type of understanding allowed us to more easily see how and why individuals who worked and participated in the system continued to perpetuate, follow or challenge certain practices depending on their own personal beliefs and values. Based upon post structuralist thought, Foucault suggested it was important to understand how discourse got its meaning or where did the meaning originate in society. He also believed that people's multiple realities were constructed through language. Considering the communication language expressed by CHVs and PHNS it represented their way of understanding their practices based upon their personal experiences. Foucault suggested there was a need to examine the deeper meanings of what created the language associated with communication experiences and practices to better understand the multiple reality of communication for health care professionals, which can transfer to CHVs and PHNs in this study.

Through examining the communication discourse that was represented by the PHNs and CHVs' examples hidden meanings emerged such as Sara's response to the loss of the coordinator and the view expressed by the majority of CHVs and PHNs that a hierarchical communication relationship existed in EHV communication practices.

The hierarchy is the binary relation that the participants identified around decision making and how decisions were communicated. The public health care institution made a decision to make program changes and it did not involve PHNs and CHVs in this process. This created a binary relation of power where decision makers told PHNs and CHVs

about the decision. Prior to the program changes there was a team who worked together and this reflects a shared relation of power that was valued for the non-hierarchical relation that was created.

Foucault, purposefully tried to shake up what became accepted as a socially constructed truth perpetuated by a dominant discourse in society. Sara's example demonstrated how she wanted to also shake up what had become accepted communication practices in her EHV practices.

Summary

PHNs and CHVs used their agency to challenge assumptions that created the accepted multiple realities of communication in their practices. PHNs and CHVs believed and valued different things about communication in their practices compared to the institutional practices that were constructed based upon what the institution valued and believed needed to be part of the communication structure. Based upon the institutional decision to eliminate the coordinator position the difference in what was valued about the position by the institution and the PHNs/ CHVs was magnified. Sara through questioning and challenging the elimination of the position demonstrated her agency to push for another way of experiencing or creating communication in her practices that was more nonhierarchical and promoted a team approach to building relationships as part of communication practices in EHV.

Ultimately, the loss of the coordinator position was believed to be a major barrier to communication between PHNs and CHVs, and between managers/family resource centers and PHNs/CHVs. As a result PHNs and CHVs felt unsupported in their practices.

Building relationships through strengths based communication

In this sub theme the importance of the role of relationships in building a strong foundation for communication practices was a value expressed by all of the PHNs and CHVs. Relationships are identified in the nursing literature as the most important part in building trust with clients (individuals, families and communities (Wright and Leahey, 2013; Aston, 2011). Family nursing and systems theory has been taught in many nursing schools worldwide as a model of how to build family nurse relationships through communication focused on strengths and non-hierarchical relationships (Aston et al., 2015, Wright and Leahey, 2013; Tapp, 2005). Some of the PHNs referred to learning about family systems nursing and how this guided their communication approaches. Other PHNs and CHVs referred to the EHV curriculum and its focus on strengths based approaches as a guide for their communication practice. The majority also valued the day to day formal (visits, meetings) and informal (going for a coffee or lunch) conversations as a way of communicating between CHVs and PHNs, CHVs and CHVs, and PHNs and PHNs that was part of the day to day practices of EHV relationships.

PHN Ruby provided the following example of what she believed and valued about relationships in her EHV practices in the following example.

But that's because of my personality, that I really believe relationships are the foundation for everything we do. So if I don't have a good relationship with my community partners, I'm not going to be able to work with them. If I don't have a good relationship with my community home visitor, how am I ever going to

promote her? Right? And one of the key things that we do with our clients is that we start where they're at. So I start to look at the assets and start to understand...

It is important to understand how Ruby valued and believed in the importance of non-hierarchical relationships as a way of starting where her clients were at. She attempted to shift the normative and socially constructed binary relation of power between herself as an expert health care professional and mothers living within vulnerability as non-experts who needed to be 'helped' in certain ways. The shift could be seen in the way that Ruby chose to relate with mothers and 'start where the mother was at'. She wanted the clients (mothers) to work collaboratively with her. Despite her position as a PHN who was in a position of authority she recognized her subject position in relation to mothers, and started 'where the client was at'.

Like PHN Ruby, many of the other PHNs and CHVs believed it was necessary to understand the diverse strengths mothers living within vulnerability brought to the home visiting relationship. PHNs and CHVs described how valuing of families' strengths contributed to building trusting relationships with the families. CHV Coral provided the following insights based upon her experiences working with families that represented how she understood their role in the relationship.

I try to always be aware of, you know, letting families make their own decisions and come to their own conclusions because I think that's where growth happens. Understanding that they have instincts and intuitions, and that oftentimes they can't follow those... and that they will, you know, be a good thing for them to use. That sometimes we just know something and we don't know why with our

parenting...and of course that they know their children best. So oftentimes they know what needs to be done easier than we would.

Health care professionals have been situated as experts with specialized knowledge within the western health care system institutional discourse (Aston et al., 2011; Cheek, 1999). PHNs and CHVs have established relationships with clients in certain ways based upon dominant health care relationship approaches (Aston et al., 2011; Tapp, 2000; Wright and Leahey, 2013). CHV Coral's example represents how she believed in her professional subject position as a CHV and shows how she fostered agency within mothers to feel they could parent as they knew their children best. Through shifting the relation of power where mothers were making decisions about themselves, Coral constructed a non-hierarchical relationship between herself and the mothers. At the same time she challenged traditional western hegemonic power relations between professionals and clients. In this study many of the participants talked about treating mothers as experts in their own lives and using a strengths based approach. The following examples from 1 CHV and 2 PHNs represent how they believed a strengths based approach was evident in their practices:

CHV Tory shared:

I think one of the hugest things is that moms see you as equal, not as an expert...emphasizing mom's strengths...

CHV Tory also described how she identified strengths in moms through reflecting back what she experienced in her practices with the moms by saying:

...But I saw you just do that and I know that you do this....

PHN Jasmine believes the EHV program:

Is strengths based...to me that is the whole philosophy that is just woven through the entire program...

PHN Aggie described how she incorporated a strengths based approach in her communication practices in the following:

I'm trying to empower mom to come back to me and make sure that it's coming from her so that she feels she has control in the decision making.

CHVs and PHNs talked about the varied relationships they experienced in their home visiting practices due to the diversity of families and their unique needs. Ruby (PHN) believed it was important to customize the relationships in her home visiting practices. Below is an example of Ruby's beliefs and how she negotiated her communication approaches with mothers.

That I have to customize it to that family... it's not cookie cutter... that I can't say this is what I'm doing exactly for every client... because it's not. I communicate very differently with every client that I have. So you know, whether it's moms that say I have no daytime minutes, you know, text me only. I will exclusively have a relationship with her as much as possible through texting and through home visiting, if she'll let me in. Sometimes they let me in, and sometimes they don't. Sometimes they just want to text me and send me pictures of something or questions about my child is sick, what is it? Right? And you know, if I give those answers, that seems to make them feel like okay, now I want to continue on. Because I've had that experience too.

Ruby's experience suggests she was challenged in her practice to overcome the traditional "cookie cutter" or socially, institutionally and historically constructed nurse client relationship that she understood from her personal and professional subject position. Ruby relied on her agency or her ability to challenge a traditional way of communicating for a non-traditional approach through texting. This decision supported Ruby in shifting the relation of power in her relationship with a mother who wanted to communicate through texting. The choice for how communication would happen between Ruby and the mother was initiated by the mother. Because of Ruby's acceptance of the mother's wish to communicate through texting the mother took control of how the communication relationship would be created not the PHN. Ruby's agency facilitated her ability to self-reflect and give her conscious attention to challenge her own social location in relation to how she would communicate with the mother in her situation (Cheek, 1999). This represented a shift in the hierarchical relation of power where the professional PHN did not control how communication would happen with the mother.

Consistently, the majority of the participants described examples of diverse life stories of mothers and families who participated in the EHV. Incorporating an asset finding, strengths or capacity based approach in home visiting practices was part of PHNs and CHVs practices.

Ruby (PHN) believed through her relationship with a mother that she was able to delve down and understand what was a genuine support or asset that affected mothers in a positive way. In the following example Ruby described how she incorporated her asset

finding approaches in her relationships that helped her to go beyond the identification of supports provided by an approved survey tool used by Public Health.

We'll identify with them. So you know, when they are saying...So a quick easy way, when they're looking at the supports. So they do a networking survey with us. They'll identify their supports. And part of it is asking them what support do they offer? But I'll delve down into it to find out if it's truly an asset or it's not, and how it actually positively affects them...so my practice with her was kind of supporting her in terms of an in the early days accessing affordable housing, accessing appropriate mental health support. I did...and I've never done this with any other client but she had quite a traumatic birth story...I've supported her accessing food banks, supported her in terms of accessing appropriate legal support, accessing appropriate daycare for her children... I was the one contact in her life for the 5 years she was enrolled in the program.

For many of the participants, finding and stating the mothers' strengths was a difficult part of the EHV practices because of the lack of positive experiences of the mothers' lives within vulnerability. Ruby a PHN acknowledged and expressed the strategies behind her thinking that then constructed how she negotiated a strengths based approach in her practice.

And at the beginning when I first started, I was like this is really uncomfortable. But now I look and I go, it's such a valuable piece of information and it really does help the client to identify the things that they're doing positively that lots of times we don't say. We don't bother to say, you know, during that feeding, you

know it was great that you used so many variations of touch. You could really tell how much you care for your baby because you were doing this. I loved how you actually, you know, stroked your baby, talked to your baby. You know, I could see how your baby was looking at you because of that. You now, it was that. You know, you can get that detailed for them to be able to really feel positive about that.

Ruby's experience is a good example of how two different health discourses have been constructed in opposition with one being the more dominant. The moment of tension that we need to begin with is her discomfort. It appears that the 'usual' taken-for-granted way of understanding and approaching mothering is to focus on the 'problem'. We know this because Ruby said that she and others did not usually talk about the positive things mothers were doing right. The way she talked about being 'uncomfortable' at first demonstrates her ability to recognize that she was going to do something different, something that had not been accepted historically as a dominant relationship approach. There was a moment of conflict for Ruby as she was affected by how she had been taught the dominant health discourse but because she believed in the less dominant strengths based approach as a way to guide her practice, Ruby decided to embrace it and incorporate it into her practice with mothers. Ruby negotiated this dichotomy by making a decision to focus on the strengths. This is another example of the agency of PHNs like Ruby to make a decision regardless of the institutional practices that guided practice that caused her to conform to a traditional, hegemonic and accepted societal norm of practice.

Ruby continued her explanation of how she incorporated a strengths based approach in her practice in the following quote:

We'll identify with them. So you know, when they are saying...So a quick easy way, when they're looking at supports. So they do a networking survey with us. They'll identify their supports. And part of it is asking them what support do they offer? But I'll delve down into it to find out if it's truly an asset or it's not, and how it actually positively affects them. Like it's great that you have your mom to talk to about this, this and this. So that way even though she's struggling, might be struggling with transportation, you know what, but you have so and so to drive you. Right? That's a great strength. Or you know, I know you are struggling with depression right now. Who are you utilizing to help you through that? And she could list 10 people that she talked about. Maybe none. Oh, okay, well, how do we work on getting some strengths in there?

The majority of participants (PHNs and CHVs) shared their examples of how they negotiated a strengths based approach in their home visiting practices. PHNs and CHVs believed that strengths based approaches in their practice supported building a family's capacity in their day-to-day relationships with the families. Strengths-based health care practices continued to be positioned in opposition to problem based practice. PHN Jasmine shared an example of the positioning of a strengths based approach in opposition to a problem based approach in the following way:

But also to address concerns in a very non-judgemental, respectful way. Because strengths based doesn't mean ignoring if there's concerns but it's about how you bring them up as opposed to in a deficit based approach...

Jasmine's example shows the tension between two ways of approaching relationships with mothers. The health care system institutional discourse of what is the best way to practice, either from a strengths based or problem/deficit based approach constructed health care professional's awareness of the choice of one approach over another. PHNs and CHVs experienced a tension between their beliefs about a practice approach and they are pushed to choose what they believe based upon their experiences of what works best for them in their interactions with mothers living within vulnerability.

The CHVs and PHNs in this study continued to speak about strengths-based as a 'different' way of practicing because of the way it continued to be less visible throughout the system. The importance of including a strengths approach in their practice was summed up clearly in the following statement by PHN Ruby.

Because there's always positives, right? There's always positives. No matter what their story is or what challenges they have, there are always assets

All of the PHNs and CHVs believed in and valued how it was possible to promote a non-hierarchical shared relation of power with clients. Acknowledging a client's contribution to the relationship with PHNs and CHVs was expressed by PHN Opal in the following quote:

Do not work harder than your client. So it really means taking the lead from the client. So allowing the client to direct what type of support they want, and not

pushing or forcing support on a client. Because you can work and work and work, and the client is really the person who needs to want to put the work in as well.

This description by PHN Opal challenges the traditional hierarchical and socially constructed nurse client relationship by suggesting that the client should direct the relationship not the nurse or home visitor. This shift in power relations provides more of a focus on the client and what they believe that they need, not what the professional believes they need.

There was a theme expressed by some of the participant's about helping "the higher ups" (people who are managers and not on the front lines doing the home visiting) to understand how their home visiting was constructed. The tension seemed to be related to certain relationships between CHVs, and PHNs/managers. CHVs believed that the PHNs and Managers did not understand what they were doing on the front lines of home visiting with the mothers and families. Hope, described her beliefs about this tension in her practice in the following way:

But I don't think they (the higher ups) kind of always get or remember because some of them may have been frontline workers at one point in time... So I think kind of more communication between frontline and higher ups would be beneficial. I'm not saying I want to tell them how to do their job but...maybe hearing a story about, you know a challenging visit, or you know, hearing my input maybe I dealt with the same challenge with 6 families now, or something like that could be beneficial to program delivery stuff.

Hope valued and believed in the bringing together of front line workers and higher up managers and supervisors to increase communication among people in the hierarchical structure she believed existed within the organization. She identified a moment of tension within the relationship between the higher ups and the frontline workers. Hope's way of negotiating this relation of power was to bring everyone together regardless of their position in the hierarchy to share stories about the challenges of home visiting.

Summary

All PHNs and CHVs believed that the way relationships were established in EHV through communication approaches was one of the most important parts of their EHV practices. Clearly strengths based approaches stood out as a way to encourage a non-hierarchical relationship between health care practitioners, managers and the mothers living within vulnerability.

Negotiating Transitions of Families from PHNs to CHVs

The importance of communication in the process of transitioning families from a PHN who initially assessed a family, to a CHV who would continue to visit a family in their home was valued by both PHNs and CHVs. PHNs were the first point of contact for mothers and provided initial screening and then assessment of mothers to determine if they were eligible for the EHV Program. This process could involve a number of home visits. Once the program was offered to a mother the PHN introduced the mother to a CHV who followed the mother or family in their home for up to three years. All of the PHNs and CHVs spoke about the relationship between the PHN and the CHV during the

transfer of the mother from the PHN to the CHV. PHN Opal described in the following quotation how she believed a client should be transitioned to a CHV and what she understood was part of the CHV role.

So that transition to community home visitor support would be once everything is relatively stable in that client's life so that they can learn more about parenting information, accessing information about growth and development for babies, be provided with support in terms of if re employment is a goal that they have, or if finding affordable housing is a goal that they have, food security. So the community home visitor can help them kind of access healthy, nutritious foods, budgeting. So kind of mainly life skills that a family would need. I think that's more of a CHVs' role.

In the next quotation, PHN Opal spoke about the importance of continuing with the communication between CHVs and PHNs after the transition and her frustration about how this practice was not formally supported.

The clients will transition over to the CHVs, and then there's really no formal structure in terms of how communication happens back and forth between Public Health and CHVs. So usually it just doesn't happen. Now once in a while, there are some CHV's I work with that are quite good at contacting me when issues or challenges arise. And there are others that I never hear from once I transition a client to them.

Opal clearly identified a moment of tension or conflict in the way clients were transitioned from PHN visits to CHV visits. She was frustrated that there were no formal

structures to support an ongoing connection between PHN's and a CHV's. The majority of PHNs and CHVs also spoke about their frustration about this gap in practice. All of the PHNs and CHVs were left to negotiate the transition in their own ways. Some reached out to each other and others did not. Without the formal structure of support the majority of PHNs and CHVs felt their practice of transition was not recognized as important or legitimate and constructed an institutional practice whereby the relationship between CHVs and PHNs was hidden and not respected. The ways in which CHVs and PHNs negotiated their practice between each other during the transition included a subversive yet keenly felt relation of power that caused frustration for many. However, the lack of structure to support the transition did not stop Opal or the majority of CHVs and PHNs from working together. The CHVs and PHNs valued and believed in the importance of connecting and communicating in order to help families effectively transition from a PHN to a CHV. They continued to practice in this manner without support or recognition by management that eventually became an invisible part of their EHV practices that they believed was necessary to support the mothers. PHN Pearl shared her understanding about the lack of structure in the next example:

I don't know if there's much of a structure. I think we individually as practitioners have our structures. But there's no kind of checks and balances in terms of somebody checking to see what my caseloads are...so I don't think there's a formal structure.

Below PHN Opal described how she renegotiated her practice to ensure she connected with the CHV before the transition happened.

And I've learned to change my practice so that before I contact a client, I will try and connect with the community home visitor and just to say is this person even still in the program or have they moved or what's their new contact information? I'm coming up on 9 months and I need to reconnect with this client.

Opal demonstrated her agency by continuing to connect with CHVs even though it was not formally supported by a structure within the hierarchical public health care system. Other CHVs and PHNs shared examples of complex negotiations that occurred within relationships in their practices that included PHNs and CHVs and systems beyond the EHV program. The systems surrounding home visiting practices included agencies external to the EHV system such as the Child Protective Services. A complex relationship was shared by Opal about a mother who was being assessed by child protective services as to whether she could keep custody of her child. The mother involved with this situation confided in Opal that she needed a different CHV. This mother's request put Opal in a position where she needed to negotiate her relationship to support the mother and at the same time negotiate her relationship with a colleague who the mother no longer wanted to have as a home visitor. In this type of practice situation the PHN personally believed that she needed to support the mother's request. The PHN described below how she was able to negotiate a new relationship for the mother based upon her personal belief in the mother's need for another home visitor.

I was able to be an advocate for her to switch to a different community home visitor because the support that she was receiving from one community home visitor in particular wasn't appropriate for her needs at that time. So I was able to

act as an advocate for her in that term. So that was a scenario where I was involved probably on a fairly regular basis with the CHVs just because there was such a high level of Children's Aid involvement in that case. So yeah, I would have regular conversations....At one point in time, we did have an EHV coordinator. So I would have a conversation with my coordinator, a conversation with the EHV supervisor at the Family Resource Center as well as the community home visitor.

This example demonstrated the impact that relationships have on PHNs' practices of negotiation when they must make a decision about how to support a mother. A relation of power was created between the PHN and the CHV and the mother as the PHN in her role had the power to change who visited the mother and acted as an advocate for her to facilitate the change. According to Foucault (1972b) there are always relations of power within work but how the PHN negotiated the relation of power in this case demonstrated her agency to push for a new relation of power for the mother that created a more positive relation. The PHN's practices of negotiating these complex relations of power were done by her independently and were not known or visible within the system to others. The mother experienced the impact of how the PHN was able to negotiate a new relation of power that was more supportive of her as a mother living within vulnerability.

Summary

Transitioning a mother from a PHN to a CHV had been facilitated by the coordinator of the EHV program. When the position was eliminated, PHNs and CHVs felt the effects of not having someone to support the transition through communication

between PHNs and CHVs. PHNs and CHVs demonstrated how they renegotiated how they transitioned mothers from PHNs to CHVs through creating their own way of communicating since the public health care institution did not provide an alternative approach when the coordinator role was cut from the EHV program delivery. Once again PHNs and CHVs used their agency to create a practice of communication that supported what was needed in the transition of mothers in the EHV program. This finding supports the need to consider the roles of decision makers within EHV and how they support practices of PHNs and CHVs in the future. Making program decisions without consulting PHNs and CHVs created tensions that were difficult for PHNs and CHVs in their practices.

Conclusion

Feminist post structural discourse analysis provided a lens to PHNs and CHVs communication practice experiences in EHV while also identifying differences between PHNs and CHVs. Three sub themes emerged from the analysis of the PHNs and CHVs' communication stories 1) Reflective practice needs supportive communication 2) Behind the Scenes: formal and informal communication and 3) Building relationships through strengths based communication.

Through exploring the relationships of PHNs and CHVs with mothers in EHV their personal, social and institutional beliefs about their communication practices emerged in the analysis. In this chapter, communication was described by many participants as an important part of EHV practices. Considered the foundation of building relationships in nursing practice, communication for PHNs and CHVs involved

individual and family focused approaches to communication practices based upon family nursing theory and systems theory (Aston al, 2015).

Moments of tensions were uncovered within relationships between some CHVs and PHNs. How relations of power were negotiated through the sharing of information with experts was presented. The dominant health care system that regulates and controls home visiting practices frequently occurred as contributing to the tensions.

A unique finding emerged in this chapter due to the elimination of the coordinator role. Clearly the loss of the coordinator caused all PHNs and CHVs to be keenly aware of what they had and didn't have in terms of support for reflection about practice.

Transition of mothers and families from the responsibility of a PHN to a CHV was also affected by program changes. Because all participants spoke about the significant impact this gap had on their practice with mothers in the EHV program, the importance of listening to their experiences becomes even more important. Unfortunately, the power relations that were supported through the institutional structures where input from PHNs and CHVs were not sought, further demonstrated the hierarchical relation of power between PHNs, CHVs and the "higher up" dominant institutional hegemonic decision makers. The invisible, unknown practices that sustained the transitions demonstrated the dedication and ability of PHNs and CHVs to work through conflicting discourses to ultimately support mothers and families in the EHV program.

A focus group was held with PHNs and CHVs where the study's preliminary findings were shared for validation with the participants. The focus group findings validated many of the same findings that emerged in the FPS analysis of the study data.

For example, all of the PHNs and CHVs agreed that communication was very strong between the PHNs and CHVs prior to the program change. However, after the program change the PHNs and CHVs all believed that communication was less clear between them and also less clear between Public Health and The Family Resource Centers. Additionally, prior to the program change the PHNs and CHVs shared how they valued coming together to communicate and share what they were experiencing. They believed that meeting 3 times per year was not enough communication sharing and they suggested having more opportunities to come together. The following quote shows how they valued communication between each other in their practices “Communication... coming together, sharing experiences, sharing practices, helping us understand how the nursing role has evolved...that’s what keeps our team strong and cohesive initially, was coming together and talking...”

Another validated finding that emerged in the focus group was the belief by all participants that relationships are foundational in their EHV practices with everyone from the mothers, to each other and with their managers. As one participant shared “So the relationship is important on all levels.”

Chapter 7: Unique Practices of Support for Mothers Living Within Vulnerability

“A vulnerable population needs to be supported in a certain way.”

This chapter is about how CHVs and PHNs developed their practices and relationships in a way that facilitated support for mothers living within vulnerability. Three subthemes that emerged from their practices and experiences were: 1) Support Means Challenging Vulnerable Stereotypes 2) Support and Authority 3) Knowledge and Learning That Support Practices.

Support means challenging vulnerable stereotypes

In this sub theme understanding how PHNs and CHVs’ practices support mothers living within vulnerability in a certain way that challenged social and institutional stereotypes and labeling was uncovered. Experiences shared in this study offered examples of the awareness of stereotypes that PHNs and CHVs had and their ability to provide respect for the mothers in the ways they practiced. Often stigma and stereotypes are associated with mothers who are in targeted programs and seen as vulnerable (Aston et al., 2014). Although CHVs and PHNs used the term vulnerable within the interviews they also indicated that they never used the word vulnerable with the mothers to ensure they didn’t make the mothers feel like they were being judged.

Most of the PHNs and CHVs used the word vulnerable to describe the mothers they worked with in the EHV program, however, some used the term ‘at risk’. It is important to note how CHVs and PHNs referred to the mothers as the program was specifically set up for mothers who were at risk and needed extra support.

CHVs and PHNs offered support to mothers in particular ways that took into consideration their socially constructed subject position of being mothers living within vulnerability. Most of the CHVs and PHNs had similar experiences in the way they supported and interacted with mothers in the EHV program. The following story told by Jade, a CHV, demonstrates the unique and flexible practices that many of the other CHVs and PHNs also implemented. Jade's experience demonstrated how the complexities of the mothers' lives who she worked with in her day to day practices in a rural community shaped her practice. Jade began her description of the families she saw in her visiting practices by referring to one family as a:

...“stereotypical vulnerable family...a young teen pregnant mom”...

This statement showed that Jade believed she supported vulnerable families. I cannot assume I understand what Jade believed to be vulnerability. Could it be that Jade recognized the struggles of mothers and families as a type of vulnerability? Because CHV Jade used the phrase ‘stereotypical’ this showed that she had certain beliefs about what a vulnerable family looked like. We need to dig deeper to examine Jade's and other participants' views about what vulnerability means. Where do their ideas come from? Could the public health system's language of vulnerability influence how Jade has normalized its use as part of her personal practice language? Jade believed that I would know what she meant by vulnerability. It looks like Jade might have accepted a normalized discourse of vulnerability that she believed others like me should also understand as a way of describing mothers and families she worked with in her home visiting practice.

CHV Jade shared the following story of how she was able to support one mother through a difficult situation. She had been visiting this mother for an extended period of time and in her opinion had built a trusting relationship. Her experience with the mother and family led to an ethical dilemma for Jade. She had worked with the mother and her family for a number of years and believed that she

“...had a very, very good...a well-established rapport and relationship with the family. There was a very high level of trust.”

Jade expressed that she believed trust was an important part of her relation with mothers living within vulnerability and families. Jade was in an institutionally constructed subject position herself as a trusting person in her home visiting relation with the mother because of how she valued trust as a foundation of the home visiting relationship. CHV Jade believed that she had established a trusting relationship with the mother but on one occasion this relationship was affected by the relation of power between Jade and the mother when Jade was faced with making a difficult decision while on a home visit. The hierarchical relation of power was created by the professional role Jade had and the related expectations that were part of that role when working with mothers. Jade's CHV role created her subject position when interacting with the mother.

CHV Jade's story focused on a family with children under 5. When Jade arrived for a home visit the mother met her at the door and suggested they sit on the porch as the youngest child had been sick for three days with vomiting and diarrhea and she did not want Jade to catch anything. After a short period of time Jade started to wonder where the children were and convinced the mother that they go inside the house and check on them.

Jade found the baby unresponsive lying on the floor. Upon seeing the child, Jade started to

“...panic internally, becoming quite concerned because the child had no response...”

Jade said that she thought the mother was:

“...totally not concerned at all. Just brushing it off...”

Jade expressed her concern about the child to the mom and suggested he be taken to the hospital and an ambulance needed to be called. The mother said she couldn't afford that and why couldn't Jade take the child over to the doctor. Jade said she would need her permission which she received from the mother and then Jade took the baby to the closest rural clinic by herself. Throughout this experience Jade was saying the following to herself...

“...thank God I did what I had to do. On the other hand, I was in turmoil knowing that I had transported a child and what was my supervisor going to say”...

Because of the rural location, an ambulance could not arrive for 90 minutes and a life flight would take 8 hours. It was suggested to Jade by a health professional at the clinic to take the child to the IWK as quickly as possible but she only had consent from the mother to bring the child to the clinic. She negotiated and managed to get consent for her to transport the child after he was given IV fluids and stabilized. Jade believed that

...there was nobody else who could act to support that child, other than Child Protection and even calling Child Protection...they would not have been able to help in a timely manner to do what had to be done...

Jade was told that her intervention saved the child's life. Jade told me that she thinks about that day often and said ...

...what if I didn't have a scheduled home visit that day?

Jade further shared her beliefs about the value of home visiting and how it supported families in the following way...

So that's an example of how the home visiting piece enabled certain things to come into action.....Child protection became involved...they put supports in place to help advocate for that family....the family learned a very, very difficult lesson...prioritizing what needs to be done to support their children...but it also speaks to some of the decision making that home visitors have to do...we're forced to make some very significant ethical decisions..

In the previous example, Jade experienced tensions in her practice that she believed was an ethical dilemma for her when she pushed to take the child to a clinic or hospital and that was against what the mother wanted for her child. It seems reasonable to think that CHV Jade's dilemma centered on her belief that going against what the mother wanted was breaking the trust and the long established relationship between her and the mother. As well, the situation had pushed Jade to take over the child's care when she had been enabling the mother to care for her children throughout the home visiting relationship. However the mother did let Jade into the home and gave her permission to take the baby to the clinic. Perhaps the mother did trust Jade and there was a negotiation of trust going on within a relation of power. First the mother had the power when she kept Jade out of her home but then the power shifted to Jade when a decision had to be

made about the baby. Could the mother have been scared as well when she saw Jade's reaction to her ill baby and that's what pushed her to shift the relation of power to Jade and allow her to take the baby to the clinic? Jade valued trust as part of her relationship with the mother and that is evident in her following description...

I had a very, very good ...a well-established rapport and relationship with the family. There was a very high level of trust.

To keep the trust as part of the relationship Jade worked hard to keep it through how she negotiated it within her relation of power with the mother. Jade was persuasive and she used her subject position of authority as a CHV to clearly tell the mother that something had to be done quickly for the safety of the child. Jade's decision shifted the relation of power away from the mother around to the direction that Jade felt strongly about. A direction that seemingly may have gone against the mother's wishes but in the end the mother supported Jade's decision. Perhaps the mother was scared and she wanted Jade to make a decision. Through this decision-making, Jade re negotiated her practice quickly in response to the situation with which she was presented and showed how she used her personal agency to both support the child while maintaining her trusting relationship with the mother.

In this example, negotiation of power involved two people, Jade and the mother. When Jade first arrived at the mother's home, the mother prevented Jade from entering by keeping the CHV, Jade on the porch. The mother stated that the child was ill and it appeared to Jade that the mother tried to prevent her from seeing the child. Although the mother did not indicate that her child was seriously ill in any way, her actions of staying

on the porch and not attending to her sick child concerned Jade. Her inaction and detainment of Jade on the porch was a way to control the situation. The mother led the situation as she negotiated her relation of power with Jade to conduct the home visit in a particular way. However, because Jade was positioned as a CHV whose job was to support and help the mother and her family, she further negotiated the relation of power in a different way to push the mother to allow Jade to see the child and then make a decision that would best support the child.

This example of negotiating power shows the need to understand the complex relationship between Jade and the mother. I believe that CHV Jade and the mother who has been part of the EHV program were engaged in a dance of power. First, the mother tried to have power over the situation through her silence. Next, Jade felt an obligation as a CHV to take control of the situation and have the power in the situation through her decision making approach focused on supporting the child. Jade had power in the form of authority connected to her position and was given permission by her supervisor and the medical emergency team to take control of the child from the mother's care. The institutions of public health and child protection supported her practices as a CHV when she was faced with the situation she experienced. Further analysis of Jade's experiences illustrates how societal/medical institutions such as public health, child protection and medical authorities that guide home visiting practices created a relation of power for Jade around how she negotiated her home visiting practice's decision making. As a result of these decisions, Jade negotiated a relation of power with the mother based upon authority that was constructed by the institutions surrounding her practice. (Foucault, 1977, 1982;

Peckover 2002). CHV Jade's experiences represented how she negotiated trust with a mother. Her story is also one of understanding how authority is negotiated in a relation of power between a CHV and a mother.

To understand the personal, social and institutional construction of Jade's experiences and practices while she worked with mothers living within vulnerability the perspectives of support and policing/ surveillance provide another lens of analysis (Peckover, 2002). Practices of health professionals are part of regulating a population (Foucault, 1977, 1982). In Jade's case, her practices were contributing to the regulation of the lives of those she defined as living within vulnerability and who participated in the EHV program. The surveillance aspect of her practice seemed to take over in the situation as she moved to protect a child (Peckover). The therapeutic gaze of the health providers such as home visitors places mothers as subjects or objects within home visiting practices. Jade had a responsibility to ensure the safety of the child as the family was under her gaze. Also reflected in Jade's practices was her concern for the mother's seemingly lack of interest in her child's well-being during the home visit. This behaviour of the mother that Jade talks about represents the gendered tone underlying home visiting where practices focus on healthy child development through the promotion of parenting skills most often associated with good mothering (Rossiter, 1990, Peckover, Foucault). Jade did not believe that the mother was acting as a good mother and was forced to intervene and act to protect the child. Further analysis of Jade's experiences illustrates how disciplinary powers can be present in home visiting practices (Foucault, Peckover). Normalizing discourses such as vulnerability, mothering and child protection illustrates a

way of understanding how surveillance through child protection for mothers living within vulnerability can sometimes be supportive in the EHV practices. From a feminist perspective, power exists within the professional- mother relationship such as Jade's example (Weedon, 1993).

PHN Ruby shared the following example of her relationship of support with one mother that was similar to Jade's story.

Oh yeah, I go with her on the bus. And I had already called mental health and said, "is it okay if I come?" Well, they wanted to know what my role would be. "Nothing, I'm just as a support. I'm not interfering at all." Right? Just support, that's all I'm there for. If the baby gets fussy, I can hold the baby or whatever in the same room. Because I can't childcare, right. And then so she made it to the appointment. And then we took the bus back and walked up to her house, and I got in my car and I left... It made me feel great that I could do that...right... and then after that, her community home visitor did it with her for 4 times. And now she's made relationships with a neighbour who takes care of her son, and she goes on her own, so it's worked.

This PHN believed that it was important for her to support the mother and go with her on the bus for her to be successful in accessing the resources she needed for her mental health issues. The PHN believed the mother could not have overcome her anxiety and fear about taking the bus and access the necessary treatment she required on her own. The PHN obviously knew that this was not usual practice or one that would be supported by her supervisors. It is also important to remember the mother was considered to be part

of a 'vulnerable' group, so perhaps this impacted Ruby's decision as she would have been aware of the mother's vulnerabilities, strengths and weaknesses that clearly included anxieties. Ruby gave support to Jade in a certain way based upon her beliefs about how Jade experienced vulnerability in her life through lack of access to required resources. Ruby's choice of how to support Jade was not usual practice. However, Ruby valued her ability to find a way in her practice to find the support that would work in the best way for Jade who lived within vulnerability. Ruby was well situated in her role as a PHN to work within the vulnerable experiences of Jade through her creative responsive practices. Nurses are known to advocate for those who experience vulnerability and often respond through their practices as advocates on behalf of those living within vulnerability (Gottlieb and Gottlieb, 2012; MacDonnell, 2007).

It is important to note that Ruby actually phoned to ask if it was okay to accompany the mother. When she was questioned she responded that she would not 'interfere'. This clearly demonstrates the way in which PHNs practice and sometimes need to navigate the health care system with and for clients in a way that goes against the status quo or the usual institutional practices. This PHN chose to challenge expectations of her role because she believed she was the best person to support the mother to access the resources she needed. Her subject position as a PHN gave her some authority yet it also restricted her practice. This PHN believed that the mother would not have been able to access necessary resources without her help.

The use of the term "nothing" in reference to the support she was providing is also an important word to deconstruct. Ruby assures the person on the other end of the

phone that she will be doing nothing, however, she also talks about how important her presence was to the mother. Support means different things to different people and in this instance, one might argue that this type of support was not always valued. Although she believed that her support was important and instrumental in helping the mother, she also recognized that she had to hide it or describe it differently to others in order for her to be able to practice in a way that she believed was necessary. This is an example of how two different discourses created a moment of tension for Ruby. The health care system was constructed in a way that did not support PHNs riding the bus with clients. This was part of a discourse that had rules, regulations, guidelines for PHN practice, boundaries and ways to offer support for mothers. PHN Ruby was aware of the rules and the institutional discourse that guided her practice. She however, decided to disrupt and challenge the accepted beliefs and practices within the organization. This challenge is an example of negotiating relations of power through a phone call and practicing differently from the way she was expected to practice. Ruby challenged the socially constructed belief created by the social institution of public health that riding the bus is not a valued support for mothers. Ruby did ride the bus anyway and by doing that she demonstrated her agency to challenge the status quo way of supporting mothers and riding the bus with a mother was not the way things were done in public health. Understanding how this meaning of support has been institutionally constructed in the PHN's practice may uncover hidden examples of support like the one Ruby shared that has major impacts on the lives of mothers living within vulnerability For PHNs and CHVs this type of support is part of

their everyday practice of negotiating their relationships with mothers through following the lead of mothers in practice relationships.

Summary

All of the PHNs and CHVs shared stories of how they negotiated their practices with mothers living within vulnerability and who they believed needed to be supported in unique ways. PHNs and CHVs also recognized the stereotypes and labels that were created for the mothers by society related to what it meant to live within vulnerability. As a result of this awareness, all of the PHNs and CHVs focused on using a strengths based approach when interacting with mothers to create a relation of power where mothers were empowered by the possibility of what they had in their lives versus a deficit approach where there was only a focus on the problems in their lives. This finding suggests a need to examine the approaches used in relationships with mothers living within vulnerability to ensure the mothers are supported in ways that are relevant to their experiences.

Support and Authority

In this sub theme the authority that PHNs and CHVs had as part of their role within the public health care system is examined. The type of authority that was socially and institutionally constructed for PHNs and CHVs affected the type of support that they provided for mothers living within vulnerability. The next three examples from PHNs (Aggie, Amber and Jasmine) represent how the majority of PHNs in the study used their subject position of authority to support mothers. A unique finding emerged related to how their authority as PHNs was negotiated differently compared to Jade's subject position within a CHV role.

Like CHV Jade, Aggie (PHN) talked about what she believed was an important part of how she supported families in EHV. Aggie believed “how you show up” involved “...meeting people where they are at” and “really listening for what’s going on at that point in their life...

Empowering mothers was a value that Aggie stated she believed was important when she supported moms in EHV. Aggie shared her experiences about this in the following way

I’m trying to empower the mom to come back to me and make sure that it’s coming from her so that she feels she has control in the decision making...its building capacity for the mom to have power and control over her own life and to be self-directing and self-determining...that’s an important value to me as a public health nurse... I want them to be confident to step out and live their own life.

In her story, Aggie shared how she put what she believed and valued into her practice by not telling the mom what to do on a first home visit and thus supporting empowerment in the mother. Rather, Aggie chose to step back and give the mother time to think about the discussion she had with Aggie and arrange a second visit to follow up with the mother. Aggie’s practice story centered on a young mother who had two children from two different fathers. The mother’s first child had one biological father and her new baby had a different biological father. The mother shared with Aggie on her first visit that she wanted to be in a relationship with the first father and not the second one. Through conversation with the mother, Aggie described how she raised awareness in the

mother about a potential problem regarding custody of the child. Aggie said to the mother...

What are some of your thoughts on some of the legal issues and custody issues?

The mother responded to Aggie by saying she would think about that and Aggie booked a second visit with the mother. On the second visit the mother said to Aggie...

... remember when you were talking to me about custody issues... I think I am going to need some support or maybe some legal aid... I was really surprised that the father of the new baby was texting me death threats and texting my family death threats and we're going to have to get the RCMP involved and different other things.

Aggie believed by focusing on the mother's beliefs and values by stepping back and coming back for a second visit she was...

...building capacity in the mom... to have power and control over her own life, and to be self-directing and self-determining...

Aggie negotiated her relation of power that had been constructed by the institution of public health and the EHV program. However the program also supported PHNs to practice in this way. The EHV program does not prescribe a certain kind of surveillance or tell mothers what to do. The EHV supports trusting relationships, however the dominant health care discourse still exists where experts are positioned to give information and guide care (Aston et al., 2015). Aggie shifted the hierarchical relation of power between her and the mother in a way that the mother was not pushed to make an immediate decision about the situation she was experiencing with 2 separate dads of her

children. Instead, Aggie's practice decisions were based upon her belief that the mother needed time to think about things on her own. Aggie's belief in how she could support the mother also facilitated the mother's personal agency to think about decisions over time versus immediately and create change in her life on her own. Aggie's subject position was one where she believed it was necessary to move away from the dominant health discourse and the authority it gave Aggie in her role as a PHN.

The dominant professional discourse emphasizes hierarchical approaches within the professional- client relationship (Peckover, 2002). There are also discourses of institutionalized social norms that have a long history of constructing how home visitors and mothers should act (Peckover). These two discourses were experienced by Aggie at the same time and a moment of tension was created between the discourses that Aggie had to then negotiate in her practice. Aggie negotiated the tensions between the discourses by shifting the relation of power around authority to one where the client was supported to have personal authority to think about possible solutions to a situation. Many of the PHNs gave similar examples about how they used their subject position of being an expert to purposefully negotiate their authority in their role to support mothers. The uniqueness of PHN Aggie's story compared to CHV Jade's and other CHVs' stories is that PHN Aggie did not refer to another authority when negotiating support. Instead, Aggie was confident in making a decision based upon her authority in her subject position as a PHN about how to support the mother's personal authority. Aggie went on and further described how she realized that through her way of negotiating her practice and her relation of power with the mother she... started to gain awareness herself of how

she may need support...and the home visitor's role in supporting moms... in difficult life circumstances...

Aggie also proposed to the mother more support for her through having continuing home visits as part of the EHV program as she worked through the custody issue. Aggie then introduced to the mother the idea of a CHV coming to her home. The mother thought this type of support could help her through her situation over a longer period of time. Aggie believed that part of negotiating her practice involved giving the mother time to think about their conversations and this approach promoted

... understanding that helped me (Aggie) to have a confidence with that mom about promoting support for her ongoing.

Aggie shared how she believed her work was challenging and she recognized the unhealthy relationships of the mothers like the one in her story. But, one of the ways Aggie negotiated her practice was to help mothers use their own agency to see the unhealthy relationships they were experiencing. Aggie believed that her approach to supporting mothers experiencing unhealthy relationships worked as she heard the following from mothers

...I think this relationship is unhealthy with my partner...

Aggie believed that...

It's almost like intuitively they know" but they need someone to support them in "self- identifying.

Aggie negotiated her practice based upon her authority as a PHN and what she believed and valued in her role as a PHN working within the NS EHV program.

However, Aggie made decisions and negotiated her practices based upon what she believed and valued about how to support the relationship with mothers living within vulnerability. When negotiating support in her practice Aggie believed that it was important for the mothers to have time outside of the relationship with a PHN to think and find their own awareness about their situation. From this building of awareness Aggie believed that the mothers then came back to the relationship with the PHN and were able to decide with the PHN what would support them the best. How Aggie described her subject position when she was facilitating support for the mother was different from Jade's description. Jade as a CHV did not have the same expert position like PHN Aggie to negotiate how she would support a mother in a life or death situation.

The next two examples from PHN Amber and PHN Jasmine are similar to CHV Jade and PHN Aggie's experiences and represent how they negotiated with mothers living within vulnerability in their home visiting practices.

Amber a PHN valued the relationship she had with a mother who had her baby taken from her because of the relationship she had with her partner living with addiction issues. Even though the baby had been taken from the mother and Amber was not supposed to continue her relationship with the mother, Amber negotiated her practice so that she was able to 'stick with her'. Amber shared that she believed that it was important to make the mother feel valued. Through "conversation" with Amber, the mother talked about things she could try to improve to get her child back. Amber had conversations with the mother through texting. Amber believed that she was able to listen to the mother through texting and thus supported the mother by providing "the right

support and the right information at the right time...so mom can make the right decision for her and her family...” The mother decided when she was going to text so Amber did not know when the mother would connect with her. Amber recognised that the mother was comfortable with texting so Amber re negotiated her practices by accepting texting as part of her supportive relationship with the mother. Through the texting conversations the mother shared with Amber” ...okay I’m going to try this and I’m going to try that”. Over time and at the end of one of the texting conversations the mother told Amber “she finally recognized that she had a drinking problem as well... and that set her on her own path...”

Amber’s story represents what she believed and valued about how she could support a mother living within vulnerability through negotiating a relationship in a way that was comfortable for the mother. Guiding Amber’s practice was her belief that she needed to be non-judgemental in how she negotiated her relationship with the mother. The dominant health discourse created a binary relation where mothers were made to feel they were either a ‘good mother’ or a ‘bad mother’ (Aston et al., 2015; Peckover, 2002). This hegemonic social construction of what it is to be a mother created stigma that surrounds mothers living within vulnerability (Aston et al.). Amber believed it was important for her to be non-judging for the following reason...

I would believe in not judging...in terms of my practice that is my most important part...I think it is such a barrier.

Amber recognized that her practice included mothers living within vulnerability who were judged for reasons such as where they live, what their house looks like from the

outside...whether or not they graduated from high school... Vulnerability means one thing in public health as clients are given a diagnosis of being vulnerable or at risk because they screened into the EHV program and they need the label to be included. The label assigned to mothers in the EHV program also creates stereotypes and stigma for them in society because of social discourse that constructs the meaning of living within vulnerability in their lives.

Judgement of mothers was experienced by both PHNs and CHVs in their practices with mothers living within vulnerability. Amber pushed herself to consider how she negotiated her practices with mothers based upon their unique life experiences. Amber expressed how she valued “navigating even your understanding of the moms depending upon what they present to you.”

PHN Amber negotiated a non-judgemental approach in her practices with mothers through “pointing out things they might not recognize themselves... helping them find their strengths, the right support so mom can make the right decision for her and her family...” Amber’s story represents how support through conversation can be directed by the mother and this gives mothers more power and authority in the relation of power with a PHN like Amber. This way of negotiating her practice of conversation pushed Amber to reflect about how she supported mothers living within vulnerability. Where did her way of supporting mothers come from? Amber believed it was important to always remember that each mother was

a person, she’s a human, and when a professional comes to your door...she (mom) might not be herself either...she’s going to be more vulnerable with me...

PHN Amber had authority associated with her professional role that had been institutionally constructed through a discourse that held a particular meaning about experts. A hierarchical expert relationship can be seen as a binary relation that may or may not contribute to feelings of surveillance by mothers who have been labeled as vulnerable. The health institution itself does not enact power over others, nor do institutions directly make people practice in certain ways. Up to this point in the analysis each person's experience and what beliefs and values they hold about providing or receiving support have been discussed and shows us how different discourses hold particular meaning for people, how they take it up (or not) and ultimately how it affects them. For example, when one discourse is more dominant than another, there may be perceived pressure to follow those practices or the opposite which would be to challenge the discourse. This is why it is important to explore how different participants understand concepts like 'surveillance'. To some it may mean 'policing' and telling people what to do. For others, 'surveillance' might mean 'checking in' and using strengths based approaches.

The traditional hierarchical positioning of mothers who are vulnerable may cause some people to see them as 'less than' and stigmatized in different ways. This type of construction of oppressive binary relations of power was challenged by all PHNs as they attempted to practice in non-judgemental ways that disrupted the binary relation of power between PHNs and mothers. Amber recognized this subject position of power she had because of her role and how it made mothers feel uncomfortable when someone came to their home to possibly judge them. Amber's sensitivity to the power associated with her

role influenced how she negotiated support in her practices by “Just recognizing that there’s a reality behind all this” and the life that mothers have lived every day without a home visitor like Amber present as a support in their lives.

Based upon her experiences Amber believed her way of supporting had moved from “I probably did too much for people “to “encouraging families to recognize their own strengths and build upon them...supporting them ...to grow a strength or capacity...” She referred to her wisdom behind how she supported families and that “you don’t know everything...always more to learn...seek out role models...not that you need to doubt your practice but you should always be digging for more and more...” I believe that Amber’s descriptions represent the deep layers of her practice and how she valued trying to understand the complex layers of the mother’s lives.

Amber had used her agency to challenge the institutional discourse that constructed PHN practices in certain ways. She continued to stay in contact with this particular mother even though it was discouraged. Amber knew that this mother needed a certain type of support based on her social position of being labelled a mother living within vulnerability. The next story is another example from a PHN.

Jasmine is a PHN who shared her personal story and belief that her “own personality” supported why she wanted to support “vulnerable...high risk...kind of complicated” families in her practice. Working in EHV with mothers experiencing vulnerability pushed Jasmine to be “challenged in” her practice and she valued having to be creative in how she supported mothers who had unique life challenges. In Jasmine’s practice vulnerable families experienced

...poverty, social assistance, child protection, mental health challenges, addictions....very, very complex families...” Jasmine also commented that while she used the word “vulnerable” to describe the families in her practice she believed it was a type of “labeling” that she tried to avoid. Jasmine acknowledged that the labels existed in her practice in EHV but she negotiated her practice on her guiding belief “I believe in my heart that people want to be the best they can be...the best parent” and her role was to “help support the mom...accentuate the positive... search for a strength... address concerns in a non-judgemental, respectful way...earn trust”. Jasmine believed when she practiced in this way she then was able to negotiate support in her practice with mothers. Jasmine was aware of the social construction of labels and judgement.

PHN Jasmine’s story also included a dilemma she experienced in her negotiation of support when she faced a situation in her practice that challenged her belief that everyone wants to be the best parent. Jasmine shared her personal story of questioning who should mother. This question arose from her experiences with a mother who:

would never have another kid in her care...it doesn’t matter that she can get pregnant and carry the baby...that was going to be basically it...she loves her kids...so what did loving her kids mean?

Jasmine said “was it that she carried them...” because the mother’s baby had six broken ribs caused by abuse. Jasmine believed that her experience with this mother affected her thinking about how she interacted with other mothers and it created an ethical dilemma for her. Jasmine had to readjust her personal beliefs about who should be a mother. As a result of how this experience affected Jasmine’s beliefs she questioned

herself as to whether or not she could re-negotiate her support practices with mothers. Jasmine expressed how difficult this practice experience was for her because she had not considered that a mother could not be a mother to her children. This dilemma for Jasmine created a tension for her because of her belief that all women can or should be mothers. This belief may be based upon societal stereotypes and assumptions about mothering in Western society (O'Reilly, 2005). This practice experience pushed her to question what she believed and valued about all mothers not only those she worked with in EHV. Working with mothers living within vulnerability can create unique situations for PHNs and CHVs and how they support mothers. Part of how they support can also involve their authority in their role to make decisions about whether a mother can mother.

Summary

All of the CHVs and PHNs shared practice experiences of how their role was institutionally constructed by the public health care system and their authority was defined by the role they worked within. PHNs' subject position had been socially and institutionally constructed to include; being a health care professional/expert, having a university degree, having the ability to conduct complex health assessments, provide education and evaluate health outcomes. This gave PHNs a certain kind of institutional authority. CHVs were positioned differently. Their authority was to 'monitor' mothers in a way that included 'support' and 'guidance' with parenting skills. They were also there to observe and perhaps 'assess' how mothers were coping. However, their assessments were different from PHNs. They did not use the Parkyn screening tool, and they had not been trained as nurses to conduct thorough health assessments. CHVs were also seen to

be ‘peers’. This created a certain kind of hierarchical yet sometimes equitable relationship between CHVs and mothers. However, it also created a certain hierarchy between PHNs and CHVs. Because the PHNs and CHVs had been positioned with certain kinds of authority through the health institution, this guided their practice and the way they interacted with each other. Uncovering the authority they had in their practice magnified the differences between CHVs and PHNs in how they practiced and supported mothers living within vulnerability and families through a relation of power. Could it be that some families’ lives are too complex for CHVs who are required to have a supervisory authority before they can make a decision about how to negotiate practice decisions? Are CHVs being asked to negotiate practices that they do not have the authority to negotiate?

All of the PHNs were able to practice under the authority connected to their role as a PHN and thus they independently made decisions without interacting with another authority. PHNs use their authority either independently or in collaboration with a peer or supervisor. Further examination of the discourse on authority would contribute to understanding how its role in home visiting practices when a professional (PHN) and nonprofessional (CHV) work together to support mothers living within vulnerability.

Learning and Knowledge that Support Practices within Vulnerability

This sub theme is about PHNs and CHVs’ beliefs and values about the socially constructed knowledge and learning that guided the way they practiced within the EHV program with mothers living within vulnerability. Four main areas emerged in the experiences and practices of the PHNs and CHVs 1). Learning from experience 2)

Negotiating oppressive curriculum practices 3) Learning from mothers 4) Other ways of learning.

Learning from experience

CHV Coral shared her story about how learning from her own experiences and others helped her to support mothers living within vulnerability in the EHV program. Coral believed that the EHV program would be a “good fit” for her because she was a mother and she believed having raised 4 children she had “a fair bit of knowledge to pass on”. Coral also talked about how she valued her learning from the families and how “they (the families) are quite open (with her) once we develop our relationship of trust”. Coral’s story suggests that she valued the relationship of trust with the families and believed it supported her in learning and understanding more about the families’ stories and thus further helping her to support families through her home visiting practices. Coral’s example represents how a layer of her knowledge and knowing how to support the families comes from the families but only when trust has been built between her and the families. The majority of CHVs also shared how they negotiated their practices of support by knowing the mothers’ stories.

Coral arrived at a home visit just after a mother had received a visit from child protection and a “5 day hearing notice that she had to go to court and that she may lose her baby...” Coral, upon reflection of this experience needed something other than the curriculum to guide her practice and shared “...I’m not saying that I don’t think that the curriculum is important...” I know of all kinds of philosophies behind it and all of the practices...” but Coral was faced with a dilemma of how to proceed with supporting the

mom and Coral shared “am I going to take out a piece of paper from the curriculum that talks about tummy time? Probably not...” Coral’s story represents the complexity of knowledge behind what she valued and believed about how to negotiate her knowledge that guided her decisions about how to practice. How Coral thought about what she should do in her practice was complex. Her story is not only about having a non-hierarchical interaction with the mothers; it is also about the critical thinking behind her decision making based upon different types of knowledge both from her personal experiences as a mother and institutional curriculum knowledge.

Additional examples from CHVs, Grace and Hope supported CHV Coral and her experiences when they shared how they believed that their experiential learning also supported their practice. Grace shared her belief that she had “walked in their shoes” by experiencing similar life experiences. Because of her life experiences she believed that she better understood what mothers living within vulnerability were going through in their lives. Through sharing examples of herself and her life experiences with mothers in her home visiting practices, Grace believed she was able to understand the families and negotiate support in her practice that was the right fit for the family’s situation. Hope also shared a belief similar to Grace that her personal experiences supported her understanding the mothers living within vulnerability in her home visiting practices because she “ had a challenge similar...not exactly the same...and people (mothers) really value somebody else having similar experiences...knowing where to go...or what to do...”

Having been a young mother at 17, Hope believed because of the support she received from others as a young mother she learned from her personal experiences that “with support that I (Hope) got...I went to school and got a degree and didn’t stop...and I want to provide that kind of...that good feeling in other people...I want to...provide support for other people...” Hope’s story represents her belief that how she understood the multiple realities or experiences of people’s lives and their personal experience of support then supported how she understood and negotiated support for other mothers.

Hope like Coral and Grace shared how she valued her way of knowing how to support mothers living within vulnerability that came from her own personal experiences and those of others as providing a way of knowing and understanding what type of knowledge contributed to how she negotiated what she learned into her home visiting support practices with other mothers. Hope believed

that’s what I do...I take other people’s experiences and my own experiences and kind of provide that to other people...and give them knowledge so they can go....okay maybe I could try that.”

This is a unique finding of this study as only CHVs shared how they believed they learned from their life experiences about how to support mothers living within vulnerability who participated in the EHV program. This was not a main focus of learning that supported PHNs’ practices.

Learning through negotiating oppressive curriculum practices

Curriculum was the main support for CHVs and their practice with mothers living within vulnerability. However, the majority of CHVs like Coral shared their stories of

how their beginning practices felt scripted by the EHV curriculum and program manual. They sought out support from peers to help them interpret the curriculum as well as feel confident in understanding how to apply the curriculum in their EHV practices.

Coral shared the following example of her feelings of being scripted by a curriculum when she supported a family “always being careful... because the curriculum is actually pretty scriptedso being careful not to sound preachy...I think if there were more training at the beginning ...it is hard to know...”

Coral’s story highlighted how she valued and believed in the importance of her relationships with the mothers living within vulnerability. It was one thing for Coral to take the EHV curriculum and the knowledge it represented, but how it was negotiated into her practice was very important to Coral. This example highlights that Coral (CHV) valued the knowledge she brought to the relationship she established with the mothers and families and it was important to her to not sound preachy in her EHV practices with the mothers and families. The word “preachy” indicates a hierarchy that Coral wanted to downplay in her relationships with the mothers. To avoid being preachy in her relationships with mothers, Coral negotiated a relation of power with mothers by working with them in ways that were non-hierarchical. For example Coral referred to the curriculum but she also developed other approaches when working with the mothers that were not scripted in the curriculum but instead based upon the mothers living within vulnerability and the experiences they brought to the EHV relationship. This example demonstrated how Coral shifted the relation of power away from her as the expert to the mothers who were experts of their own lives. Coral valued non-hierarchical relationships,

but found the curriculum interfered with her beliefs and values about relationships and ultimately affected how she practiced. As a result of her beliefs about the curriculum and how she valued her relationships with the mothers she renegotiated her home visiting approaches to support the needs of the mothers' situations. Coral challenged how to practice within EHV guided only by a curriculum.

The majority of CHVs spoke about the EHV curriculum and its usefulness to guide their practice with new mothers. They gave examples of how the curriculum both increased their knowledge as well as offered specific modules to guide their interactions with mothers. However, many of the CHVs also spoke about how it restricted or interfered with effective and supportive interactions with mothers. From what the CHVs said, it appears that the curriculum was based on a strengths based approach, however, the WAY in which it was structured for delivery was institutionally constructed to be expert and task driven. This type of institutional discourse was easily seen in the mandatory practices that were supported by the curriculum. While this type of discourse was often effective, the majority of CHVs also noted that the expert driven discourse sometimes interfered with the relationships that they had or were trying to develop. Knowing that positive relationships were foundational to effectively working with new mothers, the CHVs had to shift, change, negate or challenge the WAY the curriculum was delivered. While the knowledge/information from the curriculum was very useful, we can see through the comments and beliefs of the CHVs that they also disagreed with the suggested implementation.

The different ways that the CHVs implemented the curriculum is evidence of how they challenged the dominant discourse. They challenged the meaning of ‘support’ as they shifted towards using the information in a different way. This was based on common sense and personal experiences that told them the WAY they interacted would be more beneficial than the information itself.

This subtheme uncovered a unique question about why PHNs did not talk about the role of curriculum as a guide for their EHV practices with mothers living within vulnerability. For CHVs the curriculum was present in their practice but they challenged how it constructed their practices at times.

Learning from mothers

The learning from mothers was shared by the majority of PHNs and CHVs as a way they began to understand what it meant to be a mother living within vulnerability. Hope talked about what she learned from the mothers who lived within vulnerability and the experiences they shared with her about securing food for their families. What Hope learned from the mothers in turn helped her to support other mothers experiencing similar struggles with finding affordable food. Hope (CHV) shared a story of a mother she used to visit who was “well-resourced around finding food and keeping her food bill affordable...” The mother “knew where every food bank, soup kitchen and place was that she could get a free loaf of bread” and where “at the end of the day she could show up at a place where they were getting rid of old stock (food)...” Cheek (1999) and Weedon (1993) suggested that understanding multiple realities or ways of knowing contributed to a deeper understanding of people’s lives. In Hope’s story she referred to

how she valued the experiences of the mothers in contributing to her understanding or way of knowing what supported the mother to find affordable food. Learning from the mother living within vulnerability and her experiences supported Hope when she negotiated how her practices supported another mother in a similar situation. Before sharing a mother's experience Hope shared how she always said to a mother "I need to share this story...please tell me it's okay..."

CHVs Hope, Coral and Grace gave examples of how their EHV practices were personally, socially and institutionally constructed through a blending of different discourses on learning and knowledge that included their personal experiences, curriculum and mothers' experiences. For Hope, being guided by only the EHV curriculum was not enough to support her home visiting practices that included varied contexts. Personal views that people have of themselves and what supports them in her day to day life of practices is socially constructed by structures or institutions that surround them (Foucault, 1982). The EHV curriculum is institutionally constructed by the public health care system institution. Through her need to have something else support her practice, Hope challenged herself to think outside of the EHV curriculum and utilized the agency she had within herself to create new ways of experiencing her home visiting practices based upon how she responded to the varied experiences of herself and others that included mothers living within vulnerability. Hope, Grace and Coral (CHVs) deliberately created changes in their EHV practice that responded to their personal experiences and those of mothers living within vulnerability. The way the CHVs' practices were negotiated as a result of their experiences contributed to a social

transformation because they challenged the idea that the EHV curriculum was the only knowledge source to support home visiting practices. Through using their personal experiences as a knowledge source for their home visiting support practices the home visitors challenged the knowledge source that originated from a socially constructed and accepted institution of the EHV curriculum. Hope, Grace and Coral's stories of support that they shared, acknowledged their own and the mothers' experiences. How to negotiate practices of support in home visiting was affected by a relation of power that was created between personal experiences of the home visitors and the societal health care institution that programmed home visiting support through the EHV curriculum (Foucault, Butler, Cheek, 1999, Gardner, 2006).

PHN's ways of learning

Many of the PHNs believed that formal education was an important source of support for their practices. For example, PHN Opal believed that her EHV practices were supported by what she learned in her university nursing education. Opal shared her story of how she believed in and valued how her university education supported a higher level of assessment in her EHV practices with mothers living within vulnerability. Opal described what she valued from this education and how it supported her EHV support practices with families in the following way:

I value my compassion. I value that I am ethical. I value my critical thinking. I value my knowledge base, like my broader knowledge base....

Opal valued her education of having a BScN that was constructed by the institution of a university through a bachelor's degree in nursing. She believed that her

education supported her way of supporting mothers and families in her home visiting practices.

Opal valued fostering independence in mothers living within vulnerability and she believed she had done her job in supporting families toward independence when a mother “doesn’t need to come back” to the EHV program. Opal personally believed that she had a “higher level of assessment, looking at the holistic client... looking at the bio psycho, social, spiritual being...” that supported how she negotiated her practice of support in a holistic way with a goal of fostering independence within the mothers and families. In other words, Opal’s practice goals were focused on facilitating the agency within mothers to feel that they didn’t need the EHV forever and that they were able to live without the formal support of the EHV. For Opal she believed that she had done her job in the EHV when she had supported mothers and families to not need the EHV program

Ruby who was a PHN shared how she believed her EHV practices were supported by her knowledge from both her experiences and education. Ruby talked about a family course, systems theory, and communication theory that she learned in University as sources of knowledge that supported how she practiced. Ruby described how both her personal “experiences” and “some level of educational pieces...doing a family course...doing systems theory...learning through communication class...” influenced how she believed her practices supported mothers and families.

Summary

The previous examples shared in the subthemes of learning by PHNs Opal and Ruby show how they created their own meanings that represented their personal and

professional subjective positions within EHV practices. The power of experiential and institutional learning in home visiting practices are evident in the previous participants' descriptions. A unique finding emerged in the discourse of how support was learned. PHNs talked mainly about learning from the mothers' experiences, other experiences and formal education. PHNs did not focus on the EHV curriculum as a support for their learning.

Conclusion

PHNs and CHVs shared the many ways they experienced support in their practices and experiences. Three main themes emerged in the analysis and included: 1). Support means challenging vulnerable stereotypes 2). Support and authority 3). Knowledge and learning that support practices.

The unique findings in this chapter include how 1). Supporting mothers who live within vulnerability was dominated by a strengths based approach during interactions between PHNs/CHVs and mothers living within vulnerability. Using strengths based approaches challenged the hierarchal power relations in the nurse / client relationship within the surveillance nature of home visiting. The main message that emerges from a strengths based approach is one of addressing the determinants of health as a goal of the public health care system while working alongside mothers to build their strengths within challenging daily obstacles from living within vulnerability. 2). Support and authority was defined differently for PHNs and CHVs because of the role they have within the Public Health Care system that constructs what authority a PHN or CHV has in their practices within EHV 3). Learning and knowledge that supports EHV practices were

believed to be different for PHNs and CHVs. PHNs in this study believed that their formal education constructed a support for their EHV practices with mothers living within vulnerability and their interactions with the mothers. CHVs believed that their personal experiences, EHV curriculum and mother's experiences constructed a support for their EHV practices. The findings have implications for practice, education, policy and further research that will be presented in the upcoming final chapter.

A focus group was held with PHNs and CHVs where the study's preliminary findings were shared for validation with the participants. The focus group findings validated many of the same findings that emerged in the FPS analysis of the study data. For example all of the PHNs and CHVs shared how they valued and believed that they all needed support in their practices. As one participant shared "...when I think of a novice versus someone experienced, we both need support..." the focus group participants went on to share that they missed the support from the coordinator as she provided the reflective piece in their practice by listening to them. They also shared how they believed the coordinator represented everyone's interests when communicating with managers and this was a formal support that they appreciated as it made them feel supported. Overall the PHNs and CHVs felt they had very little support with the program change. They all believed that they needed that stable middle person in the form of a program coordinator to support them in their EHV practices.

Strengths based approaches were validated by the participants as an important part of how they practiced with mothers living within vulnerability. However, they believed that they could also benefit from this approach from their managers instead of

feeling only their deficits were the focus. One focus group participant shared her feelings about the lack of a strengths based approach from her manager with her in the following example of what verbally is said to her in regard to her practices “ but you’re not doing everything right, you’re doing this wrong, you need to do this, this and this...” Most of the PHNs and CHVs agreed with feeling this way but they did not feel this way when there was a coordinator who was there for support.

Learning also was discussed in the focus group by all the participants as something they believed they were missing in the form of “personal growth opportunities” to avoid feeling “stagnant” in their practices. The focus group participants also believed that PHNs and CHVs had different needs in their practice and that required different types of learning to support maintaining and creating new ways of practicing. This is a similar finding to the main study and provides validation of the need to consider the best continuing learning opportunities that support both the unique roles of PHNs and CHVs and their unique learning styles.

Chapter 8: Discussion

The examination of PHNs and CHVs' personal experiences working in the EHV program brought to light the ways in which their practices had been constructed and continued to be influenced by social and institutional discourses. The social discourse on mothering layered with the social discourse of being part of a vulnerable population added an interesting understanding about gender and class. This was then combined with an institutional public health care discourse that included strengths based support as well as expert driven and hierarchical relations between CHVs, PHNs, supervisors and mothers that both supported and hindered practice depending on a variety of competing beliefs and values. The descriptions given by participants illuminated how these discourses converged, conflicted and affected their practices. The descriptions also provided wonderful examples of how participants thought about, questioned and challenged certain beliefs and practices within the EHV program. It was precisely the moments of tension and questioning that demonstrated how participants negotiated their various relations within these discourses and between each other. Being positioned as a PHN or a CHV meant different things to each participant and affected how they related to each other and how they ultimately chose to practice in certain situations.

Three main findings emerged in the study 1). Building relationships with mothers living within vulnerability 2). Communication in EHV practices within vulnerability 3). The unique practices of support for mothers living within vulnerability. Each finding will be discussed and the discourses that emerged included, followed by implications for practice, education, research and policy decisions.

As you read the findings I would also like to offer you a visual illustration titled the Pearl Effect (Appendix H) to refer to as another way for you to understand what emerged in this research. In the illustration the “Pearl” looks perfect, but in reality a pearl comes in many shapes, sizes, and colors and many are not so perfect looking. A single grain of sand or a predator’s invasion attempt begins a process of multiple layers being formed around the pearl as its protection during its creation (Gillespie, 2014).

In this research, PHNs and CHVs’ practices surrounded mothers who lived within vulnerability. Like the creation of the pearl, the EHV practices were unique to each experience and multi layered.

Pearl divers are experts in unlayering everything that surrounds pearls to reveal the pearl. Similarly, in this study, research guided by FPS uncovered the multiple layers that created the experiences and practices of PHNs and CHVs within the social and institutional construction of EHV.

Building relationships within vulnerability

The first finding, building relationships with mothers living within vulnerability focused on the importance of focusing on the complexities of understanding vulnerability and the ways it affected how PHN’s and CHV’s began their relationships with the mothers in EHV. The intersection of the social and institutional discourses constructed the experiences of mothers who lived within vulnerability and their relationships with the EHV PHNs and CHVs.

Many authors have written about the social construction of mothering and how in every society a dominant discourse becomes a hegemonic truth or accepted societal way

of understanding what it means to be a mother (Strega, 2005). Mothering research is not new and it is helpful to look back to be reminded of where we are today. Almost 30 years ago, Mohanty (1988) wrote “That women mother in a variety of societies is not as significant as the value attached to the mothering in those societies” (p. 68). At the same time, Rossiter (1990) proposed that when facts became accepted as the common sense way of understanding mothering, the historical organization of mothering by society and the related language used to describe it becomes normative and accepted as a truth. Accepting everyday practices often leads to a forgetfulness about how things came to be. To understand how the social construction of mothering occurred in this study and how it affected the day-to-day practices of PHNs and CHVs the meaning of mothering was incorporated. The ‘mothering discourse’ provided a lens to understand the complexities that created the personal, social and institutional experiences of PHNs and CHVs through relations of power that were created in their practices (Butler, 2005; Foucault, 1998; Weedon, 1993).

The goal of social movements like feminism is to create change and mothers have been a focus for decades (Stephen-Abetz, 2012; Thun, 2012). Other feminist researchers have shared their perspectives on mothering and where they believe mother work is today. Kinser (2008) in her work on mothering feminist daughters suggests that mothers of the 21st century are navigating a sociopolitical climate influenced more than any other time in history by media and technology constructed knowledge that affects perspectives of mothers. Also the growing division of class in society is magnified (Kinser). Feminists are also involved with research with feminist mothers who fear becoming their mothers

which further highlights the identities, societal labels and stereotypes that even daughters gather through their experiences within mothering (Green, 2008; Jones, 2012; Middleton, 2006). The work of mothering is considered a political endeavour where mothers are encouraged to avoid surrendering to societal experts who want to create their mothering experiences (Green, 2012).

Currently a Winnipeg Women's Health clinic has incorporated feminist mothering into their philosophy that guides the practices within maternal health promotion and education (Green, 2009). A major focus of the clinic approach with mothers is to help mothers to see their strengths and provide a place for them to tell their mothering story. Mothers are guided through their mothering experiences while focusing on their strengths. The social expectation of mothering is also discussed with the mothers. With strategies like this being incorporated into a clinic the mothering discourse is helping to influence how the relation of power between a health professional and a mother is constructed. This unique practice strategy also challenges the medical health care system and societal discourses about how mothers are supported and acknowledged as mothers in society.

People's identities or subject positions are created by discourses that represent the relations of power they experience in their day-to-day lives (Butler, 2005; Foucault, 1980; and Weedon, 1993). For PHNs and CHVs in this study how PHNs and CHVs understood themselves or created their personal identities was reflected in their beliefs, values and actions that they presented in their EHV interactions with the social worlds of mothers. The discourse of mothering within vulnerability was evident in the practices and

experiences of the PHNs and CHVs' within this study. Also the institutional public health discourse emerged in the practices and experiences of PHNs and CHVs. These two dominant discourses emerged within the data analysis as critical in understanding their role as constructed through and continually perpetuated by relations of power that existed within the practices of PHNs and CHVs and the social and institutional structures that create their practices.

Understanding the dominant discourse of vulnerability and its role in EHV practices required further uncovering of its meaning in this study. Societal definitions of who are vulnerable or at risk have their roots in institutions such as the World Health Organization and the Public Health Agencies throughout the world who develop policies and ways of supporting the defined vulnerable people in the world (WHO, 2015; Public Health Agency of Canada, 2015). The institutions of Public Health and WHO are highly regarded in society as having expert knowledge. As a result, they traditionally have defined vulnerable populations to be those who are more likely to come to harm over other populations due to issues of illness, poverty, social rejection, abuse and discrimination based upon gender, race or disability (WHO, 2015). While experiences of vulnerability may be different throughout the world, women and children are considered among the most vulnerable because they are most affected by poverty, gender, inequity, stigma and gender discrimination (Varcoe & Doane, 2007; WHO, 2015). The societal and institutional discourses of vulnerability such as those emanating from the WHO, Public Health Agencies and researchers, are important to remember in this study given the direct link between the EHV program and the public health care system institution.

A feminist interpretation also contributes to understanding the discourse of vulnerability in this study. Recently, feminist scholar Judith Butler presented a position that vulnerability is experienced when societal infrastructures fail to support populations (Butler, 2015). For example, poverty results when societal economic infrastructure does not support people to meet their basic needs of survival. In these cases of survival, potential harm can be the experienced outcome. Many of the mothers in this study experienced harmful situations as evidenced in the examples shared by PHNs and CHVs due to economic struggles.

The EHV program began in 2002 as an enhancement to the Healthy Beginnings universal home visiting program to support families experiencing vulnerability like the mothers in this study. At the time, the federal government gave money to the province to develop a program focused on the early years and the department of health decided to focus on vulnerable families. A peer health model was chosen and the Growing Together Model at the Dartmouth Family Resource Center was chosen (Verbal communication, Kathy Inkpen, 2013). CHVs are part of the model that supports the work of home visiting within the homes. Program standards from the Healthy Beginnings EHV Initiative guide the program goals and the work within the program (N.S. Government, 2014). These programs, models and standards are examples of institutional infrastructures that surround EHV and mothers living within vulnerability. According to Butler (2015) it is important to identify infrastructures that support experiences of vulnerability. Butler suggests that there is a need to critically deconstruct and challenge the very infrastructure that constructs how vulnerability is understood. Butler's interpretation of the connection

between infrastructures and vulnerability has the potential to guide new ways of understanding how vulnerability and infrastructures are linked and thus supported within EHV.

Populations are sometimes exposed to vulnerability by failing infrastructures. As a result, Butler (2015) believed and made an ontological claim that a body is dependent upon relations with other societal bodies (infrastructures) and support networks to live and thrive. In other words vulnerability cannot be understood outside of relations between people and surrounding infrastructures such as EHV programs. Vulnerability through relations in people's lives created a discursive categorization of people through names that are attached to them that infer vulnerability such as being poor (Butler). As a result of having a name or label attached to a person there is usually a description or image of that person that becomes accepted as a norm or truth. This feminist interpretation of vulnerability supports the experiences presented by PHNs and CHVs in this study who believed that labels are often attached to mothers living within vulnerability. The PHNs and CHVs believed that the labelling led to the mothers feeling stigmatized by society and how the mothers saw themselves. PHN Sara's example of helping a mother take the bus was an example of the power that stigmatization had on how the mother felt about taking a bus alone to access needed resources. The mother lacked the confidence, she needed the support of the PHN.

When vulnerability is experienced by a person often the first response is to resist (Butler, 2015). However within this resistance, a person is often affected by the power held by a societal institution such as the public health care system in this study. People

living within vulnerability are often excluded from interacting with the societal institutions and miss an opportunity to have input into its impact on them directly. Thus lacking any ability to respond to traditions that supported societal norms related to vulnerability, resistance can be used to try and overcome its effects. With this resistance in mind, Butler believed that change could happen and a new space could be created where a new way of responding to vulnerability was possible that pushed for change.

This study provided the opportunity to support Butler's idea of creating a new space for understanding EHV practices that uncovered how vulnerability was understood and foundational in PHN's and CHV's practices with mothers. For example, in this study, PHNs and CHVs questioned how EHV would be offered to mothers when two program changes occurred. This challenging demonstrated the PHNs and CHVs' resistance to traditions that were rooted in EHV practice and influenced by the political power of the public health care system and a societal definition of what it meant to be a mother living within vulnerability.

In this study, PHNs and CHVs used their agency to question and challenge how mothers were excluded from the decision making regarding EHV program changes. Through questioning how the 'higher ups' made decisions invisibly about program changes, it was evident in the study how the PHNs and CHVs resisted the changes. The PHNs and CHVs through their agency shifted the hierarchical relation of power they experienced with the public health care institution by creating their own new ways of supporting mothers living within vulnerability. The two program changes involved eliminating a coordinator position and going to only an EHV program. The domain of the

political side of societal influence in creating and sustaining vulnerability and how it was supported is evident in the stories of the PHNs and CHVs questioning of change. For Butler, vulnerability and resistance to it, work together where vulnerability provides a space for political action and potential change. This study provided PHNs and CHVs a space to share their personal stories of resistance to the vulnerability they saw in their practices with mothers.

How does a mothering discourse contribute to understanding the main messages and emerging themes in this study? It was proposed before the study began that discourse exists that represents how PHNs and CHVs relate to mothers and families within an EHV program. Also, how these discourses support or hinder services for mothers and their families was a question that was also raised. What the completed analysis guided by FPS has uncovered in this study is how PHNs and CHVs experience the personal, social and institutional construction of mothering in EHV within other dominant discourses of vulnerability, health care systems/institutional structures, professional roles and authority. Examples of how the PHNs and CHVs negotiated their practices in both similar and different ways within relations of power were provided. A discourse was created and assigned to the mothers in this study by the very fact that they were participating in an EHV program for mothers labeled as vulnerable. PHNs and CHVs shared how they acknowledged the societal ways of judging mothers who needed support from a program like EHV.

For many feminist scholars motherhood is seen as a patriarchal institution that contributes to the oppression of women (Green, 2012; Kinser, 2008; Reilley, 2014);

Stephenson, 2012). Feminist scholars who research mothering experiences suggest that many feminists believe that the institution of motherhood represents gender essentialism where women are perceived in society naturally as mothers and men are not (Green; O'Reilley). There are societal expectations of what mothering looks like. This perception of difference in gender in society is seen as maintaining male dominance in society. Many feminists avoid talking about women's subject positions as mothers or devote time developing feminism that is mother centered (O'Reilley). As part of her argument, O'Reilley who is a feminist motherhood scholar, suggests that there is a difference between the institution of motherhood and women's experiences of mothering. To her, women's experiences as mothers are a source of power and not necessarily oppressive to women. However, motherhood as a societal institution has been viewed by many feminists as male defined and oppressive to women (O'Reilley, 2005).

The debate among feminist researchers about the value of research focused on mothers has created some tensions between them and suggests a further support for their continued vulnerability if their stories are not uncovered. However, whether the word motherhood as an institution or mothering experiences is used to guide research I believe this study provided another layer of understanding about mothering experiences within vulnerability based upon the examples from participants within EHV programs. PHNs and CHVs shared evidence that mothers living within vulnerability were oppressed by society in ways they were treated. Their examples of mothers not wanting to go to a food bank for fear of being labeled and not feeling comfortable riding a bus for fear of being ridiculed by a bus driver represented their oppression by society and how they were

judged. However, when considering Butler's (2015) interpretation of resistance to vulnerability, the mothers in this study also experienced moments of possibility for change due in large part to the PHNs and CHVs who navigated in their practices the hierarchical power relations that surrounded the mothers.

The stereotypical roles of mothers in society have been created through hegemonic binary power relations that have created normative ways of being a mother in society. However, when the concept of subject position is used to understand the experiences of mothers in a more complex way that deconstructs binary relations, we can see how mothers are differently positioned in relation to other people. Specifically, in relation to PHNs and CHVs how a mother positions herself in relation to others will create different reactions, tensions and supports (Porter, Short, & O'Reilley, 2005; Sawicki, 1991). Mothers have stereotypically been viewed through a social lens to mother in ways that reflect normative practices. These ways then became accepted in society as the best way (Foucault, 1998). For example, since the dominant social belief in Western society has been for mothers to be the primary caregivers of children, this shaped the EHV program to begin by screening 'mothers' assuming they would be the primary care takers of their baby. Once inside the home, PHNs and CHVs were expected to 'HELP' mothers to be a certain kind of caretaker along with their partners and other family members. This practice supported through the curriculum had been constructed partly through a hegemonic mothering discourse that included assumptions (beliefs and values) about the lack of knowledge new mothers would have. This mothering discourse was then layered with assumptions about 'vulnerable' women/mothers. The assumption

was that they ‘needed help’, a particular kind of help that probably included support and information because they were ‘vulnerable’. They were positioned as marginalized and ‘lacking’ certain things. Because mothers living within vulnerability were seen to be ‘at risk’ for poor health outcomes for themselves and their children, extra supports from experts were offered through the EHV program. A societal assumption that runs through the mothering discourse is the belief that professional experts are supposed to ‘help’ mothers become socially acceptable mothers (O’Brien & Baca, 1997; Olds, 1999, 2002; Olds et al., 2007; Rossiter, 1990; Short, 2005; Varcoe & Doane, 2007).

To break down the binary power relation that was created for the mothers, PHNs and CHVs both shared how they valued the importance of building personal power with the mothers. PHNs and CHVs used approaches in their practices to empower mothers. For example, in this study examples were shared about how both PHNs and CHVs gave mothers time to think about decisions before moving forward with an action plan about an issue. Also, PHNs and CHVs accompanied the mothers on the bus and supported them to develop their personal agency to do simple day to day activities on their own. These practices by PHNs and CHVs shifted the power away from them in their professional role to the mothers and helped build the mother’s personal agency to make decisions in their lives about how they wanted to mother. Examples of PHNs and CHVs demonstrating how they put power back in the lives of mothers was evident in their daily work with mothers and evidence of this was presented in the previous chapters.

The language of EHV is interesting to analyze. On the surface, the term ‘enhanced’ can be defined as adding to, making better or improving. However, when this

term is contextualized within a mothering discourse of living within vulnerability, the term ‘enhanced’ changes meaning. One must ask the question, what is mothering enhanced to and from? When the social discourse of mothers living within vulnerability is applied to new mothers they are often seen to be ‘victims of circumstances’ when using a lens of social determinants of health. However, more often than not, these mothers are ALSO compared to ‘mainstream’ or ‘normal’ mothers and become ‘less than’, ‘marginalized’, or ‘disadvantaged’. These social positions of being labeled as less than a normal mother have been created through stigma connected to the stereotypes that PHNs and CHVs talked about in this study. Although the word ‘enhanced’ was probably chosen with the best of intentions, as it can be understood to be strengths based, connections to negative meanings still exist. It is important to understand the meaning of words used within the EHV program that can shift between social and institutional meanings, as meaning shapes the curriculum as well as the type of interactions between PHNs, CHVs and mothers.

Summary

Finding one in this study was focused on PHNs and CHVs sharing their beliefs about the importance of understanding what living within vulnerability meant for the mothers in EHV. This focused understanding was a priority the PHNs and CHVs valued as a guide for their EHV practices. This understanding then lead to the decisions that PHNs and CHVs made about how they began initial relationships with mothers living within vulnerability. All PHNs and CHVs shared the impact of two program changes on how they were challenged to recreate their EHV practices. As a result of the program

changes a relation of power between front line workers and the public health care system emerged. Implications of finding one are discussed later in the chapter.

Communication in EHV practices within vulnerability

The second finding, communication in EHV practices within vulnerability focused on how PHNs and CHVs used communication practices to develop their relationship with the mothers living within vulnerability. All of the PHNs and CHVs shared the types of communication that they believed supported their practices with mothers living within vulnerability. The other types of communication that supported their practice was reflection and communication with each other, and managers.

A main finding within communication was PHNs and CHVs belief that mothers in EHV saw them in a stereotypical position of authority. It was previously discussed in the analysis of the data how PHNs and CHVs are seen to be in an expert role of decision making and this affects how they are seen by society and the populations who are the focus of their work. Both PHNs and CHVs have been positioned in their roles as monitoring and controlling mothers living within vulnerability and ultimately mothering generally because of their professional or para professional roles (Peckover, 2002). Their monitoring position has been called a binary relation of power where PHNs and CHVs are thought to control the decisions about mothers (Cheek, 1999). Expectations of relationships between PHNs and CHVs and mothers are also found in provincial government EHV program guidelines for EHV, national Public Health practice guidelines, and community health nurses association guidelines (Community health Nurses of Canada (CHNC), 2013; NS Government, 2015; PHAC, 2014; Vollman et al.,

2014). All of these institutional guidelines have contributed to how the binary relation has developed as they influence the way PHNs and CHVs are expected to practice in their roles.

In this study, the unique ways that PHNs and CHVs renegotiated this binary perspective with regard to power was uncovered. To shift the dominant held belief about who they were as professionals and para professionals, PHNs and CHVs encouraged mothers in their communication practices to lead and control their own decisions and supported mothers to verbally share what they believed was important for them in their lives versus telling them what should be important. PHNs and CHVs did this through supporting mothers to focus on their own strengths within their personal mothering experiences of living within vulnerability. PHNs and CHVs demonstrated that this type of practice was ‘different’. Different, because this way of practicing challenged the dominant institutional discourse that perpetuated a primary focus on problems.

Although focusing on strengths and client centred care is written in health care documents and taught in nursing schools and present in guidelines for practicing PHNs and CHVs it still continues to be positioned as a ‘less dominant’ discourse, evidenced by the multiple stories shared by the PHNs and CHVs in this study and current findings in the literature (Community Health Nurses of Canada, 2011; Gottlieb, 2012; Nova Scotia Government Healthy Beginnings, 2015; Wright and Leahey, 2013). The influence of the dominant medical health care discourse with a focus on deficits, weaknesses, illness and interventions presents an opposing discourse to a strengths based approach and still exists in health care practices (Gottlieb).

PHNs and CHVs in this study were concerned with not judging mothers in the EHV and challenged the social construction of class and identity that had become a label of the mothers living within vulnerability. Varcoe, Hankivsky and Morrow (2007) suggested that other types of social differences such as “race, ethnicity, culture, class, sexual orientation, gender identity and ability” must also be considered in the analysis of women’s health experiences (p.3). As a result of their recognition of the labeling, PHN’s and CHV’s used their communication practices to shift the relation of power away from the professional. This shifting of power gave mothers more control in the communication practices and encouraged them to share the relation of power. This study offers a unique way of understanding how PHNs and CHVs challenged binary relations of power and subsequently negotiated and shifted the more complex day-to-day relations of power through strengths based approaches. They used as a communication strategy that built their relationships in unique ways. Implications of this finding will be discussed later in the chapter.

Another main finding within the second theme was how two program changes affected both PHN’s and CHV’s communication practices. Many examples were shared by PHNs and CHVs about the effects of the changes. In particular the way the decisions were made without their input left all PHNs and CHVs feeling excluded from the decision making process. The first change was the elimination of a coordinator position who liaised between PHNs and CHVs and at times with managers. The second change involved moving from having both an early visiting program for all new mothers and an enhanced home visiting program for mothers living within vulnerability to only having

the EHV program for mothers living within vulnerability. These program changes meant CHVs would be required to work with many more PHNs.

The main concern for CHVs was what the changes meant for their communication with PHNs. Their second concern was how they would communicate and work with new PHNs who had not worked within EHV before the program change. A unique finding of this study was how CHVs struggled more with the binary relations of power due to their nonprofessional role and lack of authority to make decisions that a PHN would make. CHVs did not have a solution to the change they experienced. However, CHVs shared their experiences where we can see what they thought about the changes and how they questioned ways of re-negotiating relations of power with new PHNs. Despite the changes in the program, the PHNs and CHVs shared examples of how mothers living within vulnerability were not victims of these changes but instead were supported by both PHNs and CHVs to find their personal agency to overcome difficult situations in their relations with both PHNs and CHVs. In this example of public health care system institutional program change PHNs and CHVs saw the hierarchy as getting in the way of their practice as they were not included in the decision making about program changes. PHNs, because of their professional position and authority connected to their role were able to negotiate their relations of power more independently than the CHVs.

The importance of communication is evident in this study and in the standards and guidelines for practices within provincial and national public health documents (Community health Nurses of Canada (CHNC), 2013; NS Government, 2015; PHAC, 2014). Many experts in public health practices were consulted in generating the evidence

in the reports. Throughout the documents the descriptions and language used suggest that communication is a strategy used in community practices to build relationships with individuals, families, communities and groups. An environmental scan was recently completed by CHNC to develop competencies for Public Health Leadership in Canada. A literature review, on line survey and focus groups generated the data for the scan. Communication is clearly represented among leadership competencies in the report from the scan. Specific skills identified in the scan for a public health leader include communicating clearly and transparently and supporting capacity building (Vollman et al., 2014). Promoting involvement, building partnerships, modeling as a mentor were identified behaviours of a Public Health Leader (Vollman et al.). According to these Canadian authorities, communication is an important part of the relationships between workers like PHNs and CHVs and the Public Health leaders such as decision makers and managers. PHNs and CHVs experienced something different where they did not feel institutional decisions were transparent nor did they feel involved. The government reports cited offer a way of understanding expectations of how communication is supported within practices of public health. This study offers another way of understanding the meaning of the communication decisions that were experienced by frontline practicing PHNs and CHVs. Implications of this finding will be discussed later.

The decision to cut the coordinator forced PHNs and CHVs to work in different ways. Specifically, relations shifted. Examples of how PHNs re negotiated this relation of power were not evident in the study but CHVs talked about their concern as to whether the PHNs in this position would want to work with mothers living within vulnerability.

All of the PHNs and CHVs shared how they negotiated the change and its impact on their practices and how they used their personal agency to re-negotiate the relations of power within their practices. The stories of how the PHNs and CHVs' practices emerged within the changing structures and shifting organization demonstrated the complexities of relations of power in their practices. For example, PHNs and CHVs shared how, despite not having a co-ordinator to act as a liaison between them they figured out ways to share and obtain information they needed from each other. The PHNs and CHVs shared specific ways of how they negotiated relations of power. They challenged and worked around binary relations of power and they were not victims. However there were differences in how PHNs and CHVs experienced relations of power. For example, CHVs were required to have a relationship with more PHNs as a result of the program changes and they talked about working on this new challenge.

It was clearly evident from the examples shared in this study that the PHNs and CHVs valued their communication between each other, their managers and the mothers. Valuing communication is also evident in the communication literature on health care practices and in documents that support public health practices (Community health Nurses of Canada (CHNC), 2013; Gottlieb, 2012; NS Government, 2015; PHAC, 2014; Vollman et al., 2014; Wright and Leahey, 2013).

In this study, program changes affected how PHNs and CHVs communicated in their practices. CHVs valued their way of communicating with the EHV coordinator prior to her position being eliminated with the organizational change. CHVs shared examples in the study of how communicating through reflecting with the PHN coordinator helped

create a relationship where the relations of power between the CHV and PHN shifted so that there was a feeling of support for the CHV. The relationship was a valued part of their practice as they were able to reflect on their positive and negative experiences with the coordinator and at times get advice or celebrate the way they had supported mothers living within vulnerability in the EHV program.

In all communication between people there is a type of meaning that results (Gottlieb, 2012; Wright and Leahy, 2013). Sometimes the meaning is not understood immediately. CHVs shared how they understood the meaning of their communication with the coordinator very quickly after the position was no longer present. Sometimes meaning is not directly shared between those who are in a relationship but the meaning of the loss of this person was verbally shared by almost all of the CHVs in the study.

In this study valued relationships were developed between PHNs and CHVs through communication and strategies they developed in their practices. Based upon the stories of the CHVs' binary relationships were created between PHNs and CHVs due in part to the expectations of the professional/ expert role of the PHN and the non-professional role of the CHV. In the relation of power between the PHN and the CHV, the PHN was able to move away from the dominant role of the expert that had been socially constructed in the public health care system institution. Instead the PHN facilitated a non-hierarchical relation of power with the CHV where a sharing of the relation of power occurred in the relationship and CHVs felt like active participants and were supported.

In this study, the health care system discourse either privileged or benefited PHNs and CHVs as authorities in the lives of mothers in EHV because of their roles in the EHV program. Also, the institutional discourse privileged or benefited the decision makers or 'higher ups' because of their position in the organization to make independent decisions without consultation with PHNs and CHVs. Each had a different way of negotiating power with decision makers that represented a hierarchical relation of power within the organizational or institutional structures. PHN's and CHV's reaction to the change from this hierarchical relation of power is one Foucault (1972b) refers to as the ability or agency of people to create an action or response to power that can be positive.

The stories of the PHN's and CHV's in this study demonstrated how they negotiated relations of power and offer an example of how they were thinking about things differently, questioning and searching for solutions and implementing their commitment to continue to offer their EHV practice to the mothers living within vulnerability. The way the PHNs and CHVs understood power and how they negotiated it in their practices was unique. They were not victims of the relation of power they had with the institutional structure of the public health care system. Agency emerged within the dynamic nature of the relations of power (Foucault, 1972). Everyone has the agency to offer something to the change experience that occurs in practices due to hierarchical structural/ institutional decisions (Foucault). The response to change by the PHNs and CHVs in this study was evidence that they used their agency to create a response in their practices that continued to support families in EHV. Their reason for change was based

upon their beliefs and values about their practices. The change brought out their continued commitment to the mothers.

Summary

PHNs and CHVs used strengths based communication strategies when they interacted with mothers living within vulnerably. A strengths based approach in health care relationships is not novel. Others have spent their life's work researching and building strengths based approaches for health care practices (Gottlieb, 2012; Wright and Leahey, 2013). Government standards guiding PHN's and CHV's practices based upon strengths based approaches has been well researched through inclusion of Canadian experts in public health recently (Community Health Nurses of Canada (CHNC), 2013; Healthy Child Development Manitoba, 2010; NS Government, 2015; PHAC, 2014; Vollman et al., 2014; Community Health Nurses of Canada (CHNC), 2013; Wright and Leahey, 2013).

Kurtz Landy (2012) completed a study with 18 low income single first time young mothers who participated in an intensive nurse family home visiting program. One of their main findings was how important it was for the mothers to have PHNs and home visitors respond to their unique life situations. PHNs and CHVs who helped the mothers feel empowered and in control of their lives were valued by the mothers. A study by Jack et al., (2005) have reported similar findings. These studies also support the need to consider how communication approaches within home visiting relationships can best support mothers living within vulnerable lives. Both of these studies support the need to

consider how home visiting communication practices are responsive to the uniqueness of mothers lives.

While current Canadian government program guidelines for home visiting suggest using strengths based approaches in home visiting, this study offers a unique understanding of how PHNs and CHVs incorporated a strengths based approach with mothers living within vulnerability (CHNC, 2013; NS Government, 2015; PHAC, 2014; Vollman et al., 2014). In this study PHNs and CHVs shared the belief that experiences of vulnerability are unique to every mother and guides how they use strengths based communication practices with mothers living within vulnerability. Implications of this finding will be presented later.

Another unique finding of this study was how communication of PHNs and CHVs was affected by the organizational changes. The hierarchical relation of power established the role of the decision maker as the authority on how the program would be delivered and how PHNs and CHVs would relate to each other. Many of the CHVs described how the organizational changes made them feel excluded from decision making about their EHV practices. Both PHNs and CHVs shared how the coordinator role was a needed support for their communication practices. Based upon the data, CHVs seemed to value this type of support more than PHNs. Decision making about program changes affected EHV practices and is a unique finding of this study. Implication of this finding will be discussed later in the chapter.

The unique practices of support for mothers living within vulnerability

The third finding, the unique practices of support, focuses on the powerful stories of how PHNs and CHVs supported mothers living within vulnerability in a certain way. Often the PHNs and CHVs challenged societal stereotypes of mothers living within vulnerability through the way they practiced and the decisions they made about how to support mothers. PHNs and CHVs made decisions differently because of the authority connected to their role.

Throughout the interviews both PHNs and CHVs shared their belief that the mothers living within vulnerability were judged by society and they believed that mothers were stigmatized as a result. It was previously described that in their relationships with mothers, PHNs and CHVs attempted to shift the relation of power when they worked with mothers through focusing on their strengths. Through highlighting a mothers' capacity versus her problems, PHNs and CHVs shared their belief that they were working from a strengths based approach and in a more respectful and non-judgemental way.

A strengths based approach was previously discussed as a communication strategy that PHNs and CHVs use in their practices. This strategy is based upon the belief that clients (mothers) are experts in their own lives and are open to suggestions of what is possible in their lives through acknowledgement of what they are doing well in their day to day life (Varcoe & Doane, 2005).

The relationship established with a person is foundational to getting to know them and understand what is unique about them before finding their strengths (Gottlieb, 2012; Kaakinen et al., 2014; Kurtz- Landy et al., 2012; Wright and Leahey, 2013).

Understanding a person's current situation, past challenges they have experienced and what they hope for in their life contributes to identifying their strengths, (Gottlieb, Kaakinen and Wright and Leahey). It has been suggested that finding strengths in a person is also about ignoring weaknesses but this is not the case (Gottlieb). Health care professionals often protect clients from feeling vulnerable and help them because they recognize weaknesses in them (Gottlieb).

Shifting a focus to identifying strengths gives health care professionals deeper insights into how best to work with a person and in turn empower them to choose what they need for support (Gottlieb, Ontario Government, 2013). Strengths based approaches have also been incorporated into program guidelines for public health practices. In Ontario, the report "Mapping a Pathway for Embedding a Strengths based Approach in Public Health Practice" was released in 2013 and it describes the importance of moving away from the dominant medical model of diagnosis, treatment, assessment and intervention (Ontario Government, 2013). By embedding a strengths based approach in guidelines for public health professionals they will be expected to focus on identifying strengths in their practices with mothers and families (Ontario Government).

According to the experts noted above, a strengths based approach supports those who experience vulnerability and shifts practices to empower individuals. In this study a unique way of understanding how PHNs and CHVs implemented a strengths based approach as a way of supporting mothers living within vulnerability was uncovered in their practices and can add another way of understanding strengths based approaches in EHV practices.

The strengths based approach to interacting with mothers rejects a relation of power where the expert nurse decides what is best for the mother based upon problems that are identified by the expert. Valuing and encouraging the existing capacities of a mother living within vulnerability gives the mother voice and gives her authority about her life in the relationship with the PHN or CHV. There is a shift in the hierarchical relation of power towards the mother and away from the expert nurse's authority as a professional in the relationship (Gottlieb, 2012). Focusing on problems in mothers living within vulnerability may over shadow our ability to understand their abilities and nurture their capacity to find their personal agency and create changes in their lives through resistance to their vulnerability (Butler, 2015; Varcoe & Doane, 2005). A strengths based approach to relationship building was evident in the examples shared by PHNs and CHVs.

Another finding was the type of authority a PHN and a CHV had on the type of support they could give mothers. For example, PHNs made independent decisions about their practice but a CHV at times went to either a PHN or the Family Resource Center supervisor for a decision that was outside of their authority. A previous example was shared in the analysis about a child needing to go an emergency facility and the CHV could not make independent decisions.

A final finding was how PHNs and CHVs valued different knowledge and learning as a support for their practices. One of the major findings related to learning was how the EHV curriculum was not a support that PHNs valued, however it was valued by CHVs as a guide for their practices. CHVs valued the EHV curriculum and their

personal experiences as a guide for their practices. PHNs valued their formal education as a guide for their practices. The knowledge and learning that supports EHV practices was important to PHNs and CHVs. However, they valued different types of knowledge and learning based upon their examples.

Currently, the Community Health Nurses of Canada (CHNC), the Public Health Agency of Canada (PHAC) and the Canadian Association of Schools of Nursing (CASN) provide continuing education through on line learning, posting guidelines for practice on their web sites, annual conferences and establishing working groups as needed about public health practices (CASN, 2015; CHNC, 2015; PHAC, 2015). Support for CHVs learning was not evident in these areas however the CHVs shared how they valued learning from each other when they gathered to talk about their practices. This has implications that will be discussed later.

PHNs and CHVs valued different learning and education as a support for their practices and this has implications that will be discussed later in the chapter.

Summary

The unique ways that PHNs and CHVs supported mothers living within vulnerability began with challenging stereotypes, stigma and labels they experienced. This required a certain level of creative skill in the practices of PHNs and CHVs that led to non-traditional approaches such as riding on a bus with a mother to support her in learning how to negotiate the stigma she felt in riding a bus. Stereotypes about mothers in society are created through relations of power where mothers are positioned in relation to others as being less than another person. Reasons for the stereotypes include being a

low income single mother, not having enough food to eat, having a low level of education or living in a geographic area that is judged as not a good place to live (Green, 2009; Kinser, 2008; Stephenson, 2012; Varcoe et al., 2007). Many examples of how PHNs and CHVs challenged stereotypes were evident in the study. The unique practices of PHNs and CHVs that supported mothers living within vulnerability has implications that will be discussed later in the chapter.

A main unique finding of this study was the way strengths based approaches were used as a way of supporting relationships with mothers living within vulnerability. Powerful stories were shared about the complex relations of power that PHNs and CHVs negotiated with mothers living within vulnerability. These stories were a highlight of the study for me as a researcher. The ways PHNs and CHVs supported mothers through their practices uncovered a deeper layer of understanding of mothers living within vulnerability and the complexity of EHV practices. This finding has implications that will be discussed later in the chapter.

Authority for making certain decisions about how to support mothers living within vulnerability was dependent upon whether a PHN or CHV was practicing in the EHV role. Determining what authority PHNs and CHVs have in their supportive practices with mothers living with vulnerability affects how mothers are supported. With the new program changes, both PHNs and CHVs will work in one EHV program and knowing who has authority to make decision was identified as an important part of supportive practices for mothers. .

All PHNs and CHVs referred to a need for continued learning and education to support their practices and this has implications for what type of learning and education is required to sustain the home visiting practices.

Overall Implications

The overall implications of the study will be presented first followed by specific implications for the main findings. The findings have several implications overall for practice, education, policy/ decision makers and future research.

A major finding in this study that emerged under finding one, building relationships with mothers living within vulnerability is a need to move beyond acknowledging the importance of establishing a supportive relationship with mothers living within vulnerability. An implication of this finding is to ensure that all PHNs and CHVs have the required learning supports to understand the uniqueness of how to build relationships with mothers living within vulnerability given the change to only having an EHV program. Support for PHNs and CHVs may require diverse strategies given the uniqueness of their learning identified in the study.

Another implication of this finding is building understanding in PHNs and CHVs about what vulnerability means. The meaning of vulnerability emerged in this study as a unique experience in the lives of mothers who participate in the EHV program. Understanding the meaning of vulnerability was also found to support understanding how to use strengths based approaches in EHV practices. Understanding the uniqueness of each mother's experiences within vulnerability is foundational to finding the strengths that a mother has in her life (Gottlieb, 2012).

Another implication for future research is on understanding the relationship of PHNs and CHVs in a changed EHV program guided by FPS. This may uncover another layer of understanding about their unique practices in supporting mothers living within vulnerability. Two Canadian studies explored how young single mothers were supported by a PHN and a home visitor in a nurse family partnership program involving home visiting (Kurtz-Landy, 2012). In the studies the evaluation of the support outcomes were reported as positive experiences for the mothers however understanding how the PHN and CHV worked together in these practices is not clear (Kurtz-Landy; Jack et al., 2005). The uniqueness of this study shows how understanding the practices of PHNs and CHVs in EHV can provide a model of understanding practices in future research in a changed EHV program.

Implications from Each Finding

From finding one, building relationships with mothers living within vulnerability sub finding program change effects on vulnerability there is an implication for policy and decision makers to consider how they made program changes and why they didn't include frontline workers in the decision. This created a tension for PHNs and CHVs in this study that made them feel excluded and not supported yet they were faced with recreating their practices in response to the program changes without any support. The top down approach to decision making created a binary relation of power that was not respected by PHNs and CHVs. More inclusive ways of communication with and supporting front line workers was valued by PHNs and CHVs. Decision makers may

need to consider how decisions are shared and whether there is transparency in their approaches.

From finding two, communication in EHV practices, sub finding one, reflective practice was identified as an important support for the practices of EHV's in particular and less for PHNs who used less formal strategies for reflection about their practices. Providing emancipatory nursing practices to identify taken for granted norms and values that are experienced in practices can offer support for nurses as they reflect about the practices. (McDonnell, 2012). In this study the reflecting with the program coordinator offered CHVs the opportunity to talk about what they experienced in their EHV practices and they felt a loss of personal support when it was gone as a result of the program change. This finding has an implication for EHV program policy/ decision makers. Given how reflection was a valued part of communication practices for all CHVs finding a way to include this practice again would be valued by CHVs.

From finding three, the unique practices of support within vulnerability understanding how to support mothers and their families living within vulnerability has implications for education. Curriculum in nursing schools can expose students to the concept of vulnerability and talk about how it is unique in the lives of mothers who experience it by including case studies of mothers living within vulnerability to provide exposure to this growing population. Also policy /decision makers can add workplace learning to bring PHNs and CHVs together to learn together about new and emerging information on how to work with mothers living within vulnerability.

Strengths and Limitations

A strength of this study was understanding the practices and experiences of both PHNs and CHVs in the same study and the richness of the data in the examples and stories they shared. By using the methodology of FPS different discourses were identified. Who was speaking, who was not speaking and whose voice was heard emerged in the data analysis. Also this study provides an introductory foundation to further study the practices of PHNs and home visitors who work together in programs like EHV. If this type of blending of workers is expanding in programs like EHV then further research like this study needs to be done to further understand how the practices emerge in other areas outside of where this study occurred.

The sample size of 14 one on one interviews and one follow up focus group to validate what was heard in the interviews created significant data for analysis in this qualitative study. The main themes that arose through the FPS analysis can be transferred to understanding current practices of PHNs and CHVs in EHV.

A limitation of the study was the focus on only one health district in the province. Therefore I would suggest the same study provides a foundation for future research that could be carried out across the province to understand all PHNs and CHVs practices in relation to structural changes. Also geography and context may be uncovered as creating other ways of understanding EHV practices.

Although I was able to uncover the personal agency that PHNs and CHV had to challenge the difficulties presented to them when there were structural and organizational shifts, it would also be important to expand research in this area to uncover other ways of

understanding the shifting structures and organizational changes. A future study guided by FPS with the ‘higher ups’ as the participants called them might uncover another layer of understanding of the hierarchical relation of power experienced by the PHNs and CHVs from an institutional discourse perspective.

Conclusion

This study draws attention to the discourses that constructed practices and meaning within the EHV program for PHNs and CHVs. It has implications for developing new practices and supporting policies as it provided a deeper understanding of how PHNs and CHVs negotiated the relations of power created for them in their practices and how they stayed committed to their support for mothers despite ongoing social and institutional difficulties such as program changes. Analysis of the findings provides an explanation about how PHNs and CHVs negotiated their relationships to support mothers within a relation of power. Their personal agency to respond to change was also integral to the analysis. The changes in the program created an opportunity for all PHNs and CHVs in the study to reflect upon and share their thoughts about what worked and what didn’t work in their practice. Because it was a time of discontent, tension and conflict, the competing beliefs and values about their practices within the EHV program easily rose to the surface as an important topic for them to discuss. Discourse analysis provided the tools to deconstruct and understand HOW particular relations between PHNs and CHVs were integral to their practice and when they were disrupted, HOW it negatively affected their practice.

In this research study the experiences and practices of PHNs and CHVs who worked within the NS EHV program were examined using FPS. The personal, social and institutional experiences and practices of PHNs and CHVs revealed the role of a variety of discourses. Some discourses were more dominant than others depending on the relations of power and the ways in which participants understood and responded to different meanings and practices embedded within the discourses. The main discourses that emerged throughout the study and had an impact on the practices of CHVs and PHNs included mothering, mothers living within vulnerability, expert driven health care, and strengths based health care.

In this study, FPS offered a way to uncover and explain relations of power in society versus providing a single cause as a way to understand relations of power. FPS provided a theoretical basis for analyzing the subject positions of PHNs and CHVs in relation to dominant discourses that existed in society and surrounded their practices. FPS provided a lens that acknowledged the resistance of women like PHNs and CHVs to relations of power that tried to push another way of practicing on PHNs and CHVs. FPS supported uncovering the unique ways that PHNs and CHVs used their personal agency to maintain support for mothers despite the shifting organizational structure. Through analysing the social construction of EHV practices and deconstructing the values and beliefs of the PHNs and CHVs some of the invisible practices emerged.

Policy in public health can also be shaped by using information gleaned from deconstructing experiences within the EHV program. Possibly the ‘higher ups’ might consider how future shifts in the institutional structures can be created to support the

personal agency of all involved through transparent and constructive relations of power. Could there be a new way of understanding how to support PHNs and CHVs in their EHV experiences and practices within the relations of power in the future based upon this study's findings and ultimately a new way to support mothers living within vulnerability?

Health care systems have been traditionally organized around a hierarchical perspective (Porter- O'Grady & Malloch, 2007). Bureaucratic operating systems traditionally control instead of supporting and encouraging employees (Porter- O'Grady). Nurses and allied health professionals are provided with information about organizational leadership but it is often from a traditional hierarchical viewpoint (Long, 2007; Moody et al., 2007). Currently there is an inter-professional movement where practitioners are expected to work with other professionals and share the way they work with people. (Grant, 1995). Within inter professionalism are the individual identities of each practitioner. When roles are blurred in an inter-professional practice environment the identity of the individual practitioners are blurred as well (Grant). In this study, PHNs and CHVs worked in a type of inter professional practice environment. Both PHNs and CHVs had their own subject position or identity and there were expectations connected to their roles within the bureaucratic structure of the public health care institution. When changes affected how PHNs and CHVs worked together their roles and how they worked together to support mothers living within vulnerability were blurred. Within the changed inter professional practice environment the PHNs and CHVs constructed new ways of understanding their subject position or identity.

Future public health research focused on understanding elements of structural and organizational changes and other multiple system practices could uncover other relations of power that surround the EHV practices of PHNs and CHVs and the health outcomes of mothers and families. Through further analyzing the social construction of the organizational changes, the values and beliefs of those making decisions may be uncovered.

According to Hammarstrom & Ripper (1999) if a feminist perspective guided public health care systems there is a potential to understand how power works within a public health care system to disadvantage some groups and systematically advantage other groups (Hammarstrom & Ripper, 1999). Public health systems are developed in different ways throughout the world. For example, in Scandinavia, public health care is developed within a medical discipline and influenced by medical discourse (Hammarstrom et al.). In Australia, public health care is developed within social science that provides a perspective on health with an emphasis on class, ethnicity and how power affects the health status of populations like mothers living within vulnerability (Hammarstrom et al.). If a feminist perspective was incorporated into our western approaches to public health it is possible that the traditional bureaucratic way of making decisions could be shaken. A shift in the relations of power between and among the inter professional teams, managers and decision makers could be moved from one of a binary relation of power to a shared relation of power.

A research program focused on community home visiting has the potential to provide a foundation that can have sustained impact on furthering the understanding and

practices of programs like EHV. Peckover (2013) suggests that many studies and individual researchers have made valuable contributions to home visiting work. She proposes a more coordinated research program could offer the possibility for sustained home visiting research and the building of teams.

There is a long history of applying institutionalized social norms and values regarding parenting and family life within home visiting globally (Peckover, 2002). Foucault believed in challenging societal assumptions about accepted knowledge and truth and he pushed for consideration of the agency people had within themselves to change and create another way of experiencing their life. Feminist authors have also taken ideas from Foucault and developed these ideas further to include agency through personal and social contexts (Butler, 2005, 1990a, 1990b, 1984). PHNs and CHVs also believed in challenging accepted truths about mothers and facilitated mother's agency to work through the challenges they faced.

Home visiting has been considered to have a gendered nature and gained attention in the literature when feminist writers suggested that the work of home visiting was the responsibility of health visitors (PHNs) who were predominantly women and who were also mothers (Peckover, 2011). A feminist analysis of home visiting provided a lens to make visible assumptions about women's roles in providing care for their families. For example, there is societal pressure for mothers to stay home and breastfeed or mothers who fit into the societal norms of mothering they may feel good about their mothering (Rossiter, 1990). For those mothers who do not fit the societal norm of mothering they may feel guilty (Green, 2009, 2008, 2006; Kinser, 2008; Stephenson, 2012).

In this study the beliefs, values and practices of PHNs and CHVs were examined as well as how they understood mothering. In society, mothering has been socially and institutionally influenced and each mother has a unique experience that can be understood in different ways (Cheek, 1999; Weedon, 1993). The program and related practices of EHV is part of a societal institution that influences the lives of mothers and how they learn to parent or mother as participants during the visiting practices. The way in which EHV practices are represented in texts is an indication of broader knowledge, beliefs and value systems. Dominant medical health discourses that represent experiences in the health care system construct realities in ways that are often taken for granted and invisible (Chapman & Lupton, 1994). EHV cannot be understood in isolation of the social context in which it is situated. It is important to remember that mothering has also been described as a social experience where societal structures set up conditions in mother's lives that affect them in many ways including their health (Varcoe & Doane, 2007). EHV has also been suggested to affect the health outcomes of mothers (Aston et al., 2014). The social expectations that surround mothering affects the subject positions that mothers believe they need to take up to be a good mother (Short, 2005; Weedon, 1993).

Motherhood is considered an institution that society has created and includes multiple meanings of mothers that have been created historically through societal discourse, and the language through discourse, that is used to describe mothers' lives (Foucault, 1998; Roister, 1990; Short, 2005). PHNs and CHVs' practices in NS focus on supporting targeted, vulnerable or at risk mothers through the EHV program. The

language of targeted, vulnerable and at risk represents the way Public Health has defined the mothers who should participate in the EHV based upon their needs. A question remains for me. In providing only a target EHV program for mothers who live within vulnerability are we further labelling and stigmatizing them, or are we opening up an opportunity to create a new discourse of how to support mothers living within vulnerability? I don't have the answer but future research is needed to keep the momentum going that was created by the PHNs and CHVs' practice stories who participated in this study. Their commitment to support mothers living within vulnerability exposed the uniqueness of their EHV practices and how they responded to complex and difficult situations in the lives of mothers living within vulnerability. As one CHV shared "...a vulnerable population needs to be supported in a certain way..." and those certain ways were in the examples from PHN's and CHV's practices.

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Appendix A

Letter of Introduction for Directors of Public Health and PHNs

Principal Investigator	Debbie Sheppard-LeMoine PhD Student Dalhousie University Phone: 902-835-5359 Email: debbie.sheppard-lemoine@dal.ca
Supervisor	Dr. Megan Aston PhD RN Associate Professor School of Nursing Dalhousie University Phone: 902-494-3487 Email: megan.aston@dal.ca

December 23, 2013

Director of Public Health / PHNs

Dear Potential Participant

My name is Debbie Sheppard-LeMoine. I am a PhD student in the school of nursing, Dalhousie University. I am interested in doing a research study exploring the practices and experiences of PHNs and CHVs who support mothers and families who participate in the enhanced home visiting program.

The purpose of this study is to examine how the Nova Scotia Enhanced Home Visiting Program for families is organized, delivered and experienced through the everyday practices and social contexts of PHNs and CHVs in Nova Scotia.

If you or a colleague would like to participate and you have at least six months of experience working in the enhanced home visiting program, I would like the opportunity to hear what your experiences have been. You will be invited to participate in a one –on-one interview with me to explore your experiences and practices working in the enhanced home visiting program. The anticipated time for the interview is approximately 60-90 minutes.

Participation in the study is voluntary. If you wish to discontinue your participation in the study you may do so at any time up until data analysis. All information will be kept confidential and your identity will remain anonymous. All data collected will be securely stored with only the principal investigator and thesis supervisor having access to the data. Pseudonyms will be used when presenting direct quotes from the data to protect your identity. The results of the study will be made available to you upon the completion of the study analysis. There is also a written consent form for you to read prior to participation in the study.

The study is being conducted with approval from The Capital Health Research Ethics Board and The Dalhousie University Office of Human Research Ethics Board and

approval from the director of public health. I will contact those who wish to be a participant in the study and meet with them at a time and location that is convenient for them. Participants in the study will be asked to sign a consent form. As the interviewer I will ensure that each participant is comfortable prior to proceeding to the semi- structured interview that will be scheduled for 60-90 minutes. Each interview will be taped. You also have the choice of being audio/video taped remotely using a Dalhousie University system called Black Board Learn. All audiotapes of the interviews will be destroyed following transcription. Transcripts will be kept in a locked cabinet during the study duration and will be destroyed after five years. Please contact me at 902-835-5359 if you have further questions.

Sincerely,

Debbie Sheppard-LeMoine, MN, RN

Debbie.Sheppard-LeMoine@dal.ca

Appendix B

Letter of Introduction for Directors of Family Resource Centers and CHVs

Principal Investigator	Debbie Sheppard-LeMoine PhD Student Dalhousie University Phone: 902-835-5359 Email: debbie.sheppard-lemoine@dal.ca
Supervisor	Dr. Megan Aston PhD RN Associate Professor School of Nursing Dalhousie University Phone: 902-494-3487 Email: megan.aston@dal.ca

December 23, 2013

Director of Family Resource Centers / CHVs

Dear Potential Participant:

My name is Debbie Sheppard-LeMoine. I am a PhD student in the school of nursing, Dalhousie University. I am interested in doing a research study exploring the practices and experiences of PHNs and CHVs who support mothers and families who participate in the enhanced home visiting program.

The purpose of this study is to explore how the Nova Scotia Enhanced Home Visiting Program is organized, delivered and experienced through the everyday practices and social contexts of PHNs and CHVs in Nova Scotia.

If you or a colleague would like to participate and you have at least six months of experience working in the enhanced home visiting program with mothers and families I would like the opportunity to hear what your experiences have been. You will be invited to participate in a one –on-one interview with me to explore your experiences and practices working in the enhanced home visiting program with mothers and families. The anticipated time for the interview is approximately 60-90 minutes.

Participation in the study is voluntary. If you wish to discontinue your participation in the study you may do so at any time prior to data analysis. All information will be kept confidential and your identity will remain anonymous. All data collected will be securely stored with only the principal investigator and thesis supervisor having access to the data. Pseudonyms will be used when presenting direct quotes from the data to protect your identity. The results of the study will be made available to you upon the completion of the study analysis. There is also a written consent form for you to read prior to participation in the study.

The study is being conducted with approval from The Capital Health Research Ethics Board and The Dalhousie University Office of Human Research Ethics Board and approval from the director of public health. I will contact those who wish to be a participant in the study and meet with them at a time and location that is convenient for them. Participants in the study will be asked to sign a consent form. As the interviewer I will ensure that each participant is comfortable prior to proceeding to the semi- structured

interview that will be scheduled for 60-90 minutes. Each interview will be taped. You also have the choice of being audio/video taped remotely using a Dalhousie University system called Black Board Learn. All audiotapes of the interviews will be destroyed following transcription. Transcripts will be kept in a locked cabinet during the study duration and will be destroyed after five years. Please contact me at 902-835-5359 if you have further questions.

Sincerely,

Debbie Sheppard-LeMoine, MN, RN

Debbie.Sheppard-LeMoine@dal.ca

Appendix C

Participant Informed Consent for Interview

Study Title: Exploring the practices and experiences of PHNs and CHVs who support mothers and families who participate in the enhanced home visiting program in Nova Scotia.

Principal Investigator Debbie Sheppard-LeMoine
PhD Student
Dalhousie University
Phone: 902-835-5359
Email: debbie.sheppard-lemoine@dal.ca

Introduction

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you don't understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researcher will:

- Discuss the study with you
- Answer your questions
- Keep confidential any information which could identify you personally
- Be available during the study to deal with problems and answer questions

Participating in the study may not benefit you personally, but we might learn things that will benefit others. We cannot always predict these things.

Participation in the study is strictly voluntary and you may withdraw from the study at any time up until data analysis.

Why is This Study being done?

I am a graduate student in the PhD Nursing Program at Dalhousie University. I invite you to participate in a research study entitled "Exploring the Practices and Experiences of PHNs and CHVs who Support the Health of Mothers and Families who Participate in the Nova Scotia Enhanced Home Visiting Program" as part of my degree requirements. The purpose of this study is to understand how the practices and experiences of PHNs and CHVs support the health of mothers and families who participate in the Nova Scotia Enhanced Home Visiting Program. Little is known about how the personal, social and institutional relational practices of public health nurse and CHVs together impact mothers and families' experiences as participants in the NS Enhanced Home Visiting Program.

Why Am I Being Asked To Join The Study?

As a public health nurse or a community home visitor you have at least six months of experience working within the NS Enhanced Home Visiting Program and thus have been identified as a possible participant for inclusion in the study.

How Long Will I Be In The Study?

Data collection and concurrent analysis will take place over 6-12 months. Participants will be required to stay involved with the study until after a focus group occurs upon completion of the data analysis

How Many People Will Take Part In This Study?

Approximately 6-8 PHNs and 6-8 CHVs within the Capital District Health Authority in NS will be recruited to participate in the study.

How Is The Study Being Done?

Participants will be asked to take part in one semi structured interview that will last 60-90 minutes. The interviews will be scheduled at a time that is convenient for you to meet with me, at a place where you would feel comfortable. The interviews will be audio taped and transcribed verbatim. The raw audio files will be kept in a locked cabinet. If any audio files of interviews are obtained through Black Board Learn which is offered by Dalhousie University the files will be encrypted providing a password protected environment on a computer where only the researcher has access. When data analysis is completed the preliminary research findings from the interviews and the identified

themes will be shared with the participants in a focus group for their validation of their representation of their experiences.

What Will Happen if I Take Part in The Study?

You will be asked to take part in one semi structured interview in a confidential location of your choice either in person or remotely. You will be guided through an interview process by open ended questions which you can change or add to during the interview if you believe there are other areas you would like to cover. The interviews will be audio taped using a Dalhousie University system called Black Board Learn. Upon completion of the data analysis you will be asked to participate in a focus group.

Are There Risks to The Study?

There are no anticipated risks to participating in the study. If the interview becomes too difficult for the participant at any time, the interview will end. If you find a question too personal you are not required to answer.

What Are My Responsibilities?

As a study participant you will be expected to respond to the questions of the researcher during the interview. During the focus group you will be expected to offer your input about the data analysis and whether it represents your practices and experiences.

Can I Be Taken Out Of the Study without My Consent?

Yes, you may be taken out of the study at any time, if: there is new information that shows that being in the study is not in your best interests; the Capital Health research Ethics Board or the Principal Investigator decides to stop the study.

Will It Cost me Anything?

There will be no costs for participating in this study and no compensation will be provided for participants.

What About My Right To Privacy?

Protecting your privacy is an important part of the study. A copy of this consent will be kept in a locked cabinet.

Your name and all information about you will not be identified as a pseudonym will replace your name in all documents connected to the study. After the audio taped interview is transcribed, the tape will be destroyed. Tapes will be kept in a locked file cabinet known only to the researcher and will not be accessible to anyone except the

researcher. Any notes from reflective journaling made during the study will also be kept in the locked cabinet. These materials will be destroyed at the end of seven years after the study is completed as per protocol of the Capital Health Research Ethics Board. The results of the research will be published in journals, presented in the researcher's dissertation and at conferences. If you would like a copy of the results, a copy will be provided upon request.

What If I Want To Quit the Study?

If you chose to participate and later change your mind, you can say no and stop the research up until data analysis begins. If you wish to withdraw your consent please inform the principal investigator.

Declaration of Financial Interest

The principal investigator is not being paid to conduct this study.

What Are My Rights

After you have signed this consent form you will be given a copy.

If you have any questions about your rights as a research participant, contact the researcher for the study:

Debbie Sheppard-LeMoine
Dalhousie University School of Nursing
Phone: 902-835-5359 (Home).
E-Mail: debbie.sheppard-lemoine@dal.ca

Consent Form Signature Page

I have reviewed all of the information in this consent form related to the study called:

Examining the Practices and Experiences of PHNs and CHVs Who Work Within the Nova Scotia Enhanced Home Visiting Program

I have been given an opportunity to discuss the study and my questions have been answered to my satisfaction.

The signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw from the study up until analysis of the data begins.

Signature of Participant

Name (Printed)

____ / ____ / ____
Year / Month / Day*

Witness to Participant's
Signature

Name (Printed)

____ / ____ / ____
Year / Month / Day*

Signature of Researcher

Name (Printed)

____ / ____ / ____
Year / Month / Day*

Appendix D

Semi –Structured Interview Guide

1. I am curious about your experiences and practices as a public health nurse/community home visitor in the enhanced home visiting program working with mothers and families. Please tell me about your experiences supporting mothers and families who participate in the enhanced home visiting program.
2. How do you understand the enhanced home visiting practice supports mother' and family's health?
3. How is your practice organized within the organization that provides this service?
4. How do you interact with others who work within the home visiting program?

Appendix E

Letter of Information for Focus Group Participants

Study Title: Examining the Practices and Experiences of PHNs and CHVs Who Work Within the Nova Scotia Enhanced Home Visiting Program

Researcher: Debbie Sheppard-LeMoine, PhD Student, School of Nursing, Dalhousie University

Supervisor: Dr. Megan Aston

Dear Public Health Nurse or Community Home Visitor:

I am inviting you to take part in a focus group to review the data collected from your one on one interview. The focus group will give you the opportunity to ask questions, make comments, and give ideas about the analysis of the study data. The reason for the focus group is to ensure you believe the analysis represents your practices and experiences.

If you are interested in taking part in the focus group you can come to the focus group for PHNs on _____ date or to the focus group for CHVs on _____ date. If you have agreed to take part in the focus group, you will be asked to sign a consent form (Appendix F).

If you would like further information, you can contact me by phone at any time at 902-835-5359 (h) or e-mail: debbie.sheppard-lemoine@dal.ca.

Thank you for your interest in this research study. Information from this study will be helpful in assisting PHNs, CHVs and policy makers.

Respectfully Yours,
Debbie Sheppard-LeMoine PhD(c)

Appendix F

Informed Consent for Focus Group Participants

Study Title: Exploring the practices and experiences of PHNs and CHVs who support mothers and families who participate in the enhanced home visiting program in Nova Scotia.

Principal Investigator Debbie Sheppard-LeMoine
PhD Student
Dalhousie University
Phone: 902-835-5359
Email: debbie.sheppard-lemoine@dal.ca

Introduction:

You have already participated in the study as an interview participant. I am inviting you now to participate in a focus group to review analysis of the interview data. Your taking part in this study is voluntary and you are free to pull out from the study at any time. The reason for this study will be discussed with you. Taking part in the focus group may or may not benefit you but we might learn things that will benefit others.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you don't understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researcher will:

- Discuss the study with you
- Answer your questions
- Keep confidential any information which could identify you personally
- Be available during the study to deal with problems and answer questions

Participating in the study may not benefit you personally, but we might learn things that will benefit others. We cannot always predict these things.

Participation in the study is strictly voluntary and you may withdraw from the study at any time up until data analysis.

Why is This Study being done?

I am a graduate student in the PhD Nursing Program at Dalhousie University. I invite you to participate in a research study entitled "Exploring the Practices and Experiences of PHNs and CHVs who Support the Health of Mothers and Families who Participate in the Nova Scotia Enhanced Home Visiting Program" as part of my degree requirements. The purpose of this study is to understand how the practices and experiences of PHNs and CHVs support the health of mothers and families who participate in the Nova Scotia Enhanced Home Visiting Program. Little is known about how the personal, social and institutional relational practices of public health nurse and CHVs together impact mothers and families' experiences as participants in the NS Enhanced Home Visiting Program.

Why Am I Being Asked To Join The Study?

As a public health nurse or a community home visitor who was interviewed for the corresponding study and thus have been identified as a possible participant for inclusion in the focus group.

Who will be doing the Focus Group?

Debbie Sheppard-LeMoine, a nurse and graduate nursing student will facilitate the focus group.

How Many People Will Take Part In This Study?

Approximately 6-8 PHNs and 6-8 CHVs within the Capital District Health Authority in NS will be recruited to participate in the focus group.

How is the study Being Done?

You will be asked to take part in one focus group. We will talk about the findings of the data analysis from the interviews in which you were participants. During the focus group, you can tell me if the themes represent what you said in your interview. Each focus group will be scheduled for 60-90 minutes, at a place in your home community.

What Are My Responsibilities?

As a study participant in the focus group you will be expected to offer your input about the data analysis and whether it represents your practices and experiences.

Can I Be Taken Out Of the Study without My Consent?

Yes, you may be taken out of the study at any time, if: there is new information that shows that being in the study is not in your best interests; the Capital Health research Ethics Board or the Principal Investigator decides to stop the study.

Will It Cost me Anything?

There will be no costs for participating in this study and no compensation will be provided for participants.

What About My Right To Privacy?

Protecting your privacy is an important part of the study. A copy of this consent will be kept in a locked cabinet.

It is not possible to keep all information that you may tell me private as your community is small and people may know you by what you say and how you say it. However, I will do everything I can to make sure that your name and all information about you will not be shared in any final reports or anything put in journals. You will decide on a made up name or pseudonym that will be used in all reports and documents. All tape recordings, information, and notes about the study will be locked in a filing cabinet in my office.

All information about the study will be kept for seven years after the study is finished and reported. Then, they will be destroyed.

Any data about the study will stored on the computer will be protected by a password. This data will not be used in any other studies in the future. The computer data will be deleted after the study is reported in journals.

The results of this study and quotes will be published reports and journals, and presented at conferences. Your name will not be identified in any reporting of the study results unless you want your name made known. If you want a copy of the results, I will make sure you get one.

Are There Risks to The Study?

There are no known risks to taking part in this study. But some of you may feel that sharing your experiences are personal or upsetting. If you have any feelings of discomfort or have any concerns or fears I can give you names and how to get in touch with a counsellor or support services in your area. If you find a discussion in the focus group too personal you do not have to participate. The tape recorder can be turned off at any time, if you wish. You can ask questions to me before, during, or after the interview.

What If I Want To Quit the Study?

You can remove yourself from the study if you wish and have your data removed at any time up until one month after the focus group. If you chose to withdraw from the study, I will offer to destroy all your data or return it to you if you wish.

Declaration of Financial Interest

The principal investigator is not being paid to conduct this study.

What Are My Rights

After you have signed this consent form you will be given a copy.

If you have any questions about your rights as a research participant, contact the researcher for the study:

Debbie Sheppard-LeMoine
Dalhousie University School of Nursing
Phone: 902-835-5359 (Home).
E-Mail: debbie.sheppard-lemoine@dal.ca

Consent Form Signature Page

I have reviewed all of the information in this consent form related to the focus group for the study called:

Examining the Practices and Experiences of PHNs and CHVs Who Work Within the Nova Scotia Enhanced Home Visiting Program

I understand that my interview will be tape recorded. I agree for my words to be used as quotes in reports, publications or presentations. I am fully aware that my name will not appear on any of these quotes or statements, unless I want them to.

I have been given an opportunity to discuss the study and my questions have been answered to my satisfaction.

The signature on this consent form means that I agree to take part in this focus group. I understand that I am free to leave the focus group at any time.

_____ Signature of Participant	_____ Name (Printed)	____ / ____ / ____ Year Month Day*
_____ Witness to Participant's Signature	_____ Name (Printed)	____ / ____ / ____ Year Month Day*
_____ Signature of Researcher	_____ Name (Printed)	____ / ____ / ____ Year Month Day*

Thank you for interest in this focus group.

Respectfully Yours,

Debbie Sheppard-LeMoine, PhD(c)

Appendix G

Transcriptionist Agreement of Confidentiality

Debbie Sheppard-LeMoine a PhD student at Dalhousie University, School of Nursing is conducting the study, “**Examining the Practices and Experiences of PHNs and CHVs Who Work Within the Nova Scotia Enhanced Home Visiting Program**”

As the Transcriptionist, I agree to keep all the research information shared with me confidential.

I will not discuss or share any of the research information in any form or format (e.g., all data, materials, disks, tapes, transcripts) with anyone other than the researcher.

I agree to keep all research information in any form or format (e.g., all data, materials disks, tapes, transcripts) secure while it is in my possession.

I agree to return all research information to the researcher, Debbie Sheppard-LeMoine, once I have completed transcription.

I agree that after consulting with the researcher, to erase or destroy all information stored on my computer hard drive regarding this research project that is not returnable to the researcher.

Signature of Transcriptionist _____
Name (Printed) _____ / _____ / _____
Year Month Day*

Signature of Researcher _____
Name (Printed) _____ / _____ / _____
Year Month Day*

Concerns or questions pertaining to this study may be addressed to:

Debbie Sheppard-LeMoine
PhD Nursing Student, Dalhousie University
Department of Nursing
Debbie.Sheppard-lemoine@dal.ca
Phone: 1-902-835-5359

Appendix H

The Pearl Effect

Understanding the Social and institutional Construction of Enhanced Home Visiting Experiences

