**ENVISIONING PATHWAYS TO COMMUNITY HEALTH
THROUGH THE EYES OF NORTH END HALIGONIANS**

by

Dorothy R Barnard

Submitted in partial fulfillment of the requirements
for a degree of Doctor of Philosophy

at

Dalhousie University
Halifax, Nova Scotia
August 2010

DALHOUSIE UNIVERSITY

INTERDISCIPLINARY PhD PROGRAM

The undersigned hereby certify that they have read and recommend to the Faculty of Graduate Studies for acceptance a thesis entitled "ENVISIONING PATHWAYS TO COMMUNITY HEALTH THROUGH THE EYES OF NORTH END HALIGONIANS" by Dorothy R Barnard in partial fulfillment of the requirements for the degree of Doctorate of Philosophy.

Dated: August 18, 2010

Supervisor: _____

Readers: _____

                     _____

                     _____

                     _____

                     _____

                     _____

DALHOUSIE UNIVERSITY

DATE: August 18, 2010

AUTHOR: Dorothy R Barnard

TITLE: ENVISIONING PATHWAYS TO COMMUNITY HEALTH THROUGH THE EYES OF NORTH END HALIGONIANS

DEPARTMENT OR SCHOOL: Interdisciplinary PhD Program

DEGREE: PhD   CONVOCATION: October   YEAR: 2010

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

There are many populations poorly served by the current Canadian approach to health and illness care. These populations include members of ethnic minority groups, those with poor socio-economic status, those who are homeless, working in the sex trade or affected by mental illness. One way of potentially improving the health of communities or populations is through policy. In addition, a deeper understanding of the health needs of underserved populations could facilitate expeditious solutions mindful of resource challenges. In spite of copious research, health inequities and disparities persist. My hypothesis was that the conscious use of specific lenses to examine policies or interview data was a useful device to both better visualize and understand actions related to policy development and community member input.

Thus, this thesis research was comprised of two major components. The first was an exploration of two policies of an academic tertiary health care centre through the lenses of feminist, critical social and systems theory. The objective was to determine if viewing policy development using different lenses might influence thinking about issues related to underserved populations. The second component used the same three lenses to conduct a grounded theory analysis of eleven photo-elicitation and six photo-voice interviews with North End Halifax Community members. The focus of these interviews was on contributions to health found in the community of North End Halifax.

The results clearly show that examination of policies through the three theoretical lenses serves to highlight hidden assumptions and to broaden the view and comprehension of implications and potential impacts of policies. A better way to formulate policies is one step towards achievement of improved health outcomes. The use of three lenses in the grounded theory analysis significantly enhanced the depth of interview analysis: the feminist lens accentuated the concept of caring and relationships and the extent of the White-middle-class male perspective; the critical social lens crystallized the power disparities at play; and the systems lens stressed the need to examine root causes. The conscious use of specific lenses could facilitate a more comprehensive and comprehended view of the health needs of underserved populations.

LIST OF ABBREVIATIONS USED

ABCD	Asset-Based Community Development
APA	American Psychology Association
BBI	Black Business Initiative
CAS	Complex Adaptive System
CEO	Chief Executive Officer
CIHR	Canadian Institute of Health Research
CHSRF	Canadian Health Services Research Foundation
CME	Continuing Medical Education
COPD	Chronic Obstructive Pulmonary Disease
DoH	Department of Health
EBM	Evidence-Based Medicine
ECEC	Early Childhood Education and Care
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Disease
GBLTI	Gay Bisexual Lesbian Transsexual Intersex
HRD	Human Resource Development
HRM	Halifax Regional Municipality
IWK	Izaak Walton Killam
NDP	New Democratic Party
NGO	Non-Governmental Organization
OT	Occupational Therapy
PT	Physiotherapy
SES	Socio-Economic Status
STARS	Special Time to Appreciate and Recognize Staff
WHO	World Health Organization

ACKNOWLEDGEMENTS

CHAPTER 1   INTRODUCTION

The purpose of this thesis research was to increase understanding of ways to potentially improve access to health and health care for North End Halifax community members as an exemplar of underserved populations. This research built on the results of a pilot study examining the apparent low incidence of sickle cell disease in the African Nova Scotian population. That pilot research explored the question "What are the historical factors that could impact the incidence of sickle cell disease in the African Nova Scotian population?". Out of that grounded theory research arose the basic social process "invisible people, invisible malady". Many of the underserved populations of this thesis study (members of North End Halifax) are similarly invisible to those with privileged background and are largely forgotten within our healthcare system.

Three major contextual components related to the pilot study question evolved. Racism appeared to permeate all aspects of African Nova Scotian history and health outcomes. The sickle gene frequency was felt to have been influenced by multiple factors affecting the genetic pool of the indigenous African Nova Scotian population. The lack of data (and lack of commitment to resources to determine the incidence of sickle cell disease) had and has a significant impact limiting our understanding of the issues. Being Invisible (or becoming visible) was determined to have three associated processes: understanding sickle cell disease, accessing health care and knowing to seeing (that is knowledge leads to recognizing). In a way, sickle cell disease, and the lack of attention paid to it in Nova Scotia, became emblematic of a general perception by many of the members of the African Nova Scotian population that scant heed was given to issues related to their health and associated health care services. The pilot study increased my awareness of unaddressed health concerns related to marginalized populations such as African Nova Scotians and those living in North End Halifax.

Through this thesis research, two interwoven paths were explored to make more visible the issues related to health and health services for individuals and communities experiencing health and healthcare inequities. I chose to examine examples of health centre policies and North End Halifax community member interviews through three

lenses: feminist theory, critical social theory and systems theory. In this way I hoped to contribute new ways of thinking and thus of developing solutions.

1.1 OBJECTIVES OF THE RESEARCH

My thinking about how I, as an outsider, could make a positive contribution to improving access to health for members of the North End Halifax community (and others in similar circumstances) had two inter-linking directions. As a physician member of the IWK Health Centre, Halifax, Nova Scotia, I felt it exemplified the richness of illness care organizations. Those riches were not only financial, but in human resources, knowledge and expertise; of research and teaching; of reputation, public interest and respect. And I sensed that, as an organization, the Health Centre could be more proactive and collaborative in sharing these resources with others. As the Board of the Health Centre was ultimately responsible for the direction of the Health Centre, I thought that the Board policies could reflect that direction. I hoped that an exploration of a Board policy and a Health Centre policy through the three theory lenses would uncover a new view of the Health Centre and its potential roles in improving access to health. I hoped that it would illustrate the potential of policy development using consciously constructed, value-informed lenses.

The second aspect of my thinking related to how little I understood about the lives of North End Halifax community members and how their life-worlds might affect access to health. As a former health professional, I felt I needed a way to facilitate communication and chose the medium of photographs. The second component of this thesis research used grounded theory methodology, photo-elicitation and the three lenses to analyse transcribed interviews of North End Halifax Community members. The focus of these interviews was on contributions to health found in the community of North End Halifax.

Using the lenses and approaches described in Chapters 2 and 3, the objectives of the <u>first component of this research</u> were:

1.   to examine two broadly applicable administrative policies through the lenses of feminist theory, critical social theory and systems theory; and

2.   to determine whether the lenses elicited a different view of the policies.

Primarily, this research was a thought trial reminiscent of the one carried out by Storberg-Walker (2007) where she undertook "an intellectual exercise of examining a variety of social capital theories, imagining the various HRD *(human resource development)* outcomes from that theory." (p. 314)(italics inserted). Thought trials are built on the work of Weick, 1989; on disciplined imagination "where the 'discipline' in theorizing comes from consistent application of selection criteria to trial and error thinking and the 'imagination' in theorizing comes from deliberate diversity introduced into the problems statements, thought trials, and selection criteria that comprise that thinking." (p. 516). In this research, the three lenses functioned as selection criteria.

In the <u>second component of this thesis research</u>, (see Chapter 5 for details on approach), I explored the use of the three lenses as a means through which access to health and health care of vulnerable populations such as those found in the ethnically and socioeconomically diverse North End of Halifax could be more clearly illuminated. For the purpose of this research, access to health included examining the impacts of the social determinants of health (Cacioppo, Hawkley, 2003; Sampson, 2003; Thisted, 2003; Bonham, Ramos, 2008; Kisely et al, 2008; Raphael et al, 2008).

Study participants were members of the North End Halifax community and were recruited with the purpose of obtaining a sample that reflected the diversity of the populations of that community. This study built on the premise that the community and its members had resources and capabilities that could engender changes resulting in better community health. Photo-interviewing and photo-elicitation (use of photographs as triggers for dialogue during participant interviews) were used to obtain information from community members.

The objectives of <u>the second component of the research</u> were:

1. to determine if the use of the three lenses as a component of the grounded theory analyses of community member interviews could provide a greater depth of understanding of issues related to access to health for North End Halifax community members; and secondarily,

2. to better understand the access to health for North End Halifax community members (a community whose members include populations challenged by health inequities) through the medium of photography and grounded theory analyses of study participant interviews.

The assumptions of this thesis research are:

-there are populations (such as many members of North End Halifax) who are poorly served by our present health system, contributing to their inequities in health

-we should strive to redress these inequities

-policies are one way to affect how well our health system functions

-better ways to formulate policies (i.e. through the use of the three lenses) and to obtain knowledge from community members (i.e. using photo-elicitation and interview data analyses through the use of the three lenses) are needed to allow us to see a pathway forward to improved community health.

The underlying hypothesis of this thesis research was:

- the conscious use of specific lenses to examine policies or interview data would be useful to both better visualize and understand actions related to policy development and community member input.

1.2   REVIEW OF RELEVANT LITERATURE

Literature pertaining to access to health care systems, racial and ethnic disparities, and inequities in health and health care was reviewed. Initially, the literature was examined sufficiently to provide a general impression of the issues related to these themes.

1.2.1   Health Inequities/ Disparities:

As equity is a normative concept it cannot be measured directly. Health disparities or inequalities were defined by the National Institutes of Health, 1999, as "differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific population groups." (Krieger, 2005; p. 6). For the World Health Organization, "the concept of inequity involves notions of fairness and injustice, while difference just means difference- with no normative judgment." (Krieger, 2005; p. 6).

> *Inequities in health:* '…are unnecessary and avoidable, but in addition, are also considered unfair and unjust' while *Equity in health:* means 'everyone has the fair opportunity to attain their full health potential'; by contrast *Inequalities in health:* …as a term, is not explicit about injustice or fairness and instead could refer to differences that do not necessarily arise from inequity (Krieger, 2005)(italics as in original).

A very comprehensive definition for social disparities proposed by Krieger, 2005, (p. 6) is given below.

> Social disparities…refer to health inequities spanning the full…continuum, across the lifecourse. These…disparities involve social inequalities in the prevention, incidence, prevalence, detection and treatment, survival, mortality, and burden of …health conditions and behaviors. They arise from inequities involving, singly and in combination, adverse working and living conditions and inadequate health care, as linked to experiences and policies involving socioeconomic position (e.g., occupation, income, wealth, poverty, debt, and education) and discrimination. This discrimination, both institutional and interpersonal, can be based on race/ ethnicity, socioeconomic position, gender, sexuality, age, language, literacy, disability, immigrant status, insurance status, geographic location, housing status, and other relevant social categories.

Addressing inequities in the health of Canadians must include significant changes to the health care system and major modifications to the philosophic, economic, social, policy and political frameworks within our country. It will require giving attention to the determinants of health.

Access is a major contributor to health care disparities and has been emphasized as the centerpiece for elimination of healthcare inequities and disparities (Andrulis, 1998). Other inequities are found in satisfaction with health care, treatment and outcomes. As

summarized by Fiscella, 2003, racial disparities were found in most of the quality dimensions of health care processes- safety, effectiveness, timeliness, efficiency, acceptability, appropriateness and continuity across the spectrum of health (staying healthy, getting better, living with chronic disorders and facing end-of-life). For example, African Americans were less likely to receive appropriate care for lung and breast cancer or HIV infection. Overall, they received poorer quality prenatal care and interventions for pain control. African Americans had higher hospitalization rates, deaths from preventable disease, higher rates of pre-term and low weight infants and expressed lower satisfaction with their care (Fiscella, 2003). In the USA, the age-adjusted mortality rate for African Americans was approximately 1.6 times that for Euro Americans; the mortality rate for heart disease was 50% higher in African Americans (American College of Physicians, 2004). Outcomes were less discrepant where access to care was equal for both African Americans and Euro Americans (Kressin et al, 2007). Infant mortality and hypertension, unexplained by socioeconomic status, were significantly higher in African Americans (Lillie-Blanton, 1996).

The etiology of health care disparities is multi-factorial and, as summarized by Fiscella, 2003, includes patient/ user factors (practicalities such as job, child-minding, transportation; feelings such as distrust, fear, preferences; language differences); physician factors (bias, racial discordance, training); health plan (health care components covered, location of services) and community/ societal factors (segregation, availability of safety net providers). Others have highlighted the contribution of neighborhood characteristics, age and attitudes towards health risk (Kirby et al, 2006).

1.2.2   Examples of Nova Scotian Health Inequities/ Disparities

a.   **African Nova Scotians**

Disparities in health are illustrated by the higher frequency of heart disease, diabetes, hypertension, cancer, arthritis, HIV and chronic asthma in African Nova Scotians compared with Euro Nova Scotians. Specific examples of increased mortality include breast and prostate cancer; the prevalence of obesity is higher in African Nova Scotians compared to other Nova Scotians (Benton, Loppie, 2001). In general, African Nova

Scotians are younger, have a lower median income, are less likely to have completed high school, and more likely to be unemployed than the total Nova Scotian population (Nova Scotia Community Counts, 2001). This is relevant as education and socio-economic circumstances are inextricably intertwined and recognized components of the determinants of health. These long-term effects and challenges were created through history, marginalization and discrimination. These inequities are invisible to the majority of Nova Scotians.

b.   North End Halifax Community

This community of approximately 20,000 people is compared with the Halifax Capital Health District as a whole in **Table 1** (Community Counts, Nova Scotia, 2001).

Table 1   Demographics

	North End Halifax	Halifax
Single-parent families	26%	16%
Minorities	15%	7%
African Nova Scotians	11%	4%
Median income	$19,000	$59,000
Not in labour force	30%	12%
Ages 20-54 years	70%	53%

Although official statistics are not available, the aggregate health of North End Halifax community residents is believed to be the poorest within the Atlantic Provinces. Elements contributing to community members' poor health can be traced through the history of the community.

The community has a proud and troubled history that has contributed both to its present circumstance and its resilience. Halifax has been described as a collection of neighbourhoods. Stereotypically the South End is upper class, the West End middle class, and the North End lower class (the East End is the business district). Colloquially, as exemplified in a myriad of ways including print and voice journalism, many hold

residents of North End Halifax in poor regard. Many members of the North End community have come to believe the poor opinion others have of them. And as McDaniel, 1997, stated, "It is the intention of the observer that determines what is observed", thus often preventing new understanding or changing of unfavourable views. Past interventions, largely emphasizing deficits, have addressed the symptoms (indeed people became labelled as symptoms) rather than a cure for the ills or root causes (see Section 1.2.4).

The history of North End Halifax contributes to an understanding of the populations that have settled in the area. The following synopsis was based on Erickson, 2004. Halifax was a fortress built with the arrival of Cornwallis in 1749. Aside from the British, early settlers included Germans whose heritage is still apparent in the area. The face of the North End changed from naval town; thriving and wealthy during the Wars of Independence; followed by recession and decline, through prestigious housing to blue collar workers' homes; from a successful economic district to a landscape of vacant lots and departed businesses. Adversity plagued the area through railway line hazards, the Halifax Explosion, the post-war depression and the evacuation of citizens from their Africville homes from 1960-1970.

In the 1960s and on, urban renewal further changed the North End - the population declined, and industry and commerce moved to the East End. It became an area where those living with poverty or housing insecurity, mental illness or addiction, unemployment or involvement in the sex trade found some companionship and acceptance. New immigrants came to the area because of its cheap housing and the varied backgrounds of other residents. In the 1970s, segments of the area (largely on the periphery) became gentrified as gas prices increased (thus discouraging commuting) and houses in other areas of the Halifax peninsula became scarce and expensive. Rich in history, this area now has one of the most diverse populations in Halifax (socioeconomically, culturally and educationally); a population that can take pride in its survivorship, resilience, ingenuity in adapting to changing circumstances, inclusiveness and the support they have provided for each other within the community. These strengths

are the foundation on which the community can form the fabric of a new future; one of building on its innate capacities. Through their labour, they have also facilitated (largely unrecognized) the health and wealth of Haligonians living in other sections of the city.

1.2.3   Access to Health Care Systems

Access, accessibility to and availability of health care services/ systems remain ill-defined concepts without a universally accepted formulation (Khan, Bhardwaj, 1994). For the purpose of this research, access to health care was understood to minimally encompass access to the entire spectrum of health and health care services - health promotion, disease prevention and screening, investigation and diagnosis, treatment and interventions (episodic and ongoing), rehabilitation, monitoring and evaluation, survivorship and chronic disease, and end-of-life care.

Implicitly access includes the determinants of health. In essence, access is the ability to obtain needed services and resources. Components of access include availability, accessibility, accommodation, affordability and acceptability (Khan, Bhardwaj, 1994; Racher, Vollman, 2002). These components roughly parallel the hierarchy of access as outlined by Hongvivatana, 1984: availability, accessibility, acceptability, contact and effectiveness, each successive component involving fewer people. This hierarchy of access was envisioned as an interactive, dynamic process. The ability to access services was facilitated or impeded by information, culture, organizational characteristics and physical surroundings (Khan, Bhardwaj, 1994). Factors included the number and location of health care providers, the organization of services and the scope of services. User related factors include understanding of and comfort with health providers and services, and type of health concern (Barnard, pilot study data, 2008; Khan, Bhardwaj, 1994). Khan and Bhardwaj, 1994, as geo-environmentalists included spatial (geographic) and aspatial (social, financial, cultural, political) elements as well as opportunity and cost dimensions. An important factor for members North End Halifax is that our

> (h)ealth care delivery is not geared toward a client with lack of knowledge regarding services (availability), little to no money and inability to recognize need for service (accessibility), or inexperience with the use of the system and an unwillingness to seek help (acceptability) (Whitener, 2000; p. 31).

9

It was understood, for this thesis research, there were important elements of an equitable health care system other than access. Although many aspects of access have been studied, there was scant literature that examined the premises on which access was formulated or built. Access and improvements to access are fundamental to improving health outcomes, in particular for disadvantaged populations.

As stated by Braveman, 2003,

> (a) particularly crucial issue is recognizing that information in itself, no matter how technically sound, will not produce greater equity; pursuing equity requires swimming against the tide of prevailing forces, who may feel threatened by efforts to achieve a more equitable distribution of society's benefits (p. 185).

1.2.4   Previous Research Related to North End Halifax

This research was founded on the belief that within the North End communities there were many resources (assets) on which a healthier future could be built. The research was undertaken with the philosophies of appreciative inquiry (Grant, Humpries, 2006) and asset-based community development (Kretzmann, McKnight, 1993). It was undertaken with the knowledge that others had studied the North End Halifax community in the past. Such studies included a Master's Thesis *The relationship between policy, planning and neighbourhood change: the case of Gottingen Street neighbourhood, 1950-2000* (Melles, 2003)*, Historic North End Halifax* (Erikson, 2004)*, Imagine Bloomfield (School)* website*, The Gottingen Street Neighbourhood: issues, opportunities, and actions in community development* (Bohdanow, 2006; individual student project report)*,* and *The North End Community Health Centre: leading the way in primary health care* (Moore, 2009; student assignment). Other related studies included *Halifax Regional Municipality Active Transportation Plan* (2006), *Our Health: a Community Health Assessment Survey* (prepared for Community Health Boards and Capital Health, 2009), *Health and Homelessness in Halifax* (Community Action on Homelessness, 2009), the Corpus Sanchez report "*Changing Nova Scotia's Healthcare System: creating sustainability through transformation*" (Final Report, December 2007). Although highlighting the general poor health of Nova Scotians, this report did not address the other social determinants of health. Other studies included *HRM by design* (www.hrmbydesign.ca), *Nova Scotia Chronic Disease Prevention Strategy* (Dalhousie University, Unit for

Population Health and Chronic Disease Prevention, 2003)*, and* The Tides of Change: addressing inequity and chronic disease in Atlantic Canada- a discussion paper (Hayward, Colman, 2003). *The Tides of Change*, an outstanding document, explicitly recognized and accentuated the impact and importance of the social determinants of health as well as highlighting that individual factors such as life style had relatively minor impacts on health of populations. The report emphasized the role of social and economic exclusion. Living in areas with a high proportion of low-income families affected the health of all community members, irrespective of individual incomes. The built environment as well as racial segregation, social networks, political organization and community resources may have led to the differences. As the authors state, "over 40% of chronic disease incidence and more than 50% of premature deaths due to chronic disease are avoidable." (p. 6).

To accomplish the goals of the thesis research, a rather complex amalgam of theories, methodologies and methods was undertaken as illustrated in the following Figure (**Figure 1**).

Figure 1

Thesis Research Journey
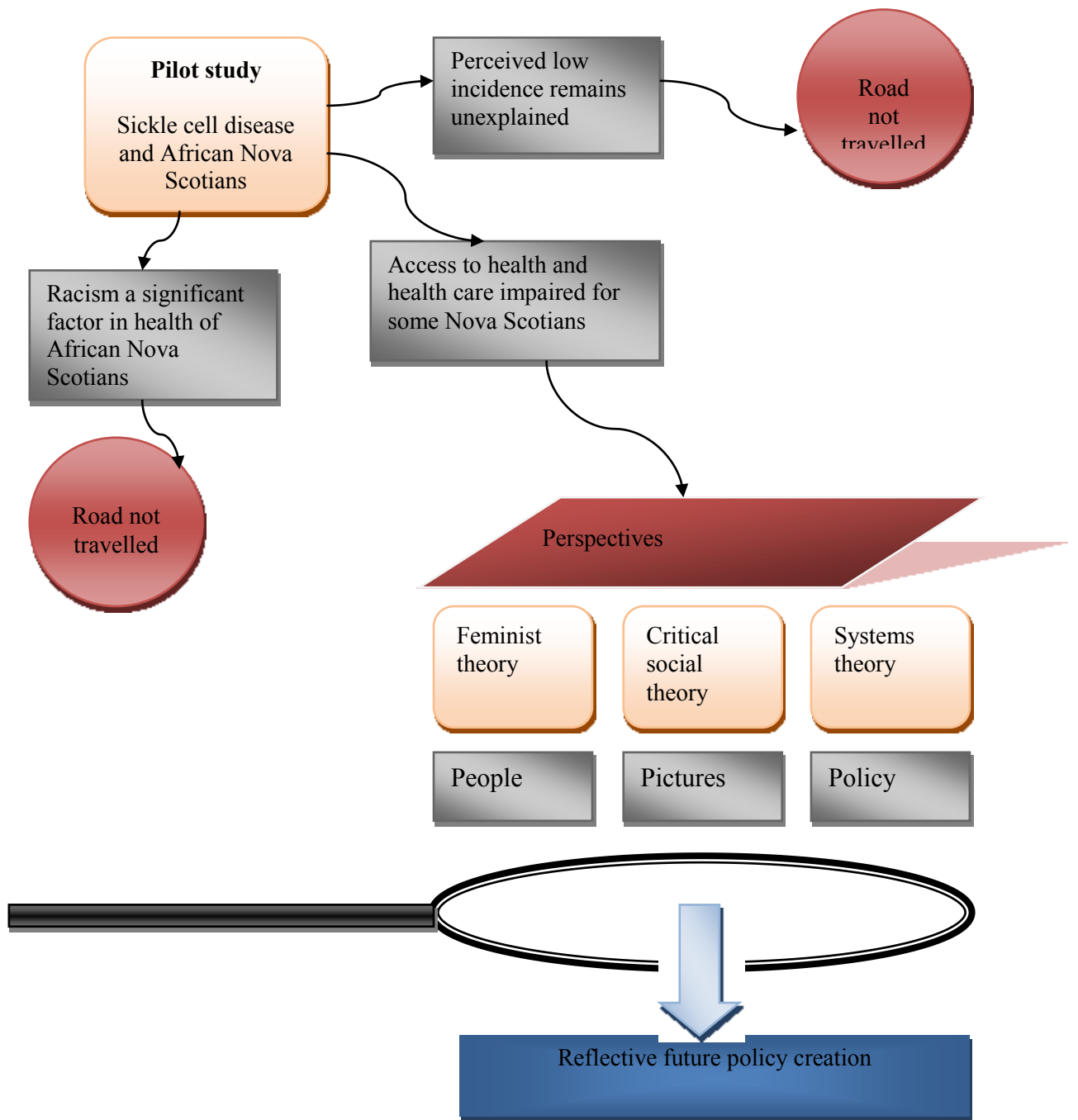
CHAPTER 2   THEORY-DRIVEN TRIFOCAL LENSES

This chapter outlines the formulation of the three lenses used in data analyses.

> Although a particular piece of research can be seen as a quilt, with the product being a single article that announces a discovery, comparing a science like biology, for example, to a quilt creates a different and richer metaphor. The best comparison would be to a quilt that has remained in a family for generations and has been repaired and reworked many times, occasionally with whole sections ripped out and remade. Over time, the quilt may take on a very different look, become more textured and rich. No one person could create such a quilt, nor could one group of people make it; the only way to generate such richness is with a large community of quilters working over time and space (Flannery, 2001).

This metaphor captures for me the essence of my hope for this thesis research - that it will become a contribution to the quilt of an integrated community health system. In addition, as Flannery explained in her article, the metaphor of a quilt captures many aspects of conducting research with a feminist lens as well as allowing for the juxtaposition of the view from other lenses to form a complementary whole. It is a metaphor that is inclusive of all peoples. As stated by Flannery, 2001, "the patchwork quilt has replaced the melting pot as the central metaphor for cultural identity in the United States." (p. 632). It is a metaphor in stark contrast to the more traditional (masculine) metaphors for scientific research. These include objectifying, conquering, exposing, reducing and constructing in comparison to the more feminine expressions of engagement and relationships.

2.1   MULTIPARADIGM INQUIRY

As described below, this research was undertaken using multiparadigm inquiry (Lewis and Grimes, 1999). Multiparadigm inquiry includes multiparadigm reviews, research and theory building. In multiparadigm reviews, the researcher attempts to expose the underlying assumptions in the background literature examined (or in the instance of this thesis, in the policies examined). In multiparadigm research, different lenses (for example, feminist, critical social and systems theory lenses) can be applied in parallel (Bradshaw-Camball and Murray, 1991) or sequentially (Gioia, Donnellon, Sims, 1989) in data analyses. Regardless of whether the analyses are parallel or sequential, it is suggested that a paradigm itinerary be developed. For this thesis research, each data source was analyzed first with a feminist theory lens, then a critical theory social lens and

finally a systems theory lens. I endeavoured to recognize the influence of the lenses on cultivating diverse interpretations, to accent their differences and to balance the insights generated each with the other (Lewis, Grimes, 1999). In metaparadigmatic theory building (for the analyses and grounded theory building from community member interviews), patterns spanning differing understandings were explored (Lewis, Grimes, 1999). "(I)nsights and biases are most recognizable from opposing views. Highlighting contradictions *and* interdependence invokes a creative tension that may inspire theorists to question paradigm dualisms" (Lewis, Grimes, 1999, p. 676)(italics as in original). Through the methodology of grounded theory examination of community member interviews, I used the lenses to conduct mental experiments, compare the insights exposed and contemplate their disparities to build an encompassing theory (Lewis, Grimes, 1999).

2.2   RESEARCH FRAMEWORK BACKGROUND

2.2.1   Roads Not Taken

I initially considered adopting a participatory action research framework. However, both practical and philosophical reasons dissuaded me. As highlighted by Varcoe, 2006, since I was a White Anglo-Saxon Protestant physician involved in research examining issues of Nova Scotian health care systems for underserved populations, no matter my intentions, an irreconcilable power differential would exist secondary to socioeconomic, professional, educational and/ or ethnic circumstances. Although I did not have experience or expertise in the area of access to health and health care systems for underserved populations, and thus the tacit and experiential knowledge of those who did might balance knowledge differentials, I undoubtedly had both shared and unshared perspectives, agendas and objectives for the research undertaken. Varcoe, 2006, also stressed that as an outsider researcher, one must be conscious that a stance which "dictates that all groups should be treated equally…obfuscates any need to redress entrenched inequalities" is an approach resulting in those with privilege feeling they are "not obligated to challenge the marginalization and stigma that generally accompany difference from the dominant group." (p. 534). Participants in my pilot study also noted that equal treatment entrenched historic inequities and power imbalances.

I also considered Co-operative Inquiry as a way to do research with rather than on people (Reason, 1999).

> In co-operative inquiry a group of people come together to explore issues of concern and interest. All members of the group both contribute to the ideas that go into their work together, and also are part of the activity that is being researched. Everyone has a say in deciding what questions are to be addressed and what ideas may be of help; everyone contributes to thinking about how to explore the questions; everyone gets involved in the activity that is being researched; and finally everybody has a say in whatever conclusions the co-operative inquiry group may reach…all those involved act together as 'co-researchers' and as 'co-subjects' (p. 211).

Co-operative inquiry recognizes four different ways of knowing - experiential, presentational, propositional and practical. In this context, experiential knowing is through direct experience with a person, place or thing; presentational knowing involves the expression or communication of experiential knowledge; propositional knowing is to understand through "ideas and theories" (p. 211); practical knowing is demonstrated through competence or skill. Such an approach recognizes the worth of the knowledge we all possess. However, co-operative inquiry requires considerable upfront time and resources to develop a group of people to work together as described above; time and resources that I did not have. Fortunately, some of the strengths of both participatory action research and co-operative inquiry are captured by other approaches. I chose to undertake a thought trial for the policy analyses (using the three theory lenses) and photo-elicitation community member interviews analysed through grounded theory and the three theory lenses. Photo-elicitation allowed for greater research participant control over their engagement in the research.

2.2.2   Trifocal Lenses for Data Analyses

For the following discussion, it is understood that method is the way of gathering data, methodology encompasses the theory and analysis used, and epistemology includes the theory of knowledge chosen, its nature and scope, basis for and claims to knowing. I acknowledge that each lens as constructed by myself was but one of many potential framings. There was no intent to claim the value of a particular lens as I developed it but rather that a consciously formulated lens used as a tool in policy development or analysis,

or examination of research data, does lead to different results. The framing of the lenses to be used for data analyses is described with the understanding that, like their physical counterparts, lenses do not give perfect depictions of either truth or reality, vary with the viewer and may have flaws of refraction. As McDaniel, 1997, highlighted, what is observed about an object, situation or phenomenon is determined by the intention of the observer, and obtaining knowledge through one view may blind the viewer to other perspectives.

The reasons for my choices of the three theories for use as lenses were varied. Interest in the systems theory lens was derived from my own experiences as a health professional within a non-system approach to health and health care delivery and the deep-seated belief that a systemic approach would ultimately lead to improvements in the health of communities. My rationale for choosing the other two lenses emanated from a very rudimentary understanding of feminist theory and critical social theory. The ideas of relationships and caring within feminist theory and opposition to oppression in critical social theory resonated with my intuitive glimpses of how things might look very different when examined through these lenses rather than with the traditional male, White, middle-class viewpoint. Lenses or paradigms that have been used by others (as a single paradigm/ lens) include positivist/ postpositivist, constructivist, ethnic, Marxist, cultural and queer theory (Denzin, Lincoln, 2005). For me, these did not feel comfortable or appropriate to my thesis research. Feminist, ethnic, Marxist, cultural and queer theory have been combined as critical paradigms (Denzin, Lincoln, 2005). All of the three chosen lenses appeared to have merit for examining health access inequities.

For fruitful exchange of information to occur in the context of this thesis research, clarity on my definitions of the lenses of feminist, critical social and systems theory was essential. For none of the three lenses was there a single agreed to encompassing theory. For the purpose of my thesis research, I chose to use the theory within each that I felt would result in the greatest difference of refraction from the other lenses as well as my relative comfort with the tenets of that theory. Because I was examining policies of the IWK Health Centre, I also chose versions that were compatible with the espoused values

of that organization. The use of the three lenses, I believed, would increase the knowledge found inherent in the data examined.

Table 2   Comparative Features of the Three Theoretical Lenses

Feminist*	Critical**	Systems***
▪ Counter de-valuation of women ▪ Counter the subjection and objectification of women ▪ See knowledge as socially situated/ culturally, socially and temporally [standpoint theory] ▪ View knowledge is power ▪ Recognize some knowers are privileged over others ▪ Counter gender inequities leading to social injustice ▪ Take action against systemic/ structural gender inequity ▪ Maintain respectful relationships ▪ Espouse that anyone can be a 'knower' ▪ Connect in knowledge, community knowledge ▪ Expose interdependent oppressions ["exploitation, marginalization, powerlessness, cultural imperialism, violence"]^ ▪ Researcher mindful of how she affects research outcomes ▪ Research to improve the lives of women ▪ Consider gender relations ▪ Consider gendered nature of interactions ▪ Eliminate objectification ▪ Accept knowledge as contextual, non-dichotomous ▪ Reject dichotomies- objective/subjective, rational/irrational, reason/emotion, culture/nature ▪ View reality as relational ▪ Work to emancipate ▪ Stress egalitarian relationships ▪ Accept all is political/ the personal is political ▪ Aim for liberation	▪ Expose unchallenged, unacknowledged, hidden power relations ▪ Identify domination, power relations ▪ Question dialectically ▪ Aware of language impact ▪ Examine with a view to plan for change [transformative action] ▪ See knowledge is subjective ▪ View reality as constructed ▪ Understand knowers are empowered ▪ Action oriented ▪ Work to building movements for social change ▪ Recognize that injustice and domination are systemic ▪ Acknowledge that power defines 'truth' ▪ Concede there are privileged knowers ▪ Liberal individualistic in its acceptance of competition, emphasis on autonomy, separateness, independence	▪ Consider the views of many ▪ Hierarchy of wholeness ▪ Combine subjectivity and objectivity ▪ Interconnectedness ▪ Interdependence ▪ Interrelatedness ▪ Interbeing ▪ Maximizing the whole

*Hawkesworth, 1989; Mills, 1994 (^p. 211); Maynard, 1995; Chafetz, 1997; Collins, 1998; Winter, 2000; Anderson, 2001; Sielbeck-Bowen et al, 2002; Grasswick, Webb, 2002; Dietz, 2003; Sherwin, 2004; **Wuest, 1994; Fenby, 1991; Hartstock, 1998; ***Khisty, 2006

As I attempted to formulate the theory lenses, I chose the framework of theory as a tool for seeking new explanations (Calhoun, 1995). For the purpose of this thesis research, feminist theory, critical social theory and systems theory were considered as equally valid but different lenses through which to interpret data; where one was not subsumed by the other. Using the metaphor of trifocal lenses, one lens might be more

appropriate to see and understand the data under some circumstances and the others under other situations, always being aware of the view through the lenses not used. In my defining each lens, I was taking the stance that for the purposes of this thesis research, this was the framework through which I would view the data. As the objective was to examine the utility of the lenses, I do not make any claims regarding the definitions used and freely acknowledge there are other designations that are equally or more legitimate. In addition, the lenses were formulated through my own biased eyes and understandings and within a largely Canadian/ Nova Scotian context.

a. Feminist Theory

For me, feminist theory included concepts such as choice, self-definition, self-respect, non-domination, abrogation of powerlessness, integration not marginalization, lack of objectification and freedom from oppression. The development of a suitable feminist theory lens was complicated by the lack of a single agreed to definition of feminism, feminist or even women in the context of feminist theory; nor was there a common language of feminism (Braithwaite, 2002; Ermath, 2000; Hemmings 2005; Torr, 2007; Walby, 2000; Winter, 2000). There was no consensus regarding whether feminism could only apply to women, particularly when other vulnerabilities were present (poverty, socioeconomic status, disability, ethnicity, sexual orientation, etc)(e.g. Olesen, 2005; p. 236). The issue was further complicated by frequent conflation of sex, gender and sexual orientation (in North America, characteristics that are defined by Anglo-American society).

In many ways truths and knowledge only have value through application, although others would argue that knowledge may be attained for a purpose totally unrelated to its eventual use (Hawkesworth, 1989). Feminist knowledge (epistemology) is purported to value heterogeneity, complexity of relationships, diffusion of power and attention to gender (Hundleby, 2002). The quest for a feminist way of knowing was fuelled by the perception that research theories, methods, concepts and interpretations suffered from a pervasive androcentric view (Hawkesworth, 1989). All feminist epistemologies conceive knowers as "situated in particular relations to what is known and to other knowers"

(Anderson, 2001). Situated knowledge includes experience through our bodies (located in space and time), first- or third-person knowledge, emotions, attitudes, values, personal knowledge of others, thinking styles and relationships (Anderson, 2001). Code, 1991, stated that reality as expressed in language had the power to maim, frame, diminish and exploit; that reality was defined by language and words delimited our understanding and knowings. Although feminist epistemology is not without critics, I believed that as a component of a trifocal lens, the particular feminist theory chosen could yield valuable contributions about access to health vis-a-vis the populations served.

Feminism

Historically, three waves of feminism are recognized. The first wave feminist movement was in the 1830-1920s with activism for women's suffrage. The second was from the late 1960s to the Reagan-Bush era with resurgence of women's organizing together with a more academic focus. The third began in the mid 1980s with the dominant culture of post-feminism/ post-modernism with greater recognition of, and emphasis on, diversity and differences (Siegel, 1997). The differing emphases only hint at the spectrum of feminist theories available for adoption within an analytical framework. Smith, 1990, suggested that those employing feminist theory problematize the everyday world to create new views and knowledge. In addition, she cautioned that most data came pre-packaged by others, thus potentially shaping their interpretation to reinforce present ways of thinking.

Many feminists view the state or government as masculine; law and policy frequently see and treat women in the manner that men see and treat women (Harding, 1991). Feminists emphasize the control that the dominant male culture exerts, in ways active and passive, on the lived experience of women. Hartstock, 1998, believed that the construction of one's relational self lead away from dualisms to connections and continuity with people and nature. In contrast, the male construction of self was seen as one of dualisms of abstract versus concrete, mind versus body, culture versus nature, ideal versus real and change versus stasis. Harding, 2004, wrote that to "achieve a feminist standpoint one must engage in the intellectual and political struggle necessary to see nature and social

life from the point of view of that distained activity which produces women's social experiences instead of from the partial and perverse perspective available from the 'ruling gender' experience of men." (p. 26).

For me, the aims of feminism for "action coordination and social transformation (*by*) interrogating existing conditions and relations of power with a view toward not only interpreting but also changing the world" (Dietz, 2003; p. 400; italics inserted) had value. I felt it was important to examine the generally traditional androcentric foundations within the health and illness care system. Scientists and, I believed, those with influence on the design of health care systems, created distance for themselves from the values and interests generated by class, race and gender diversity (Wuest, 1994). Ermarth, 2000, contended that using androcentric perspectives as the default norm helped to perpetuate patriarchal thinking and power. As Goldenberg, 2007, stated, men require "the female-as-Other in order to have subjectivity." (p. 146). Ermarth, 2000, suggested instead a "subversive theory" to "destabilize power relations rather than reconfirm them." (p. 116). This, she stated, required solidarity among women, an awesome quest.

Feminist Approaches to Research

Three major types of feminist inquiry have been identified (Harding, 1991) - feminist empiricism, standpoint theory and postmodern theory. Harding pointed out that there was a critical difference between sociological relativism (listening carefully to the views of others) and judgmental relativism (failing to adjudicate between different systems of beliefs and their social origins). Her solution was a posture of strong objectivity…strong objectivity that contrasted sharply with value-free objectivity usually promulgated within scientific research, and which posited the interplay of the researcher and participant. Creswell, 1998, stated the goals of feminist research approaches were to create non-exploitative relationships, to avoid objectification and to produce transformative research.

At most, through research, we come up with an approximation of the real. Lather, 1991, believed that all feminist approaches were mindful of power and subjectivity in the struggle to achieve transformative change. Many feminist researchers embraced the notion of undertaking research that facilitated empowerment of the oppressed to change

their realities through greater understanding of their oppression. This approach borrowed from the concept of research as praxis inducing change in the research participants' world through deeply respecting the capacities of research participants and populations being studied.

Undertaking feminist research entails careful attention so that one does not unintentionally impose contrary structures that impede the freedom of participants to convey their message. The relationships of the researcher and the participants shape research outcomes. In addition, the researcher must be aware that she or he has significant impact on the research outcomes through interpretation of the results (an interpretation often hidden as stated objective facts). Harding, 1991, emphasized the importance of including "the class, race, culture, and gender assumptions, beliefs, and behaviors of the researcher her/ himself…placed within the frame of the picture that she/ he attempts to paint" (p. 9). The background of the researcher influences the information obtained during interviews through asking and framing of the questions; "the researcher's expectations of the outcome in research affect what is actually found" (Harding, 1991; p. 47). The researcher must avoid imposing her or his understanding of reality on participant contributed research results (Lather, 1991).

Destructive effects of deviance as construed by the dominant or any other group using its own standards as the norm or ideal by which others are compared can subtly infiltrate analyses of non-dominant groups (Harding, 1991). Deviance is the consequence of how one applies rules or sanctions of her or his group to another and not a result of the other's acts (Harding, 1991). Along with many others, her writings illustrate the subtleties of influences on our knowings and our often unquestioning acceptance of the common view. Within feminist research, the social roles of women (and of men) are believed to be, in a large part, created, constructed and imposed by men and reality is subjective and subject to social definition (Harding, 1991). Social structure and an individual's position in that social structure determine an individual's knowing of the world. Many of the models or frameworks used in research assume a single society and fail to incorporate the informal, deviant, mundane, local and other constructs that affect results.

Feminist post-modern approaches to research favour qualitative methods (Campbell, Wasco, 2000). Feminist science is defined by the questions it asks and not the content or subject of the research. All feminist approaches to research embrace a focus on correcting the biases of sexism and androcentricity in scientific inquiry (Anderson, 2001). For the purpose of a feminist lens through which one could view research, I understood that lens to include the concepts of relationships, context, the viewpoint of the participants (including methods and methodologies of their realities), reciprocity between the participants and the researcher, research conducted in a manner to respect and not objectify research participants, and an approach that allowed research with the purpose of advancing social change. The adoption of a feminist lens through which to conduct a research study affected the questions asked (of the relevant policies and of interviewees) as well as method/ methodologies.

Variations of Feminism and Feminist Theory

Some have stated the act of defining feminist theory "*shuts down the very possibility of debate.*" (italics as in original)(Winter, 2000, p. 106). Narrow focusing can leave out issues of prostitution, culture, religion, disability, ethnicity, violence, political impact, lesbianism or capitalism for example. Some feel attempting homogeneity of definition of women negates the differences that identify who we are as individuals (leading to race-blindness, sex-blindness, etc)(Mayeda, 2005). Types of feminism include liberal feminism (egalitarian, social change through laws and regulations, civil rights), Marxist feminism (capitalistic outlook, control of production by men, gendered division of labour), socialist feminism (work in home and family lead to women's oppression, women treated as an inferior class, change through increasing consciousness and knowledge, eradication of capitalism), radical feminism (patriarchy, power of men, need to change society in a fundamental way, exclusion of men from their groups, concern with violence and sexuality), cultural feminism (how culture defines fundamental biologic differences between men and women), ecofeminism (male dominance harmful to both women and the environment) and postmodern feminism (importance of historical context of events; power relations)(Potter, 2002; Dietz, 2003).

Recent variations include difference feminism (affirming positive account of femaleness), diversity feminism (challenges the coherence of the concept of woman; considers race, ethnicity, class, sexuality) and deconstruction feminism (dismantles "polarities of male and female", "rejects any notion of an a priori female subject grounded in a pre-sexed body" or anything that presumes "heterosexuality as the privileged locus of ethics or existence")(Dietz, 2003; p. 403). Feminist relational theory encompasses the concepts that all persons live through connections or relationships with others and with organizations; that an individual's autonomy is constrained by context; that we should pay specific attention to how options and opportunities are circumscribed by power; that we must identify how different groups are impacted differently through engrained patterns of privilege and disadvantage (Sherwin, 2008). These multiple expressions of feminism reinforce the concept that gender effects are systemic and impacted through feedback loops by demographic, environment, economic, political, ideological and family constructs (Chafetz, 1997). The three major feminist theories of knowledge are standpoint theory, feminist empiricism and feminist postmodernism (Hawkesworth, 1989). These theories are somewhat simplistically presented below. All challenge the deep embeddness of considering the norm from a White mid-class heterosexual point of view; problematizing others of differing gender, ethnicity, social class and/ or culture (Maynard, 2002).

Standpoint Theory

Standpoint theory rejects the notion of *a* truth. A standpoint encompasses a shared discourse that provides a space in which to dialogue, theorize, strategize and mobilize to better women's lives. A standpoint should circumscribe and structure a feminist understanding of the world, an understanding fundamentally opposed to that of the dominant other. Although the understanding of the dominant group cannot be dismissed as false or irrelevant, the new standpoint must be justified by theory and political struggle; it becomes an initiator for liberation. Numerous authors have described standpoint theories, all of which differ in one or more significant aspects. Most seem to build on the premise that the socially disadvantaged position of women gives them epistemic privilege, albeit an earned privilege, because of their enhanced understanding

of social relations advancing the growth of knowledge in many areas (Grasswick, Webb, 2002).

The dominant groups are influenced by history in and on which their interests (and theories) would have been privileged and framed. For a member of a dominant group, it is incredibly difficult to consciously consider the innumerable subtle and not so subtle ways one's life systematically has been made easier at the expense of those who are outside a dominant group. Smith, 1997, stressed less the privileged status and more the tacit knowing of women. Others, including Hawkesworth, 1999, have been strident in their criticism of feminist standpoint theory in its earlier formulations as it appeared to denigrate the multiple oppressions and differences among women. To counter this, others have suggested a collective identity of women, not based on a unitary view, but on shared experiences and memories. Yet I wondered if this would not result in an unhelpful homogenized lens; others have called this as essentializing women (for example, Chafetz, 1997). Currently, most standpoint theorists focus on the pluralistic, contingent benefits of the experiences, views or standpoints of the disadvantaged for questioning the status quo (Anderson, 2001).

Feminist Empiricism

Within empiricism, it is accepted that there is a world that exists independent of human knowing; a truth that accurately depicts the world to be discovered through research by a neutral objective investigator. For feminist empiricism, the removal of misogynist biases facilitated discovery of the "unmediated truth about the world." (Hawkesworth, 1989; p. 535). Empiricism as pristine infallible objectivity has been abandoned as unattainable. Feminist empiricism views experience as providing the primary justification for knowledge (Anderson, 2001). Current versions stress that situated knowledge is central, that facts and values are intertwined and, pragmatically, there are many theories. Feminist empiricism emphasizes that there is a valid place for feminist approaches to science and, in essence, favours feminist over androcentric biases. However, it advocates that such biases are not detrimental if they are acknowledged and proponents are held accountable.

Current feminist empiricism shares increased commonalities with feminist post-modernism (Anderson, 2001).

Feminist Post-Modernism

Feminist post-modern theories are rooted in post-structuralism and post-modernism (Sands, Nuccio, 1992). Structuralism sought undergirding organizing constructs to explain events and phenomena. As with post-modernism, post-structuralism rejected fixed meanings and truths, but saw the discovered underlying structures as having unstable, changing interpretations as influenced by particular social, political and historic contexts. Deconstruction of texts through examining the biases induced by social, political and historic contexts destabilized the authority normally given to the dominant group(s). Discourses, researchers and readers are not neutral. Differences are emphasized; universality is doubted; binary categories are scorned as too restrictive; essentialization is banished. The latter provides a dilemma for the centrality of woman in feminism, particularly in its frequent (mis)understanding as being Eurocentric, middle-class woman. The promotion of sameness in the face of multiplicity is problematic; increasingly feminists acknowledge the heterogeneity of women and women's issues.

Like standpoint theory, feminist post-modern theory rejected the concept of a truth and claims that all truths can only be partial, influenced by the perspective of the viewer and defined by history, perspective, relations, and contexts (Hekman, 1990). Post-modern feminist theorists espoused plurality and diversity in seeking truth, somewhat in conflict with the desire to rid science of androcentrism. They rejected the concept of *a* woman's perspective and advocated for recognition of women's place in science, embracing intersectionality. They highlighted the ability of women to appreciate the view of other perspectives (Anderson, 2001). However, lack of a shared identity as women risks fragmentation and loss of political power. The focus of post-modernism "is on the grounding of experience, the very focus that denies us the fantasy of decontextualized scientific truths. Validity from a postmodern perspective is thus understood in terms of a conception of knowledge as local, partial, and inevitably constituted in a complex network of power regimes" (Cosgrove, 2003; p. 98). Like standpoint theory, postmodern

feminist theory has variations including those related to a deconstructive or post-structuralist slant.

Ethic of Care

For me, the feminist lens became inextricably intertwined with the feminist ethic of care. This ethic was originally based on women's care activities and conventions. Second-generation care theorists proposed care, connection and a sense of community as central to all human life (Hankivsky, 2004). Ethical elements of care include attentiveness (particularly to differences), responsibility, competence and responsiveness (seeing others on their own terms; listening to the voice of those whose experiences are/ will be impacted; allowing everyone their own knowledge)(Hankivsky, 2004). It implies interdependencies and connectedness among people and emphasizes the relational aspects of life (Meagher, Parton, 2004). The ethic of care is firmly based on feminist theory, particularly honouring women's knowledges and experiences. This approach is in contrast to the more usual (masculine) approach of individual power, influence, rights and duties (Machold et al, 2007). The ethic of care encompasses both individual and organizational caring; it includes the broader social and political dimensions of inequities and environmental sustainability; it embraces care for self along with care for others; it involves processes of reciprocity within relationships (Machold et al, 2008). Campbell, Wasco, 2000, stated that "feminist epistemologies accept women's stories of their lives as legitimate sources of knowledge, and feminist methodologies embody an ethic of caring through the process of sharing those stories." (p. 778).

Justice (generally perceived as an androcentric position) versus care (as a more feminist stance) has been characterized as promulgating learning principles versus developing moral dispositions; solving problems through seeking principles having universal applicability versus responses having applicability to a particular individual; claiming rights and fairness versus accepting responsibilities and relationships (Hankivsky, 2004). Oppressive conditions can be created through caring, thereby fostering the recognition of a need for a <u>balance</u> of justice and care within an ethic of care. Colonialism, maternalism and parochialism are seen as pathologic forms of caring; the limitations of impartiality

and constraints on personal choice mitigate reliance only on a justice ethic. Justice was seen to disregard the political, social and economic realities of people's lives. As "values direct the questions we ask, determine what information we consider to be important, select the actors that we see as integral to the policy process, and determine the consequences of choosing to react or not to react to a specific social problem or issue", the lens of care can moderate the lens of justice (Hankivsky, 2004; p. 31-32). Combined they can result in "an approach that reflects an understanding of how oppression, domination, disadvantage, and suffering are shaped by a series of collective social, political, and economic decisions *and* social economic relations." (Hankivsky, 2004; p. 39)(italics added).

As alluded to previously, women's work (in their expected domestic roles of mother, housekeeper and in work roles exemplified by domestic services and healthcare professions such as nursing and social work) is often devalued and used as justification for lower wages (Cockburn, 2005; MacGregor, 2004). Yet caring about and for others is a strength that, well modulated, can facilitate change for the betterment of individuals and communities. Although often conflated, and inevitably entangled, the ethic of care is different than the practice of care. For health professionals, this means balancing objective professionalism with compassion and empathy. The ethic of care (a de-gendered ethic of care) emphasizes "responsibilities and relationships rather than rules and rights" (Cockburn, 2005; p. 73); it is pragmatic rather than abstract; it is a "moral activity" (Cockburn, 2005; p. 73). The feminist ethic of care assumes each person is viewed as an individual, thus different; each individual's worldview is taken into account; context is recognized as important. "Authentic caring needs to embrace mutuality and respect, along with a moral capacity for asymmetrical relationships that does not necessitate diminishing moral worthiness. These are relationships whereby difference is neither evaluated, ranked nor controlled, but is seen as a dynamic component within accepting...relationships" (Clapton, 2008; p. 578). It requires "the ability to see another's reality as a possibility of one's own, allowing feelings to be aroused motivating action. When one is able to understand how another might feel in the same situation (position-taking with the person), the other's reality becomes real to the one observing." (Reitz-

Pustejovsky, 2003; p. 35). The ethic of care sees people within relationships and interconnected (Kenny, 2004). Machold et al, 2007, described the dimensions of care as caring about (incorporating the values of attentiveness, focus, and susceptibility), taking care of (responsibility), care-giving (competence, empathy) and care-receiving (responsiveness, receptiveness).

Supplemented with principles of justice (no longer considered by feminists as dichotomous with respect to an ethic of care) - respect for persons of all ages, meaningful autonomy (fostering the fullest appropriate participation of persons of all ages in decisions that affect their well-being), solidarity (acknowledging the interdependence of citizens in the sharing of risks and benefits across the lifespan), protection of the vulnerable, responsible citizenship (enabling every member of the community to participate actively in public policy decisions in an informed manner), accountability and sustainability (Machold et al, 2007), the ethic of care can be removed from a dependent carer-cared for stance. In this way, recipients of care become partners to achieve goals in common and providers acknowledge their dependence on the recipient, for the efforts of one would be devoid of worth without the others. Care needs (including those related to the determinants of health) and the manner of caring can only be defined mutually. It is important for the dominant others to know more about and understand the differences in other community members' cultures, histories and structures to enable equitable distribution of resources and addressing of identified needs (Reitz-Pustejovsky, 2003). Hines, 2007, raised the issue of sexuality within an ethic of care, stating that the ways in which sexuality influences the meaning and practice of care is affected by the "uncritical assumption within the literature of the universality and desirability of heterosexual-family-network systems." (p. 464). Within the context of this thesis, and within an ethic of care, family is as defined by each individual.

My feminist theory lens included the concepts that all people are knowers; knowledge is situated; relationships are crucial; language is important and is a means of exerting power; binary thinking is unhelpful; involvement not distancing is essential; domination of or by others is to be eliminated; autonomy is circumscribed; diversity is a strength. The

ethic of care reflects reciprocity, equity, relationships and choice (Silvers, 1995). These concepts helped to shape the questions used. As with the two other lenses, the questions used were my initial trial to determine the usefulness of lenses and are not purported to be the best or most appropriate questions under other circumstances.

Questions for Analyses with a Feminist Theory Lens

1. What embedded assumptions/ biases/ values can I detect in the information presented- particularly related to positioning of women and the knowledges and experiences of women? (e.g. social role expectations, cultural expectations; have differences been problematized instead of accepted as legitimate differences; that is, not normed to white male mid-class). Were these biases or inaccuracies expunged?

2. Have the differences in power between participants and researcher(s) (or for the policy analyses, between the hierarchical levels) been acknowledged? The impact of power differentials noted?

3. Have the political aspects been recognized? (i.e. have any political constraints been applied)

4. Did the information address "women-centered efforts to improve the quality of life for those who are oppressed"? (Roy, 2004; p. 265)

5. Did the information seek to improve society through eliminating constraints based on gender?

6. Did the hypotheses and evidence or information address how culture may have shaped the behaviours/ results? (Akman et al, 2001; Roy, 2004)

7. Were the informant's conceptual framework and viewpoints clearly identified?*)*

b. Critical Social Theory

Along with a feminist lens, I examined the data for the research question using a critical social theory framework. As summarized by Carr, 2000, critical social theory is most commonly associated with the Frankfurt School established in 1923 under the direction of Carl Grunberg. Others included Max Horkheimer, Theodor Adorno, Leo Lowenthal, Franz Neumann, Friedrich Pollock, Eric Fromm, Herbert Marcuse and Jurgen Habermas.

Critical social theory, as with other theories, is not a single theory but a group of theories that share at the core

> an interest in emancipatory knowledge and the desire to promote a social science capable of stimulating autonomy, clarification, a sense of responsibility, and the democratic process. Critical theory perceives modern man as manipulated, objectified, passive and conformist in relation to the machinery of society and the dominant forms of rationality. Yet at the same time man is seen as partly or *potentially* autonomous, capable of self-reflection, and critical questioning (Alvesson, Skoldberg, 2000; p. 124)(italics as in original).

Critical social theorists believe that all thought is profoundly affected by largely unchallenged power relations based in history and on social relations and constructs (Kincheloe, McLaren, 2005). These power relations include those of race, gender, sexual orientation, socio-economic status and Eurocentricity. Domination is expressed through institutions such as the media, schools, family, church and businesses. Oppression results as individuals unquestioningly accept their treatment as "natural, necessary or inevitable" (Kincheloe, McLaren, 2005; p. 304). Critical social inquiry seeks to tackle injustice without the veil of neutrality. It recognizes that all research is affected by the interpreter of results and that "perception itself is an act of interpretation" (Kincheloe, McLaren, 2005; p. 311). Language, in the eyes of critical theorists, shapes the world as we understand it.

> Criticalists begin to study the way language in the form of discourses serves as a form of regulation and domination. Discursive practices are defined as a set of tacit rules that regulate what can and cannot be said, who can speak with the blessings of authority and who must listen, whose social constructs are valid and whose are erroneous and unimportant. (Kincheloe, McLaren, 2005; p. 310).

Critical theorists view the world using a dialectic frame where social phenomena are examined through historic contexts and understood in terms of their own opposites. Critical inquiry proceeds through the posing of dialectic questions to incite transformative actions. Paradoxically, this approach may result in a greater appreciation for the spectrum of contributing socially defined factors such as gender (regarding gender as manifesting along a spectrum of quintessential female to quintessential male), life to non-life, and race (regarding race along a spectrum of colors)(Poon, 2006; Fendler, Tuckey, 2006; Kendall, Tannen, 2003).

The task of critical social theory is to distinguish what is socially and psychologically invariant from what is, or can be made to be, socially changeable, and to concentrate on the latter. (Alvesson, Skoldberg, 2000; p. 110).

The core processes of critical social theory are enlightenment, emancipation and empowerment (Manias, Street, 2000). A theory was considered critical if it is "explanatory, practical and normative all at the same time" (Carr, 2000; p. 211). A central interest of critical theorists is the releasing of individuals from constraints imposed by self, history and society to encourage greater rationality (Allen, Benner, Diekelmann, 1986). As described by Alvesson and Deetz, 2000, critical research

generally aims to disrupt ongoing social reality for the sake of providing impulses to the liberation from or resistance to what dominates and leads to constraints in human decision making...typically oriented to the inductive study of socially constructed reality, focusing on meanings, ideas and practices. (p. 1).

These authors, based on work of Brookfield, suggested that critical social research involved "identifying and challenging assumptions behind ordinary ways of perceiving, conceiving and acting"; understanding the impact on beliefs and consequent actions of history, culture and social position; "imagining and exploring extraordinary alternatives, ones that may disrupt routines and established orders"; and "being appropriately sceptical about any knowledge or solution that claims to be the only truth or alternative." (Alvesson, Deetz, 2000; p. 8). This seemed to me to be an eminently useful way to change the almost passive acceptance of how health and illness care are presently delivered and the inequities that have resulted. Critical social research is based on dissensus discourse with the objective of disrupting dominant sets of knowledge structuring (Alvesson, Deetz, 2000) and with the understanding that science is political, life is created and researchers have positions. One way of balancing differing values is through dissensual decision making.

In *dissensual* decision making, by contrast (to consensual decision making), rather than progressively *excluding* different values, a decision is taken on a dynamic balance of relevant values, a balance that is determined in a given case according to the concrete particulars of that case. In dissensual decision making, then, rather than progressively excluding different views (as in consensual decision making), different views are kept 'in play' to support different decisions in different circumstances...differences of values...thus cease to be a 'problem' to be resolved and become a positive resource for balanced decision-making...in *dissensual*

decision making, your 'wrong' for me taken together with my 'wrong' for you, end up as right for us both. (Fulford, Colomba, 2004)(italics as in original).

This seems a delightful approach to me where the ins and outs of the discussion/ dialogue about issues are honoured and preserved, increasing the richness and resilience of solutions obtained. Dissensus is not compromise, rather an expanded solution.

Critical social research challenges privileged communities and languages. Habermas, as discussed in Alvesson, Deetz, 2000, emphasized communicative action and its impact on the life-world.

> Habermas argues for the systematic improvement of the lifeworld through an expanded conception of rationality focusing on the creation and re-creation of patterns of meaning…(to permit) interactions that are guided by communicatively achieved understanding rather than by imperatives from the system world - such as those contingent on the money code or formal power - or by unreflective reproduction of traditional cultural values. (p. 90).

Communicatively achieved understanding implies "undistorted communication, the presence of free discussion based on goodwill, argumentation and dialogue." (Alvesson, Deetz, 2000; p. 90). Communicatively achieved understanding is undertaken by individuals with the expectation that others will attempt to understand them and accept the views given as valid; where power, status, prestige, expertise, authority, tradition do not overcome inclusion, expression and acceptance in determining decisions. Decision-making is thus based on sound, evidence-informed arguments following dialogue in open forums. Enactment of this philosophy should enable more voices to be heard.

Foucault, as reviewed by Manias, Street, 2000, believed that power relations were immersed in discourses, often disguised as unquestioned norms. For example, law and medicine have discourses based in institutionalized traditions. Such dominant discourses often determined what counts as true, relevant and important knowledge. Foucault believed that power was not possessed but exercised, it was multi-directional and could be both repressive and productive; he contested that power could be given to another to empower that person. For Foucault, knowledge and power were intertwined, thus power was never static; power was intimately related to resistance, a responsibility of all

individuals. Foucault "focused attention on the power in knowledge, rather than the power of knowledge." (Alvesson, Deetz, 2000; p.46). Others have criticized Foucault saying his views curtail changes of political action by his relativism. However, I believe that actions to enable all kinds of knowledge to be heard and valued can lead to sharing of power with those seldom recognized as powerful.

Alvesson and Deetz, 2000, described three components of the intellectual role in critical research - insight, critique and transformative re-definition - to render the familiar unfamiliar. Insight involved uncovering how conventional meanings were formed and perpetuated. It addressed the "non-obvious", "makes sense of something" and "enriches understanding" (p. 141). The ideal was "to pay attention to experiences and meanings as well as discursive and other processes of an ideological and material nature that may constitute experiences and prescribe meaning" (p. 141), examining empirical data from many angles. Critiquing information required addressing or deconstructing the privileging of particular meanings and discourses as influenced by economic, social and cultural power and domination. Information could be derived from "(o)bserved events, situations, incidents and social practices, accounts of experiences, social conditions, expressions of ideas, thoughts and beliefs, and indications of economic, structural and technical arrangements" (p. 150). In this way critique built on insight and the two are intertwined. Critique "explicitly relates to the conditions of power, constraint, social asymmetries, ideological domination, cultural inertia that gave privilege to certain ways of understanding and ordering the world." (p.144). Transformative re-definition facilitated translating the uncovered insights and critique into actions through creating responses to the new knowledge obtained, by suggesting ways individuals can re-think, reflect and change their experience. The suggested transformative re-definition must connect with the input received from people involved in the study or other sources of data.

Some accept that feminist theory research can be subsumed under critical theory research (for example, Hammerseley, 1992). Others feel that by subsuming feminist theory one has subjugated the research to an androcentric anachronism as critical social theory was

33

developed under such a framework (Campbell, Bunting, 1991). These authors felt that feminist theory and critical social theory differed substantively in ontologic (reality is relational versus constructed), epistemologic (knowledge is contextual, non-dichotomous versus subjective, communal, emancipatory) and methodologic bases (dialogic, non-hierarchical versus revealing hidden power imbalances). They claimed feminist theory "has the primary goal of presenting a women-centered patterning of human experience" (p. 9), whereas gender does not have primacy in critical social theory. "(C)ritical theory is most interested in knowledge for the emancipation of all humanity or of particular oppressed groups, whereas feminist theory is equally interested in knowledge to improve the condition of any one individual woman." (Campbell, Bunting, 1991; p. 10).

Feminist and critical theories have many aspects in common. Both agree that "knowledge is socially constructed and that it does not exist outside of the context in which it was created" (Campbell, Bunting, 2000; p. 10), that understanding personal and community meanings of social structures is important to understanding human behaviour and that social structures can lead to oppression. Agger, 2006, (p. 99) felt that feminist theory "has contributed a great deal to the development of critical social theory" and that it complemented critical social theory. A defining difference is the viewpoint of feminism versus that of androcentrism (Menkel-Meadow, 1991).

I choose to view my critical social theory lens as highlighting unchallenged, unquestioned power relations lead to oppression; understanding can be increased by examination of opposites; power relations circumscribe our worlds; critical social research seeks to change our construct of the world towards one less defined by dominant populations. Thus my critical social theory lens is distinguished from the feminist theory lens with its emphasis on the ethic of care and the centrality of challenging androcentric foundations and viewpoints. From this understanding, the following questions were developed.

Questions for Analyses with a Critical Social Theory Lens
1. What are the social, economic, historical, political, cultural constraints/ oppressions/ ideologies implicit in the information?

2. How do they perpetuate the present circumstances? What does it allow us to see? What does it overlook? (Alvesson, Deetz, 2000; p. 63)

3. Whose interests have been/ are being served by the way things are? (Stevens, Hall, 1992)

4. Whose voice is dominating? Whose voice unheard? (Manias, Street, 2000)

5. What are the theories-in-action (assumptions, values, beliefs) underlying the information?

6. What power differentials are being expressed in the information?

c. Systems Theory/Systems Thinking

Given one goal of this thesis research was to change the paradigmatic optics through which we viewed access to health, the lens of systems theory was critical. Effective system change cannot be achieved through isolated interventions targeted at single components or parts. Components such as organizational structure, values, policies, routines, relationships, resources and power structures must be enmeshed in interventions. A paradigm shift is required in how we perceive access to health and in the strategies used to induce change (Foster-Fishman et al, 2007).

> Effective strategies for systems change must have the capacity to attend to both the larger structural components and dynamics that contribute to human suffering as well as the individual *people* who occupy and/ or maintain that system. (Christens et al, 2007; p. 232)(italics as in original).

Systems theory can provide both a needed degree of complexity and simplicity to guide the development of a new paradigm through which to address the design of an improved health system for particular populations. The systems approach requires seeing the world through the eyes of another, "to allow subjectivity and intuition to be considered alongside objectivity, combined with dialectical debate." (Khisty, 2006; p. 4). It requires acknowledgement of the views of one's enemies. Within a system, there is a hierarchy of increasing wholeness in that each successive element includes the preceding element yet becomes only a component of the next. System paradoxes include "the whole is greater than the sum of its parts", "the whole is less than the sum of its parts" (in that the whole dampens or modulates characteristics of its elements), "the whole is more than the whole" (in that the whole acts on its parts that in turn act on the whole) and "the whole is

less than the whole" (as for example, individuals are unaware of society and society is unaware of the dreams and hopes of the individual). Systems theory does not encompass "value, moral wisdom or compassion." (Khisty, 2006; p. 9-10).

Recent systems thinkers have adopted the concept of "interbeing" (conceived to embrace the ideas of "interconnectedness, interdependence, and interrelatedness") as a way to incorporate value, wisdom and compassion. "Interbeing means you cannot exist by yourself alone, you have to 'inter-be'. " (Kristy, 2006; p. 10). "To put it in a nutshell, the concept of interbeing removes the deception of being separate and one begins to possess a profound sense of commonality which is so essential an attribute for understanding the basis of the system approach." (Khisty, 2006; p. 11). An important aspect of systems thinking is the emphasis on optimizing each component and its complementarities with other elements to maximize the whole rather than maximizing each component (Haines, 1998). This is seldom if ever done in health care. Efforts are usually compartmentalized without thoroughly understanding the impact on other aspects of the system.

General systems theory was rejuvenated by von Bertalanffy in the 1920's (Cabrera, 2006). General systems theory combined logic and mathematics to define a language of accepted meaning such as equifinality, centralization and hierarchical order. As initially conceived, system-theoretical approaches included cybernetics, control theory, information theory, graph and network theory, and relational mathematics. Extrapolated from biology, early systems theory served to move the conception of systems from a mechanistic metaphor to an organic one. Von Bertalanffy (1972) viewed systems as open, affected by feedback and not completely understandable through just examining constitutional parts.

Key concepts of general systems theory include that a system is:
- composed of inter-related sub-systems, parts or elements
- explicable only in its totality- holism
- for biologic or social systems, open for exchange with the external environment
- a means of transforming inputs to outputs
- bounded from its environment (permeable)
- subject to negative entropy if not open

- in dynamic equilibrium
- balanced by negative and positive, forward and backward feedback
- hierarchical in relation to other systems
- multiple goal seeking
- capable of equifinality (different ways to same ends)

(Kast, Rosenzweig, 1972)

Whereas these concepts can be applied to organizations, there is some discomfort about the extent to which social systems "anchored in the attitudes, perceptions, beliefs, motivations, habits, and expectations of human beings" can be considered analogous with biologic systems (Kast, Rosenzweig, 1972; p. 455). The challenges of understanding a social system are compounded by the reality that its parts cannot be separated one from the other without destroying essential features of that system, nor can it be reconstructed once disassembled (for example, the human body) (Phillips, 1972). However, as systems are both structural/ material and relational/ organizational, others argued that a

> thing can still be the same thing when one of its characteristics is altered, for most things are defined by reference to a cluster of characteristics, and one or two characteristics can leave or join the cluster without the thing becoming different...so it would appear that a great deal of reliable and relevant information can be ascertained by studying elements in isolation from the whole system. Whether accurate predictions about the whole can be made on the basis of knowledge of the parts will depend on what laws and theories have been established in the field concerned. (Phillips, 1972; p. 474).

The knowledge gained must always be considered conditioned by its extraction from the whole. As outlined above, systems theory is largely mathematical in its expression (hard systems thinking). In order to increase the usefulness of general systems theory to better understand social and other systems, soft systems methodology was developed (Checkland, 2000). Soft systems methodology was based on the following principles:

- the real world is a complexity of relationships
- relationships are explored via models of purposeful activities based on explicit world-views
- inquiry is structured by questioning perceived situations using the models as a source of questions
- "action to improve" is based on finding accommodations (versions of the situation whereby those with conflicting interests can live with it)
- inquiry in principle is never-ending; it is best conducted with wide range of interested parties; process should be given away to people in the situation (p. s16)

General systems theory augmented with soft systems methodology appears well suited to exploring access to health.

Systems/ Systemic Thinking

Many believe that viewing healthcare organizations as systems will optimize the effectiveness of available resources and achieve outcomes better than through isolated interventions targeted at single organizational components or parts, thus creating a greater whole. With a systems view, organizational structure, values, policies, routines, relationships, resources and power structures (formal and informal) become enmeshed in all interventions undertaken.

Systems thinking is an approach to problem solving in which challenges are viewed as parts of an overall system. Systems thinking is based on the belief that <u>component</u> parts of a <u>system</u> can best be understood in the context of relationships with each other and with other systems, rather than in isolation. Systems thinking enables tempered consideration of challenges within a broader context rather than a reactive approach to current circumstances before understanding the wider long-term implications. The only way to fully understand why an event occurs and persists is to understand the part in relation to the whole.

In complex adaptive systems (see below) such as healthcare organizations, systems thinking helps to understand that events and their results are separated by distance and time; that small catalytic events can cause large, and often unexpected, changes. Systems thinking helps to integrate silos into a cohesive, productive whole for the benefit of all. "It is about how little things can make a big difference…The tipping point is that magic moment when an idea, trend or social behaviour crosses a threshold, tips and spreads like wildfire." (Gladwell, 2000).

> There are many ways to think about systems thinking. Some scholars view it as a specific methodology such as systems dynamics, while others believe it is a plurality of "methods". Others see systems thinking as systems science, while others see it as a general systems theory. Still others see systems thinking as a social movement. (Cabrera, 2006; p. 7).

For the purpose of this thesis analyses, systems thinking was not thinking about systems but rather a systemic way of thinking. Inevitably, systems thinking is informed by knowledge from all kinds of systems (Cabrera, 2006). The focus of systems thinking is not on the whole rather than the parts, but rather a balance between reductionism and holism. As for systems, systems thinking requires conceptual boundaries, albeit arbitrarily chosen, and thus becoming situated "within a context of externalities" (Cabrera, 2006; p. 63). Systems thinking includes seeking root causes and alignment of components. In addition, systems thinking is affected by the perspective(s) taken. Systemic thinking involves adopting a holistic viewpoint and consideration of the multiple interdependencies of a system's components.

Complex Adaptive Systems

The newer conception of systemic thinking embraces a "transdisciplinary socio-bio-technical systems thinking [that] is explicitly…*in contrast to* old, linear, status quo-preserving, objectivist, determinist, predictive, structural-functional kinds of systems thinking. Or *inclusive* of these in a very new way of thinking holistically about *all* human diversity." (Wadsworth, 2008; p. 154)(italics as in original)(bracket inserted). Complex adaptive systems theory was based on complexity theory, chaos theory and quantum theory (where the world is fundamentally unknowable)(McDaniel, 1997).

> A complex adaptive system (CAS) is a collection of individual agents that have the freedom to act in ways that are not always predictable and whose actions are interconnected such that one agent's actions changes the context for other agents. (Plesk, 2000; p. 312-313).

> 'Complex' implies diversity- a wide variety of elements. 'Adaptive' suggests the capacity to alter or change- the ability to learn from experience. A 'system' is a set of connected or interdependent things... A (*complex adaptive system*) has a densely connected web of interacting agents, each operating from its own schema or local knowledge... (*They*) are dynamic, massively entangled, emergent (self-organizing) and robust. (Begun et al, 2003; p.255)(italics inserted).

Complex adaptive systems have several key properties- adaptable elements, simple rules, nonlinearity, emergent behaviour/ novelty, unpredictability in detail, inherent order, context and embeddedness and co-evolution (Plesk, 2000). As outlined by Rau, 1998, aggregation, nonlinearity, flows, diversity, tags (labels of recognition), internal models

and building blocks were identified as components for complex adaptive systems. Self-stabilization, goal-seeking, program-following, self-reprogramming, anticipating, environment modifying, self-replicating, self-maintaining and repairing, self-reorganization and self-programming were identified as components. Distributive being, control from bottom up, cultivation of increasing returns, growth by chunking, honouring errors, pursuit of multiple goals, use of metaphors and seeking persistent disequilibrium are additional descriptive features of complex adaptive systems (Zimmerman et al, 2001). Key elements in complex adaptive system design are using biologic metaphors to guide thinking, creating conditions so the system can evolve naturally over time, providing simple rules and minimum specifications, setting forth a 'good enough vision', and procuring a wide space for natural creativity to emerge from local actions within the system (Plesk, 2000). Planning is evolutionary, based on ongoing learning; "relationships coevolve for the purpose of learning and the creation of meaningful systems." (Begun et al, 2003; p. 266).

Health care organizations/ systems have been characterized as complex adaptive systems (Begun, Zimmerman, Dooley, 2003), requiring systems thinking to adequately understand those complexities (Waldman, 2007). Whereas much of systems theory was based on explanations of inanimate systems, complex adaptive systems theory was based largely on observations of living systems. Pascale, 1999, defined four principles of complex adaptive systems:

1. equilibrium is a precursor to death for complex adaptive systems (emphasizing that ongoing new input is essential for thriving systems)
2. the bounded instability of complex adaptive systems permits them to evolve (noting a system's permeable circumference)
3. self-organization and emergence ("the propensity of simple structures to generate novel patterns, infinite variety, and, often, a sum that is greater than the parts"; p. 85) are key characteristics
4. "One cannot direct a living system, only disturb it" (p. 85). Complex adaptive systems have weak cause and effect linkages, where small changes may have a large effect and vice versa.

Complex adaptive systems are guided by a few simple rules or patterns, often referred to as fractals ("a set of simple equations that combine to form endless diversity")(Pascale, 1999, p. 89) such as the fronds of a fern or the components of a head of cauliflower.

With respect to this thesis research, community health can be viewed as a complex adaptive system. As referred to in Bopp and Bopp, 2006, there are many determinants of community health. Endeavours to improve the health of a community are complex, diverse, encompassing of interactions/ interdependencies of many individuals, groups, organizations and agencies and, within a framework of Achieving Better Community Development, each "operates from its own schema or local knowledge" (p. 38-39). Community health is well suited for examination using a complex adaptive systems lens.

McDaniel, 1997, noted 12 leverage points for change strategy within complex adaptive systems- giving up planning and control, moving to the edge of chaos, creating new organizations with new forms, developing self-referent organizations (so boundaries of the organization are knowable), enhancing the quality of connections, teaching people what other people are doing, creating learning organizations, thinking about organizational design as an ongoing process, not being responsible for setting goals for workers or for organizations (facilitate instead goal discovery by organizational members), decreasing emphasis on competition and increasing emphasis on cooperation, working smarter, and providing for the emergence of visions and values. These leverage points seem suited to community health systems.

The changes required to address health equity for North End Halifax community members are complex and immense and would seem to necessitate paradigmatic change or "a paradigm shift in how a problem is perceived and what strategies are used to address it; how things are done is fundamentally altered within the targeted context" (Foster-Fishman et al, 2007, p. 201). They also noted that

> When the root of the problem rests in the fundamental nature of the system, attending to second-order change is more likely to lead to more comprehensive and long-term solutions because it requires attention to the underlying root causes of a problem (p. 201).

Table 3   Components of Paradigmatic Change (Foster-Fishman et al, 2007)

System boundaries	Fundamental parts- potential root causes	System interactions	Levers for change
Definition of opportunity Identification of relevant levels/ layers, niches, organizations and actors	System norms System resources System regulations System operations	Dampening and potentiating interdependencies System regulation through feedback Interaction delays	Parts to leverage change: -cross-level influences -direct system behaviour -feasible to change Interactions or patterns to leverage for change: -differences that create niches compatible with system goals -long standing patterns that affect change goals Gaps in feedback mechanisms Needed cross-level/ sector connections

For my systems theory lens, I included seeing and integrating many differing perspectives, interconnectedness, instability, enabling and inhibiting loops, an amalgam of people and structures/ settings and actions, interbeing, simple rules, root causes and alignment. I visualized a way to recognize and incorporate systems embedded within other systems.

Questions for Analyses with a Systems Theory Lens

1. What are potential system issues related to this?

2. What are potential system inconsistencies/ incongruencies/ incompatibilities related to this?

3. What system relationships are affected by this?

4. What system interdependencies could potentiate or negate this (Foster-Fishman et al, 2007)?

5. Are there delayed consequences of this?

6. Are root causes considered by this?

7. Can the policy/ process, etc be replaced with a simple rule (and Standard Operating Procedure)?

CHAPTER 3   POLICY ANALYSIS #1

3.1 EXAMINATION OF POLICIES

The purpose of examining Health Centre related policies was to determine if, in the future, viewing policy drafts through the lenses of feminist theory, critical social theory and systems theory during the development of policy might not only change the optics of the policy but the outcome or framing of the policy as well. The two policies examined were chosen to illustrate an overarching organizational policy and a frontline policy that might have significance for diverse or under-served populations. I chose to begin with one of the Governance Policies of the Health Centre Board as an exemplar of a tertiary care health centre policy with the expectation that the direction and level of functioning of the Health Centre would emanate from the Board. The policy chosen for analysis was the *General Governance Commitment Policy*, a policy that describes the role of the Health Centre.

I chose as the second policy for analysis the Health Centre's *Conflict of Interest Policy*. Although the *Conflict of Interest* policy might not intuitively appear to impact populations with challenges accessing health and health care, it serves to portray how a narrow conception of a policy can unintentionally distance some of the populations for which the Health Centre has a mandate to provide care. The policies were analyzed through the three lenses, utilizing the questions developed in Chapter 2. The analyses of these policies are given in this Chapter and Chapter 4. As my thesis work was related to understanding access to health for underserved populations (those experiencing disparities in health outcomes), my analyses emphasized these aspects within the policies examined.

For the analysis of the *General Governance Commitment Policy*, I examined the first section of the policy through a feminist lens, the next section with a critical social theory lens and the final section with a systems lens. This approach was chosen to allow in-depth review through each lens; to decrease the repetitiveness and length if each section had been analysed with the three lenses; and because, by happenstance, the three policy sections seemed to fit well with the lens used.

43

3.2   POLICY IMPACT

The import of policies lies in the guidance they give and the values they reflect. "Values are views about what is important. In the political and policy arenas, they are beliefs about the ends or goals of social institutions and the virtues they ought to embody." (Peter et al, 2007; p. 1628). They are principles or criteria for choosing among actions and interventions; they can be applied at the level of individuals, organizations or societies. Values have an impact on "justice, equity, entitlements, rights, responsibilities, citizenship, and public participation." (Peter et al, 2007; p. 1629). Values are practiced along a spectrum and rarely as absolutes; in fact organizations and individuals can hold apparently contradictory values simultaneously (DeCelles, 2007).

Policies are the outcomes of choices, conscious or unconscious, that curtail options and alternatives (Hankivsky, 2004). Although transparent, explicit decision-making in policy development is increasing, much is still shrouded in mystery (Dobrow et al, 2003). I chose to start with analysing one of the Health Centre Board of Governance policies because of the impact such policies should have on the functioning of a tertiary health centre and, thus, its relationships with the community (communities) within which it is located. The Health Centre, with its focus on pediatric, adolescent and obstetrical medicine, has the potential to significantly contribute to population health and health outcomes (Bhutta et al, 2005; Rounds, Ormsby, 2005). The Board policies have the potential to impact the immediate and long-term outcomes of individuals, groups, agencies, institutions and communities. The following analyses are not purported to be exhaustive or unbiased, rather to illustrate how expanding views and viewpoints can significantly change how policies evolve.

Policies can be regulatory and directed at internal organizational functioning or aspirational and directed at influencing others outside the organization; policies can be directed at individuals, professionals, organizations or society (APA, 2007). They can help to shape a vision of the future, outline priorities, achieve consensus, provide information, guide planning and establish benchmarks (World Health Report, 2000). They can instigate change that results in improved health outcomes (Plotnick et al, 2006);

mitigates effects of poverty on health (Ross, 2003); leads to cultural change strategies that foster socially supportive, healthful environments (Stokols, 1996); and reduces health inequities (Neema, 2005). For example, community design policy has been shown to be effective in increasing walking, cycling and public transport use (Giles-Corti et al, 2007). Policy interventions paired with environmental interventions led to improvements in eating, physical activity and achievement of a healthy weight (Sallis et al, 2006). However, policies may also have negative effects as exemplified by policies that serve the interests of the economic elite through tax reductions and exemptions (Raphael, 2007) resulting in fewer funds for governmental services to address the needs of those living in poverty. Thus all policies require careful thought before their implementation. Involvement of those potentially affected by the policy, although seemingly essential, is often omitted (Neema, 2005).

For the Board, relationships and responsibilities include agenda setting, funding and ensuring appropriate delivery of service through understanding of the needs of the populations served. The impact of relationships (such as inter-governmental relationships and collaboration or community connections) on policy can be examined through policy effectiveness (including health outcomes and efficiency), respect for principles of democracy, and accountability (Wilson et al, 2004). The World Health Report, 2000, emphasized that public interest can be protected through appropriate, effective health policy and strategies to orient health systems as a whole towards achieving public-interest defined goals (stewardship goals). Whereas such stewardship may lie primarily with the governments (national and provincial), there is the opportunity for significant impact at a more local level through Community Health Boards, Health Centres and Community Health Clinics.

The impact of policies is affected by associated regulations and legislation (World Health Report, 2000), congruence of policy and associated targets or incentives, local control, capability/ capacity, key performance indicators, enforcement or perceived enforcement, costs to monitor and enforce the policy target (Coffield et al, 2007; Lovato et al, 2007; Plotnick et al, 2006); evidence, clarity, funding, designation of accountability, response to

change, competing priorities (APA, 2007); political feasibility and acceptability (ideologic, social, economic and legal)(Dobrow et al, 2004; Sallis et al, 2006); advocacy and lobbying (Fafard, 2008), gaming (Davitt, Choi, 2008) and perceived threat of litigation (Freudenberg, 2005). Policy levers include planning, inspection, targeting, funding and designating initiatives (Coffield et al, 2007). Policies may have unexpected outcomes, particularly when there is lack of alignment of resources, capacities and incentives, and when the policy is not considered in the context of the whole system(s) in which it applies. Many policies require a programmatic approach to achieve the intended effects (Lovato et al, 2007). Without appropriate supports and resources, the aspects of a policy that are implemented may not be determined by population needs but rather aspects most closely matching the existing knowledge, practice or skills (Lloyd et al, 2008). Evidence-based health policy is conceived as sitting mid-way between evidence-based practice and traditional political decision-making, accounting for both evidence and context (Dobrow et al, 2004). Participation, research and evidence may be integrated at all stages in the development of policy.

> Policy-making is a social process and evidence is socially constructed. Analyzing and promoting certain policy options is a process of facilitating conversations and dialogue between different participants in the policy process... Proponents of healthy public policy need to analyze discourse, identify different and competing policy frames, and promote dialogue between members of the many communities that will feel the impacts of policy and program change. (Fafard, 2008; p. 21).

Normative, logical, empirical and legal reasoning are aspects of policy analyses (Kenny, Giacomini, 2005). A normative analysis of policy is one that examines the "identified values, concepts and assumptions with respect to the values that ought to direct policy and practice." (Peter et al, 2007; p. 1632). The good within an ethical framework can be recognized by its consequences (consequentialism, utilitarianism), its consistency with principles (deontology) or the character of the agent (virtue ethics)(Kenny, Giacomini, 2008). In the context of policy, one ethical dilemma is the defining, identifying, justifying and equitably distributing benefits and harms. Substantive ethics pursues the reasons underpinning policy (for example reciprocity, sustainability, concern for the vulnerable, stewardship and balance of power), whereas procedural ethics are concerned with the

46

processes of development of policy (inclusion, fairness, transparency, participation)(Kenny, Giacomini, 2005).

> Procedural ethics starts with the notion that there will be competing and conflicting ethical criteria in a diverse and pluralistic society. At a material and political level, there will be competing interests. Procedural frameworks generally strive to ensure that interests are explicit and appropriately represented, deliberations are publically accessible and visible, and decisions may be challenged or revised in response to legitimate concerns. Specific ethical concerns include how to fashion the decision making roles of experts, citizens, activists, or consumers, how to cultivate consensus and move forward when it fails, and how to identify and represent the interests of those disenfranchised and for various reasons "not at the table". (Kenny, Giacomini, 2005; p. 257).

Woven in the following analyses, both substantive and procedural ethical aspects of the Health Centre Board Policies were considered.

3.3 IWK HEALTH CENTRE BOARD – GOVERNANCE POLICY ANALYSES

3.3.1 Purpose:

I felt through policy modification or development there was the potential to engender and enforce change (see for example, Mooy, Gunning-Schepers, 2001; Matson-Koffman et al, 2005). The purpose for analysing two current health related policies was to explore and increase understanding of potential ways significant health reforms might be instigated by examining policies (revision or development) through different lenses.

> Policies shape how money, power and material resources flow through society and therefore affect the determinants of health. Advocating healthy public policies is the most important strategy we can use to act on the determinants of health. (Canadian Public Health Association, 1996; p. 1).

3.3.2 Background:

The Board of the IWK Health Centre is in the process of updating their Governance policies, thus potentially providing the opportunity for input to the process. Circumstances, both at the Health Centre and within the realm of healthcare generally, indicated this was an opportune time to re-examine Board policies. The healthcare system is facing shortages of health professionals, an aging population, rapidly increasing technologic advances with associated increased costs, more knowledgeable clients, higher

client expectations, readily available health information, greater demand for accountability, generational differences in attitudes to work-life, and dissonance between health needs of individuals versus those of populations (Williams, Fulford, 2007). Policy change can redress the specific aspects of a policy (first-order change) as suggested by new knowledge; the processes or systems of a policy (strategic or second-order change); and the overarching framework and goals of the policy (third-order change)(Breton et al, 2007). I believe third-order policy change is needed to address the role and responsibilities of the Health Centre within the Nova Scotian/ Maritime health and health care systems.

Arguably what follows is a biased examination by a white, Anglo-Saxon, Protestant, heterosexual female physician and member of the Health Centre community with all the distortions that heritage endows. However, I have attempted to visualize a broader picture through viewing the policies with the lenses of feminist, critical social and systems theories. The intent was not an exhaustive analysis but rather to increase awareness of how our past and viewpoints influence our thoughts and actions. This analysis perforce understates the many valuable accomplishments of the Health Centre that might have been elucidated if examined using an appreciative inquiry lens (Watkins, Mohr, 2001).

The Health Centre is a tertiary hospital for pediatric, obstetric, perinatal and newborn care as well as some women's services. As the only tertiary care pediatric hospital in the Maritimes, patients come from Nova Scotia, New Brunswick, Prince Edward Island, and, occasionally, from Newfoundland. It serves as a secondary care hospital for most of Halifax County as well as providing limited primary care. The Health Centre is responsible to and largely funded by the Department of Health (DoH)(Nova Scotia). In order to provide context, the Vision, Mission and mandate of the DoH are given below.

DoH Vision
> Generations of Nova Scotians living well.

DoH Mission
> Working together to empower individuals, families, partners, and communities to promote, improve, and maintain the health of Nova Scotians through a proactive and sustainable health care system.

DoH Mandate

      The Department of Health is committed to the ongoing improvement of the health care system through strategic planning, legislation, resource allocation, policy and standards development, monitoring and evaluation, and information management.

The IWK Health Centre core value, belief, mission and vision statements were developed after extensive consultation within the Health Centre, with those who participate in services through the Health Centre as well as partners, collaborators and other stakeholders. These statements (which follow below) are aspirational (in the sense of something to which the organization aspires) and do not necessarily reflect practice.

IWK Health Centre Core Values and Beliefs

Care and Passion
- Taking pride in providing safe, high quality care to the populations we serve
- Building successful relationships with patients and families as partners in decision-making and care
- Making a positive difference in people's lives
- Contributing to a culture of inclusion and diversity

Excellence and Leadership
- Building our reputation for excellence in the Maritime community and beyond
- Contributing to a sustainable health care system through formal and informal partnerships
- Pursuing excellence in care, teaching and research through a spirit of discovery and innovation
- Leveraging our reputation and influence to advocate for the health of the population
- Being accountable for our relationships, decisions and actions

Worklife and Relationships
- Bringing collaboration and teamwork to all that we do
- Creating a supportive work environment that values and respects all members of our team
- Being open and honest
- Supporting employees, physicians and volunteers in achieving and maintaining a healthy lifestyle

IWK Health Centre Mission
- To make a difference in the health and well being of women, children, youth and families
- To bring together care, research, teaching and advocacy for the best possible results
- To be global leaders in research and knowledge sharing

IWK Health Centre Vision

Healthy families. The best care.

The Joint Commission for Accreditation of Health Care Organizations, 2004, stated the "governance of an organization sets the framework for supporting quality patient care, treatment, and services...a framework that supports the ultimate goals of the healthcare organization- to provide quality care at reasonable cost...to create an environment that enables an organization to fulfill its mission and meet or exceed its goals" related to that organization's mandate (p. 1). Policy formulation is the single most important function of a Board (Pointer, Orlikoff, 1999). The Board policies prescribe ends (for example, vision, goals, strategy, populations served) and proscribe means (for example, related to performance, finances, quality of care). Pointer and Orlikoff, 1999, suggested that Board policy be specific enough so that the Board could accept and be responsible for any judicious interpretational and implementation of the policy. Such accountability requires mutual Board and Health Centre trust, experience, and regard for the importance, risk and potential of misinterpretation associated with the policy (Pointer, Orlikoff, 1999).

The Health Centre Board of Directors has not developed its own Board specific vision, values and beliefs statements or principles to guide the development of their Board policies although it has ratified those of the Health Centre. I believe that it is important for the Board to have its own vision, values and beliefs both for the benefit of the publics they serve (transparency) and for their own benefit to guide their actions in carrying out their mandate. The Board Bylaws were recently updated and approved by the provincial Department of Health. The governance policy examined below was approved 28/03/00. The policy sections were analysed in chronologic order; the section under analysis is presented in italics. **Table 4** contains the entire IWK Health Centre General Governance Commitment Policy.

Table 4   General Governance Commitment Policy

GENERAL GOVERNANCE COMMITMENT

PURPOSE (Mission) ENDS

The purpose of the IWK Health Centre is to be a centre of excellence providing family centered care, learning and advocacy for Maritime children, youth, women and their families through the prudent management of our resources.

CARE ROLE

Deliver necessary, high quality family centered tertiary, and selected secondary and primary health care services to meet the needs of children, youth and women in the Maritimes.

To provide:
1.   Specialized and interdisciplinary acute and continuing care to children and youth throughout the Maritimes.
2.   Secondary and primary health care to children and youth in Nova Scotia – as agreed with District Authorities and other key partners.
3.   Tertiary and selected secondary and primary level mental health assessment, triage and treatment for children and youth in the Capital Health District; and as needed by other Nova Scotia Districts and Maritime Provinces.
4.   Maternal-Newborn care within the Capital Health District; secondary and tertiary Maternal-Newborn care and related sub-specialty services in Nova Scotia; and to other Maritime provinces as required.
5.   Selected tertiary Women's Health services as agreed with and/or required by District Health Authorities in Nova Scotia; and, selected secondary and primary Women's Health services in cooperation with the Capital Health District.
6.   Selected children's, maternal newborn and women's health services for the Newfoundland Health Care system.
7.   Family centered care where leadership in linguistic and cultural competency is encouraged and demonstrated.
8.   Leadership in the introduction of alternative delivery models aimed at more effectively meeting the needs of those we serve and open to ensuring the effective integration and coordination of health services.

TEACHING AND RESEARCH ROLE

Provide learning and research opportunities for students, staff and volunteers, patients and families, our key partners and our community. Ensure that knowledge related to children/youth and women's health is used to influence standards of care and the availability of skilled health care providers.

To be:
1.	An Academic Health Centre for students needing experience and learning associated with health care for children, youth and women; in cooperation with key universities and colleges.
2.	An organization where a culture of learning is manifest and where all staff, volunteers and families are assured of opportunities to learn from and teach one another; and, where the experience and wisdom of patients and families and, of key partners is recognized, valued and embraced.
3.	A research organization where children, youth and women's health-related research and the pursuit of knowledge are valued activities and a part of all that we do; and, where research findings are systematically shared and contribute to improved standards of care delivery.
4.	An organization dedicated to strengthening the capacity of key partners in our community through cooperative learning and research and the sharing of knowledge and experience.
5.	An organization dedicated to the pursuit of knowledge which contributes to the improved health of children, youth and women.

LEADERSHIP ROLE

In cooperation with our partners, be an effective advocate for, and promoter of the health, and health care needs of all Maritime children, youth, women and their families.

To be an organization that:
1. Actively promotes family centered care throughout the health care system.
2. Actively promotes healthy life styles and development for children, youth and women in the Maritimes.
3. Advocates effectively for funding of services in response to health service needs of children, youth and women.
4. Advocates effectively for public policy and programs to foster healthy families and communities.
5. Contributes to the reduction of childhood and youth injury.
6. Contributes to the reduction of abuse and neglect of children, youth and women and of family violence.
7. Contributes to leadership in efforts to increase literacy and reduce poverty in our society.
8. Supports and contributes to the empowerment of women and the marginalized to control their own health and health services needs.
9. Focuses our efforts on the needs of those we serve and on partnership not ownership.
10. Contributes, and is an advocate for, the availability of skilled health care workers and professionals.

3.4   FEMINIST THEORY LENS ANALYSIS

The feminist theory lens was used to examine the Mission and Ends Statement and the Care Role Section. This policy section was initially reviewed overall through a feminist theory framework and then using the specific questions as outlined in Chapter 2. The intent of the analysis was to show how the policy might be different if developed using a feminist lens; not to determine whether the policy is right or wrong in its specifics.

3.4.1   General Governance Commitment (Policy E-1)

This policy addresses the purpose (or ends or mission) of the Health Centre. It incorporates the care, teaching and research, and leadership roles of the IWK Health Centre.

The Mission and Ends statement, as the introductory and overarching statement, ideally should have great impact. Words, as found in the Mission and Ends statement, are recognized as having importance, conveying meaning and constructing our worlds. Language can "organize our thought and experience...Language is seen as both carrier and creator of a culture's epistemological codes. The ways we speak and write are held to influence our conceptual boundaries and to create areas of silence as language organizes meaning in terms of pre-established categories." (Lather, 1991; p. 111).

In my overview analysis using a feminist theory framework, I felt the Board Purpose statement as written conveyed a sense of the Health Centre as giving rather than sharing or receiving; as knowing rather than mutual learning; as leader rather than follower or walking together with others as equals; as owner of resources rather than having been loaned or given by taxpayers the means to accomplish its mandate; as powerful, graciously allowing others to partake of its services; as being a *centre of excellence* rather than striving to become excellent. The word *providing* negates the essence of family centred care where families are partners with health professionals. There seems an uneasy blend of the older cultural and social expectations of knowledge and power residing with the health professionals, of developing dependency rather than enhancing capacity, of provider and recipient, of strength versus vulnerability with the rather wistful hope of an equitable relationship as contained in the words *family centred care*. Although arguably related to the syntax of the Purpose Statement, there is provision of *learning* for Maritime children, youth, women and their families, omitting the requirement for ongoing learning by members of the Health Centre organization (but covered under the Teaching and Research Role Statement). The implicit bottom line, and thus controlling factor, is *prudent management of ...resources*. There is no attention paid to the consequences of choices made by the Health Centre other than resources (financial or other).

One might expect that the Mission and Ends Statement would situate the Health Centre within the context of agencies involved in improving the health of Nova Scotians/ Maritimers. One view would suggest that the Health Centre, as a tertiary care centre, is a costly organization that addresses a very limited portion of the health of Nova Scotians. For example, Woolf et al, 2004, found that in the United States, in the years from 1991 to 2000, medical advances prevented 176,633 deaths but equalizing the death rates of African Americans would have saved 886,202 deaths. A seamless healthcare system is an oft stated ideal, envisioned by the public as a system whereby their journey along the health and wellness to death trajectory would be linked from one component of care (or intervention) to the next, each step building on past ones. From a population perspective, a health care system (or health system) might be visualized as one where interventions/ care addressing all of the determinants of health might be shared, coordinated and achieved. A cursory examination of the synopsis of the social determinants of health given in Chapter 6 highlights the challenges of achieving health for populations. There is no indication that the Board situated the Health Centre as only one small component of a larger milieu contributing to the health and wellness of a population. A feminist lens helps to more clearly see that most health and illness is lived far removed from a tertiary care centre. It highlights the opportunity for the Health Centre to adopt an expanded social role.

The very directive, economically based underpinning of the decision-making for the Health Centre has profound impact. In the absence of defined Board values or principles, there is no guidance for how *prudent management of resources* is defined or measured. It is implied that the *resources* are those of the Health Centre without acknowledgement of either the resources that patients and families bring or, more pertinently, expend in obtaining their health care or the resources of other institutions and agencies when they directly or indirectly become implicated in continuity of care begun at the Health Centre. And what are costs or benefits and for whom? What responsibility does the Health Centre bear within the healthcare system? Does the Health Centre have responsibilities for restitution; for redressing inequities?

The sense embedded in the Mission and Ends statement is that of business (resource management), paternalism (decider/ provider), less of maternalism (carer) and virtual absence of egalitarianism (shared voice, responsibilities and connectedness; sense of community).

> Generally, an act (or omission of an act) can be said to be paternalistic when it is carried out intentionally on behalf of a person *(or persons)* other than oneself, against the person's wishes or without consent, with the explicit purpose of doing good for, or avoiding harm to, that person. Importantly, it is the good of the targeted person or group that provides the impetus for the paternalistic decision making and action. It is equally important to note that paternalistic rationales for decision making and action have been invoked systematically to dominate and control persons on the basis of their sex, sexual orientation, race, ethnicity, religion, class, and other's judgments about their sanity and health. (Cody, 2003; p. 288)(italics inserted).

Maternalism is a less well defined and researched subject. The most prevalent definition retrieved from the web is "the quality of having or showing the tenderness and warmth and affection of or befitting a mother", exemplified by the care of a mother for her child (www.wordreference.com). Although perhaps not intuitive, caring in a protective or maternalistic way can be disempowering or seen to render the recipient as child-like (Christensen, Hewitt-Taylor, 2006). It can also set women up to be the caregivers instead of with an ethic of care where everyone has a role in giving and receiving care. Inextricably entwined in the Mission and Ends statement is the historic web of a system populated by paternalistic physicians, administrators and Boards, and maternalistic caregivers. Undoubtedly, the largely female workforce and the traditional predominance of women pediatricians have had consequences on the power balance intricacies. Inevitably, those perceived to have less power become the usual recipients of paternalistic attitudes and actions (Cody, 2003).

The Board Mission and Ends statement portrays a mix of paternalism and maternalism; a benevolent organization, endowed with wisdom, power, knowledge and authority generously offering solace. There is no suggestion of mutuality of responsibilities, accountabilities, knowledges, entitlements or powers. Recipients of care or services remain less than the Health Centre and health care providers. Examination of the roles subsumed under the Mission and Ends reinforces this portrayal. The *Care Role* (the first

sub-section of the *General Governance Commitment* policy) exhibits similar attitudes as discussed below.

3.4.2   Care Role

CARE ROLE
   Deliver necessary, high quality family centred tertiary, and selected secondary and primary, health care services to meet the needs of children, youth and women in the Maritimes.

   To provide:
   1.   *specialized and interdisciplinary acute and continuing care to children and youth throughout the Maritimes*
   2.   *secondary and primary health care to children and youth in Nova Scotia - as agreed with District Authorities and other key partners*
   3.   *tertiary and selected secondary and primary level mental health assessment, triage and treatment for children and youth in the Capital Health District; and, as needed by other Nova Scotia Districts and Maritime Provinces.*
   4.   *Maternal-Newborn care within the Capital Health District; secondary and tertiary Maternal-Newborn care and related sub-specialty services in Nova Scotia; and to other Maritime provinces as required.*
   5.   *selected tertiary Women's Health services as agreed with and/or required by District Health Authorities in Nova Scotia; and, selected secondary and primary Women's Health services in cooperation with the Capital Health District.*
   6.   *selected children's, maternal newborn and women's health services for the Newfoundland Health Care system.*
   7.   *family centred care where leadership in linguistic and cultural competency is encouraged and demonstrated.*
   8.   *leadership in the introduction of alternative delivery models aimed at more effectively meeting the needs of those we serve and open to ensuring the effective integration and coordination of health services.*

Patients and users of the care services are portrayed as passive beneficiaries. Neither the Care Role statement, nor the list of "to provides" that follows, reflects potential for patients or users of the services to participate in Health Centre decision-making related to the *Care Role* (albeit conceivably indicated at a higher level of the policy). Arguably, those with the greatest investment and vulnerability are rendered voiceless. Both at the Health Centre and at many other health care institutions, there is movement towards more patient/ family involvement in decision-making regarding their own or family member's health care, "away from paternalism and towards a culture of shared power, respect"

(Entwistle and Watt, 2006; Christensen, Hewitt-Taylor, 2006; p. 696) as implied in family centered care. Yet, there is no indication that there is a function for patients, families and those *provided for* in decision-making about future directions of the Health Centre, appropriate or desired partnerships for the Health Centre, or institutional level decisions about programs or services. However, the eighteen-member, largely business and health professional Health Centre Board has participated in focus groups and forums with the public. Along the spectrum of participation, from being informed, consulted, giving advice, partnering, having delegated powers or control, the role of the public appears to be rudimentary except with respect to their or their family's healthcare (Quantz, 2001).

There is little indication of how and by whom the definitions of *high quality* and *services to meet the needs*, or how the services *selected* will be determined. With the exception of the explicit statements regarding *selected tertiary Women's Health services as agreed with and/or required by District Health Authorities in Nova Scotia;… selected secondary and primary Women's Health services in cooperation with the Capital Health District; (and) selected children's, maternal newborn and women's health services for the Newfoundland Health Care system*, the implicit assumption is the Health Centre makes these determinations. The inclusion of a stronger voice of the public in the selection would inevitably change the spectrum of services from those determined by the Board as delegated to the Health Centre senior administration. Whereas the Health Centre has included, and no doubt will continue to include circumscribed input from patients, families and others, control lies within the organizational hierarchy. The voices of the public are rather muted as the Board membership does not reflect the populations served by the Heath Centre. The Board includes three medical staff, the Dalhousie University Dean of Medicine, the CEO of the Health Centre and thirteen business people. There is one Francophone but no non-White members; there are five women.

Decision-making related to health care and health care organizations is complex. Activities of decision-making have been described to include recognition and clarification of a problem, identification and appraisal of potential solutions, selection of

action, implementation and evaluation of the adopted solution (Entwistle, Watt, 2006). Involvement in decision-making has been conceptualized to include feelings and views by participants about their roles, efforts and contributions as well as efforts and contributions related to the decision-making and relationships with others in the decision-making process (Entwistle, Watt, 2006). There is no indication or guidance provided in this policy that patients, families and the public should be engaged in decision-making processes or in appraisal of the effectiveness and value of the Health Centre services. The policy makes no mention of the potential influence of organizational members (employees, volunteers, physicians) on the functioning and future of the Health Centre.

3.4.3 <u>Thoughts Based on the Feminist Theory Questions</u>:

1. What embedded assumptions/ biases/ values can be detected in the information presented- particularly related to positioning of women and the knowledges and experiences of women? Were these biases or inaccuracies expunged?

Although the Board has not defined their own values and beliefs, they did ratify those of the Health Centre. These values include care, passion, excellence and relationships (see p. 49). Excellence, care and learning can be viewed as expressions of care and passion; there is little emphasis on relationships. The "to provides" are pragmatic but imply a commitment to the health of children, youth and women. The Board has not adopted any readily discernable ethical framework for defining the Care Role of the Health Centre; in particular they have not embraced the ethic of care. Founding the policy on an ethic of care might have highlighted a sense of community and connections, relationships and reciprocity and a passion for redressing inequities. Excellence does imply competence; however, there is little reflection of attentiveness and responsiveness to others or of the Health Centre's more communal responsibilities within a health and illness care system. The policy as written appears to favour a more traditional social role of the Health Centre as a paternalistic giver of services and fails to value the potential contributions of others (the public, patients, families, health professionals). The intended meaning of *deliver* is unclear and it likely contains the commonly accepted role for hospitals to give and patients to receive care.

The need for integration, coordination and continuity of healthcare services is noted. Women in all contexts, but perhaps especially within a pediatric/ maternal/ women's healthcare context, are the ones with the greatest first hand exposure to all aspects of the health trajectory and are generally the unofficial health care providers. The phrase *open to ensuring* does not convey any firm commitment to facilitating linkages and partnerships to truly *meet the needs of those we serve*. As those who bear most of the burden related to disconnected health services and by the determinants of health, women (and others) will be disadvantaged. Failure to situate the Health Centre within the healthcare environment hampers the effectiveness of any leadership *in the introduction of alternative delivery*. In this and other role descriptions, lack of placing the Health Centre within a larger system indirectly implies the self-perceived primacy of the Health Centre in any new approach. Neglecting to recognize and value the absolutely necessary contributions and strengths of others biases the approaches or visions to realize change.

There are parallels between the positions of women's knowledges with respect to men, hierarchies within the Health Centre, and patients/ families or those served. Patients, families and those served are portrayed as less knowledgeable than the organization and its healthcare workers (social and cultural role expectations). Patients, families and those served are conceived as having problems needing fixing (problematized), rather than in reality being the only validation for this complex organization to exist; they are not conceived as valuable resources themselves (normed as not well rather than well). Not unexpectedly, the emphasis under the Care Role is one of illness rather than wellness care or services. Under the Care Role, health is problematized or medicalized.

2. Have the differences in power been acknowledged? Their impact?

Power differentials are neither acknowledged nor addressed and thus not redressed. Patients, families and those served are positioned as less powerful than the organization and its healthcare workers. There is no acknowledgment of the socially imbued challenges to achieve partnering in care as espoused in family centered care. There is no suggestion of equilibrating positions, either internally or externally, although there is mention of partnering with other agencies. The majority of the Health Centre's workers

are women and the persistent under-ranking of women compared to men still exists within the organization. This is neither acknowledged nor addressed. There are and will be difficulties recruiting adequate numbers of skilled and knowledgeable health professionals, yet no attention in the Board governance policy is given to maximizing the work-life of its work force (a value of the Health Centre)(Harris, 2008). It is generally acknowledged, although perhaps changing with newer members of the workforce, that work-life balance is more challenging to achieve for women, a significant component of which is related to traditional gender-based power structures (for example, Charles, Harris, 2007).

3. Have the political aspects been recognized?

There is no explicit acknowledgment of political impacts on the Health Centre's care role aside from the somewhat opaque references to other Health Districts. Elements of recent political concern, such as family centered care, linguistic and cultural competence, and mental health, are included as is the present Department of Health's emphasis on primary care. There is recognition that the mental health of children and youth is an area of need. This may reflect an understanding that mental illness should have no more stigma than that of other illnesses. The attention paid to diversity and inclusion is an area of prominence for the Department of Health. The political jostling of physicians (almost all Department Heads are men), mid-level managers (the majority of whom are women), nursing and other health professionals (the majority of whom are women) and senior administration (gender balanced) with respect to decision-making related to care services available is not addressed. An equitable and ethical approach to policy formulation is mandatory. One such approach is critical healthcare ethics.

> Critical healthcare ethics...calls attention to the inseparability of politics and ethics in a way that facilitates policy analysis. The first, relational autonomy, entails the conviction that persons are socially embedded and that identities are shaped through social relationships and by a complex intersection of age, race, class, gender, and ethnicity...a view of persons as interdependent/ relational...The second, care/ethic of care, calls attention to the centrality of moral emotion and receptivity, the vulnerability, suffering, and uniqueness of people, and the importance of relationships...The third, social justice, pays attention to how people are differentially situated by class, race, age, ability, gender and so on. The notion of equity is central here because it recognizes that these differences must be accounted for both when distributing societal goods and upholding human rights...The fourth,

61

citizenship, requires that (*all*) are not only provided the formal rights of citizenship, including legal, social and civil rights, but are also provided with the means to be included in the broad political identity of a democratic society that is the means for public participation...Social justice and citizenship are necessary to situate ethical dimensions of policy within a broad, political understanding of the role of healthcare services within societal structure. (Peter et al, 2007; p. 1632)(italics inserted).

These political aspects have not been broached within the policy nor has the Health Centre's obligatory interdependency with others necessary to accomplish its mandate.

4. Does the policy address "women-centered efforts to improve the quality of life for those who are oppressed"?

There is no evidence of efforts to redress prior and present inequities in health, health care access or health care services with the exception of mental health. There is mention of women's health and the implied involvement of women in family centered care.

5. Does the policy seek to improve society through eliminating constraints based on gender?

The provision of antenatal, obstetrical, perinatal and other women-focused services is an important component of the mandate of the IWK Health Centre. However, efforts to support equitable influence of women with respect to the institution are not part of this Board policy.

There is no evidence in the policy statements that endeavours be undertaken to eliminate constraints based on gender. Social policy created within a framework of the ethic of care (as referred to above) has been suggested as one way to contextualize choice to recognize differences such as gender, sexuality, ability, class, geographic location and ethnicity (Hankivsky, 2004). Much of the policy under examination appears to be based on a liberal justice theory where citizens are seen as autonomous, equal, moral, independent agents capable of making choices that enable them to pursue their individual interests; separate from each other with clear distinction between public and private domains. With this stance, decision-making is objective, neutral, impartial (scientific) and abstract and founded on the common man (middle class, educated, Anglo-Saxon, able-bodied). The underlying assumption is that each individual is capable of attending to her/ his own basic

needs (Hankivsky, 2004). Based on such an approach, those who are different or disabled were treated with paternalistic pity and charity, conditionally allowed access to the mainstream of society through their acceptance and emulation of able-bodied, White, middle-class male norms (Hankivsky, 2004). With such a basis for choice, policy will conceal, widen and buttress disadvantages and discrimination; in essence it preserves a hierarchical, paternalistic, racist and classist environment. Social problems are attributed to personal failures and caring (or needing to be cared for) is perceived as a weakness. In contrast, the ethic of care acknowledges our differences and interdependence.

6. Does the policy convey how culture may have shaped the behaviours/ results?

The policy appears to be founded on the healthcare cultures of the past - as expanded on above. These cultural expectations and perceptions fail to heed a newer and larger role of the Health Centre within communities, the province and more globally. It pays no attention to roles and relationships that engender connections with and responsibilities towards others.

7. Were the policy's (or policy maker's) conceptual framework and standpoints clearly identified?

The Board has no explicitly stated values or principles on which they base their actions and activities. They have not formulated their own vision or mission. The implied values include concern for and valuing of financial resources over other resources; Kantian autonomy (respect for individual autonomy) versus relational autonomy ("allows us to see that sometimes autonomy is best promoted through social change rather than simply protecting individuals' freedom to act within existing structures"; Kenny et al, 2010; p. 10); exhibiting power rather than enabling empowerment of others; pragmatism rather than vision. The policy does express openness to newer ways of delivering care.

The use of a feminist theory lens in the development of this portion of the General Governance Commitment policy might have drawn more attention to the middle-class biases evident in the policy, visualized an ethic of care, allowed others more say in the future of the Health Centre and directed more emphasis to redressing the present

inequities in the health of populations who receive, or who could appropriately receive, care through the Health Centre.

3.5 CRITICAL SOCIAL THEORY LENS ANALYSIS

The second lens used was the critical social theory lens to examine the Teaching and Research Role section of the Board *General Governance Commitment* policy. The questions guiding the analyses were those developed as outlined in Chapter 2.

3.5.1 Teaching and Research Role

TEACHING AND RESEARCH ROLE
Provide learning and research opportunities for students, staff and volunteers, patients and families, our key partners and our community. Ensure that knowledge related to children/ youth and women's health is used to influence standards of care and the availability of skilled health care providers.

To be:
1. *an Academic Health Centre for students needing experience and learning associated with health care for children, youth and women; in cooperation with key universities and colleges.*
2. *an organization where a culture of learning is manifest and where all staff, volunteers and families are assured of opportunities to learn from and teach one another; and, where the experience and wisdom of patients and families and of key partners is recognized, valued and embraced.*
3. *a research organization where children, youth and women's health-related research and the pursuit of knowledge are valued activities and a part of all that we do; and, where research findings are systematically shared and contribute to improved standards of care delivery.*
4. *an organization dedicated to strengthening the capacity of key partners in our community through cooperative learning and research and the sharing of knowledge and experience.*
5. *an organization dedicated to the pursuit of knowledge which contributes to the improved health of children, youth and women.*

Power is an essential concern of critical social theory and can be discerned through examination of discourse. Power relations - often based on gender, race, sexual orientation, socio-economic status, education and ethnicity - are expressed through institutions and their policies. Power is exerted through constraints by the powerful on the non-powerful based on what is said (content), the social relationships manifest in the

discourse and the subject positions of the participants (Fairclough, 2001). Written materials such as policies are perforce one-sided. As a consequence, the Board has total control over the content of the policies, limiting the substance to areas they choose to present. Their representation of patients/ families/ researchers/ health professionals, etc prevails, thus the power behind the discourse. The language employed, the level of literacy, the conventions of understanding are influenced by the positions and thus perspective of a relatively homogeneous Board membership. Discourse is modulated by their culture, ethnicity, gender, age, ableness, education, literacy and socioeconomic status. The wording of this section of the policy follows a conventional format, miming phrases and content dictated by expectations of those with influence (for example, *Ensure that knowledge related to children/ youth and women's health is used to influence standards of care and the availability of skilled health care providers.* These are expectations of the provincial Department of Health).

The Board conveys some of its power through exclusivity as exemplified by the distribution of the policies themselves. The Board policies are not widely read within the Health Centre or by outside communities. Access to them is controlled although organizational transparency is both promulgated and claimed; they are not available through the IWK Health Centre public website (or intranet). The power exhibited through this controlled distribution both decreases the understanding of the general public of the Health Centre's roles and hampers the ability of the community to impact those roles. The language conforms to the anticipation of lofty aspirations. The setting is one of power housed within the Board and Health Centre membership (as illustrated by the statement *to be an organization dedicated to strengthening the capacity of key partners in our community through cooperative learning and research and the sharing of knowledge and experience*).

The Board has the obligation and power to determine the policies through which the Health Centre must be governed and function, and there is the unquestioned assumption they have the right to develop those policies in a way they deem appropriate. As creator and owner of the policies, when the meaning of words or phrases is unclear or uncertain,

the Board has the power to determine their meaning (in the conventional and not legal sense). For example, the Board could adjudicate on the definition of family centered care. In its most subtle and hidden form, accepted meanings become naturalized or commonsense, understood without enquiry. The expectation by the Board of others sharing the same understanding as their own can serve to widen the gap between the knowers and the listeners (Fairclough, 2001). As such, the analyses that follow eschew the implicit view of individuals as "economically motivated, autonomous, and equally equipped to compete for resources with little responsibility for the well-being of others" (Peter et al, 2007; p. 1632), a status that reflects androcentric, Eurocentric privilege.

By the phrasing *provide learning and research opportunities*, the sense is one of control over the resources available to the researcher or learner, those who will be permitted to undertake research, access to the particular subjects for research, and/or the type of research to be performed; those who will be privileged to access the learning opportunities. The Health Centre Research Ethics Board is one means of control over the research (as well as protection for researchers and research participants) under the auspices of the Health Centre and the Health Centre Board. Values and ethics are implicitly and explicitly expressed through research - through the methods employed, the questions asked, the analysis approach and the participants recruited.

The principal relationship expressed through the overall Teaching and Research Role statement appears to be that of giver of knowledge to willing receivers. However, under the "to be" subsection, there is more indication of interaction, interdependency and reciprocity. A major thrust of the policy is the incorporation of knowledge into standards of care; the implication is that knowledge is obtained through research. The principles and values embedded in the research shape the *standards of care*. One definition of standards as developed by the Canadian Partnership Against Cancer Standards Action Group (Annual Report 2007-2008, Canadian Partnership Against Cancer) is:

> A standard defines the performance expectations and/ or structure and processes that must be in place in order for an organization to provide safe, high-quality services across the continuum (*of health*). Standards are characteristically

organizational based documents that address service provider education and roles, organizational behaviour and health system requirements (italics inserted).

Standards often are supported through practice guidelines, procedures and processes. Guidelines can be considered a form of normative practice and are based on research and/ or best practice results. Clinical practice guidelines have been defined as systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific circumstances (Field, Lohr, 1992). Standards and guidelines can have significant impact on health outcomes and on the distribution of resources. With respect to the *availability of health care providers*, this impact can affect the supply (number), distribution, efficient use and performance of health workers (Chopra et al, 2008). Thus research and the choices made related to research have a powerful influence on decision-making and functioning of the Health Centre. Such power relations circumscribe our worlds. This powerful impact should be balanced with an equally powerful sense of responsibility for choices related to research and standards of and guidelines for care.

Decision-making, particularly about resource allocation (which generally reflects implicit values and principles), is a weighty responsibility for the Health Centre. Guidance about how such decisions should be made and executed are a Board responsibility, one the IWK Health Centre Board has not articulated clearly. Most individuals recognize they are a part of a larger community and that health has a significant impact on opportunity. Therefore health is generally believed to be different than other commodities, creating an imperative for a more equitable distribution among citizens (Daniels, 2001). Daniels, 2001, proposed *accountability for reasonableness* as a just way to address acquisition of health (encompassing of all the determinants of health is more problematic). Rawls' theory of justice based on equal liberties, equity of opportunity, fair distribution of resources and support for self-respect was adapted by Daniels to formulate accountability for reasonableness. The use of procedural justice is one way to work through sticky dilemmas. Daniels, 2001, suggested that a process based on publicity (reasons for decisions are publically accessible), relevance (reasons and principles accepted as relevant by those impacted), appeals (mechanism for challenging the decision), and enforcement (voluntary or public regulation) was needed. Research and education are

powerful influences that impact the standards of care and thus determinants of health. Given the bottom-line of *prudent management of ...resources*, albeit without description that circumscribes the resources of the Health Centre versus those available to the Health Centre, it is surprising no guidance is provided through which resource decisions might be determined (i.e. the means).

Within my critical social theory lens, language shapes reality, thus the importance of key words related to this policy section. Teaching, research, learning, knowledge and standards are all words that evoke quite divergent meanings depending on the user and listener. For this analysis, I concentrated on research and knowledge as evidence for standards of care. Interestingly, under the Teaching and Research Role, the word evidence is not used.

> Learning something is a learner's coming to acquire, through action and, perhaps, passion and with respect to a relevant critical condition, a statement, skill, disposition, attitude, interest, or other matter that may be referred to by a grammatical object determined by a usage of a verbal form of "learn". But whether learning is nothing more than a single action or a cluster of actions and sufferings, it is an event, simple or complex, in that it is going from one state (not having the content of concern) to another (having that content).(Heslep, 2006; p. 29).

Education involves more than the dissemination of information from educator to learner. Education has at least five components: learning, content, setting, teaching and end result (Heslep, 2006).

A key element for the Teaching and Research Role is shared meaning of the definition of knowledge and an understanding of what (whose) knowledge counts. Plato referred to knowledge as remembrance of a previous state or a belief that could be justified as true (Watson, 2005; Meyer, Sugiyama, 2007). Locke (Hill, 2006) sceptically defined knowledge as our perceived acceptance, connection with or repugnance of our ideas. Knowledge is an object for barter, an object that confers power and honour on its owner. Constructivists conceive knowledge as never completely attainable, always developing and changing, and inextricably entangled with the knower. Criticalists deal with mutually exclusive binaries. They also view knowledge as an object that can be owned, bought and sold, and is separate from the knower. Knowledge is a way to achieve power and thus

domination over others. Knowledge in the hands of the oppressed becomes a way to emancipation. Criticalists separate tacit from explicit knowledge where tacit knowledge is know-how obtained through doing and generally possessed by workers, whereas explicit knowledge is scientific and felt to be of higher status. In a constructivist paradigm, individual knowledge envelopes truths as conceived by the individual; a linking together of concepts, patterns and elements. Individual knowledge contributes to organizational knowledge which becomes an amalgam of individual understandings of concepts, models, cultures, documents, methods and other knowledges. Within the policy, designating the organization as *an organization where a culture of learning is manifest and where all staff, volunteers and families are assured of opportunities to learn from and teach one another; and, where the experience and wisdom of patients and families and of key partners is recognized, valued and embraced* partially recognizes this.

Meyer and Sugiyama, 2007, conceived explicit knowledge as knowledge that can be "produced through communication", implicit knowledge as knowledge that can be recognized through actions and tacit knowledge as knowledge that cannot easily be articulated (p. 19). Tacit knowledge and explicit knowledge are understood as anchoring the ends of a spectrum of knowledge where implicit knowledge, largely unexpressed in language but capable of being expressed as such, occupies the mid position. Dialogists view knowledge as discipline - a system of correction and control; as being entwined with and inseparable from power (Schultze, Stabell, 2004). Another knowledge typology is that of practical knowledge (skills), acquaintance knowledge (knowing a thing or a person) and propositional knowledge (presented in the form of propositions). Propositional knowledge comprises of inferential (deduction, induction) and non-inferential knowing (Zins, 2007). Viewing knowledge in a broader sense enables respect for those often considered unknowledgeable.

Evidence can be considered a particular form of knowledge. As defined by the Canadian Health Services Research Foundation, knowledge is

considered scientific evidence when it is generated through explicit, systematic, and replicable methods. Evidence on people's values, habits, traditions, and

professional experience can be considered scientific evidence when it is gathered using social science or other replicable methods. (CHSRF, 2005).

Evidence was defined by the Canadian Health Services Research Foundation (CHSRF) as

information that comes closest to the facts of a matter. The form it takes depends on context. The findings of high-quality, methodologically appropriate research are the most accurate evidence. Because research is often incomplete and sometimes contradictory or unavailable, other kinds of information are necessary supplements to or stand-ins for research. The evidence base for a decision is the multiple forms of evidence combined to balance rigour with expedience - while privileging the former over the latter. http://www.chsrf.ca/other_documents/evidence_e.php.

A systematic review conducted by the Canadian Health Services Research Foundation found

three categories of evidence: medical effectiveness research (context-free scientific evidence); social science-oriented research (context sensitive scientific evidence); or the expertise, views, and realities of stakeholders (colloquial evidence). These views of evidence are not incompatible and each has a role to play in producing evidence-based guidance for the health system. (Lomas et al, 2005; p. 5).

These definitions reflect the usual understanding of evidence as held by healthcare researchers and health professionals. However, these beliefs are not universally held. Nursing knowledge has been described as either empiric (research-based, science), aesthetic (art), personal or ethics knowledge (Scott-Findlay, Pollock, 2004). These authors suggested that only research-based knowledge be labelled as evidence. They argued against inclusion of experiential or qualitative evidence. Although they acknowledged personal, clinical and craft knowledge were highly valued components of health care and should be included in decision-making processes, they refuted their being valued as evidence. They claim that if the goal of evidence is to increase accountability and limit variation in practice as well as achieve a particular standard of practice, research-based evidence only should be labelled as evidence to clarify meaning and distinguish it from modifications related to patient preference and clinical experience. They suggested the use of knowledge for other types of information - tacit, craft, ordinary or personal as examples. They further suggested the abandonment of the term evidence or the equivalence of research with evidence. Given this, the Board policy statement may reflect a similar stance.

Generally, in the healthcare setting, research based evidence is sanctioned as explicit (capable of transmission to others) and the most legitimate form of knowledge, particularly for evidence-based health care. Evidence-based health care (evidence-based medicine) is espoused as highly desirable. The ideal is for care that has been demonstrated as efficacious in well designed (usually implying randomized, relevant, patient-centered clinical trials) to be combined with clinician expertise and patient's choice (values) for health care decision-making (Sackett et al, 1996). Evidence-based medicine (EBM) has been responsible for remarkable improvements in care such as in the outcomes of children with cancer. As normatively conceived, the core methodology for evidence-based medicine is information obtained through a randomized clinical trial. Other forms of research such as observational or qualitative research do not carry the same esteem.

Yet there are challenges associated with randomized clinical trials as these trials have strict inclusion and exclusion criteria that often limit particular groups from participation; criteria related to gender, age, ethnicity, presence of other health problems and, indirectly, socio-economic status. Complex conditions are challenging to research. The hypotheses tested, the methods used and the analyses undertaken all are influenced by the values of the researcher (Scott-Findlay, Pollock, 2004). A well designed study can be poorly executed; the outcomes measured may only be short-term due to constraints in funding the research or challenges of long-term involvement by research participants. In addition, there is very little opportunity to adapt a clinical research protocol to an individual patient and there is no opportunity for individual health professional/ patient/ family choice within a clinical trial. The stance adopted by the Health Centre regarding research and its application to standards of care as discussed above are not articulated within this policy. Yet the outcomes of an implicit or unconscious stance are profound. By not explicitly considering the impacts on those poorly served by our present Health Centre and health and illness care systems, their oppression and inequities will continue.

Uninformed application of research to standards, guidelines and practices of care can be harmful. Clinician expertise and patient's choice risk being lost to the power of managers,

administrators and health care funders once the results of a randomized clinical trial become available. When the results of randomized trials are used to change the standard of care without an understanding and consideration of the differences in context between trials and actual clinical care given in a non-research setting, they may lead to injury. This risk of mis-interpretation has implications for which drugs costs are covered, treatment protocols offered and choices presented to patients/ families for their care. Pointing to the results of a randomized clinical trial makes it easier to justify drug treatments, over rehabilitative care for example, as there are few randomized trials of rehabilitative care. Rationing/ priorization decisions based only on evidence-based interventions can be seen to in fact jeopardize the standard of health care (Meulen, Dickenson, 2003).

Although randomized controlled trials are often perceived as value-free, there are ethical assumptions buried in evidence-based health care as noted above (Dickenson, Vineis, 2002). Patients with co-morbidities, those who are homeless, those living with addictions are seldom eligible for randomized clinical trials; the majority of study participants are middle-class and well educated. Many marginalized populations are directly or indirectly excluded, thus forfeiting their being encompassed in standards or guidelines for care. In addition, the decisions regarding cost effectiveness are embedded with explicit and implicit values (Meulen, Dickenson, 2003).

A physician's assumed primary duty is to the individual patient in contradistinction to the focus of evidence-based medicine which is more population centered. Where evidence from clinical trials is not available, physicians and other health professionals may rely on experience, intuition and patient input, as well as disease and intervention knowledge, attempting to use the best available information to foster the patient's well-being. Yet there are innumerable examples of futile or even harmful effects from such a freedom of choice (autonomous) approach. Thus, an equitable balance is needed to capture the acknowledged benefits of evidence-based care and individual and societal values. There must also be recognition of the intrinsic power imbalances embedded in the research journey from initial observation or trigger, through design, obtaining funding, enrolling participants, reporting results and assessing the cost-effectiveness of its application (Gerber, Lauterbach, 2005).

The veneration of science hampers questioning of the underlying assumptions and values adopted for its creation to the detriment of shared values such as equity and inter-relatedness, and often favour a utilitarian framework. Others suggested that research/ evidence-based care requires objective evidence related to the social value of an intervention (Biller-Andorno et al, 2002). The effectiveness of an intervention depends on the definer, their values and particular goals. Appropriate definers in addition to researchers, health care professionals, health care organizations and funders would include those most impacted - patients and their families. However, credible methods through which to fairly obtain input are limited, and they often conflate benefit to populations of patients with those to individual patients (Biller-Andorno et al, 2002). Most effectiveness evaluations include an economic impact. Yet the elements considered in the cost impact may narrowly include the expenses to the organization or funder; rarely more broadly measured to include those costs to the patient/ family, the environment, and the larger community (Homer et al, 2008). Valuing is explicitly or implicitly implicated in any evaluation and a resilient method of fairness seems elusive. There are dangers inherent in accepting evidence-based care as a means to standardize or rationalize resources without in-depth consideration of processes to be employed in reaching decisions, thus perhaps the use of the word *knowledge* rather than evidence and *influence* rather than determine is indicative of a consciousness by the Board of such hazards.

> Because healthcare resources are limited, in many countries it is the government's responsibility to allocate them fairly. In this sense justice is served by the most objective and efficient allocation of resources; to the extent that EBM maximizes an efficient allocation, it is an important contribution to just health care. As...various examples...show, the existing level of evidence cannot be the sole criterion for the distribution of health care resources...social values and patient preferences will have to be taken into consideration...other criteria have to enter into allocation decisions in order to avoid discriminatory effects...In the context of distributive justice in health care, the reasoning: 1) no available evidence 2) no allocation of money for research or treatment 3) no medical attention to patients with the respective condition would be a vicious circle. (Biller-Andorno et al, 2002; p. 273).

Such oppressive decision-making as outlined in the above final sentence might be averted through a stewardship philosophy. Stewardship has been proposed by World Health Organization as an appropriate framework through which to address health policy by achieving a balance between efficient and ethical, trust-based forms of decision-making

(Saltman, Ferroussier-Davis, 2000). Stewardship requires the best interests of the collective or organization come before the interests of individuals; however, it does not mean the interests of individuals are disregarded (Davis et al, 1997). Such an approach, based on social contract theory, may help to achieve and maintain equity of access to health and improvement in service delivery effectiveness and efficiency. Stewardship is compatible with addressing power issues that construct our worlds.

Learning requires a practice environment, learning resources and motivational strategies (Besier, 2004; p.39). The practice environment allows exploration, experiential learning and adaptation, and requires nurturing support. It often necessitates increased flexibility within the organization to facilitate adjustments to new learnings. Learning resources include awareness, access, affordability and time. Motivation requires strong components of mutual values and the opportunity to use one's knowledge and skills as well as alignment of feedback to individuals to facilitate desired ends. Motivation can build on dissonance between values and practice through re-framing to achieve mutually congruent goals (Besier, 2004); a stance compatible with critical social theory. Thus learning, research and evidence are in themselves complex and convoluted issues.

3.5.2 <u>Thoughts Based on Critical Social Theory Questions</u>
1. What are the social, economic, historical, political, cultural constraints/ oppressions/ ideologies implicit in the policy?

This portion of the policy exhibits the ideologies of an academic health centre. Implicit in the statement *to be an academic Health Centre for students needing experience and learning* is the organization's belief that it has knowledge worth sharing. Although the policy does not provide a clear indication of their concept of knowledge, it likely includes the colloquial assumption that knowledge in a healthcare context, with the expectation of *influenc(ing) standards of care and the availability of skilled health care providers*, is equivalent to the scientific (true/ false) knowledge, authorized knowledge of health professionals. The policy conforms to the historical expectation that health care (illness care) institutions/ health professionals house the information needed by others (students, patients, families, staff). Although the policy states *all staff, volunteers and families are assured of opportunities to learn from and teach one another*, as stated there is no

expectation or obligation to avail oneself of such opportunities. There is a great diversity of experience, knowledge and position within the Health Centre hierarchy and in private life. There is no encouragement expressed in the policy to utilize these diversities (and likely opposites of viewpoints) to research and teach new ways of being. The power of knowledge is portrayed as residing with the institution. In the descriptive statements, the Health Centre will *cooperate* with universities and colleges - a word of lesser interdependence or equity of power in the relationship than perhaps words such as partner or share; cooperate is a word intuited as having more control. Inequitable constraints may be imposed by those wishing to access learning opportunities.

The implications of evidence or knowledge as applied to policy require thought before policy is enacted (Petticrew et al, 2004). Whereas there is the explicit/ implicit expectation that the results of research will be used in decisions related to interventions designed to improve health (this being an area of science), there is no implied or explicit expectation that the Board's decisions and policy making will be similarly guided by research results or evidence; nor is there an expressed expectation that the functioning of the Health Centre administratively would be based on research, evidence or standards. The culture of evidence-based/ evidence-informed health care places demands of proof on health professionals that are not mirrored by the Board (or, in the present organizational culture, administration).

There are significant challenges for policy-makers attempting to utilize evidence in policy development, particularly those policies associated with health disparities (Macintyre, 2003). For example, although there are numerous data about health discrepancies, there is little information on interventions that attempt to reduce the known disparities. Calling for evidence is sometimes perceived as a delay tactic instead of spending money (Macintyre, 2003). As stated before, evidence is not value-free (Kenny, 2006). Evidence-based principles in use for healthcare cannot be directly applied to policy. As policy is often broader than the usual clinical decision-making, methods of assembling the "evidence jigsaw" comprised of multiple forms of "policy relevant evidence" need to be

developed (Whitehead et al, 2004; p. 819-820). In addition, more studies addressing evaluation of outcomes related to policy need to be undertaken (Whitehead et al, 2004).

The purpose of health policy is to guide the best decisions for populations; the purpose of Board policies might therefore be conceived as guiding the best choices to enable provision of services and interventions to optimize the health outcomes for the populations served (*standards of care delivery*). Norheim, 2002, suggested that suitable criteria for decision-making regarding new interventions were severity of the disease if not treated, effectiveness of the proposed intervention, cost effectiveness of the proposed intervention and the quality of evidence on which the first three criteria were based. With respect to the Health Centre, similar criteria could be employed not only to determine services to be provided but also organizational administration and functioning. The quality of evidence could be assessed by its validity (study design, analysis), importance and applicability, all of which are value-influenced (Norheim, 2002). Whose values are heeded will significantly change such an assessment.

2. How does the policy perpetuate the present circumstances? What does it allow us to see? What does it overlook?

The policy overall perpetuates the tradition of the academic health centre as a relative controller of knowledge. Whereas there is no explicit recognition of disparities and inequities in the services available through the Health Centre within the Board policies, such disparities and inequities indubitably exist. However, they are implicitly recognized by the statement under the Leadership Role for the organization *to support and contribute to the empowerment of women and the marginalized to control their own health and health services needs*. This statement eschews any understanding that we as a society and the Health Centre as an organization have far more responsibility for the health outcomes of *women and the marginalized* than they have as individuals.

> Disparity is a *descriptive* term that refers to differences between population groups in health status or access to medical care. It carries no moral loading and no connotation of right or wrong. Inequity is a *normative* term. Inherent in its meaning is a critique of differences as unfair, unjust, or morally wrong. (Gamble, Stone, 2006; p. 96).

Health disparities encompass health status, access to care, quality of care and differences in susceptibility to certain disorders such as sickle cell disease (Gamble, Stone, 2006). Redressing health disparities and inequities entails redistribution of resources, thus becoming an electric, contentious issue. Much of the research to date has concentrated on demonstrating disparities without pursuing the etiologies of inequities or seeking interventions to rectify detrimental differences. Inequities are the result of seemingly innocuous, insignificant decisions, rules and policies (Gamble, Stone, 2006). Knowledge is a powerful tool with which to begin to address health disparities. Rawls' principles of ethics include solidarity with and giving priority to the weakest (Kenny, Joffres, 2008). The Canadian healthcare system is based on the principles of universality, equity, fairness, solidarity, transparency and accountability as well as criteria including sustainability, comprehensiveness, equity of health outcomes and accessibility, quality and responsiveness, and efficiency and value for money (Kenny, Joffres, 2008).

The policy does not mention organizational learning from examination of its own mis-steps and errors, learnings that in many cases are more accepted within an organization than those solved elsewhere. Feedback and learning are important for complex adaptive systems such as the Health Centre to evolve and prosper. Nor does it portray the limited translation of research into application for standards, clinical practice or organizational functioning. A learning organization requires that those who perform research (or possess/ produce information) interact regularly with those who might use the results, that there are resilient communication pathways for effective knowledge exchange, and that all information (integrated research, personal experience, trusted sources and knowledge management system) is captured and "packaged" to share with others (Chunharas, 2006). Such learning when done utilizing a critical social theory lens would highlight inequities and unjust power differentials.

The policy does emphasize the importance of teaching, learning and research for all involved in the health and illness care systems. It identifies the potential for disciplined research and education to shape our values, beliefs, behaviours and actions to improve health outcomes.

3. Whose interests have been/ are being served by the way things are?

The interests of academics (researchers and educators) are served by the way things are. There is perceived prestige in being an academic tertiary health centre (as contrasted with a community, non-teaching hospital). The direction of teaching or educating appears to emanate from rather than to the Health Centre. The fact that *the experience and wisdom of patients and families and of key partners is recognized, valued and embraced* is encouraging for acknowledging a wider view of teachers than traditionally conceived. Yet, one wonders about the experience and wisdom of those who by implication are not *key partners* and thus not valued. As the accent is placed on the word *key*, it is unlikely, although the Health Centre is involved in women's health, that women who work in the sex trade would be considered key partners, yet their health needs are poorly served by the Health Centre (based on my professional interactions within the Health Centre). The membership of the Board itself suggests that the wishes of the economically advantaged are sought more than the needs of those who are inequitably underserved by the Health Centre.

4. Whose voice is dominating? Whose voice unheard?

The responsiveness principle of the ethic of care requires the provision of opportunities for the voices and perspectives of those rarely heard (Engster, 2005). Academic health centres are viewed as elitist both by members of the Health Centre and by other health centres and the general public. Such elitism can silence the voices of those who either perceive themselves as unworthy to be heard or are perceived by others as not worthy to be heard and understood (for example, those who are socio-economically disadvantaged, those who are illiterate, those from other cultures). The unheard are found both within and external to the Health Centre. The dominant voice is definitely the socio-economically advantaged, well-educated Euro-Nova Scotian. The need for increased knowledge of and research about underserved populations is not highlighted in spite of the statement under the Leadership Role that the Health Centre *supports and contributes to the empowerment of women and the marginalized*. It is likely that when a *standard of care* is being considered the dominant population is the one for which the standard is developed, a standard that may not be applicable or optimal for other populations. This

was illustrated in the past through the assumption that diagnosis and treatment of myocardial infarction would be the same for men and women thus justifying the exclusion of women from clinical trials (Ostlin et al, 2003). More recent examples include the effects of cultural differences such as those felt by Aboriginal populations (Smylie et al, 2010), or those adversely affected by the social determinants of health that curb the ability to carry out and benefit from a particular standard of care (Langille, 2009). Similar findings of mis-match between the population for which the standard was researched and designed and those of another ethnic background have been noted (Ford, Airhihenbuwa, 2010).

5. What are the theories-in-action (assumptions, values, beliefs) underlying the policy?

Some of the *theories in action* appear to recognize that knowledge, learning and research have positive value; that knowledge, learning and research should be accessible and available to all (albeit largely controlled by the Health Centre); that different knowledges have value. Implicit is the belief that teaching and research will *increase the availability of skilled health care providers*, perhaps both through enhancing their knowledge base and serving as an attractant to join the Health Centre's staff; that health care providers would wish to be part of an organization whose standards of care reflect current knowledge. Implicit also is the belief that sharing of research findings will lead to *improved standards of care delivery*. However there is a substantial body of literature bemoaning the failure of health care providers (and administrators/ managers with respect to health care delivery) to implement the results of research (for example, Graham et al, 2002).

Traditional bioethics (principles of beneficence, non-malificence, respect for autonomy, and justice) is a common ethical framework through which health care and health care delivery are considered. More recently, this principalist approach has been challenged by casuistry (ethics derived from case study), narrative, pragmatic and feminist bioethics. Hedgecoe, 2004, states that "failing to see what counts as an ethical problem *in the first place*, prior to the application of ethical theory, is socially constructed." (p. 130)(italics as in original). The North American emphasis on autonomy has substantively impacted

decision-making and health care delivery. Traditional bioethics is felt to give a "dominant role to idealised, rational thought", "to position individuals as the sole judge in ethical decision-making, in that it regulates social and cultural aspects to the status of at best, curios, and worst irrelevancies", and assumes a typical physician-patient relationship (Hedgecoe, 2004; p. 130). Traditional bioethics also assumes accuracy of the science associated with a particular ethical dilemma (for example, stem cell transplantation - an assumption challenged by Giacomini et al, 2007).

Critical bioethics offers an alternative, approaching ethics from a bottom-up rather than a top-down manner, whereby lived experiences of patients and health professionals are analysed to engender ethical reasoning. "In critical bioethics, the results of empirical research feed back to challenge, and even undermine, an analyst's cherished theoretical frameworks", thus critical ethics is empirically based (Hedgecoe, 2004; p. 137). In contrast to bioethicists who theorize, players in ethical dilemmas have a lived experience to contribute to the ongoing defining of theory. These experiences may indeed show that the principles commonly espoused are not universally applicable. Reflexivity and scepticism are important components of critical bioethics; who we are determines our responses, and acknowledgement of our personal context (social and cultural) will dispel the perception of neutrality and objectivity of traditional bioethics yet retain the usefulness of bioethical examination of dilemmas (Hedgecoe, 2004).

The public interest, the common good, solidarity, accountability and social justice were suggested foundational concepts or values for public or population-based policy (Giacomini et al, 2008). Other elements in published health reform documents include access, autonomy, client-centeredness, collaboration, efficiency, equity, evidence, prevention, public participation, quality, responsibility, protection of the vulnerable and population health (Giacomini et al, 2008).

6. What power differentials are being expressed in the policy?

Within this section of the policy, knowledge is power. There is reference to *opportunities to learn from and teach one another*, and *the experience and wisdom of patients and*

families and of key partners is recognized, valued and embraced, suggesting the potential of distributed power. This is somewhat countered by the statements that the Health Centre *cooperates* (assists/ lends a hand/ works with) and *contributes* (gives) rather than collaborates (joins forces) and shares (reciprocity); expressing positions of power rather than equality or equity. The strength or utility of the experienced power is dependent on the valuation of the particular knowledge and the context in which it is being applied.

In summation, there is little evidence that the development of this policy was viewed through a critical social theory lens. The use of a critical social theory lens might facilitate the emancipation of those marginalized and disadvantaged by the present Health Centre functioning, the development of an environment more supportive of sharing power and knowledge among all associated with the Health Centre, and make more explicit the principles through which the organization functions.

3.6 SYSTEMS THEORY LENS ANALYSIS

The systems theory lens was used to examine the Leadership Role section of the Board *General Governance Commitment* policy. The questions guiding the analyses were those developed as outlined in Chapter 2.

3.6.1 Leadership Role

LEADERSHIP ROLE
   In cooperation with our partners, be an effective advocate for, and promoter of the health, and health care needs of all Maritime children, youth, women and their families.

To be an organization that:
1. *actively promotes family- centred care throughout the health care system*
2. *actively promotes healthy life styles and development for children, youth, women in the Maritimes*
3. *advocates effectively for funding of services in response to health service needs of children, youth and women*
4. *advocates effectively for public policy and programs to foster healthy families and communities*
5. *contributes to the reduction of childhood and youth injury*
6. *contributes to the reduction of abuse and neglect of children, youth and women and of family violence*
7. *contributes to leadership in efforts to increase literacy and reduce poverty in our society*
8. *supports and contributes to the empowerment of women and the marginalized to control their own health and health services needs*
9. *focuses our efforts on the needs of those we serve and on partnership not ownership*
10. *contributes, and is an advocate for, the availability of skilled health care workers and professionals*

This policy section appears to view leadership from the standpoint of the Health Centre as an organic whole. The leadership role statement addresses what, rather than the manner in which, the Health Centre should lead to achieve cooperation with partners. Viewing the policy through a systems theory lens, I expected that the policy related to leadership would serve as one way to align the organization to move, like an amoebae responds to a chemo-attractant, towards common goals. I envisioned there would be guidance regarding the principles and values through which leadership would be

demonstrated. It is difficult to infer from the policy the vision of leadership the Board supports. Interestingly, the leadership role statement does not contain the word leader (or head, manager, chief, person in charge, director, boss, organizer, principal as synonyms for leader - although not particularly cogent for an organization), or leadership (management, guidance, headship, control, direction) but rather *advocate* and *promoter*, neither of which intuitively suggest leader. Nor are they, along with *contributes*, *supports* or *focuses*, characteristics the word leadership naturally evokes. Yet these words hint at approaches leaders should take. However, the synonyms for leadership given in the Word Thesaurus are very traditional, Eurocentric and androcentric, regarding organizations as mechanistic. More recently leaders are seen as resource facilitators and enablers (Sampson, 2003).

An important challenge for leaders within the health care system today is the need for a move from a focus on individuals and individual efficacy to collectives and collective efficacy; a challenge that may be able to be met through the development of trust within work relationships and deeply rooted shared expectations (Sampson, 2003). As written, the policy and leadership role do not limit leaders and leadership to those with positions within the formal hierarchical structure (a beneficial stance).

Leadership is inextricably linked with organizational people, structures and, thus, its actions. The Health Centre as a system has permeable boundaries with internal and external social environments intricately intertwined to impact organizational function. Some implications for leadership within organizations conceived as systems (complex adaptive or other) include a change to participative leadership/ management and awareness of organizational environment (Rau, 1998). Viewing an organization as an organic system of relationships may aid diagnosis of problems and subsequent interventions through systemic examination of those relationships and connections. Understanding organizations and the leadership required may be enhanced by considering the generation of emergence as demonstrated by complex adaptive systems (Rau, 1998). Rau, 1998, suggested that organizations with large connectivity and high levels of frustration ("conflicts among the different optimization constraints") can best generate a

number of states with equal optimality and thus resilience (p. 64) whereas those with little connectivity and few conflicts tend to stagnate and degenerate. Differences and diversity can engender instability and opportunities to engage in novel solutions and actions.

In order to understand if the leadership approach taken is effective, measurement of outcomes is important. Yet, measurement within a complex adaptive system is challenging. The intention of the observer determines what is observed, measuring one element accurately results in the inaccuracy of another and the attempt to understand one attribute of a system decreases the understanding of others. The goal for measurement of a complex adaptive system is sense making (McDaniel, 1997). Rau, 1998, for his complex adaptive system assessment chose building blocks (quality, prevalence, quantity; autonomy or decentralization), flows (boundaries, interaction coordination, generation of meta-interactions; rate of change, longevity), diversity and fitness landscapes (evolving components and sub-structures; continuous improvement; engages in activities that vary from the 'norm'), non-linearity (not predicted by normal cause and effect), balance (multiple goals, flexibility, adaptability; reserve 'stock'; comfort with contradictory requirements), social organization (human component, geometric structure, linkages; honouring errors, cooperation, learning organization; evolutionary) and energy (re-cycling, efficiency, reserve). These elements are at variance from the Health Centre's present measurements. The Health Centre's Key Performance Indicators include recruitment to hard to fill positions, compliance with wait time standards, ratio of secured capital funding to capital spending, rate of adverse event reporting and rate of growth of research dollars.

Effective complex adaptive systems can be achieved through leadership that supports release of planning and control by organization hierarchy, movement to the edge of chaos, creation of new organizations with new forms, development of self-referent organizations (so boundaries of the organization are knowable), enhancement of the quality of connections, informing people about what others are doing, creation of learning organizations, thinking about organizational design as an ongoing process, not being responsible for setting goals for workers or for organizations (facilitate instead goal

discovery by organizational members), decreasing emphasis on competition and increasing emphasis on collaboration, working smarter, and providing for the emergence of visions and values (McDaniel, 1997). The leadership role as described in the policy embraces some of these elements.

Providing planning guidance at a systems level would seem an important role for the Board. Systemic planning has been compared with systematic planning (the historic approach the Health Centre has taken to planning). The simplicity paradigm (systematic planning) is one of universality rather than multiplicity, determinism versus organization, dependence versus autonomy, prediction versus surprise, separation versus wholeness, group identity versus individuality, quantity versus quality, uni-causality versus multi-causality, objectivity versus culture, rational-analytic versus detail, dynamic and preference intricacy as found in the complexity paradigm (systemic planning). Systemic planning encompasses the use of both the simplicity and complexity paradigms as context dictates. Systemic planning adopts a search-learn-debate approach. The leadership role as portrayed in the policy does not refer to planning - internally or with others externally.

One way of guiding planning is through simple rules. Leadership has been described as a value-laden activity where leaders are enablers and sense-makers (Brown, 2002). Values can form the basis of simple rules within complex adaptive systems. Values are deeply held beliefs that serve as trans-situational guiding principles to influence an individual's or organization's behaviours and actions. They may be implicitly or explicitly expressed. Values can be final values or existential objectives (what will we be in the future, what we strive to achieve) or instrumental (ethical/ social values {e.g. integrity} and competence/individualistic values {e.g. flexibility}) that enable attainment of the desired final outcomes (Brown, 2002; Dolan et al, 2003). Shared values can act as organizational glue within a complex adaptive system; they can be modeled by leadership. When the expression of values is perceived to be congruent with the behaviours and actions of organizational members, and when there is an environment of honesty, credibility, competence and trust, values can serve as a rudder to balance stability and change. From a leadership perspective, Brown's study, 2002, showed that honesty-based trust was

important for communicating self-transcendence values (valuing collective interests, teamwork, altruism) and openness to change. Typical health care system values include high quality of patient (population) care, professional excellence of those involved in health and health care, and economic (resource) sustainability (Mills, Spencer, 2005). Such overarching values, which might also include compassion and altruism, can function as guides for organizational members so that efforts, actions and behaviours are aligned to move the Health Centre towards its goals.

A strange attractor (a complex adaptive systems term), a phenomenon that can create order out of chaos, can enable alignment. Such strange attractors can be organizational values. Strange attractors both define limits of system behaviour yet render system behaviour as unforeseeable (Dolan et al, 2003). Values embedded in an organizational culture can serve to create a well-worn path that facilitates their execution (Mischen, Jackson, 2008). Values-based policy recognizes that there is no single correct answer for most dilemmas. Williams and Fulford, 2007, propose a systemic values-based approach to policy, strategic and service management and practice. Such an approach may facilitate resolution of "common clashes in organizations between serving the individual or the community; achieving quality versus reducing costs; upholding patient rights or organizational control; and allowing freedom versus maintaining order and control." (Graber, Kilpatrick, 2008; p. 188). It can also underscore inconsistencies in alignment of actions and words, of rewards and espoused beliefs and allow them to be resolved.

> It is increasingly impossible and, arguably, inappropriate to separate ourselves from the realities of public policy, societal mores, money supply, service management and the inevitable influences of our own priorities and self-management. (Graber & Kilpatrick, 2008; p. 230).

Although the Board has no espoused values specific to its functioning, Health Centre values such as *building successful relationships with patients and families as partners in decision-making and care* could form a useful path; others such as *taking pride in providing safe, high quality care to the populations we serve* (underlining added) may place the emphasis on the less effective value of pride. Such an emphasis (probably unintentional) could function as an inhibiting feedback loop perhaps fostering

competition when pride is perceived as self-importance or when pride is equivalent to satisfaction, it may lead to decreased incentive for continual improvement.

Values-based policy can complement evidence-based (or evidence-informed) practice (Williams, Fulford, 2007). Emphasizing the circular relationships between policy and practice, Williams and Fulford, 2007, developed a model integrating values-based and evidence-based approaches to meet the dual obligations of quality care at affordable costs. The model highlights the need for balancing evidence and values as well as the systemic approach to enable alignment of policy, strategy and practice. The National Institute for Mental Health in England developed ten values-based capabilities for their workforce: working in partnership, respecting diversity, practicing ethically, challenging inequities, promoting recovery, identifying people's strengths and needs, providing user-centered care, making a difference, promoting safety and positive risk taking and personal development and learning (Williams, Fulford, 2007). One way of balancing differing values is through dissensual decision making as described in Chapter 2.

Values shape organizational culture and organizational culture has a profound effect on creating conditions for a system to evolve naturally over time. Leaders have a significant role in nurturing an organizational culture that supports the achievement of the organization's mandate (Cameron, Quinn, 2006). Four archetypical organizational cultures have been identified, each having value for particular circumstances. The four major culture types are hierarchical, clan, adhocracy and market. Organizations with a clan culture have shared values and goals, an emphasis on individuals, employee involvement, teamwork and participation. An adhocracy culture is found in organizations where employees are risk takers and innovators; a hierarchical culture is found where formal structure and rules predominate; a market culture is found where employees are competitive and goal-oriented, emphasizing winning. All four major culture types have strengths and weaknesses and may be more suited to a particular context than another; all organizations must exhibit characteristics of all four, some aspects more than others; all organizations require both stability and adaptability. Clan and adhocracy organizational cultures are particularly appropriate for complex adaptive systems.

"Maintaining values-based human interconnectedness is the principal way in which complex adaptive systems can survive...it is imperative that individual and collective values are identified and clarified, appreciated and affirmed, and ultimately aligned with institutional purposes for the greater good." (Moody et al, 2007; p. 320). High quality leader-membership relationships can increase felt obligation towards an organization and organizational citizenship, and decrease withdrawal from the organization (Piccolo et al, 2008). My suggested leadership approach for the Board, based on the literature reviewed above and on the elements of the Board *General Governance Commitment* policy, is one that encourages clan and adhocracy cultures; one that embraces values-based leadership; one that is participative, organic (adaptive; see question #3 below), full of interwoven connections; one that considers, from an equity perspective, all those impacted.

3.6.2   Thoughts Based on Systems Theory Questions

1. What are potential system issues related to this policy?

The *General Governance Commitment* policy does not situate the Health Centre within the larger health/ health care system(s). Some acknowledgement of the Health Centre's position as one component of a larger system is conveyed (within a larger system to address *literacy and poverty* or *public policy and programs to foster healthy families and communities*). However, its interconnectedness is relatively muted. There is little evidence of utilizing the diversities of viewpoints available to the Health Centre, embedding these perspectives in the various activities proposed for the organization to take a lead.

Primary health care is presently perceived as the cornerstone of the healthcare system (Rosser, Kasperski, 1999) and this policy implicitly recognizes this primacy. However, there is dissonance between the organizational leadership roles as stated in this policy (focused more on the non-medical determinants of health for Nova Scotians) versus the activities of the Health Centre (which are largely directed towards medical or illness care). There is insufficient guidance on the balance of efforts and resources to be expended related to leadership in the broad areas of primary to quaternary care for which the organization is responsible. Indeed, tertiary care, the de facto major role of the Health

Centre and an area where leadership could be exhibited, is not mentioned specifically and only indirectly linked to the 'to be' statements.

The leadership role statement does not address accountability (nor do any of the other statements within the *General Governance Commitment*).

> A domain of accountability is an activity, practice, or issue for which a party can legitimately be held responsible and called on to justify or change its action. Accountability in health care consists of at least six domains: professional competence, legal and ethical conduct, financial performance, adequacy of access, public health promotion, and community benefit. (Emanuel, Emanuel, 1996; p.230).

In a strong team, peers are directly accountable to each other as well as to the Health Centre for their activities. For a culture of accountability to thrive, there must be a willingness to confront difficult issues and to challenge the status quo. To be accountable, progress must be tracked against goals and issues must be addressed as they arise. To focus team or service activities, leaders must be cognizant of the strategic priorities of the Health Centre. Teams and services are accountable to ensure they contribute to the success of the Health Centre as a whole.

Healthcare professionals and management are accountable for their decisions and actions to the patients/ families they serve, to colleagues, to their profession, to the healthcare organization of which they are a part, to the University, to the public and communities served, to funders and to society. The essence of accountability is answerability; being accountable means being open and having the obligation to answer questions regarding decisions and/ or actions. Some accountabilities are reinforced by sanctions. Sanctions can be requirements and penalties embodied in laws and regulations; but sanctions also include professional codes of conduct, public exposure or negative publicity. Self-policing among health care providers is an example of a sanction where professional codes of conduct are used as the standard. Within the context of the IWK Health Centre, team/ service performance and financial accountability are important.

Within the healthcare system, there is general lack of clarity related to accountability. For an organization such as the Health Centre, transparency of, and agreement on,

accountabilities at the Board, leadership, health professional and patient/ family/ citizen levels are needed (Kenny, 2006). Components of accountability include establishment of a relationship, agreed-to responsibilities, applicable authority, "answerability", performance and appropriate sanction (Kenny, 2006; p. 69). Particularly under leadership, a system of accountabilities would seem appropriate. Harber and Ball, 2003, have developed six principles for accountability design:

1. you can't be accountable for anything over which you have no control.
2. accountability for outcomes means that activities/ efforts/ processes are not enough.
3. accountability for results requires real empowerment and room for discretion and judgment.
4. accountability must be dynamic: outcomes and targets change as circumstances change.
5. accountability and stewardship for the organization belongs to every employee.
6. accountability is meaningless without fair and appropriate consequences.

Accountability differs significantly from blame. Accountability is based on agreements and performance of tasks in a respectful manner (Harber, Ball, 2003). Accountability seeks root causes and strives to understand to design better responses. Qualities of accountability include respect, trust, curiosity, inquiry, moderation and mutuality. This requires relinquishing control, control that is often more fictitious or illusionary than real. The Health Centre is striving to move from "name, blame, shame" to more of an accountability system. Strategic plan components (launched in December of 2007) of "raising the bar on leadership effectiveness" has had stuttering progress and has been on hold from October 2008, and "program leadership structure (co-leadership)" has been somewhat more successful but is still not completely launched within the Health Centre. The Health Centre's Co-Leadership Model should help to improve accountability, as may the deliverables defined in association with provincial Department of Health Alternate Funding Plans for Health Centre physicians. Physician compacts, under consideration by the Health Centre, could provide a systemic approach to accountability (Silversin, Kornacki, 2000). Within the policy, if developed through a systems lens, systemic approaches to leadership could be promulgated. Such a view could also facilitate alignment of processes, rules and regulations to reinforce desired behaviours.

The **Health Centre Core Values and Beliefs** are incompletely reflected in the Board policies. For the most part, however, the Health Centre value statements are statements of things valued rather than the underlying values held. For example, *contributing to a culture of inclusion and diversity* (rather than having values of respect for diversity, for example) or *building our reputation for excellence in the Maritime community and beyond* (rather than having a value of integrity). There is little to hint at values such as compassion, empathy, care for others or community (where the word care is used not in the sense of treatment or intervention), of spirituality, sharing, integrity, trust, or altruism, service and stewardship. There is no indication of consideration of the diversity of values among different cultures and communities. Influencing and clarifying values and aligning them with the needs of the organization have been identified as key leadership functions (Graber, Kilpatrick, 2008). Organizational norms, that define the accepted way of being or acting, are derived from the organizational values. The Board as a leadership group has not yet contributed to the clarification and shaping of the organizational overarching values through its own policies. The Board could provide guidance to navigate the quagmire of conflicting issues - of reducing costs versus quality and spectrum of services; patient rights versus organizational dominance; hierarchical control versus a complex adaptive system approach with self-organizing elements.

To change rhetoric to reality, espoused values must be aligned throughout an organization with actions rewarded or accepted. For example, within the Health Centre individuals are rewarded more than teams (albeit this is gradually changing). During STARS (Special Time to Appreciate and Recognize Staff) week, there is one category of team awards (and four presented this past year) versus seven categories of awards for individuals. Although improving, budgeting processes and staffing policy, rules, and practiced procedures hamper collaboration though impeding temporary placement of staff to avert or deal with a staffing crisis in another Health Centre Program's service for example. Complex adaptive systems use simple rules to guide organizations; such rules could be based on values such as respect for all individuals, honouring diversity and consideration of the greater community in all actions and behaviours.

91

An historic dilemma in any systemic approach to governance of healthcare organizations, including the Health Centre, is the separation of responsibility and accountability for resource sustainability (administration) and quality of care (clinicians) (Mills, Spencer, 2005). Honouring both responsibilities requires administration <u>and</u> clinicians to be held accountable for quality of care/ services and sustainability of needed resources. This issue is not addressed in the present Board policies. Values-based leadership, practice and decision-making can facilitate the necessary communication, understanding, collaboration and respect needed for shared accountability. Such a system would require relaxation of rules, regulations and formal relationships - increased responsibility for all organizational members and decreased control by the traditional hierarchy (Mills, Spencer, 2005). "This means that *every* stakeholder should be aware of the values and goals of the organization and the ways in which their activities are constrained by them and support them...intrinsic motivators, a shared ideology, and a belief that the actual activities of the organization are congruous with the organization's stated values and goals, provide the strongest motivator for the individual or group to work for the goals of the organization." (Mills, Spencer, 2005; p. 28)(italics as in original). This is one systemic approach to leadership that could be incorporated into the policy.

A systemic look at the policy highlights the need to recognize the implications one part of the policy has on another. *Focusing on the needs of those we serve* presupposes an understanding of those needs within an organizational system providing care to diverse populations. For example, a vital part of *patient/ family centered care* is the opportunity to speak in one's language of comfort. As a well communicated illness history provides about 90% of a diagnosis (Bennett, 2003), the unaddressed language issue becomes a huge safety risk or, if addressed, an effective, efficient way of improving health outcomes. Implicit in family centered care is that all individuals feel comfortable and safe within the healthcare environment, irrespective of their culture.

Within the context of a complex adaptive system such as the Health Centre, one might take issue with how the policy is written and the preciseness of the "to be's". To provide guidance through a high level policy such as the Health Centre Board *General*

Governance Commitment Policy, and to encourage and accommodate ongoing development and change, less emphasis on details such as *contributes to the reduction of childhood and youth injury* and more stress on ways of being that tie the organization together might be beneficial (such as have respect for all individuals).

2. What are potential system inconsistencies/ incongruencies/ incompatibilities related to this policy?

One reason postulated for the failure of health care reform is lack of agreement or congruence between norms of principles at a general, high level (for example, the meaning of health), mid level (for example, responsibilities of society to provide services to improve health) and low level (individual responsibilities for health)(Ruger, 2007). Clarity of thought about and explicitness in expression of the principles involved in Board policy development and related decision-making would facilitate a systemic approach.

Within the entire policy, as well as under the role of leadership, healthy workplace issues are not addressed. Particularly under the leadership role with its focus on health promotion, attention to the well being of health care providers (formal and informal) would seem applicable.

If the mandate is truly one of being *an effective advocate for...health and health care needs of all Maritime children, youth, women and their families*, it is implicit that to benefit the health of a population, the most effective use of limited resources would be to deflect monies away from the Health Centre to address such issues as poverty (Raphael, 2009). As noted above, the majority of the "to be's" associated with the Leadership Role are directed towards the social determinants of health and not the current de facto emphasis of the Health Centre on tertiary and quaternary care. As with other acute health centres, the greatest portion of health care dollars (Medicare) are spent for illness care of the very young and the dying. Evidence suggests that more dollars spent on pre-conception, pre-natal and early childhood development as well as dampening the adverse effects related to the determinants of health would result in a healthier population (Hofrichter, 2003).

3. What system relationships are affected by this policy?

The policy mentions many relationships including *partners*; *children, youth and women in the Maritimes*; *communities*; and *skilled health workers and professionals*. It implies relationships with other organizations and agencies. Other than through cooperation, the policy does not provide guidance about forming and maintaining relationships. A policy defined systemic leadership approach to partnering and collaboration could facilitate achievement of Health Centre goals such as *contributing to the reduction of abuse and neglect of children, youth and women*.

The Health Centre could choose to define their leadership roles using a different framework. Leadership within a complex adaptive system has been defined as having three roles - administrative, adaptive and enabling (Uhl-Bien et al, 2007). Sustainability in this knowledge era requires organizational learning at a pace and in quantity not seen in the past. This necessitates a change from the industrial, bureaucratic model to one that is more nimble and utilizes the knowledge of all organizational members, a leadership grounded in complexity. The leadership role becomes one of enabling adaptability, attainment of knowledge and learning. With this approach, leadership is not rationalized to those with positions in the organization's bureaucracy but rather can be found throughout the organization. The leadership paradigm changes from one of designated individuals influencing and motivating others into acting towards task objectives and aligning with organizational goals to one that is connective, dynamic, distributed and contextual (Uhl-Bien et al, 2007). Uhl-Bien et al, 2007, suggested that administrative leadership focus on alignment of vision, goals, plans and tasks.

As further discussed by Uhl-Bien et al, 2007, enabling leadership catalyzes and manages the "entanglement between the bureaucratic (administrative leadership) and the emergent (adaptive leadership) functions" of an organization (p. 305). Adaptive leadership emerges non-linearly from "struggles among agents and groups over conflicting needs, ideas, or preferences; it results in movements, alliances of people, ideas, or technologies, and cooperative efforts. Adaptive leadership is a complex dynamic rather than a person (although people are, importantly, involved)." (p. 306). Adaptive leadership is multi-level

from resource acquisition and strategic relationships to focused planning and resource allocation to development of core services. Emergence (adaptability, learning and creativity) can arise from inter-relationships of context (networks of interaction, complex patterns of conflicting constraints, patterns of tension, inter-dependent relationships, rules of action, direct/ indirect feedback, and rapidly changing environmental demands) and mechanisms (resonance/ aggregation, catalytic behaviours, generation of both dynamically stable and unstable behaviours, dissipation and phase transitions, non-linear change, information flow and pattern formation, and accreting nodes)(Uhl-Bien et al, 2007). Enabling leadership fosters conditions that increase interconnectedness, interdependencies, exchange of ideas and information, collaborative solutions and beneficial tensions or challenges (elephants on the table, diversity of views); both within and external to the organization. Enabling leadership removes barriers to collaboration, interconnectedness and exchange of resources. Non-useful adaptations (those which do not further the mission and follow core values) are discouraged. Enabling leadership would facilitate an organic, systemic involvement of Health Centre members to achieve its goals. Such guidance could be included in the leadership role policy.

4. What system interdependencies could potentiate or negate this policy?

Within any organization there are many interdependencies. These include pooled interdependency (shared resource pool), usually managed through standardization, rules and procedures (Carroll, 2002). There is also sequential interdependency where the output of one task is the input for the next (such as formulating an ethical decision-making framework for the organization before difficult decisions erupt); these interdependencies can be managed through plans, schedules and feedback. Reciprocal interdependency, occurs where the output of one task is the input of the other and vice versa, such as with sub-goals of a larger goal when optimizing one sub-goal may adversely affect another. This can only be managed with difficulty and through mutual adjustment (Carroll, 2002). This requires acknowledgement of the interdependence, focus on the over-arching goal and effective communication.

The leadership role delineated in the policy addresses the what of leading but not the who and how. From a systems theory perspective both the what and the how are critical. Leadership guidance about the balance of interdependencies (tightness of couplings and networks), critical to achieving desired change, can be deduced to favour emphasis on primary health, family/ patient centered care and partnerships. These are largely externally based interdependencies, thus even more challenging than internal interdependencies. For issues of primary health and partnerships, reciprocal interdependencies would appear to be needed. For such complex endeavours, a decentralized system/ network appears to achieve goals faster and more accurately but perhaps more expensively. Through seeking a balance of adaptability and efficiency/ differentiation and integration - the edge of chaos where communication is effective and efficient and interdependencies loose enough to permit change and adaptability - goals can be achieved (Carroll, 2002).

In order to effectively meet future challenges, the Health Centre as an organization has begun a journey to move from a loosely integrated three Program, siloed organization to an integrated one; one where the whole is optimized rather than individual parts. In most cases, this approach to optimization results in greater benefit to both the organization and its various components. This required significant changes in leadership thinking. In her thesis, Bowers, 2006, notes that "bureaucratic culture, embedded conflict and personal time constraints" (p. 6) can become barriers to change. An unstated assumption in this policy is the preparedness of Health Centre's leaders for the challenges ahead. This requires shared sense-making and changes in the perceptions leaders have of themselves. In such circumstances, enacted values can anchor change. The goals implicit under the policy's Leadership Role cannot be achieved without the Health Centre becoming interdependent with other health care organizations in the larger community (communities). Partnership is only one way through which organizations act out their interdependencies.

Curiously, strategic (or other planning) is not mentioned within this policy. While it is likely an unstated expectation, strategic planning may inhibit emergence in complex

adaptive systems. An important aspect of organizational functioning is the interaction of the physical environment with the functioning of organization members. The attainment of the goals listed under the Leadership Role (for example, family centered care, achievement of healthy lifestyles, empowerment of the marginalized) is significantly influenced by physical environmental factors. Lack of attention to the physical environment may attenuate achievement of goals.

The Health Centre does not have a clearly articulated, publically transparent position within the context of the local, provincial, regional, national and international health systems. This lack of clarity may hamper efforts to demonstrate appropriate leadership to achieve improved population (defined either as the populations cared for through the Health Centre or other larger populations) health outcomes. Societal, geo-political, time-sensitive and other external influences are largely unrecognized and unaddressed within this policy. From a systems lens, the Health Centre would benefit from alignment with these and other external forces.

The health of a community can be approached through the lens of complex adaptive system theory, as suggested by Glouberman et al, 2003. A system of networks and relationships built from self-organizing elements enables the whole to accomplish that which the parts cannot do alone. Although unpredictable, ongoing responses/ learning and adaptation result in system-wide improvements. For the Health Centre, there are extensive interdependencies both within the organization itself and with its many external communities, partners and stakeholders.

5. Are there delayed consequences of this policy?

Rau, 1998, raised the dilemma of how our cultural and world-view perspectives ground and limit our understanding of the world. We see and favour data that reflect our individual interpretations and outlook which may prevent us from perceiving data that is disconfirming.

> While modern organizations drive towards precision and the definitive, humans may actually be more successful in a world which is imprecise and that requires innovation. While it is acknowledged that an underlying premise of systems

dynamics regarding the human tendency towards inability in foreseeing long-term effects of the action(s), the need to recognize a key human strength in processing the ambiguous needs to be remembered and addressed. (p. 55).

The most undesirable delayed consequence of this policy could be failure to obtain the results intended. Absence of foundational Health Centre Board principles and values on which to build, and lack of a systemic approach for the Health Centre within the greater health system, may lead to stumbling and dissatisfaction with both the vision of the leadership position for the Health Centre as expressed in the Leadership Role and the current enacted functioning of the Health Centre with its major focus on illness. If viewed through a systems theory lens, the Board *General Governance Commitment* Leadership Role policy could direct the Health Centre to visualize itself as being within a larger interdependent system to avoid an isolationist stance that could lead to its expiration.

6. Are root causes considered by this policy?

This is a challenging question. If the question is slightly rephrased to "Have the root causes of the organization's ability to achieve (or not) leadership in the areas defined been considered?", the question becomes somewhat easier to explore. The Health Centre has traditionally, both internally and externally, been considered largely a tertiary care centre. While acknowledging the worthiness of health promotion and disease/ illness prevention, and paying cursory attention to the determinants of health, there have been few incentives to encourage or facilitate actual pursuit of leadership in these areas. In fact, attention to these areas requires a tectonic cultural shift for many organizational members. The majority have not received educational emphasis about nor conceived themselves as pursuing these areas of the spectrum of health within their occupational position or career goals. For most organizational members, neither nature nor nurture has prepared them to become leaders in these areas. Furthermore, members of staff, families and the public have questioned whether this is actually a valid role of the Health Centre, thinking more that it is a politically expedient direction to garner provincial funding. If re-framed as leadership in linking of the Health Centre with others within health and health care systems, root causes remain unexamined within the policy. However, with this re-framing, examination of root causes would be feasible and leadership to enable an environment conducive to achieve the change desired could be explored.

7. Can the policy/ process, etc be replaced with a simple rule (and Standard Operating Procedure)?

The task of leadership in a complex adaptive system is to let go of control, sponsor the co-creation of simple rules, create conditions/ nutrient environments for system change, and allow leadership and change to emerge throughout the organization (King, Peterson, 2006). Other suggested leadership components for complex adaptive systems are good enough planning, multiple actions, listening to the shadow system, intuition, chunking (bundling work), metaphors and wicked questions (Kitson, no date). One metaphor Kitson uses is that of a prism in reverse, where multiple elements become focused on a single aim. Regine, Lewin, 2000, felt relationships are the most important thing, generating an ethic of authenticity and care. According to Block, 2008, leaders shift the context within which people gather, name the conversation through powerful questions and listen rather than advocate, defend or provide answers. They shift scarcity to gifts, generosity and abundance; they transform meetings to gatherings and engagement; they look for possibilities instead of problems; they offer chosen commitment and accountability.

In summary, the use of a systems theory lens might have better situated the Health Centre within a larger health and illness care system, emphasized interdependencies and interconnectedness, promulgated adoption of enabling leadership, and freed the organization to develop organically, embracing all of the talent and passion contained within its members. It might have stressed seeking root causes and alignment, encompassed viewpoints as seen through the eyes of diverse populations, and encouraged the organization to contribute in ways more suited to the rapidly changing health environment.

CHAPTER 4   POLICY ANALYSIS #2

4.1   POLICY IMPACT

The second policy examined using the trifocal lens was the Health Centre *Conflicts of Interest Policy*. This policy appeared to be particularly germane to health and health care inequities. The importance of conflict of interest lies in its inextricable linkages with ethical behaviour. For this analysis, the policy was examined through the three lenses sequentially. Segments taken from the policy are given in italics. This approach was chosen to highlight differences elicited with the three lenses.

The impact of conflicts of interest can be illustrated by examination of industry-research relationships. The pharmaceutical industry spends billions of dollars on physician-targeted marketing from which they reap significant benefit (Lemmens, Singer, 1998; Groves et al, 2003). As outlined by Steinman et al, 2006, these endeavours include research grants, scholarship funding, engaging local champions, contracting of local leaders, sponsorship of conferences, CME and lectures, as well as the ubiquitous pens, pads and water bottles. These marketing tools have been shown to alter physician prescribing practices (Psaty, Rennie, 2006). Although these activities are strictly curtailed now, their effectiveness in altering behaviour through relatively subliminal influences provides a valuable lesson. Even token gifts induce feelings of gratitude and reciprocity (however, some question whether studies examining the effect of *de minimis* gifts can be separated from the social circumstances surrounding them- including other marketing efforts. [Terry, Burke, 2003]).

In the years following the Oliveri affair (see for example, Thompson et al, 2001; Schafer, 2004), many measures have been put in place to decrease negative effects of industry sponsorship on research. These include the CONSORT statement (standards for reporting of research) (Moher et al, 2001), individual journal criteria for declaration of conflict (for example, Davidoff et al, 2001 for the N Eng J Med), American Society of Clinical Oncology policy for clinical research oversight (which includes registration of all clinical trials at the time of Research Ethics Board approval)(2003)(similar suggestion given by Rennie, 2004, for all national and international clinical trials), principles for clinical

research developed by the Pharmaceutical Research and Manufacturers of America (voluntary participation), Good Publications Practice guidelines and guidelines of the International Committee of Medical Journal Editors as outlined by Gold et al, 2004. There remain unaddressed gaps - the reality of voluntary adherence with guidelines, issues with access to the raw data, and the role of the industry sponsor in review of manuscripts prior to submission for publication (Gold et al, 2004). These measures address financial and business gains with minimal emphasis on other forms of conflict of interest such as the effects of industry sponsorship on research participant coercion. Innumerable specialty organizations have developed codes of ethics. However, the lack of robust systems to enforce the standards and guidelines (Freedman et al, 2006) makes it imperative that Health Centre processes be put in place to facilitate and support the enactment of the standards and guidelines related to conflict of interest and affect change early in processes and activities.

Of note, there is little evidence on effective interventions to address conflict of interest in health research fields (Mastroianni, Kahn, 1999; Lipton et al, 2004; Lind, 2005). Studies have shown improvement in disclosure but lack of universal adherence (Hussain, Smith, 2001; Papanikolaou et al, 2001; Buchkowsky, Jewesson, 2004). Indeed, there are those that feel disclosure may have a perverse effect (Cain et al, 2005) actually increasing mistrust. It is unlikely that any system of standards and guidelines or policies and procedures will entirely prevent the misconduct of research or conflict of interest in conduct of business or practice. The root causes of professional misconduct include individual values and inaccurate self-assessment. Addressing these necessitates changes in behaviour and alignment of values, systems, structures, incentives and disincentives that support the desired behaviour. At a minimum, within an academic centre, this requires reconsideration of the elements used for promotion and tenure as well as how expressions of respect for academic excellence are determined. Institutions are also influenced through the financial benefits they receive as a percentage of the grant monies obtained (Downie, 2009). As stated by Ferris et al, 2004, it's time to leave the "name, blame and shame mindset". We need to move to an examination of root causes and substantive changes to the systems for ethics and ethical conduct; changes that anticipate

and mitigate the human factors wherever possible. We need to implement "better systems based on good governance, preventive ethics, institutional learning, and continuous policy improvement." (Ferris et al, 2004). The system must have teeth without being so draconian as to stifle initiative.

The issues and concerns outlined above are paralleled by more generic conflicts of interest as experienced within Health Centres. For example, Hannabuss, 2001, states that

> (e)ven a cursory study of organisational culture will confirm how complex, muddy, dissensual, contingent, and partisan much decision making is. The budget is a politically-arrived-at instrument, the department dynamics replete with unresolved tensions, the alliances between professionals and managers in an uneasy compromise, the investment in new systems full of uncertainty and potential blame. (p. 358).

The issues of day-to-day life, as further examined below, are the stuff of which conflicts of interest are made, much of which is not addressed within this policy. In many ways, the tragedy of freedom in the commons is a metaphor for our current dilemmas related to conflicts of interest (Hardin, 1968). This metaphor captures the consequences of misuse of resources held in common such as our health and illness care system(s). Tragedy is averted through all affected adopting a community rather than individual mindset with appropriate associated incentives and disincentives. It is generally accepted that one cannot optimize more than one thing at a time. "What should we as an organization with our given mandate optimize? Or what is the primary, over-riding interest of the Health Centre?" becomes a fundamental question in managing or balancing with respect to conflicts of interest. "Freedom of the commons brings ruin to all." (Hardin, 1968; p. 144). The challenge for the Health Centre is not only to determine the facet or responsibility to be optimized (for example, excellence in illness care for the dominant population versus optimal health for all populations), but also to truly act with that optimization as the foundation for all endeavours. In this way, the Health Centre would have a guiding star to facilitate all members working together to achieve its mandate. Such a touchstone could serve to provide context for examining conflicts of interest.

102

Universities and health centres have the responsibility to include in the education of faculty, students and staff, information about ethical conduct and the issue of conflict of interest. Consideration of utilizing not only individual criteria for promotion, but also team criteria or contributions to interdisciplinary endeavours, requires greater emphasis and reward (Cohen, Spiegel, 2005). Mello et al, 2005, suggested there is a need for more commonality, nationally and internationally, in Conflict of Interest standards and policies in order to increase the collective impact on the system. In addition, there must be a system in place to address non-adherence with the policies and guidelines (see for example, CIHR, 2004).

4.2   CONFLICT OF INTEREST OVERVIEW

The development and implementation of a Conflict of Interest Policy is complex and a significant challenge. Thompson, 1993, defined conflict of interest as conditions that emphasize professional judgment related to a primary interest that becomes unduly influenced by a secondary interest. In the context of the policy under examination, "professional judgement" can be interpreted as judgment required by any Health Centre representative in the performance of her/ his duties. A conflict of interest does not in itself imply wrongdoing nor does it impute the character of the individual(s) involved. In a conflict of interest, the benefit gained by the individual reduces the well-being or state of another or one group over another or an individual over an organization (Epstein, 2007). Conflicts of interest are ubiquitous, context dependent, often subtle and an intrinsic part of all work circumstances. Conflicts of interest can be placed along a spectrum of those that are permissible if appropriately managed to those that are proscribed because they cannot.

A critical foundation for determining conflict of interest lies in the answer to the question of "What is or should be the primary interest of Health Centre personnel?" One could argue that, for the Board and all other Health Centre representatives, maximizing the health outcomes of the populations served is the primary interest. This is a complex conflict of interest dilemma for the Health Centre (populations versus individual patients/ families; illness care versus addressing adverse effects of the determinants of health; an

103

economic contributor to the community and a centre of employment versus patient service deliverer). Similar conflicts are faced by Health Centre personnel. Organizational ethics circumscribe the way in which an organization defines its mission and values, identifies potential value conflicts, seeks optimal resolution of these conflicts and manages its own performance related to those values and conflicts (Gibson et al, 2008). The Board, through its *General Governance Commitment Policy* could stipulate the primary interest for the Health Centre as an organization and for Health Centre personnel. This could then serve as a guide for behaviours and decisions related to potential and real conflicts of interest.

As an academic Health Centre fulfilling the three major roles of clinical care, research and education, there are many circumstances that can be perceived as conflicts of interest. Complicating efforts to manage conflicts of interest, all healthcare professionals have a fiduciary relationship with patients and families; a relationship in which there is unequal power with respect to illness care, where the healthcare worker is entrusted to protect the best interests or well-being of patients, families and users of services (Lemmens, Singer, 1998).

> In their socially sanctioned role as professionals, physicians have specific moral responsibilities. Generally, the doctor's role defines these responsibilities. For treating physicians, the duty is to patient care; for researchers, the duty is to the integrity of the research; and for educators, the duty is to the teaching of students... (*their*) "primary" interests. (Sollitto et al, 2003; p. 84)(italics inserted).

Interestingly, these primary interests are all individual rather than community or population-based. Other professionals have similar conflicts of interest because of their roles as clinicians, researchers and educators. As all Health Centre representatives have a responsibility and accountability to the Health Centre as an organization, there is further potential for conflict of interest situations between the primary interests of the individuals within the Health Centre and those of the Health Centre as an organization. Secondary interests are those interests which have the potential to affect the duties related to an individual's or organization's primary interest. The more easily recognized secondary interests include financial gain (cost cutting) or jumping the queue. However, more subtle secondary interests include visibility (individual or organization), being accepted as a

member of an exclusive group, scholarly recognition, promotion, prestige or favouring one patient group over another. These secondary interests can be wishing to keep a service intact or wanting to be the first to achieve a certain Health Centre goal or favouring Eurocentric populations over others.

> Secondary interests are wholly legitimate things to have. It is only when a secondary interest gains priority over a primary interest, or when either partner *(participant)* fails to minimize the risk of sacrificing primary interests, that the risk of...morally unacceptable behaviour becomes apparent...conflicts of interest represent situations in which the primary interests of the partners do not fully overlap. (Hurst, Mauron, 2008; p. 120)(italics inserted).

The balance of organizational versus individual primary interests is complex and one that engenders challenges particularly for practicing clinicians in managerial or administrative positions. Professional Codes of Ethics or Codes of Conduct generally delineate the patient/ family/ client health and well-being as the health professional's primary interest. However, others have argued that codes of ethics based on Hippocratic ethics are no longer useful in an era of scarce resources and seemingly limitless options. The reality is that those scarce resources are necessary for the health professional to perform her or his role. Kenny, 2006b, suggests that the medical profession (and conceivably other health professions) should "reconceive its role as one of balancing commitments to the well-being of patients with just stewardship of health care resources." (p. 1385). Arguably, this could also be the primary interest of the Health Centre as an organization.

> If equitable access (*to health*) is the aim of health policy (*or health organizations*), as it should be, it can only be brought about by devising goals of health care that make such access possible or (more minimally) that do not put obstacles in its way. If the improvement of the health of the population as a whole is the principal policy aim, as it should be, then it is a mistake to allow individual benefit to remain the test of successful policy and for the provision of high-technology, acute care medicine to remain the highest de facto goal (Callahan, 2002; p. 18)(italics inserted).

Yet the Health Centre has other significant accountabilities to its employees, funders, other stakeholders and society in general. How this interest in common between individuals and the Health Centre is pragmatically carried out is heavily dependent on how the inherent conflicts of interest are visualized and managed.

What is the spectrum of potential conflict of interest challenges that Health Centre members face? For ease of discussion, they can be considered under the broad roles of the Health Centre - provision of healthcare services, education, research, employer and steward of resources. The examples below help to broaden the view of what can constitute *conflict of interest* (actual, potential or perceived).

Examples of conflict of interest challenges-
-related to the provision of healthcare services:

- when engagement in non-Health Centre activities impairs the individual's ability to fulfill her or his normal duties;
- when scheduling is done primarily for the benefit of the health care worker rather than primarily for the benefit of the patient/ family

-related to education:

- when a Department Chief or Division Head/ Leader favours her or his own academic career to the detriment of colleagues for whom she or he has the obligation to develop academic potential (Chervenak, McCullough, 2004 & 2007)
- when educational sessions are funded by industry

-related to research:

- when a Research Ethics Board favours a particular type of research (for example, quantitative) over another equally valid approach (for example, qualitative) or profitable versus not.
- when the researcher is also the care provider

-related to employer/ employee relationships:

- when work assignments are influenced by potential of gaining future favours over choosing the person most suited for the activity
- when a blind eye is turned to wrong-doing because it could adversely impact on promotion

-related to stewarding resources:

- when resource allocation decisions compromise respect for the environment
- when an individual uses her or his position and/ or insider knowledge to unfairly gain resources for a particular team or service area

- when a member of the Board strongly advocates for a particular group without due consideration for all populations served

Conflict of interest is primarily an ethical, not a legal, issue. Although there are legal implications, focusing the issue with a legalistic (or financial) lens marginalizes the majority of challenges most Health Centre representatives face.

Although literature regarding conflict of interest dates back to at least the 1960s, it has only been in the last decade that most organizations have developed their own conflict of interest policies. Less emphasis has been placed on non-financial conflicts of interest than financial (see Liddiard, Ritvo, 1986; Erlen, McDaniel, 1994; Levinsky, 2002; Lipton et al, 2004). The motivation for establishing conflict of interest policies was a profound loss of public trust - in the business world, in the research world and in the healthcare world (Lemmons, 2004). For Canada, the sentinel case was probably the Oliveri controversy (see Thompson et al, 2001; Schafer, 2004, for example). This loss of trust has had significant ripple consequences that have resulted in direct and indirect effects on the health outcomes of individuals and populations (see for example, Calnan, Rowe, 2008). It is to counter perverse, unethical and biased decision-making that conflict of interest policies have been created. As stated by Fogel, Friedman, 2007, "(o)ne paramount motive that causes people to become unscrupulous is the presence of a conflict of interest." (p. 237). In circumstances where the risk of blatant wrong-doing in the face of conflict of interest is slight, conflict of interest policies provide the opportunity to enhance understanding of the scope of this challenge. Most attention to conflict of interest within the healthcare system has been on the interplay of research and industry sponsoring as well as pharmaceutical and equipment marketing to physicians.

The Canadian Institute of Health Research (CIHR) defines conflict of interest as follows:

> Conflict of interest is a set of conditions in which professional judgment concerning a primary interest (such as, for example, a patient's welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as, for example, financial gain).

> More specifically, institutional conflicts of interest can affect appropriate decision-making with respect to the conduct of research in a variety of ways. For example,

such situations may involve institutional decision-makers and research ethics board members responsible for approving and overseeing commercially-sponsored research, where an institutional decision-maker inadvertently or otherwise, encourages or permits research that fails to meet standards of research ethics, or that undermines the safety or respectful treatment of research participants. An institution may also exert pressure on a researcher or a research team to delay publication or otherwise restrict communication of research findings which are damaging or unhelpful to its reputation or financial position. (CIHR, 2004).

Conceivably, conflict of interest considerations might be an important aspect of screening with respect to recruitment and appointment of Health Centre employees and medical/ dental/ scientific staffs, and particularly for the determination of members of the Health Centre Board of Directors. This is one way that addressing conflict of interests can become embedded within the Health Centre culture and can provide the opportunity for education.

A fairly frequent dilemma for health professionals is the receipt of gifts from patients and their families and friends. The philosophy and sociology of gift-giving has been studied by many. Engberg-Pedersen, 2008, analysed gift-giving from a Judeo-Christian perspective and explored whether there can be a true gift.

> On the one hand, a gift is by definition an entirely non-self-interested act; it is gratuitous and completely devoid of egoistic calculation. On the other hand, gift-giving (at least in premodern societies) involves a whole system of expectations and obligations, at the basis of which lies precisely that which was denied by speaking of the gift as a gift: self-interest and egoistic calculation…the idea that for an act to be truly other-regarding and altruistic - and a gift is necessarily that - it must not involve any self-regarding concern whatsoever...but…true other-regard (acting for another person for his or her sake) does not necessarily exclude some form of self-regarding concern…(*There is*) a strong element of inclination in gift-giving, while at the same time insisting…that a gift be done for the sake of the receiver and - in contradistinction from a loan - without any thought of being paid back (p. 16)(italics inserted).

The legal definition of a gift is a transfer of property with nothing given in return. A gift is something given without compensation (Webster's Dictionary, 1991). Inherent in these definitions the giver expects nothing of the receiver. Also implicit, the recipient is not due a gift. Yet most of the literature examining gift-giving identifies reciprocity and

obligation engendered in the receiver (for example, Engberg-Pedersen, 2008; Edlund et al, 2007; Adloff, 2006).

Successful implementation of a policy requires oversight and monitoring. This is delineated within the policy for most members of the Health Centre; it is not described for the Board. As raised by Epstein, 2007, "who guards the guardians?" or in this case who monitors the Health Centre? The Health Centre has a self-appointed Board and thus could be conceived as self-policing. This is a controversial issue closely linked with behaviours related to conflict of interest and with self-regulating professions. The autonomy and authority of professions such as law and medicine has been increasingly curtailed over the last century partially in response to increasing public mistrust in the ability of professions to adhere to their fucidiary responsibilities without some outside surveillance (Adams, 2009; Cruess & Cruess, 2008). In the case of the Health Centre, the Department of Health functions as an external guardian. This independent assessment provides balance (D'art, Turner, 2003).

The Health Centre's Conflict of Interest Policy is given below. This policy does not address conflict of interest with respect to research.

Table 5   Conflict of Interest Policy

Section A   Policy Background

The Health Centre is committed to fulfill its mission in an honest and ethical manner. The Health Centre's mission of serving patients, families and the community through the delivery of quality health care, research, teaching and advocacy is achieved through participation in diverse activities that require IWK employees, medical, dental and scientific staff, students, volunteers, Board of Directors and agents to interact with many public and private organizations in the local, regional, national and international marketplace. In this complex business and academic environment, it is inevitable that conflicts of interest may arise. When these circumstances arise, it is important the Health Centre have a policy that educates on conflicts of interest and outlines a process to identify, declare and address the potential, perceived and actual conflicts.

It is the ethical and legal responsibility of all Health Centre representatives to ensure decisions and actions which affect the Health Centre, the services it provides and the community it serves are taken in the best interest of achieving the Health Centre mission and are not influenced by personal interests. Policies and practices must reflect the Health Centre's commitment to maintain the trust of patients, their families and the public by ensuring the acts of all persons affiliated with the Health Centre are conducted honestly and with integrity.

Although not specifically stated, *Health Centre representatives* appear to include *IWK employees, medical, dental and scientific staff, students, volunteers, Board of Directors and agents*. A definition of *agents* is not given. Within the following analysis, *Health Centre members* refers to employees, physicians, dentists, students, Board of Directors and volunteers. The Board of Directors *Code of Conduct* also deals with conflict of interest.

Section B   Purpose

The purpose of the Health Centre policy is to:
-educate employees, medical, dental and scientific staff, students, volunteers, Board of Directors and other agents about situations that generate conflicts of interest;
-set out a process for identifying and addressing potential, actual and perceived conflicts of interest so that the public can maintain confidence that decisions and actions are not influenced by personal, financial or business interests;
-set out protocol aimed to reduce the incidence and impact of conflicts of interest; and
-ensure consistent application of measures to prevent and address conflicts of interest.

Section C   Definitions

A **conflict of interest** is a situation in which someone in a position of trust and in the discharge of one's duties and responsibilities has competing business, financial or personal interests. Such competing interests can make it difficult to fulfill his/ her duties impartially. Even if there is no evidence of improper actions, a conflict of interest can create an appearance of impropriety that can undermine confidence in the ability of that person to act properly or objectively in his/ her position. A conflict of interest is not, in and of itself, evidence of wrongdoing.

A conflict of interest takes many forms. Examples include, but are not limited to, cases in which a person or the organization:
-uses Health Centre resources for private business purposes without authorization;
-conducts a review, assessment or evaluation of a project or colleague, the outcome of which may affect personal interests;
-initiates, conducts or participates in a research project or influences the decision process for approval that may affect his or her personal business, financial interests;
-acceptance of gifts or free services from a vendor, service provider or contractor of the Health Centre when the employee, staff or agent is in a position to determine or influence the Health Centre's purchases from those persons;
-uses his/ her position to provide access to health services outside of the normal process to himself/ herself or other third parties;
-acceptance of financial incentives that could be perceived to influence clinical research studies;
-uses his/ her position as a Health Centre Representative to promote the personal, financial or business interest of a closely associated person.

A **business interest** means any corporation, partnership, sole proprietorship, firm, franchise, association, organization, holding company, joint-style company, business or real estate trust or society or any other separate legal entity organized for profit or charitable purposes in which a person or closely associated person:
   -has a financial interest;
   -acts as a trustee, director or officer;
   -acts in a position as an employee, agent or otherwise, which includes responsibilities for a segment of the operational management of a business; or
   -acts in a position as an employee, agent or otherwise, which includes responsibilities for influencing or determining the direction of the corporation.

Section D   Protocol

Health Centre Representatives shall not participate in an activity or decision that involves an actual or potential conflict of interest unless such activity or decision has been approved in advance by the Board, her/ his Director or Division/ Department Head and, if such approval has been given, any terms or conditions made by the Board, Director or Division/ Department Head are filled.

All Health Centre Representatives shall take the following measures to mitigate and manage conflicts of interest:

Disclosure
On an annual basis and as circumstances arise, all Health Centre Representatives shall disclose to the Board Chair (Board of Directors), his/ her Director (employee, volunteers) or Division/ Department Head (medical, dental, scientific staff, student) any involvement in outside employment or other activities, business interests, financial interests and relationships if such involvement:
-may give rise to a real, apparent or potential conflict of interest between the person's duties and responsibilities and his/ her personal, financial or business interests; or
-may affect the person's capacity to perform his/ her duties and responsibilities objectively and impartially.

Withdrawal from decision-making or business process
Health Centre Representatives have a duty to ensure that all decisions or commitments made on behalf of the Health Centre are made in an accountable and transparent manner. Persons who have made a disclosure under this policy or are otherwise considered to be in a conflict of interest with respect to a decision or matter of business may be required to withdraw from the decision-making or business process.

All Health Centre Representatives shall comply with the following requirements while acting in any capacity for or on behalf of the Health Centre, it being understood that the following are not intended to be exhaustive examples of the prohibited conflicts of interest. Should these circumstances arise, the Health Centre Representative shall comply with the Protocol set out in Part D of this policy.

Non-acceptance of benefits or gifts
Acceptance of gifts for fulfilling the Health Centre Representative's role or position can create the perception that your judgment is compromised or can be influenced and/ or create a sense of obligation. To avoid an actual or perceived conflict of interest, no Health Centre Representative shall accept any gift, including travel and accommodations, of more than token value from any person or organization as a consequence of their services, role or position within the Health Centre.

Prohibition against promotion of a private interest
It is often difficult to separate when one is acting in his/ her personal or professional capacity. While in the Health Centre or acting on the Health Centre's behalf, one must refrain from promoting personal interests. To avoid an actual or perceived conflict of interest, no Health Centre Representative shall use their position within the Health Centre to offer or to promote goods and services in which they or a closely associated person have a personal, financial or business interest.

Prohibition against self-referral or referral to closely associated person
No person who provides professional services, operates or has a business or financial interest in a private facility or practice shall use their position within the Health Centre to generate referrals to a service outside of the publically funded health care system, unless such a referral is made with the full disclosure of the business or financial interest to the patient.

No person shall use their position within the Health Centre to generate referrals to or to promote the use of services or facilities outside the publically funded health care system in which a closely associated person holds a personal, business or financial interest, unless such a referral is made with the full disclosure of the financial interest to the patient.

Non-disclosure of information
No person shall be involved in outside employment or other activities that involve the use of Health Centre premises, equipment or supplies, unduly interferes through telephone calls, internet use or otherwise with regular duties or is performed in such a way as to appear to be an official act or to represent the Health Centre.

Use of position/ relationships to influence access to health care services
No person shall use his/ her position/ relationships to secure access to health care services for any person outside of the normal procedures to the detriment of other patients (including increasing the waiting time for other patients in the system).

Section E   Disclosures and Reviews

(note: the following does not apply to research projects. The process followed for such projects is set out in the Research Ethics Board Operating Procedures).

On at least an annual basis, this policy shall be on the agenda of the Medical Advisory Committee, Joint Management Operations Committee, Professional Practice Chief Council and Board of Directors so as to ensure each Director/ Vice President or Division/ Department Head are informed of the policy, the requirement of disclosure and Health Centre Representatives are reminded of the policy and requirements.

The Board Chair and each Director and Division Head/ Department Head shall review all disclosures made to them in a timely manner and, upon consultation with the affected person(s) and other Health Centre resources such as Legal Counsel, the Ethics Committee or Professional Chiefs, make a determination as to whether the personal, financial or business interest conflicts with the affected person's professional duties. If it is determined there is an actual or potential conflict of interest, the Director or Division Head/ Department Head may implement terms and conditions to ensure the avoidance of the conflict of interest. The Director or Division/ Department Head and the affected person shall monitor the circumstances and make adjustments to any terms and conditions implemented as required.

In circumstances where a Board Chair, Director/ Vice President or Division/ Department Head is made aware of a potential, actual or perceived conflict of interest which the affected person has not brought to his/ her attention, the Board Chair, Director or Division/ Department Head shall follow up with the affected person to determine whether a conflict of interest exists in the manner set out above.

The Board Chair's determination that a Board Member has an actual or perceived conflict of interest shall be final. The determination that any other Health Centre Representative has an actual or perceived conflict of interest may be reviewed. In the event the affected Health Centre Representative does not agree with the Director's or Division/ Department Head's determination a conflict of interest exists or the terms and conditions implemented, the affected person may seek a review of the Director's or Division/ Department Head's decision by setting out his/ her issue with the decision in writing and providing to the Vice President responsible for the department, within ten (10) days of receiving the Director's or Division/ Department Head's decision. A copy of this correspondence must be provided to the Director, Division/ Department Head and, where applicable, the Professional Practice Chief at the same time it is provided to the Vice President.

The Vice President shall review the decision in a timely manner and where he/ she feels appropriate consult the Director, affected person and other Health Centre resources such as Legal Counsel, the Ethics Committee or Professional Chiefs. The Vice President shall have the discretion to uphold, set aside or modify the Director or Division/ Department Head's determination and any proposed terms and conditions. The Vice President's decision on the matter shall be final.

Section F   Reporting and Non-compliance

Reporting
All Health Centre Representatives shall report any real or perceived conflicts of interest of which they have become aware to his/ her Director or Division/ Department Head, who, depending on the nature and materiality of the conflict of interest, will report to the relevant Vice President. In any case where such a report has been made, the report will be treated confidentially to the extent possible. There shall be no consequences for individuals making reports of actual or perceived conflict of interest so long as any report is made in good faith.

Non-compliance
Non-compliance with any provision of this policy may result in disciplinary action, up to and including the possibility of termination of employment. It is also important to understand that a violation of certain provisions of this policy may be a violation of law and may subject the person involved to criminal prosecution or civil liability.

4.3   FEMINIST THEORY LENS ANALYSIS

The first lens used was the feminist theory lens. The questions guiding the analyses were those developed as outlined in Chapter 2.

1. What embedded assumptions/ biases/ values can be detected in the information presented- particularly related to positioning of women and the knowledges and experiences of women? Were these biases or inaccuracies expunged?

Implicit in the policy is the premise that conflicts of interest must be managed or avoided.

However Epstein, 2007, stated

> (t)he regulation of conflicts of interest is more perilous than one would suppose, because it raises this disturbing possibility: the mechanisms that people use to control conflicts of interest- disclosure, deliberation, oversight, litigation- can never be made foolproof. The introduction of one form of intervention may have the desirable effect of eliminating some conflicts of interest. Yet at the same time, that new layer of oversight could spawn new conflicts of interest, many of which were overlooked or underappreciated when the governance structure was created. (p. 73).

The policy is largely concerned with conflicts of interest involving Health Centre representatives and individuals or parties external to the Health Centre. Scant attention is paid to internal conflicts of interest such as balancing managing economic/ resource

constraints with providing high quality care whereby an individual's code of ethics is in conflict with lack of resources needed to provide appropriate care (Gibson et al, 2008) or if a health professional's religion and values differ from those of a patient with respect to the care the patient wishes. The focus concentrates on the traditionally masculine concerns of business and finances, on *quid pro quo*, in self-protection (Hadfield, 1995) and, as highlighted by Machold et al, 2007, on power, influences, rights and duties. A feminist theory approach might include more emphasis on relationships both for their inherent conflicts of interest and as a foundation for the management of conflicts of interest. Feminist theory emphasizes approaches based on obligations, reciprocal responsibility, limitations of individual rights and concern for family/ community (Brems, 1997). A feminist framework might have resulted in a different interpretation of conflicts of interest than presented in the Health Centre policy.

Implicit in the policy is the expectation that individuals (and the Health Centre) can actually achieve complete self-*disinterest* as for example in *use of position/ relationships to influence access to health care services*. As Adloff, 2006, implies it is unreasonable to expect that individuals will consistently disregard their own interests in the interest of others. Within a health centre setting, a source of personal satisfaction is patient-professional relationships which are sometimes challenged by conflicts of interest between meeting the needs of a particular (favoured) patient versus equitably meeting those of all of one's patients.

2. Have the differences in power been acknowledged? Their impact?

The policy appears to be normed to individuals with power and influence (researchers, administrators for example) who have something readily perceived as having value to be exchanged for the direct or indirect benefit of the individual. Differences in power both related to ability to influence others and to be influenced by gifts are not examined in the policy. The impact of gifts, drug samples and other items to physicians has been studied. Somewhat incredibly, even seemingly trivial gifts such as pens or message pads can impact a physician's clinical judgement. Physicians who relied heavily on commercial information (supplied through pharmaceutical marketing) were less likely to prescribe

medications in accordance with patient needs (Groves et al, 2003). For some physicians, gifts and food were seen as a perks of the job or a sign of career accomplishment and status (Katz et al, 2003). It is likely that CEOs, administrators and management (and others) are equally influenced by gifts of entertainment tickets and invitations to dinner from agents seeking to do business with the organization or generate good will for their cause. Intuitively, one would guess that persons of limited means would be more influenced through gifts, yet it is the subliminal message implied by the giver of the worthiness of the receiver and the subtle engendering of obligation that seems to affect all irrespective of economic status or organizational position. "Food, flattery and friendship are all powerful tools of persuasion, particularly when combined. Individuals tend to be more receptive to information when it is received while eating enjoyable food." (Katz et al, 2003; p. 41).

Differences in power are inferred as those who are likely to be in a position to, for example, have *a business interest* or accept *gifts of free services from a vendor, service provider or contractor of the Health Centre where the employee, staff or agent is in a position to determine or influence the Health Centre's purchases from the persons* are likely to have positions of relative power within the organization. The policy is not clear with respect to gifts given to groups rather than individuals (for example to a service rather than an individual physiotherapist, even though an individual representative of the group would receive the gift on behalf of the group). The policy is also silent about members of the Board of Directors or representatives of the Health Centre who donate gifts to the Health Centre or who are instrumental in securing donations to the Health Centre and any conscious or unconscious influence that might have.

Potential issues for those in positions of power are preferentially addressed in contrast to the majority of Health Centre personnel whose major conflicts of interest are related to face-to-face encounters with patients and families. Yet from an organizational ethical standpoint, those everyday conflicts of interest could be considered more significant. For physicians, the means to reciprocate giving is through using the benefactor's products; for

those in administrative positions, it is through patronizing the agent's organization; for health professionals, it is through preferential treatment for a particular patient/ family.

3. Have the political aspects been recognized?

Patronage is an old-fashioned (Montgomery, 2007) but still thriving example of political conflict of interest. Patronage is generally an asymmetric relationship with the patron having greater power than the client for whom the patron uses her or his (traditionally his) influence to assist or protect. The client then has a reciprocal obligation to her or his patron. Bearfield, 2009, classified patronage into organizational, democratic, tactical and reform patronage. Organizational patronage has been used to build empires of people loyal to the patron's cause in return for favours granted. Reciprocity underpins patronage (Goodell, 1985). Although these descriptions were related to public administration, they could conceivably be found within a health centre. Students given summer positions by a mentor may feel pressured to help build that mentor's research empire through justifying adding the name of their mentor to a research publication. Or Health Centre personnel preferentially chosen time and again for participation on Health Centre working groups may feel more predisposed to the ideas of the "in group" as led by their sponsor, some of which may not be in the best interests of the patient population for which they are responsible. Patronage appointments circumvent normal procedures of hiring or selection. Although the Health Centre has strict guidelines related to appointments and hiring, subtle examples of patronage occur through preferential placement of one's student in learning environments, nominations to popular committees or participation in a mentor's research project.

Within feminism, all is political and decision-making around a health centre public image, for example, can both engender and conceal conflicts of interest. Professional boundaries and expectations (anonymous, 2002; www.crnns.ca/document), choosing which religious and cultural holidays to have the Health Centre celebrate (and how lavishly), deciding which meetings will have meals, and determining information to provide patients when obtaining consent to treatment all are potential conflicts of interest.

4. Does the policy address "women-centered efforts to improve the quality of life for those who are oppressed"?

Women form the majority of frontline staff whose ubiquitous conflicts of interest as faced daily are not addressed. Neither the Definitions (Section C) nor the Protocol (Section D) capture the issues women face daily. Conflicts of interest can occur between two good or beneficial actions. A clinician's duty to a patient may be in conflict with her duty to family. Stewardship of limited resources can be in conflict with patient advocacy. Time for documentation can impinge on time for patient contact (Tonelli, 2007).

The policy is written in pragmatic language lacking in nuances suggestive of context dependency (Blacksher, 1998). For example, with respect to clinical practice guidelines, the issue of intellectual conflicts of interest has been raised (Guyatt et al, 2010). Both developers and users of clinical practice guidelines may have a strongly held belief or interpretation of evidence that conflicts with the consensus decision of the guideline writing group or institutionally adopted guideline. Women, and those in health professions dominated by women, may have a different worldview, thus values and beliefs, than those of men and men dominated professions. Because women are more likely to be recipients rather than designers of guidelines (predominately written expert, scientist men {gleaned from a cursory review of published guidelines}), they are more likely to experience conflict. If adopters of an ethic of care, they are more likely to see the difficulties applying clinical practice guidelines to vulnerable or marginalized populations. Issues of diversity and cultural impacts are not addressed in the policy. These concerns would relate not only to unconsidered impacts on patients who are not Euro-Canadian and middle class, but also cultural practices, socio-economic stresses and ability to understand information given in a manner or language not easily understood.

5. Does the policy seek to improve society through eliminating constraints based on gender?

Women are more likely to construct moral reasoning around connectedness, relationships and caring rather than rights and autonomy (Machold et al, 2007). A policy written from the perspective of feminist ethics might lead to more questioning of the impact of disclosure addressing conflicts of interest (Haines, Olver, 2008). Although specifically

addressing research ethics (not covered in the policy under examination), the issues are similar to those addressed in the policy. The authors question, as have others, whether the act of disclosure is sufficient. They feel that not only may disclosure not accomplish needed distance from decision-making related to the potential conflict of interest, it may lead to failure to address the conflict in a preventive manner; disclosure may allow the individual to feel free to give more biased information than she or he might have without public disclosure (a variant of buyer beware). The authors state that self-regulation is rarely effective. In other cultures, the stringency of control over conflict of interests varies. In Japan, for a physician to accept a gift is a civil offense (Akabayashi et al, 2005).

Disclosure also implies that those receiving the information in the context of a disclosure fully understand the implications (Kassirer, 2001). Disclosure may alter perceptions of trust (Kassirer, 2001). Members of the Health Centre, particularly those in positions of relative power, receive gifts such as free tickets to concerts or hockey games (although often shared with staff and or patients/ families) that are considered just ways of doing business. As objective as one tries to be, can one fail to be influenced consciously or subconsciously by gifts or other favours? Years of personal observation on a clinical care unit suggest that patients and families who give flowers, food or favours tend to be treated differently than those who do not. The givers and receivers are known and identifiable to each other, thus, no doubt, increasing mutual reciprocity compared with more distant gifting or funding.

In an article with parallels to clinical care, Fisher, 2006, stressed the differences in perception of the conflicts of interest as experienced by the researchers (predominantly male) and the research coordinators (predominantly female). Similar issues are experienced in the clinical setting, particularly related to treating patients according to standards of care or clinical practice guidelines. Fisher also noted that lack of attention to research coordinators emanated from the "more general invisibility and undervaluation of nursing within healthcare." (p. 681). Because of her proximity to the participant, the coordinator was exposed to the participant's responses to the study intervention sometimes engendering conflict in balancing research and care. The coordinator (and

bedside health professional in the clinical scenario) tended to see the patient as an individual and thus evaluated to herself or himself the suitability of the treatment or intervention. Another common conflict of interest is the fallback task of the nurse to explain the words and actions of the physician to a patient or family, thus intersecting her or his thoughts and perceptions versus those of the physician. Nurses are more likely to feel conflicted about reporting adverse patient-physician relationships for fear of reprisal. Failure to view conflicts of interest through a feminist lens constrains the view and content of the policy.

In decisions related to hiring or choosing an individual for a preferred task, gender (and other) stereotypes may still subtly bias for or against qualified applicants, choosing someone like oneself might be more comfortable than choosing someone with a different background or ideas. The interviewer may be conflicted by self comfort versus slightly better suitability of another candidate for the position.

6. Does the policy convey how culture may have shaped the behaviours/ results?

There is little background given for the policy. Perhaps implicit in the structure of the policy is the impetus of public scandals in precipitating the development of the policy.

7. Were the policy-makers' conceptual framework and standpoints clearly identified?

The policy-makers' conceptual framework and standpoints were not clearly identified. The impacts for those in positions of relative power were emphasized.

There does not appear to have been consideration from a feminist lens in the creation of this policy. A feminist lens might have expanded the framing of conflicts of interest to encompass those experienced by most Health Centre staff. It may have aided the recognition of the limitations of disclosure as a means of managing conflicts of interest.

4.4   CRITICAL SOCIAL THEORY LENS ANALYSIS

The second lens used was the critical social theory lens. The questions guiding the analyses were those developed as outlined in Chapter 2.

1. What are the social, economic, historical, political, cultural constraints/ oppressions/ ideologies implicit in the policy?

In her dissertation Battalora, 1999, discussed how inextricably intertwined our unconscious acceptance of the norm as portrayed by White elite men is in the laws, policies and customs of North American history. She stated "(b)ecause the racial positionality of whiteness is not seen, white racial perspectives are often presumed to be racially neutral" (p. 4) yet "privileges accumulate and get entrenched in social structures such as law, religious institutions, schools, banks, neighbourhoods, and the home and get are *(sic)* performed on a daily basis through individual acts and institutional practices." (p. 185). We tend to dichotomize our world into White or non-White, heterosexual male or non-heterosexual male, Christian or non-Christian, not poor or poor, educated or not, Euro-American or other - both consciously and unconsciously - all the result of social construction. Often subliminally embedded is the fear of loss of the largely unearned privileges accorded to being an elite White male (and the hierarchy emanating from that status)(Battalora, 1999), including the definitions and understandings of ethical behaviour. The policy does not clearly identify the principles and values behind the policy. However the issues addressed reflect issues of individuals who are in positions of relative power and who, in the context of the Health Centre, are predominantly middle class Euro-Nova Scotians.

Battalora's concerns are echoed by Myser, 2003, who stated "there has been inadequate attention to and questioning of the dominance and normativity of whiteness in the cultural construction of bioethics in the United States." (p. 1). Relationships are seen as contracts and the capacity to think rationally is envisioned as thinking that is scientific, logical, objective and clear - not mudded by feelings and emotions - an approach that preserves the "fable of equality" (p. 4). Cultural differences in ethics have been documented, for example, between approaches to business ethics of Americans (United States) and Egyptians (Beekun et al, 2008), and between Chinese and Australian ethical reasoning (Tsui, Windsor, 2001). Consideration of the view from cultural and other diversities (socio-economic, ableness, linguistic etc) is lacking.

2. How does the policy perpetuate the present circumstances? What does it allow us to see? What does it overlook?

In Section A, the introduction to the policy, the importance of addressing conflicts of interest is not highlighted. Rather, the perspective of the Health Centre in maintaining an acceptable reputation and achieving its mission (as ends rather than means) are emphasized. There is no recognition of Health Centre responsibility to society (a perspective that might encompass greater attention to conflicts of interest related to environmental concerns, for example). Conflicts of interest are significant because of the harms they may engender in those to whom the Health Centre is accountable. Conflicts of interest inevitably erode trust (the belief that "individuals and institutions will act appropriately and perform competently, responsibly, and in a manner considerate of our *(patients')* interests.")(Mechanic, 1996; p. 173)(italics added).

Delineation of the purpose of the Conflict of Interest Policy within the context of the Health Centre and its mandate would facilitate a move from the present circumstances of a relatively narrow understanding of the issues to one firmly grounded in principles and Health Centre values. The Mayo Clinic identified four goals within their conflict of interest policy "to safeguard patient safety in all clinical practice, research and education efforts; to protect the integrity of the institution and the individual; to support and not impede research efforts; and to acknowledge and develop guidance for the institution and for the individual." (Camilleri et al, 2005; p. 1341-1342). Although these four goals may not be the most applicable to the Health Centre, they provide an example of areas of emphasis and could be placed within the larger context of the purposes of the Health Centre and the impact that conflicts of interest can have within that context.

The effects of religious beliefs and attitudes towards others of different faiths, ethnicity or social status, are unrecognized or acknowledged. For many non-Anglo-Saxons, the ethical principle of beneficence has primacy over autonomy (Hudson, Russell, 2009). Indigenous peoples in North America and elsewhere respect family/ community over individual rights and reciprocity over contracts (for example, Asch, 1998; Fogel, Friedman, 2007; Hudson, Russell, 2009; Levin, Schiller, 1998). Peoples of differing

faiths, backgrounds or abilities, for example, likely have incongruent concepts of conflict of interest (for example, Akabayashi et al, 2005; until recently the Japanese paid little heed to clinical ethics and associated conflicts of interest).

Not only have men "firmly established themselves as the norm with women in counterpoint to them..., (individuals are seen) as *dis*abled as opposed to able, *in*sane as opposed to sane, *sub*normal as opposed to normal." (Brown, Smith, 1989; p. 106)(italics as in original)(bracket inserted). "The rules of the dominant society are understood by everyone…The dominant group are *(sic)* oblivious to ...the different rules which apply according to gender, class and race. These rules are so pervasive that we internalise their strictures and standards." (Brown, Smith, 1989; p. 108). The approach taken to the Health Centre policy presumes a common understanding of conflicts of interest and perpetuates an emphasis on financial gain and gifts. It provides little encouragement for dialogue, learning, deep thinking and substantive organization change. The opportunity to strengthen organizational citizenship was not taken.

3.   Whose interests have been/ are being served by the way things are?

As the conflicts of interest encompassed by the policy are relatively narrowly defined, the opportunity to stimulate more in-depth reflection for Health Centre representatives has been overlooked resulting in relative *status quo*. The policy does not mention the intrinsic, inextricable, systemic conflicts of interest embedded in organizational-health professional relationships and health professional-patient/ family relationships. Thus these areas remain unchallenged and unaddressed. Much of our thinking about conflict of interest is focussed on the premise of independent professionals and the expectation that the conflict of interest tensions between health professional and patient/ family are attended to through professional codes of ethics. Professional to professional or professional to institution conflicts of interest are not well addressed. Conflicts of commitment to an organization are seen as "a situation where the Outside Professional Activities of a Member are so substantial or demanding of the Member's time and attention as to adversely affect the discharge of the Member's responsibilities." (University of British Columbia Board of Governors policy #97).

Another unheeded area is the issue of choice exemplified by the range of health professional options availed in carrying out her or his duties. For example, when physician choice in instrumentation or surgical technique (often based on where the individual trained and particular familiarity and comfort) necessitates several surgical set-ups in a circumstance where there is no one superior method. Or disinterest in developing common standards, guidelines, protocols and procedures when such approaches have been demonstrated to decrease error and improve patient outcomes (Khushf, 1998). Physicians rather than other health professionals are more able to exert this freedom of choice. Indeed, nurses and other health professionals are more constrained in how they can carry out their roles thus engendering role-personal values conflicts. Because these issues are not viewed as conflicts of interest, neither the Health Centre nor individuals within the Health Centre are encouraged to self-reflect, identify conflicts of interest and institute changes that might be to their real or perceived disadvantage (for example, loss of freedom of choice related to Operating Room equipment). Thus the policy, by omission, protects the interests of the physicians over other health professionals.

4. Whose voice is dominating? Whose voice unheard?

The voice of the individual is heard over the voice of the Health Centre as an organization, as is the voice of the dominant population heard over others. Non-dominant cultures may have very different views on gift giving as a conflict of interest. For example, a study examined the gift-giving behaviours of individuals from the People's Republic of China (Qian et al, 2007). Within the Chinese culture, there are hierarchies and traditions embedded in gift-giving that a simple ban on receiving gifts would disrespect. The power to choose which differences matter, and thus which principles and values count, is vested in the dominant Euro-centric, androcentric culture (Labacqz, 1998). Other voices are muted. The voices of patients and families and the public are unheard.

The Health Centre as an organization with its attendant conflicts of interest embedded in its structures, accepted protocols and processes, is not identified as either capable of or bound by policy to address potential issues. Organizations are felt to have an ethical

125

framework separate from that of the individuals who comprise the organization (Khushf, 1998). Such ethics include business matters, approach to quality, employment principles and government relations (Khushf, 1998). The Health Centre as an organization appears not to be held accountable, thus amenable to correction, in the same way as individuals within the Health Centre. However, the Health Centre has in fact undertaken rigorous examination of some of its potential organizational conflicts of interest including issues related to company sponsored infant formula versus breast feeding.

5. What are the theories-in-action (assumptions, values, beliefs) underlying the policy?

Rather than "integrating emotions such as compassion, women are more responsive to the plight of others, ... men's moral understanding more resembles the reflective equilibrium of an impartial observer" (Nunner-Winkler et al, 2007); this policy is pragmatic. Some of the theories-in-action appear to include that preservation of the Health Centre's reputation and mission is paramount over the integrity of individuals, that having a policy on *Conflict of Interest* will appropriately modify behaviour, and sanctions will influence attitudes. The ethical framework appears to be that of traditional bioethics (principles of beneficence, non-malificence, respect for autonomy and justice). The policy is written as if only individuals (and not organizations) can have conflicts of interest; as if Health Centre acceptance of donations in return for large company associated portraits (such as Colonel Saunders) might not be perceived as free advertising and thus a conflict of interest similar to that of research-industry relationships. There appears to be the assumption that the policy will be implemented and that the policy has value.

6. What power differentials are being expressed in the policy?

As noted above, the principles and values embedded in this policy appear to be based on the dominant Euro-centric, androcentric culture. Although the creators of this policy may have been unaware of their framework, the ubiquitous power of the dominant culture perspective appears to have guided their thoughts.

Overall, this policy does not seem to have been viewed with a critical social theory lens. The use of such a lens might have led to the incorporation of ethics, principles, values and perspectives of non-dominant cultures.

4.5   SYSTEMS THEORY LENS ANALYSIS

The third lens used was the systems theory lens. The questions guiding the analyses were those developed as outlined in Chapter 2.

1.   What are potential system issues related to this policy?

There is inadequate recognition of systemic conflicts of interest. Within an academic health centre, conflation of clinical care and clinical research, and dual roles of clinician and administrator are two examples of systemic conflicts of interest. With physicians increasingly becoming remunerated through Alternate Funding Plans, a systemic conflict of interest has been introduced through agreements requiring particular deliverables. These agreements generate inherent tensions between a focus on patient care versus one on deliverables; between professional values and organizational (Department of Health) demands. For example, the need to demonstrate productivity (that is record pertinent data) may compromise time spent with patients; the Department of Health standardized time for a particular encounter may not fit a particular service's patient population. These tensions have long been felt by other health professionals as employees versus independent practitioners (Rushton et al, 2007). For example, following a physician's order with which the nurse disagrees because it is not culturally suitable for the particular patient or the expectation of expediency over time-taking expressions of concern.

Other systemically embedded conflicts of interest include the institutional need for resources, a conflict that promotes consideration of owning franchises such as Tim Horton's (selling of foods with little or no nutritional value). They include the balancing of an individual patient's/ family's best interests with the best interests of the populations served. These are examples of competing interests or obligations that may adversely affect one party or the other.

2. What are potential system inconsistencies/ incongruencies/ incompatibilities related to this policy?

Because difference was not considered, the policy is weighted towards reacting to rather than providing a framework for preventing and managing/ ameliorating the many of conflicts of interest experienced by Health Centre members (see Chervenak, McCullough, 2004 and 2007). Because potential internal and non-financial aspects were not emphasized, many of the conflicts of interest experienced by most individuals as they carry out their daily work are underrepresented. In the creation of this policy, the Health Centre missed the opportunity of seeking input from diverse populations (Hern et al, 1998) and thus averting related conflicts of interest. For example, a Health Centre standard might be that all patients and families receive information in a language with which they are comfortable, but the time to obtain a translator may interfere with the time the clinician has allotted to that encounter.

Another dilemma is the policy method for annually stating potential conflicts of interest, a requirement that has no meaning for the majority of conflicts of interest experienced by Health Centre members.

3. What system relationships are affected by this policy?

Conflicts of interest are but one aspect of an entangled web of professional and organizational ethics. Professionalism is an area that impinges on conflict of interest. Patient-professional relationships are enmeshed with the dynamics of power, trust and dependency. Issues of professional relationships and boundaries encompass sexual harassment and abuse, breach of confidentiality, invasion of privacy, social/personal interactions, creation of unwarranted dependency and conflicts of interest. With respect to conflicts of interest, these can vary from financial exploitations to differences in values and attitudes; it can be giving differential treatment based on feelings for the patient rather than the patient's needs or taking advantage of patient's feelings of indebtedness for personal gain (College of Registered Nurses of Nova Scotia, 2002). There is no encouragement to seek out perverse incentives that potentiate conflicts of interest within

the organization (for example, more recognition for individuals than for teams while promulgating teamwork as the essential way to achieve the Health Centre mission).

4.   What system interdependencies could potentiate or negate this policy?

As conflicts of interest are integral and foundational elements of ethical challenges, the interdependency of the Health Centre's approach to decision-making, professionalism, involvement of others and guiding viewpoint must be heeded. Other values as embraced by the Health Centre such as family centered care and evidence-informed practice have intrinsic and systemic conflict of interest components. For example, non-dominant cultures may have differing beliefs regarding decision-making within families or the meaning of truth (Oliffe et al, 2007). Evidence-informed/ evidence-based practice may give rise to conflict of interest between achieving the best medical, standard of care decision for a patient or the best quality-of-life decision (Brody, 2005). The issue of what is or should be the primary interest of Health Centre representatives (or for the Health Centre as an organization) has not been addressed. Without a common understanding of that primary interest, issues of conflict of interest may result in being arbitrarily resolved (managed). The primary interest of the Health Centre and Health Centre members serves as a touchstone with respect to conflicts of interest. Family centered care, evidence-informed practice and standards of care are all entangled in *Healthy Families. The Best Care.*

5.   Are there delayed consequences of this policy?

Enactment of this policy should witness greater awareness of conflicts of interest, and identification and management of readily perceptible conflicts of interest. By failing to include more consideration of non-financial conflicts of interest, an opportunity may have been delayed or lost to increase the understanding about and actions to address the many conflicts of interest each of us face every day.

6.   Are root causes considered by this policy?

Conflicts of interest have been characterized as "judgment damaging" (Meyers, 2007). Thus conflicts of interest have the potential to affect all activities. Root causes that might

potentiate the risk of conflicts of interest include mis-alignment of achievements that enhance chances of promotion- for example, where obtaining a financially large research grant (and thus perhaps contribute significantly towards a goal of the Research Department) for a relatively minor increase in scientific knowledge is rewarded more highly than a financially inconsequential grant with the potential to significantly increase scientific understanding. Health Centre activities that increase the risk and consequences of conflicts of interest, and which could be ameliorated, were not sought or addressed.

Generic root causes that have been identified for conflicts of interest include "placing budgetary considerations ahead of quality, placing schedule considerations ahead of quality, placing political considerations ahead of quality, arrogance, fundamental lack of knowledge, skills and education, a pervasive belief in entitlement and autocratic behaviours resulting in endullment." (Mackie et al, 2006; p. 130). Endullment was defined as the opposite of empowerment. Important elements in the solution include ethical leadership, utilization of external ethics expertise, internal ethics mechanisms (including hiring, performance evaluations, education and reinforcement practices reflective of ethical conduct), ethical external engagement/ partnering and ongoing evaluation and reporting of ethical conduct (Mackie et al, 2006).

There has been only an indirect examination of the impact of the perverse incentives of the academic tenure and promotion system and the differences between desired outcomes of the University or Health Centre as organizations and the individual researcher or worker on the quality of the research or work produced and the emphasis of that research or work (Wicks, 2004). The prestige of the University and Health Centre often are intertwined with the number of publications produced and the number of research dollars attracted (Downie, 2009).

Inherent in the day-to-day activities of clinicians is the unavoidable conflict of interest in the time and attention paid to patient A versus patient B or group A or B of patients. This conflict is ubiquitous, often unconsciously unheeded; often a source of work related stress.

7. Can the policy/ process, etc be replaced with a simple rule (and Standard Operating Procedure)?

A simple rule might be to ask:

- Have I considered how this action/ decision of mine might be biased or influenced by the action of the other to favour me rather than to accomplish my role?
- Would I print an account of my actions on the front page of the newspaper?

Conflicts of interest are ubiquitous and common. Four simple rules to mitigate conflicts of interest are:

- If a conflict of interest or potential conflict of interest exists, disclose it to involved others before any action or decision that might be affected is taken.
- If uncertain whether a conflict of interest is present, disclose the concern to another in a position to guide you.
- If concerned about your or others' actions/ decisions, engage in dialogue to increase mutual understanding.
- Understand that disclosure may not be enough and the root causes of the conflict must be addressed.

In all circumstances, individuals must choose the path (decision/ action) that maximizes the health outcomes of individuals and populations within the Health Centre's mandate. Dak, 2002, stated that a

(p)otential conflict of interest exists whenever a neutral observer might question whether a personal gain might undermine an employee's (or Board member's or member of Medical, Dental and Scientific Staff's) ability to be objective in his or her job duties. The key elements in the anatomy of a conflict are: personal gain that results from *direct* and *predictable participation*, with the potential to *compromise objectivity*. (p. 8)(bracketed insert added; italics as in original).

The use of a systems lens might have illuminated the many interconnections and interdependencies entwined in understanding conflicts of interest.

Analysis of this policy through the trifocal lenses of feminist theory, critical social theory and systems theory amply demonstrates that a significantly different policy might have been created through consideration of the thus expanded view.

CHAPTER 5 INTERVIEW METHODS

5.1 BACKGROUND

As with words, pictures are socially constructed and interpreted (Banks, 2001). Photographs have long been used in studies of people, populations and environments. The "hybrid photo-image-text...(opens) new spaces for dialogue, resistance, and representation of a new way of knowing that changes the way of seeing and has the potential to change...understanding." (Kirova, Emme, 2008). "Photographs are signs which bear an iconic resemblance to the reality they represent." (Emmison, Smith, 2000; p. 3), yet are able to "communicate the intangible aspects of cultures which previous, purely verbal renditions...fail to capture." (p. 31). The photographer and the viewer contribute to the meaning of any picture. The photographer expresses her or his viewpoint through the subject chosen, its framing and context. The viewer brings her or his history and life experiences to any interpretation. Five ways of utilizing photography in research include use of photographs to stimulate conversations (photo-elicitation); to systematically record or document a subject or phenomenon (photo-documentation); to use the images to provide data for analysis (composition, subject etc); to have study participants take their own photographs for dialogue (photo-voice); and narrative visual exploration of social interactions (photo-novella)(Emmison, Smith, 2000). The use of photography is one way that individuals can reflect and visualize how life might be thus leading to changes in perception, increased confidence, renewed aspirations, recognition of social capital and stronger relationships between community and authorities (Purcell, 2009). Examination of photographs can help to expose unconscious values, biases and assumptions (Killion, 2001). Photographs can be used to engender dialogue about the determinants of health- for example, spirituality and sense of purpose using photographs of places of worship; cultural integrity through photographs of culture specific meeting places; and education through photographs of schools and libraries.

Photo-documentation has a long history in social research, where the researcher is the photographer and seeks to create images to illustrate and/ or record circumstances. Such documentation is itself socially constructed (Banks, 2001), recording only a particular moment in time, framed by an individual perspective. Documentary photography is rarely

performed from the perspective of the community members involved. Some researchers supplement the photographs with copious notes of the context (technical and social) surrounding the taking of the picture. Photo-documentation is used to capture the wholeness of an observation, or information that is difficult to portray in words or is too evanescent to describe (Emmison, Smith, 2000). Photo-documentation has been used to supplement community resource mapping. Taking photographs permits the researcher to view a neighbourhood in a manner that is usually socially acceptable and accepted (Pink, 2001). Including participant photographers, along with the researcher, has been very effective in capturing "life in the city" (Moore et al, 2008).

In **photo-elicitation**, the photographs are used to prompt thoughts and conversation between the viewer and the researcher.

> Specific examples of social relations or cultural form depicted in the photographs can become the basis for a discussion of broader abstractions and generalities; conversely, vague memories can be given sharpness and focus, unleashing a flood of detail... (T)he awkwardness that an interviewee may feel from being put on the spot and grilled by the interviewer can be lessened by the presence of photographs to discuss. (Banks, 2001; p. 88).

The photographs themselves are not specifically analysed, rather used for reflection or as interview stimuli to generate memories and sense-making (Emmison, Smith, 2000). The images are chosen by the researcher with the expectation that they will have significance for the study participants. In essence, the researcher brackets, through choice of what to photograph and then what to present to study participants, consciously or unconsciously, that which is ignored, omitted or included. In **photo-feedback**, participants are invited to respond by writing their feelings about and answers to questions related to the photographs (Sampson-Cordle, 2001). This approach is felt to reduce feelings of vulnerability that participants may have with a formal interview, yet it may limit the richness that an interview can provide. In **photo-interviewing**, the photographs are utilized as prompts for conversation, supplemented with semi-structured interview questions. Sampson-Cordle, 2001, cautioned the researcher to be sensitive to variations in an individual's ability to problem-solve or interpret photographs, to the vulnerability of the participant related to controlling of the interview and to the question of accuracy of

the photographs as representations of community or individual life. For this study, the photographs were used as a trigger for conversations rather than an in-depth dialogue about the actual photograph itself. The interviewee largely directed the conversation with minimal guidance by the researcher.

Photo-voice was developed by Wang and colleagues as a methodology under-pinned by Paulo Freire's contention that all human beings are capable of critically perceiving the world through dialogue with others and his belief in the power of a visual image to elicit critical thinking about one's life; feminist theory of power accruing to "those who have voice, set language, make history, and participate in decisions" (p. 561); and community-based context inclusive of all peoples (Wang, Redwood-Jones, 2001). Photo-voice can be used "to enable people to record and reflect community strengths and concerns; to promote critical dialogue and knowledge about personal and community issues; and *to reach policymakers.*" (emphasis added)(Wang, Burris, 1997; p. 369).

Photo-voice is a vehicle through which vulnerable, marginalized or underserved populations can gain the power to express their views and generate change. Photo-voice can effectively balance power, create a sense of ownership, foster trust, build capacity and respond to cultural preferences (Castleden et al, 2008). The approach to photo-voice as described by Wang, Burris, 1997, is a variation of community based participatory research and the process is guided by a facilitator. A group of community participants come together to examine a particular scenario. It includes participants taking photographs to reflect their view, selection of photographs (choosing those that most accurately or importantly reflect the scenario as determined by each participant photographer), both the participant photographer and members of the group discussing the photographs (contextualizing, story-telling), and codifying the photographs to identify themes, theories and issues. These in turn are used to enable policy makers to visualize the scenarios as seen through the eyes of community members so that better approaches to improvement can be made.

This study used the process of **photo-elicitation/ interview**. Participants in Component 2 of this study responded to photographs taken by the researcher and participants in Component 3 to photographs they themselves took. This approach was taken as **photo-voice** is essentially a variant of community-based participatory research which was beyond the resources of the present researcher.
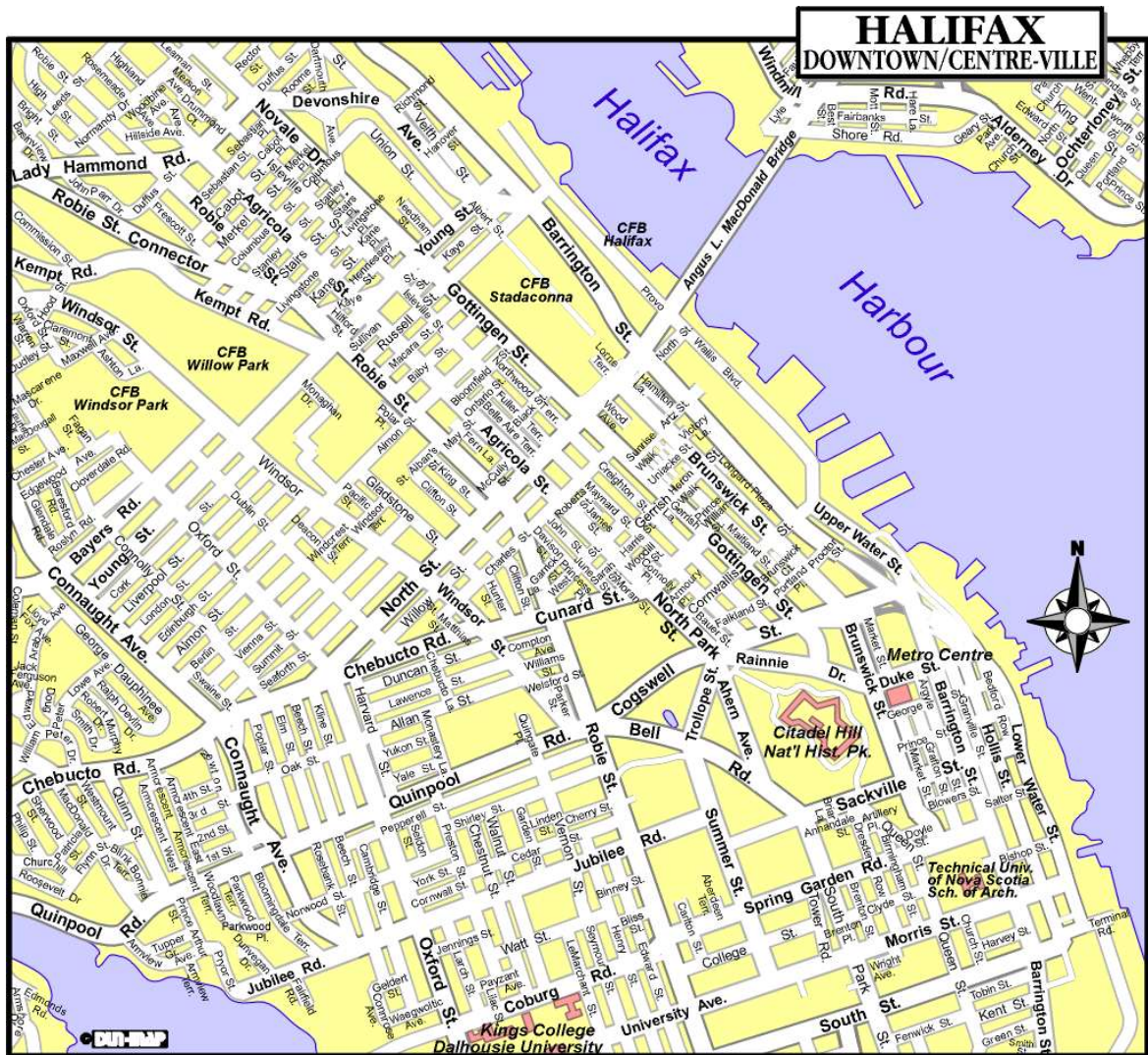
Public Works and Government Services Canada (www.pwgsc.ca)

I chose to study and photograph an area of Halifax (bounded by North, Robie, Cogswell and Barrington Streets) as a specific geographically defined area reflecting many of the challenges people face in achieving health. Through the medium of photography and by concentrating on this Halifax community, I hoped to be able to learn about "the interconnected and multi-level nature of the social issues operating within (the) area" (Nowell et al, 2006) and its health-related environment. Connections explored included

"social connections (kin/ friends), functional connections (production, consumption, transference of goods and services), cultural connections (religion, tradition, ethnicity), and circumstantial connections (economic status or lifestyle)." (Nicotera, 2007).

5.2   STUDY ASSUMPTIONS AND HYPOTHESIS

The major assumption for this of the study was the premise that by viewing through the eyes and listening to the words of North End Halifax community members, I would be led to a greater understanding of the health and health care environment of the community and that understanding could enable me to posit an alternate approach to achieving a healthy community.

My hypothesis was that viewing the interview data through the three lenses would enhance my ability to better see the information contained in the interviews.

5.3   STUDY LIMITATIONS

The study was limited through my biases - some self-recognized and others likely subconscious and unrecognized - in my construction, execution and interpretation of the study. In addition, the participants in this study can only reflect a fraction of the views and potential contributions of the North End community members. Indeed, the participants are likely unrepresentative of the community yet their input enabled a richer understanding of the health and healthcare environment of North End Halifax. I came to the study with the belief that there were resources within the North End Halifax community that could be built on to increase that community's health. This was not based on any true knowledge of the neighbourhood but rather a profound, innate belief that with appropriate lenses the potential to enhance the good and right can be found in any situation. Other than that belief, and years of working as a health professional and living within the greater Halifax region, I came with a curious and open mind knowing the depth of my ignorance about the community, seeking to find elements on which improvements could be built. So in keeping with a grounded theory approach, I did not have any preconceived notions about what those elements might be. There were constraints on taking pictures with identifiable people. Although some pictures of people

were taken with their permission, many scenes that captured life in the streets of North End Halifax were not able to be photographed for the purposes of this study. Photographs without the input of the photographer (and sometimes even with that input) can only portray a surface view.

In addition, my thoughts and perspectives were influenced by coincidental experiences during the time of my PhD studies - travel through China, volunteer work in Cambodia, the attainment of a graduate certificate in Health Leadership from Royal Roads University (particularly from the course Building Sustainable Communities), volunteer work at the North End Community Health Clinic, participation on the Health Centre Diversity and Inclusion Committee, chairing the Health Centre Workplace United Way Campaign (and the chance to visit neighbourhoods through the eyes of United Way sponsored agencies/ individuals) as well as work related to global health, Board policies, best practices in ambulatory care and co-leadership model development at the Health Centre. Over time I became more familiar with the sights, sounds, smells, tastes and feel of North End Halifax in both a metaphysical and physical way.

5.4   STUDY DESCRIPTION

5.4.1   Study Outline
  o **Component 1**- photographs of the North End Halifax community- environment
  o **Component 2**- photographs to elicit stories from people of North End Halifax
  o **Component 3**- photographs taken by people of North End Halifax and their stories

a. **Component 1:**

Documentary photography has been used as one measure or description of neighbourhoods (Nicotera, 2007) and organizations (Dowdall, Golden, 1989). To provide a focus around which to conduct interviews, I was the photographer in this component. In the photographs taken, I attempted to capture aspects of all public places…houses, non-governmental organizations, services, libraries, gardens, businesses, transportation, shelters and recreation spaces for example. The images were obtained by walking through

the neighbourhood. Emphasis was placed on obtaining pictures that illustrated health-related environmental factors (health determinants) and highlight strengths of the neighbourhood. These photographs did not contain identifiable individuals. These and other photographs could contribute to a compilation of a North End Halifax Community Asset Map (Kretzmann, McKnight, 1993; McKnight, Kretzmann, 1996), a method that emphasizes a community's strengths. It is hoped that any researcher biases related to the photographs taken were countered by the next two steps which involved community members - through their comments on the photographs chosen for conversation in Component 2 and through subjects chosen to photograph and discuss in Component 3. Magilvy et al, 1992, approached their study of home care for rural elderly by first documenting the rural settings through photographs taken by the researchers, then, as they became more familiar with community members, they increasingly involved local citizens in obtaining and interpreting pictures.

b. Component 2:

As quoted by Moffitt and Vollman, 2004, "Melies (1996) suggests that a true understanding of the health and illness status of a group can result only from the group's own knowledge concerning its values, priorities, responses to life's disruptions, perceptions of health, help-seeking behaviours, and contexts in which people live." One way to attain that understanding is through community member interpretation of photographs. Photo-elicitation (Harper, 2002), is an approach where photographs are used as "triggers during interviews to promote dialogue" which is recorded, transcribed and analysed (Oliffe et al, 2008). It can enable participants to more freely express their thoughts and tell about their experiences (Magilvy et al, 1992). Participants have a chance to determine what becomes visible (Warren, 2005). The photographs obtained in Component 1 were used in conversation with a spectrum of community members.

c. Component 3:

According to Wang, 1999, photo-voice is a methodology that allows participants to visually record aspects of their lives from their own perspective, to highlight issues in which they take pride or have concern, and to catalogue information for influencing

policy. These components of photo-voice were captured in component 3. Unfortunately, the full photo-voice approach as described above was unable to be carried out in this study (basically a variation of community-based participatory action research). Rather, community member participants took photographs and these were used as prompts in conversation with the researcher. The researcher amalgamated the information obtained from all participants in a document designed to help portray issues as viewed through the eyes of community members.

5.4.2 Questions Addressed Through the Study

a. Can the medium of photography help to elucidate community assets for building better health?

b. Can the viewpoints of community members be leveraged to illustrate a new pathway for community health that can be communicated to policy and decision makers?

c. Can viewing the data obtained from the photo-elicitation/ interviews through the trifocal lenses of feminist, critical social and systems theory change and/ or broaden the understanding obtained without the use of such lenses?

5.4.3 Objectives of the Study

The objectives of the study were:

1. through the medium of photography and grounded theory analyses of study participant interviews, to better understand the access to health for North End Halifax community members (a community whose members include populations challenged by health inequities); and

2. to determine if the use of the three lenses as a component of the grounded theory analyses would provide a greater depth of understanding of issues related to access to health for North End Halifax community members.

This study had the potential to elicit an understanding of the health-related environment of North End Halifax in a different way thus, perhaps, leading to different approaches to redress health inequities.

5.4.4 Seeking Study Participants

For both Component 2 and 3, a minimum of six participants were sought. Those participating in Component 2 did not participate in Component 3. This number was felt to both be feasible and to provide meaningful data. As the data were continuously analyzed in keeping with a grounded theory approach, additional participants were sought to achieve saturation as needed. I attempted to recruit participants that mirrored the population of the area of North End Halifax being studied. Study participants were not remunerated for their participation; travel expenses related to the interview were covered.

5.4.5 Selecting Study Participants

Participants in the face-to-face interviews were chosen for their ability to deepen my understanding with respect to the questions being studied. It was hoped that a broad representation of community members would be able to participate…those living with poverty, long term community members, recent immigrants, persons of influence within the community, those who are physically well and those with chronic illness, those who are well educated and those who are not. The target age range spanned from youth to the elderly. As there was no funding available for translation/ interpreter services, participants were required to be able to communicate in English. Participants did not have significant visual impairment. There were no other specific exclusion criteria.

5.4.6 Contacting Study Participants

The initial participants were purposefully recruited through community members (who were not involved in the research study) known to the investigator (business persons, health professionals, friends of friends). Further participants were identified and recruited through "word-of-mouth" and information posters. These community members were provided with materials explaining the study in general and obtained oral permission for the investigator to contact the potential participant to further explain the study and obtain consent to study participation.

5.4.7   Study Participants

The sample for this study included seventeen individuals. No specific demographic information was obtained from the interviewees. They came from a wide variety of backgrounds including academic, professional, business, disabled and homeless. They included those who were impoverished, heterosexual, homosexual, politician and community organizers as well as people from the African Nova Scotian and Aboriginal Nova Scotian communities. They included both women and men from ages mid-twenties to early sixties. Some were members of specific organizations, but all participated in the interviews as individuals and not as representatives of any organization. All except one worked and/ or lived in North End Halifax. The health professionals worked with North End Community Health Clinic and their partners; there was representation from Mobile Outreach Street Health (MOSH). The interviews took place at a location of the interviewee's choice - in their home, their office, the North End Community Health Clinic and in my office. Although interviewing participants in my office might have been problematic with respect to implied positional differences, this did not appear to affect the conversations…perhaps because my office is a glorified closet and it was the participant's choice to come there.

5.4.8   Study Participant Involvement

a. Component 1

For component 1, I took photographs that were catalogued, described and grouped according to themes that emerged from the review of the photographs. I kept a detailed diary on the photographs as they were taken. The photographs were stored on a CD-ROM. Some images were enlarged for public display. Fifty were available as prints for use during interviews as described under Component 2. The fifty prints chosen I felt were reflective of aspects of the health-related environment of the neighbourhood. It is understood that, for this component, both the choice of what to photograph and the final choices of the photographs to be used in component 2 were affected by my viewpoints and knowledge (Killion, 2001).

b. Component 2

Individuals for participation were chosen through purposive sampling/ convenience sampling and snowball identification to address gaps in the information obtained through prior interviews (theoretical sampling). The number of participants approached was determined by the perceived "saturation" of the information gleaned (Glaser, 1992). Eleven individuals consented to participate in interviews.

After appropriate consent was obtained, the participant was given about 10 minutes in which to review the 50 photographs from Component 1 and choose 10 for dialogue. As the interviews were expected to last around one hour, choosing 10 photographs for conversation was felt to allow sufficient but not excessive time for each photograph. After clarification by the researcher of any questions about the photographs, the participant was asked 'Why did you choose this particular photograph?' and 'What does this photograph mean to you?'. Participant interviews were digitally recorded, professionally transcribed verbatim and analyzed using a grounded theory approach. The transcriptionist signed a Pledge of Confidentiality prior to receiving the audio discs for transcribing. Following transcription and verification, the discs were stored in a locked cupboard at the Health Centre to be kept for 5 years and then destroyed.

c. Component 3

Six individuals consented to participate. These participants were required to donate more of their time than those who participated in Component 2. Participants were provided with two disposable cameras - one for color photos and the other for black & white photos. I felt that taking a photograph that will be developed as black & white forces the photographer to look with a different perspective and alternate emotions might be evoked by the pictures themselves, as has been documented by McIntyre, 2003. The participant was asked to photograph, over a two week period, images that illustrated to her/ him health-related environmental factors that could be built on to improve the health of community members. One camera (27-exposure disposable Black's[R] camera) was labelled color and the second 27-exposure disposable Black's[R] camera was labelled black & white. The photographs were taken any time of day. No statement was made to

participants about the number of pictures they were expected to take. The number of photographs taken varied from 20 to 54. All but one of the cameras was returned for development of the pictures and a copy of each of her/ his pictures was given to the participant. These were brought to the interview and the participant was asked to choose seven black & white and seven color photographs for conversation. In contrast to Component 2, it was expected that participants would have thought about the photographs beforehand and would also be eager to speak about as many of their photographs as possible, thus the reason for fourteen photographs in total. For both component 2 and 3, the numbers as planned usually fit well with the predicted interview length. Some wishing and able to converse longer either had more to say about each photograph or chose to talk about more than the suggested number.

5.5   ETHICAL CONSIDERATIONS RELATED TO PHOTOGRAPHS

Fang and Ellwein, 1990, enumerated several ethical considerations for the use of photographs in research.

1. Confidentiality: In addition to the usual attention to confidentiality, the storage and destruction of photographs was important. For this research, the photographs were stored on CD-ROM and kept in a locked cupboard when not being used. Only photographs where consent was obtained or where the photographs did not contain identifying information about individuals were used for either publication in any form or for conversation with community members.

2. Informed consent: during the informed consent process, participants were made aware that any photographs of individuals would only be used after obtaining consent and after the individual saw the photograph as it would be used. With respect to photographs taken by community participants, they were only used in accordance with the participant's wishes and with his/ her consent. Participants were given a copy of all photographs they took; the original was retained by the researcher. There was no financial remuneration from the researcher to the participant for the photographs.

3. Informant reactions: as participants might have had unexpected reactions to the photographs, the researcher endeavoured to present the research and the

photographs in a manner sensitive to the individual's situation. Participants were able to choose the photographs they wished to discuss.

4. Corresponding narrative: Explanatory information about the photographs was given to participants in Component 2 to situate the photograph in context.

5. Conceptual control of the researcher: The photographs were chosen so that they should not harm participants or the community/ community members in any way.

Every effort was made to avoid intrusion into individual's private space, to disclose embarrassing or potentially harmful facts about individuals, to place individuals in a false light through alterations of the photographs or to use the photograph in a way that resulted in depriving the individual of commercial benefit (Wang, Redwood-Jones, 2001). The informed consent processes addressed the ethical concerns and information needs identified by Wang and Redwood-Jones, 2001. Participants in component 3 were given a handout that explained the project to share with any individuals they included in their photographs.

Verbal informed consent to be contacted by the investigator was obtained by the community member from potential participants. Most then contacted the researcher directly themselves. Written informed consent to participate in the study was obtained by the investigator in a face-to-face meeting with potential participants. There were three separate consents - one for consent to participate in the study; one for use by participants to solicit permission to photograph people and one for consent by the photographer (and/ or the subject) to publish the photograph.

5.6   RESEARCH INSTRUMENTS

The photographs were an essential research instrument, used as described above. A semi-structured interview guide was used. After I answered any questions, the participant was asked 'Why did you choose this particular photograph for conversation?' or 'Why did you choose to photograph this particular subject?' and 'What does this photograph mean to you?'. Participant interviews were analyzed using a grounded theory approach.

5.7   DATA ANALYSIS

Information obtained was examined using a grounded theory method (Glaser, 1992). By using this method, the theory about the particular area being researched emerges from the data as the data are collected; an inductive process rather than an examination of an a priori hypothesis or theory (Glaser, 1978). In later writings, Glaser (2001) stressed that grounded theory was not a description of or about the data collected, but rather strived to explicate the behaviours in the area under study from the generated data-derived concepts. One challenge with adopting the triple lens theory paradigm was its place in grounded theory as a methodology/ method. In general, grounded theory is a methodology/ method utilized to generate hypotheses, most often within a post-positivist paradigm. Detractors of the use of grounded theory from a critical theory view state that it does not facilitate examination of many aspects of social interactions and the factors that impact them or power relations. Others claimed that these considerations have been incorporated by more recent researchers (MacDonald, 2001). Grounded theory has been used within a feminist research framework (for example, Keddy et al, 1996; Wuest, Merritt-Gray, 2001) and a critical feminist framework (Kushner, Morrow, 2003).

Distinctions among criteria, concepts, etc contained in the data are earned through examination and not received from previous learnings or wisdom. Glaser felt that through pursuit of answers using grounded theory, the researcher was a crucial and integral component of the generation of the theory from the data because of the particular individual characteristics she or he brought to the research (Glaser, 1978). Although the researcher must approach the research with as few preconceived ideas as possible, it is understood that the researcher brings to the analyses her or his own particular knowledge, skill and expertise that assist in the development of concepts from the data.

In order for developed theories to be useful, Glaser, 1978, felt the theory must have fit, relevance, work and modifiability. By this he meant the categories determined must be congruent with the data (fit or validity), have *relevance* as created through the process of data examination to resonate with a reader's thoughts and highlight the importance within the substantive area, can explicate the past and predict the future in a way that is

understandable and plausible in accounting for how the main concerns of participants related to the area of interest are resolved (work) and are adjustable to a new theory as further data are obtained (modifiability). In order to undertake grounded theory research, the researcher must have the ability to distance her or himself from the analyses, expect clarity to be initially illusive, know that reiteration will be required, and remain open to the evolution of the theory (theoretical sensitivity)(Glaser, Holton, 2004). Researchers are cautioned about using their prior experience to attempt to fit the data into any preconceptions.

Within the context of grounded theory, the presence or absence of a variable can be considered as merely a point on the spectrum of that variable. The core variable accounting for the variation around the area of interest can be a process, condition, dimension, consequence or range that integrates the theory so it becomes dense and saturated (Glaser, Holton, 2004).

The place, phase(s) and pace of literature reading differ significantly from quantitative research (and other qualitative research approaches). Glaser (1978) recommended collection of data first, followed by data analyses and theory generation. Review of the literature relevant to the field under study comes after the theory is "sufficiently grounded and developed." (p. 31). This sequencing is designed to avoid pre-emptive, preconceived concepts influencing the researcher's contribution to new knowledge and understanding. In grounded theory, one does not start with a problem, but rather an area of interest and the "problem" becomes defined by the participants/ those involved from whom information is obtained (Glaser, 1992). He suggested that literature review was best utilized during sorting and writing, where found ideas can be connected with the researcher's emergent theory. However reading of unrelated literature was encouraged throughout the process - to increase one's foundation of ideas in general, style, models, integrative schemes, etc. According to Strauss and Corbin, 1998, the literature review was to stimulate thinking about properties or dimensions to best obtain the varied meanings and interpretations of events, relationships, actions and objects to build variation into the theory. However, they cautioned that it must be the research

146

participants' perception of the events, relationships, actions or objects that matter, not those of the researcher.

The interviews were examined as soon as they were transcribed. Each line of the interview was analyzed by hand and given an open code ("coding the data every way possible." [Glaser, 1978, p. 56]) to capture the essence of that sentence. Coding using no particular lenses was done first, followed by the feminist theory lens, the critical social theory lens and the systems theory lens. These codes and the content of the interviews were constantly compared - initially incidents compared to incidents; then generated concepts compared to incidents and finally concepts to concepts to generate properties as per Glaser, 1978. Open coding was performed on all the interviews, but as the interviews proceeded, fewer and fewer new codes were generated. Later interviewees were chosen to expand ideas brought out in earlier interviews (theoretical sampling)(Glaser, Strauss, 1967). By the seventeenth interview, the coding and emerging categories and concepts appeared saturated (provided a complete picture)(Glaser, 1978). Several hundred codes were generated from the seventeen interviews.

The open and in vivo codes were grouped into larger categories to create second level or selective coding. Within selective coding, the initial open codes were seen to be expressions of an underlying pattern (Glaser, 1978; p. 55). In turn, these selective codes were clustered under theoretical codes that begin to give rise to concepts of how these elements could be related through a hypothesis to address the research question (Glaser, 1978; p. 57). The complexities of the research question resulted in an eventual overall concept that involved a fourth level of grouping into categories or concepts. Throughout the processes of interview analysis and coding, notes and theoretical memos were written. In the notes, ideas generated by the interview content were recorded. Theoretical memoing, which included notes, diagrams and hand-written ideas, were the means through which the codes and categories emerged into a hypothesis or core variable. As with the notes, theoretic memoing began with the first interview and continued past data collection. Although only a limited number of type-written memos were generated, many hand written notes and drawings were used. This iterative process of interviewing, coding

147

and memoing proceeded until a core variable or basic social process emerged from the data. Following the discovery of the core variable, all elements and properties previously identified were reviewed for congruence with that core variable. For each of the four approaches, I developed the concept map prior to examining the literature. In writing up the analyses, I have woven applicable literature and interview quotes into the discussion of the core variables and concepts.

The study was stopped when the area under examination was explained with the fewest concepts and greatest scope. The thematic analysis using memos and coding performed on the information from the photographs and interviews was situated within the framework of the thematic analysis of the literature review (Miller, Crabtree, 2005). The data obtained from the photographs and the interviews were repeatedly reviewed, compared and contrasted to gain the best understanding of the information and to synthesize the results. Information obtained from the photographs and interviews was reported both through the analysis and the use of direct quotations.

Each participant's portfolio (transcript of interview, photos taken [if applicable], photos used in interview and my impressions) was assembled as it become available. Data analysis was carried out as soon as all components of a participant's portfolio were complete. These analyses were supplemented by conversations with colleagues, individuals affiliated with the community and professionals experienced in health and health care of underserved populations.

Process rigor for the study was achieved through my documenting, prior to initiating the interview process, my inherent biases and expectations of the study outcomes (Thorne et al, 1997). As suggested by Thorne et al, 1997, a reflective journal was kept to document the "reactive processes of interpreting or countering bias within the research process". A record of field notes linked to the issues under study was maintained. Through repeated interviewing, emerging concepts or themes were challenged and refined. Confirmation of the trustworthiness, credibility and dependability of the study results was sought through comparison with published literature and an audit trial of my progress through the data

analysis (Creswell, 1998). As per Glaser's guidance (2002), member checking of the interpretations and theory was not performed.

> Inviting participants to review the theory for whether or not it is their voice is wrong as a "check" or "test" on validity. They may or may not understand the theory, or even like the theory if they do not understand it…GT (grounded theory) is not their voice: it is a generated abstraction from their doings and their meanings that are taken as data for the conceptual generation. (p. 5).

In addition, this research study was based on an appreciative inquiry approach. Moore and Charvat, 2007, describe eight principles of appreciative inquiry.

> In every society, organization, or group, something works; what is focused on becomes the reality of the organization; the language used creates the reality; the reality is created in the moment, and there are multiple realities; the act of asking questions of an organization or group influences the group in some way; people have more confidence and comfort to journey to the future when they carry forward parts of the past; if we carry parts of the past forward, they should be what is best about the past; and it is important to value differences. (p. S65).

Appreciative inquiry was built on the theories of social constructivism and positive imaging (Watkins, Mohr, 2001).

Figure 2   Grounded Theory Approach Schema (Glaser, Holton, 2004)
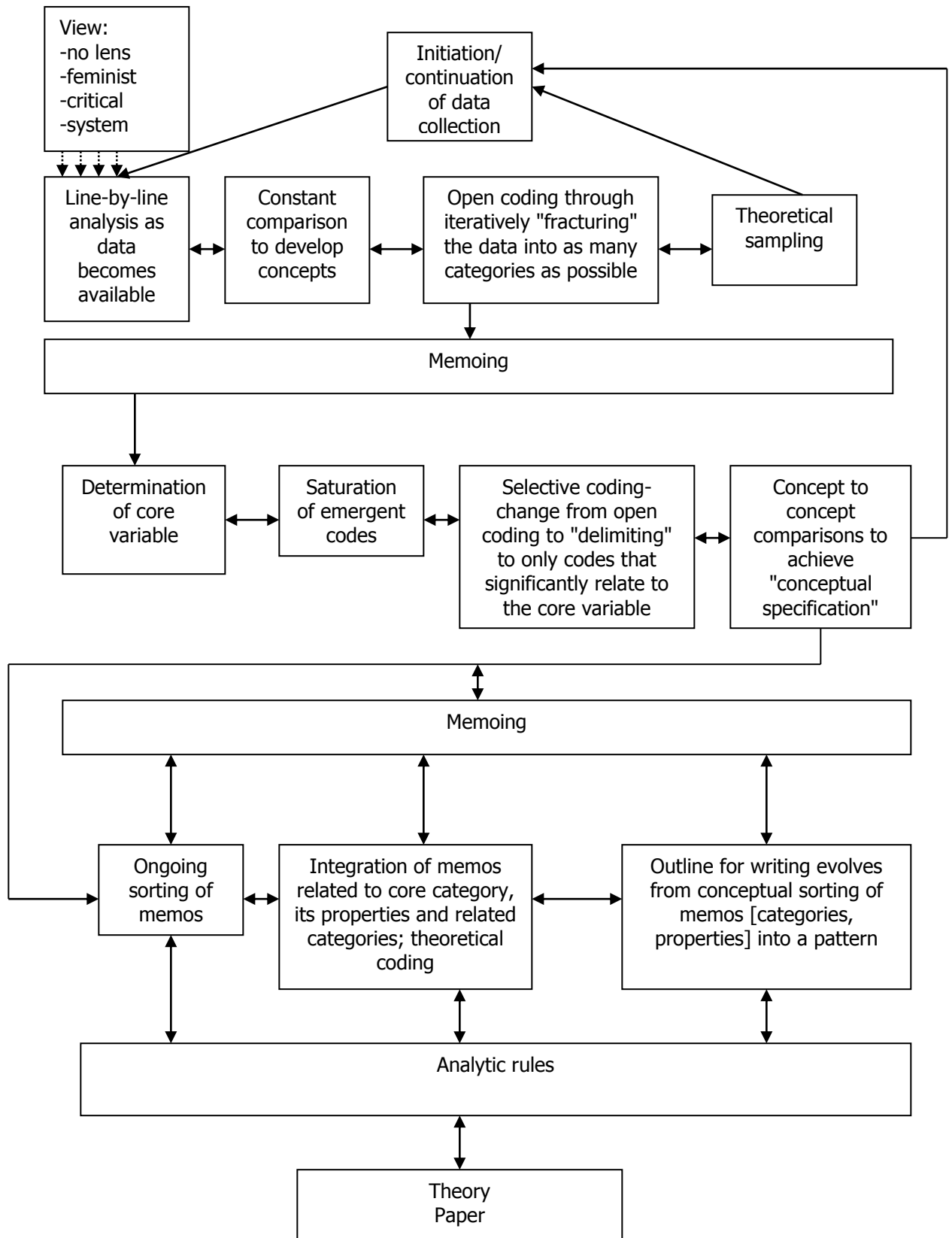
CHAPTER 6 INTERVIEW ANALYSES- NO PARTICULAR LENS

6.1 INTRODUCTION

The major focus of this part of the thesis research was to determine if visioning data through different lenses might improve data mining and thus expand the understanding of present circumstances to provide insight for pathways towards a healthier future for the North End Halifax community. Each of the seventeen interviews was analysed using grounded theory methodology, first without a particular lens and then through a feminist theory lens, a critical social theory lens and a systems theory lens.

Two frameworks (confidence in the innate assets and resourcefulness of North Enders, and the ability of different lenses to widen viewpoints) become intertwined in the analyses of the study interviews. The analyses are presented sequentially, beginning with the analyses done without a particular (conscious) lens (this Chapter), then through the feminist (Chapter 7), critical social (Chapter 8) and systems theory lenses (Chapter 9). The similarities and differences in the analyses are discussed in Chapter 10. In Chapter 11, conclusions from the examination of the Health Centre policies and the participant interviews are presented and consolidated. For ease of following the analyses, the interview quotes were italicized; (...) indicates a section of the interview that was omitted (usually in the interest of brevity). I tried not to repeat quotes from the interviews and instead used another's input for similar issues. The following quote gives an overview glimpse of the community of North End Halifax.

> *So, in many ways, as somebody who lives here and who has worked here for a long time, I feel totally blessed. I love this constituency, this community. It's just powerful. It's powerful in terms of these organizations and the people who make these organizations what they are. I think that this community is very resilient and it's resilient because of all of those… the things you have in those photos and what they represent. It's a resilient community. Could it be better? Yeah, but we have a ton to build on here. Absolutely.* (community member)

The following photo and quote epitomized for me the potential for healthy development in North End Halifax.

> *It's a mural called "United we shine". Yeah, well 'cause that neighbourhood has a very negative stereotype and here you come and now, hidden away, you know, under someone's porch is this beautiful mural and lovely, lovely little verse that*

says "UNITED WE SHINE. Our community is made up of its members. And its members are as vibrant as the colors on this wall. We must look forward to the future. Our eyes are on our young. The old must lead the new, so together WE ARE ONE." And there is a rainbow outline and it looks like, you know, the people themselves must have stood against the, stood against the wall and outlined themselves. (community member)

(photograph by participant #3)

6.1.1   Value of Using Photographs

For me, the use of photographs in the study participant interviews was invaluable. They enabled a degree of comfort for both me and the study participants. They facilitated free flowing conversations and helped to focus the dialogue. I believe they contributed significantly to the eventual vibrancy and richness of the interviews. Some participants could not resist and talked about more than the initially planned number of pictures. Individuals who had participated in Component #3 (taking their own pictures) were especially reluctant to converse about only a selection of their photographs and I, also, had curiosity about each one taken. Some were very articulate about why they took a particular picture.

I wanted to somehow… I wanted to make myself part of this. I've got these 14 photographs and I wanted to have things in the neighbourhood that have to do with my health or my idea of optimal health care. And for me one of them has to be being able to walk around in my own community, which I do a lot of. I'll walk anywhere in my community 24/7. I figure you can get in a heap of trouble anywhere, anytime, and I just don't ever want to not walk around my neighbourhood. Some pretty tremendous shit would have to go down before I would say, "oooh, I'm staying home after dark." And walking is important. It's very

important to me to reduce my stress which, you know, is never done successfully enough, to reduce my anxiety which is never done successfully enough. And as a form of exercise it's right at the top of the heap because a) it's something we do naturally and b) it's free. And so my walking is, that's why I took this picture of my right foot, me walking in my neighbourhood is a huge part of my, what I consider to be part of my healthcare. (community member)

(photograph by participant #1)

6.1.2   Presentation of Results

For each of the four grounded theory analyses of the interviews, I first give a brief description of the themes and basic social processes as they emerged from the data. This is followed by a concept map illustrating the overview. Both the overview and the concept map were developed prior to in-depth review of the literature. I then present each of the components, starting with the basic social process and then supporting themes, threading together interview quotes, pictures, discourse and literature to create a tapestry of my interpretation of the results. Because there were themes in common among the four analyses, to decrease repetition detailed discussion was presented only once (e.g. food security). *Please note,* the photographs and the interview excerpt given previous to or following it are not necessarily provided by the same individual.

6.2 GROUNDED THEORY ANALYSIS - NO PARTICULAR LENS

(North End Community Garden; photo by participant #2)

Using grounded theory methodology (no specific lens) to examine the interview data, *from othering to togethering* was identified as a basic social process for the achievement of health for North End Halifax community members. Embedded within *othering to togethering* is moving from seeing each other as us or them; as dissimilar rather than as a diverse group of people with many interests and needs, able to work together towards common goals. Six components of *from othering to togethering* evolved from the data - **seeking a foundation of security for all** requires fundamental changes in approaches to resource allocation, **communicating to understand** will help us to live and work together, **desegregating segregations** recognizes the barriers between groups and the imperative to breach these barriers, **seeing North Enders as citizens** emphasizes the value and responsibilities we all have to enable health for community members, **promulgating housing as a key to health** becomes a way to create a thriving neighbourhood, **creating a new future on community strengths** provides the foundation and building blocks for improvement efforts. These linkages are illustrated in **Figure 3**.

Figure 3   Concept Map- No Particular Lens

Including determinants of health approach

Adopting a stance of basic rights   Seeking a foundation of security for all

Calling for food security

Using boundary objects

Image making   Communicating to understand

Gathering places

Exposing divisions

Understanding impacts   Desegregating segregation

Removing separations

From othering to togethering

Seeing North Enders as citizens

Adjusting our views

Enabling participation

Promulgating housing as a key to health

Sheltering

Affordable safe housing

Neighbourhood

Built environment

Creating a new future on community strengths

Community heritage

Community diversity

Community accomplishments

Community children and youth

6.3   FROM OTHERING TO TOGETHERING

Historically, othering has been a means for justifying and maintaining existing power relationships. Othering can mean separation and implies superiority of one group (or individual) over another. In her dissertation study, Etowa, 2005, found *othering* to be a component of the concept of *discovering* where Black nurses perceived they were deemed inferior. The other can be exotic, exciting, different or just not like me (MacNaughton, Davis, 2001). Othering tends to homogenize people into groups or categories (Young, 2010).

> Cultural psychologist Ernest Boesch (2007) argues that there is no other, but in fact " 'other' simply means not like I" and that "There is no other without an 'I' " (p. 5). Further, he says that our images of "others" are not consistent, but continually changing as we come to know one another in various ways and in multiple contexts. Boesch contends that throughout our identity development, the increasing body of experiences with others "refines" our understandings of who they are and why they think and act as they do in relation to us. He calls this the development of empathy for those whom we see as others. (Gomez, White, 2010; p. 1016).

Thus, in the above sense, othering is necessary to prevent the unthinking belief (and consequent associated actions, behaviours and attitudes) of sameness (as embodied in the White, middle class worldview). Study participants tended to view othering as separating, segregating and sitgmatizing. However, shifting that view towards seeing othering as a step towards greater understanding of each other and the uniqueness of all people, can help achieve togethering as a way of moving forward. The idea of togethering, as it

155

evolved from the interview analyses, seemed to be a way of collaborating and identifying with the larger North End community; a way of honouring diversity and achieving inclusiveness; a way of seeing health and access to health as a community issue rather than just an individual issue.

> *I took a picture of just a painting on the wall of one of the subsidized houses, and just "United we stand, United we shine", a rainbow just represented the health of acceptance and multicultural unity that is the basis of, of health, not necessarily access to our health care system, but, but that the support that is needed, the benefits that come from support within the community and the, the positive, and I, I can never underestimate the positive impacts as supportive peers have for each other when we try so much as a health care system, to make a supportive health care system. The support systems that are in place that can be supported, um, and this picture just struck me that way; as a real, a real community up access to health as opposed to an institution down. Access to health. Yeah.* (health professional)

The components of *from othering to togethering* are augmented in the subsequent discussion. Although separate concepts have been identified, as with the intricacies of North End Halifax community members' access to health, they are perforce interlaced and thus exhibit some overlap. As per grounded theory, the basic social process evolved from the substantive codes which in turn evolved from the interview analyses. Each substantive code fit into the basic social process to contribute to its description in a manner reminiscent of a patchwork quilt. There is no particular logic in the order in which the components are presented.

6.4   SEEKING A FOUNDATION OF SECURITY FOR ALL

Seeking a foundation of security for all contained the themes including the determinants of health, adopting a stance of basic rights and calling for food security. These concepts recognized the fundamental importance of the broader, often forgotten or ignored, impacts on health; the humanity of basic rights; and the call to action using food security as a paradigm for other securities. These concepts became woven together to highlight the importance of security for all. Security enables an inclusive foundation for moving from *othering to togethering*.

Study participants discussed the need to feel secure about their access to housing, food, employment/ income, health (healing), psychologic well-being, relationships, social supports and education; with housing being by far the most frequently mentioned.

So, it's important that, you know, that they, they have, um, if they have safe and secure housing in place. That they can feel, um, if they are so they can move their lives in directions that are important to them. (health professional)

In addition, note was made of spiritual, fuel, physical, personal and information/ knowledge security (Macintyre et al, 2002). These elements are factors within the determinants of health.

(photograph by participant #1)

And in educating myself about different aspects of my health, which I have over the years, as soon as I'm, the first thing I'm diagnosed with type II diabetes I go, "holy fuck," and I go to the library. I have hypertension and I go, "holy fuck," and I go to the library. That's actually my first line of defence is to go to the library. My second line of defence might be Google but the library is on my way home so I'm going to go there first. And it's extraordinary really that we have free libraries…And walking in the door of the North Branch Library gets you in the door of a thousand other libraries. (community member)

Often subtle, as in the quote above, the impacts of the social determinants of health were pervasive in community member's conversations about their everyday lives.

6.4.1 Including a Determinants of Health Approach

Study participants deeply appreciated the impact on their and others' health status by components comprising the determinants of health. Their personal experience with the effects of these factors heightened their awareness of the importance of influences outside the illness care system to an extent not usually seen in dominant population communities.

The community garden that was done through the North End Community Health Centre…It's just, I think that the one area of, I think that we as health care professionals treating at the North End Community Health Centre, we've, I think that we've got some work to do on ourselves and how we offer and how we think about health. Um, because, if we're truly a community health centre, I feel like we need, we should be responding to people's health in more ways like this, than in, you know, checking hemoglobin A1cs and etc…Well, I think that the more of this we do, potentially the less issues around mental health and the true mental illness issues will surface in the appropriate ways and will get treated through a medical model, which in fact they should. But when you talk about sense of community and just wellness and how people feel, this, it's this kind of work that will be a mental health program. Not referring somebody to the therapist and making sure, and "how come they didn't make the appointment"? (health professional)

There is an extensive literature on the determinants of health, the general components of which are highlighted in **Table 6**.

Table 6   Determinants of Health (biomedical and social)

Health services
Spirituality and sense of purpose*; Values, morals and ethics*
Safety*
Economic security (income and social status); Poverty
Employment and employment security***
Working conditions***
Income distribution***
Meaningful work as service to others
Adequate power*
Social justice; Equity*
Cultural integrity and identity
Aboriginal status***
Community solidarity and support (social environment)
Strong families and child development; Early life***
Healthy ecosystem (physical environment
Education
Social safety net (social support networks); Social inclusion*** Human services
Food security***; Housing security***
Gender **
Personal health practices and coping skills**
Biology and genetic environment**

Definition unique to *Bopp, Bopp, 2006; **Public Health Agency of Canada; ***Raphael, 2004.

Others have expressed similar ideas within a well-being framework. This framework includes physical health (safe housing, food security, needed household items, clothing and healthy body), mental health (relationships, sense of respect and belonging, trusted network of people), socio-cultural (place within a community), political (sense of rights and responsibilities, engagement in community), economic (access to employment, opportunities to learn skills), and environmental and spiritual (connections with community)(McIntyre-Mills, 2010). Most agree that these factors have impact over one's life span, some having more influence within a particular life stage (early childhood development or congenital malformations for example); others have an additive, compounding and/ or cumulative effect (Mackenbach, Howden-Chapman, 2003). The life stage perspective includes latent effects (biologic or developmental effects that manifest later in life), pathway effects (experiences and trajectories that influence health) and cumulative effects (advantages and disadvantages accumulated over time)(Raphael, 2004).

Particularly striking is the relationship between socioeconomic status (SES) and ill health. In Canada, as well as almost all other countries, this relationship exhibits a gradient of health from the poorest for those in the lowest SES to the best for those in the highest (Humphries, van Doorslaer, 2000). The root causes for this gradient are unclear but are felt to encompass both material resources and social cohesion, self-esteem, trust, our market-oriented society and emphasis on individuals (Coburn, 2000). Social democratic countries, such as Norway, have the smallest gap in income between the lowest and highest SES; they also have more supportive services for families, lower poverty rates and higher health status of the general population (Navarro, Shi, 2001).

For North Enders, many of these determinants are enmeshed in their everyday lives. Although all of the determinants are associated with health, they do not all affect health inequities (Kelly, Bonnefoy, 2007). Social positions are perforce unequal as they result from social hierarchies and socio-economic position. They mould an individual's lifeworld of psychosocial, behavioural and environmental risk factors for health that, in turn, influence physiology and development of diseases (Graham, 2004). Although some

determinants are relatively immutable (ethnicity, gender, genetic endowment), society's response to them is modifiable. There are several theories used to explain health inequities - materialist/ structuralist (inadequate income leads to stress and poor health), psychosocial (discrimination based on socio-economic status causes stress), social production (capitalist priorities on wealth and power accumulation are achieved at the cost of the disadvantaged) and eco-social (social and physical environment interact with an individual's biology and reactions to how they live). Within the eco-social theory, the theory most compatible with how North Enders perceived health inequities, an individual's lifestyle choices are derived from her/ his life chances as defined by her/ his environment (Kelly, Bonnefoy, 2007).

> Introducing class into the debate *(about the determinants of health)* begs the question of how the organization of capitalist societies both creates and maintains inequities in economic, social, and political power, thereby shaping both the determinants of population health and population health itself. (Raphael, 2006; p. 659)(italics inserted).

To address health inequities through a determinants of health framework requires changes that allow all people the prospect for the best attainable health. Examples include well paying jobs that enable food and housing security, or the opportunity to participate in physical activities because one has the access, time and money so to do.

> *As I said really the economy is our Goliath and we are David looking at this problem because the economy drives our need to produce and do stuff which takes away our time from making a nice meal for ourselves or cooking or just the basic things...I think economy is a huge part of the problem and when you look at subsidizing policies and when you look at obesity it can all come, be argued that the economy is a big part of the problem. Because it's hard to eat well when you're poor. But for reasons that, not just because fruit and vegetables are not affordable, it's for a whole lot of other reasons. It's because, it's stress. It's stress. And it's just not, that's why people should be sharing more, sharing more meals and appreciating time for meals and appreciating what you're eating. It's a drive through world.* (community member)

Braveman and Gruskin, 2003, noted "that most societies have far less tolerance for social disparities in health than in wealth or other social privileges" and this "provides the health sector with a powerful tool for mobilizing public opinion" (p. 542). The Canadian Institute for Health Research (CIHR) established a Reducing Health Disparities Initiative in 2002. In a CIHR sponsored international symposium, presenters identified the

160

particular margination of individuals living with intellectual disabilities (Oullette-Kuntz et al, 2005); and documented that health disparities were accentuated in people who were homeless (Frankish et al, 2005), or who were recent immigrants (Beiser, 2005), or who were Aboriginal (Adelson, 2005), or who were among the almost 50% of Canadian adults who lack the literacy skills needed to fully participate in a knowledge-based economy (Rootman, Ronson, 2005), or who were women (Spitzer, 2005). As suggested by the following study participant exerpt, social inclusion is an important element of health disparities.

> *And there's probably more health issues related to being alone. Even how you eat. Or not feeling as needed or part of a group, I think, affects health. So, that is good in terms of helping people.* (community member)

Social inclusion needs a proactive approach to well-being that "calls for more than the removal of barriers or risks. It requires investments and action to bring about the conditions for inclusion." (Mitchell, Shillington, 2002; p. viii). Social inclusion and re-dressing the inequities related to the determinants of health can be enabled by an underpinning of basic rights for all.

6.4.2   <u>Adopting a Stance of Basic Rights</u> (discussed in greater detail in **Section 8.7**)

> *Short answer, housing is a basic right. Um, attention to the conditions that can create secure housing is a basic right.* (community member)

Study participants felt that it was a basic right for everyone to have access to the means to achieve the best attainable health, a stance upheld by international treaties (Braveman, Gruskin, 2003). Perforce, this requires the means to mitigate the determinants of health; to ameliorate systemic disadvantage. A rights-based approach that is community focused, not individual focused, with a just balance between autonomy and population good is needed. This would entail resources being re-directed from illness care to health attainment and achievement of equity with respect to the determinants (root causes) of health. Whereas poverty is not itself a violation of human rights, government inaction or creation of conditions that perpetuate poverty (as a key determinant of health) is (Braveman, Gruskin, 2003).

(photograph by author)

The Halifax Coalition Against Poverty and Dal Legal Aid have been active in rights-based work.

> (Dal Legal Aid is) *constantly working together both in case work and community activists kind of issues. It's a good organization and deserves a lot of credit for high quality and better staff it's been able to maintain and the commitment of everybody there including the students that they that do current work. And I think legalized human rights are a big issue and Dal Legal Aid is right in there and they are not afraid to get their hands dirty, and always willing to take the high road and be supportive of community. It's provided a lot of leadership over the years.* (community member)

Civil, political and socio-economic rights are inextricably intertwined and affect health of populations through policies and programs (London, 2008). Food security was recognized by study participants as one basic right.

6.4.3 Calling for Food Security (discussed in greater detail in **Section 7.9**)

> *There have been times in my life when I have not been as ambulatory as I am now when I would say to myself, Christ, for the past two weeks I've eaten out of the corner store. I haven't gone to the grocery store. I've eaten Kraft Dinner. I've eaten Mr. Noodle which is so full of trans fat it'll kill you before you can get the pot washed. I've eaten, you know, whatever crap you get in corner stores, cans of highly processed stuff. It's all high sodium. It's simple sugars. It's just B-A-D with a capital B. But my corner is half a block up, isn't it, and shopping at a corner store is a conundrum because you pay more money and you cannot eat in a healthy way. If you ate only at the food bank and the corner store you'd be dead in a year, I'm pretty sure.* (community member)

162

(photograph by participant #1)

Food insecurity is associated with poor health, mental illness, and developmental consequences for children (Chilton, Rose, 2009). Key elements to a right-to-food approach include government accountabilty, public participation, attention to vulnerability and discrimination, and strong connections between policies and health outcomes (Chilton, Rose, 2009). Rights-based approaches imply reciprocal responsibilty and accountability. For those of us able to benefit most from the right to health, because of our heritage and circumstances, come greater obligations and responsibilities to those who are less fortunate.

(photograph by particpant #6)

Brunswick Street United Church. Um, a church that is truly involved in some, um, very, meeting social needs in many ways. They run the breakfast in the morning that feeds just about all of Turning Point, for sure. And many others. (health professional)

A human rights-based approach to addressing health determinant elements, such as food security, encourages those usually not privileged to be heard to have their input honoured, respected and equitably incorporated (London, 2008).

163

6.5 COMMUNICATING TO UNDERSTAND

Communicating to understand was important for all interview participants as they conveyed perspectives about their community and achievement of health. As a category, **communicating to understand** encompassed the themes of <u>using boundary objects</u>, <u>image making</u> and <u>gathering places</u>. <u>Boundary objects</u> became a way of facilitating understanding; changing the sometimes negative <u>image</u> of the community was important to gain empathy and support for community members; and <u>gathering places</u> were necessary for meaningful conversations accessible to all community members. These themes contributed to **communicating to understand**, a basic step for moving from *othering to togethering*. However, miscommunication was a worry.

> *It's competition between the two agencies - why is that happening? It is unnerving for the province to unilaterally just to do that. There's no consultation of community, we want to do something, what would be good for the community. I'm very cynical in a lot of my ways but my cynicism is based on experience more than attitude and I believe if a lot of these kinds of projects provide the province with an opportunity to move outside of social housing, they'll take social housing unit that should have people in them and offer them up to agencies to provide services and they don't have to deal with the clientele anymore.* (community member)

Miscommunication or failure to communicate hampers the facility with which governments, Non-Governmental Organizations (NGO), non-profits and businesses work together to initiate change. Changes to improve the health of North Enders will require collaboration among many groups and individuals.

> *One of things that really, really connected the community then was the early talk shows, which were very different than these, and there was a CJCH talk show that literally was like an open public meeting every morning of the week and all those people I swear who weren't working would sit home and listen to that talk show every morning. So if you wanted to generate any kind of public debate or criticism around issues you could call up the talk show and things would start rolling.* (community member)

Venues for community members to converse and exchange ideas are imperative so that future developments can be truly designed to address the needs of all community members. In the past, radio talk shows formed a valuable conduit. Today, CBC Radio One programs such as Maritime Noon and Mainstreet provide a limited forum. Another community within Halifax Regional Municipality facing similar challenges to North End

Halifax has managed to enhance communication with its community members, albeit not to the extent desired or needed.

> *And the focus in those early days was very much on services but there was a full time staff person whose job it was to go around and help agencies work together, you know, to be that, to make sure that the connections got made, right. If you want people to - and this is a mantra of mine - if you want people to collaborate, you have to have somebody whose job it is to nurture the collaboration, bring the people together, because too often the kind of collaborative work that needs to be done is on the edge of somebody's desk, on multi people's edge of their desk. And so often the first thing that falls off, and we've also heard stories mostly at the federal government level of staff people who have collaborated with other departments and then had their wrist slapped because it wasn't part of their job description. So it's an issue...* (Resources are needed*) to bump us up from networking and communicating to more partnerships and more collaboration across the community.* (community member)

Study participants felt an urgency to change the present circumstances within North End Halifax; they noted the lack of a group with sufficient power to implement change; they identified the need for a new vision for their community; they named barriers. And they were proud of their successes. People inspired by focus and generosity are able to act as linkers, bridgers and mobilizers for individuals, agencies and organizations. They are an example of boundary objects as explained below.

6.5.1 Using Boundary Objects

The concept of boundary objects was first developed by Star, Griesemer, 1989.

> Boundary objects are objects which are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common use, and become strongly structured in individual-site use. These objects can be abstract or concrete. They have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable, a means of translation. The creation and management of boundary objects is a key process in developing and maintaining coherence across intersecting social worlds. (p. 393).

Boundary objects inhabit several worlds; their role is to structure relationships between these worlds (Allen, 2009), worlds such as those within and outside North End Halifax. Health policies are an example of boundary objects that can effectively bridge interfaces between groups, communities and departments. Boundary objects become a standardized platform through which explanations and perceptions can be explored. Examples of

people acting de facto as boundary objects are the community organizers of the 1960s-1970s or the community linker in Spryfield. Boundary organizations include the Black Educators Association, Metro Housing Authority, Coalition Against Homelessness and Halifax Coaltition Against Poverty. Although largely focussed on particular populations, these organizations served to involve groups and individuals to broker their disparate knowledges to gain mutually understandable communication (White et al, 2010).

(Black Educators Association)(photograph by author)

Gardening was the most frequently mentioned boundary activity and way to develop common understandings. Gardening, in the view of study participants, had many meanings- nuturing, creating, sharing, producing, environmentally green, beauty, means of self-expression, sustenance and belief in the future.

> *I know that there's lots of gardening on and some of it's gone on for a long, long time, people who have been long-term residents in the neighbourhood. They're like people everywhere, they look forward to the nice weather to get out in their garden and they certainly do lots of gardening and vegetable gardening as well as flower gardening so it's pretty neat.* (community member)

In a clinical setting, a discharge summary template designed together by those sending the information and those receiving the information is a boundary object. Photographs, maps and drawings can be boundary objects facilitating knowledge transfer (Miller, 2005). Boundary objects are inherently plurivocal and open to individual interpretation, thus the importance of dialogue to accompany their use (Oswick, Robertson, 2009). Boundary objects can not only aid communication among community members, but can

166

assist with communications to others outside the community. They can be important in helping to update understanding of community lifeworlds and image of North End Halifax.

6.5.2   Image Making

Participants took photographs of dumpsters, dark alleys, deserted properties, ugly fences and drug lord houses.

(photograph by participant #1)

And then you'll see debris thrown everywhere. You know, there is a lot of garbage in our neighbourhood, I find, compared with other neighbourhoods in town. And I sort of subscribe to the broken window theory that if there's a place with one broken window the likelihood is that you're going to get another broken window and so your best bet is always to fix that window. (community member)

They also took pictures of magnificent gardens, stately churches, well kept homes and playgardens. Study participants spoke of the need to correct public perceptions of their neighbourhood;

One of the first things we said was to change the imaging. So we are going to take all the plywood off the windows. I'm going to buy some plexicon glass, bullet proof glass. And I'm going to put it on the windows, so when you're driving down the street it just looks like a window, doesn't look like it's all boarded up. I said I'm not going to board up the front doors, I will continue to board up the back doors 'cause people will kick them in, go in and destroy the units. That means that you're going to have to let the people know around here that if they see someone kicking them in to call us so we can come right away and fix it. So we did that. (community member)

(photograph by author)

Others mentioned the visual quixotic paradoxes;

And so this building that's on the corner of Cunard and Gottingen Street is a former bank. And is mainly used for storage for the costumes for the Tattoo and so this photo is, is a picture of what had been the night deposit. And someone put a photograph of what they'd taken of a piece of cardboard that someone that had written on "Spare change wanted" and whatever they wanted spare change for, you know, all the cash is gone. You know, so this, you know, so I just thought addressing this is, this is a night deposit and someone looking for spare change. I just thought that was classic. (community member)

(photograph by participant #2)

And this is an industrial shot, 'cause you know, our neighbourhood is bordered by the harbour and so was shot looking towards the MacDonald Bridge is looking, is the Canadian Armed Forces Dockyard. And, and the billboards, they were the last

part of the reason. The first one has this very smug looking handsome young man with his arms crossed saying "Smart strategies for a guaranteed retirement income" and the adjoining billboard is advertising "6/49, it's, the prize is $15 million dollars" . (community member)

(photograph by participant #3)

And others pointed out contrasts in exhibiting neighbourhood pride (or not).

This is the back of Victoria Hall, which is a gentile boarding home for well-to-do ladies. And one of the staff there decided, you know, that that garden should be redone, and so they, it's quite gorgeous. And directly across this street, from it, is this house, horrible, it has been, you know, every so often been referred to as an unsightly house. There is, gets, get towards the criminal, so that that fellow is back there and just leaves it. (community member)

(photographs by participant #3)

Members of the community can most accurately portray their North End Halifax, untranslated by others (Fee, Russell, 2007) through voice, print, photographs, music and art. Updating the image of North End Halifax in a process that includes the spectrum of community members would be enabled by natural gathering places.

6.5.3   Gathering Places

Within North End Halifax, the Library, the Micmac Native Friendship Centre and Brunswick Street Mission have served as meeting places for the community.

> *The library is really the community, well, for the whole community. It's always had the reputation of being a place where people are welcomed and any kind of public meeting or event or concern that the community had, that the staff at the library made sure there was space, and a structure, for people to come and talk to sort it out. It's a very active building and they focus a lot on youth and children in terms of tutoring programs and education as in terms of health and how important that is. Early childhood learning to certain degree, perhaps not as pronounced. Certainly the educational component in the library has been a pillar.* (community member)

(photograph by participant #4)

> *They, um, they* (Brunswick Street United Church)*, they do, they do a lot, they open their doors on a regular basis to all of the community to use the sanctuary. I mean, it's the place, you know, it's like the, the social meeting place for, for anyone to host events. It's, um, it's a very, um, you know, if you're going to have something that's going have more than say, 30 people, it's usually the place that you have it.* (community member)

Yet there are few natural or spontaneous gathering places for informal or chance encounters. In the late 1960s to early 1970s, at a time when there was significant community activism, there were more natural gathering places such as the Halifax Neighbourhood Centre; more neighbours sitting on front stoops chatting with each other.

> *There's not a community centre and I didn't know whether that was a good thing or a bad thing. Yeah. It's actually a good thing. I've grappled with this a lot myself over a long period of time. I think we need a community council of some kind but not, I think the strength in this community is all of the little groups…and so that fragmentation, I think, has a history in the community. But all of these little organizations give a lot of different people an opportunity to be really active where if you had one organization you'd have a small group that would be active and*

you'd lose that kind of dynamism - there's no such word - but you'd lose that dynamic, I think. And I've thought about this a lot. There have been many attempts to try to do a more coordinated centralized. It's resisted like mad. It fails every time and people just felt, oh, you know, I don't want to give up my autonomy, blah, blah, blah. (community member)

Understanding the neighbourhood must be achieved by seeing it through the eyes of community members. For example, churches play a fundamental role in the lives of many North Enders and are natural gathering places.

This church, like many of the churches, particularly in the Black community, is more than a spiritual place. They can be the social service place for the community. They can be the support, the kind of psychological support to give people the courage and the strength to keep going when things seem so dismal to people. And you see this all the time in these churches. They embrace people in a way that many organizations, including other churches, don't necessarily do. (community member)

Enabling North End community members to collectively define the image of their community can also facilitate desegregation.

6.6   DESEGREGATING SEGREGATION

The need for **desegregating segregation** was widely recognized by community members. **Desegregating segregations** comprised <u>exposing divisions</u>, <u>understanding impacts</u> and <u>removing separations</u>. <u>Exposing divisions</u> was important showing the many ways in which people are separated one from the other. <u>Understanding the impacts</u> of distancing people becomes a way to visualize change through <u>removing separations</u>. **Desegregating segregations** is a necessary step to achieve *togethering*.

There were segregated schools until 1955, you would have found them in Halifax proper, and all of the Black communities had their own schools, I'm from Africville, so we had our school in Africville. From primary to believe it only went to grade 8 and after to grade 8 we came in town to other schools. But there were segregated schools for the Black population. That's why I talk about the Black Report. It took a look at the quality of education. Finding out that the quality of education was far below that of the White students in the schools, both from a resource point of view right up to the actual teachers themselves. A lot of cases they weren't professionally trained teachers, they were someone from the community who might have had grade 10 but they were hired to teach children. So the quality of education was lacking and so that's the work that there, and it's an ongoing piece of work that they're continuing to work on. (community member)

Incidences of social exclusion or segregation are still common on North End Halifax. The cornerstones of social inclusion are valued recognition (individual and group respect), human development (nurturance of skills, talents, knowledge), involvement and engagement, proximity or sharing of physical and social spaces, and material well-being (having the resources to fully participate in community life as one would wish; equity of opportunity)(Mitchell, Shillington, 2002).

> *But you know it's strange because I think the shift in terms of demographics in this community has been gradual enough that the people coming in have bought in to that spirit and have really embraced it and share in it. This area is a very, a lot of people in the arts live in this area, lot of folks who aren't so stiff live in this area and one of the attractions was the fact that you could sit out on your stoop at night and have a conversation with your neighbour. So they bought into that and I can still see that continuing.* (community member)

Poverty is a major cause of social exclusion and a frequent cause of intergenerational health disparities. Adequate income is important for what it enables people to do: have adequate nourishment, safe housing, good health and self-respect; the ability to make choices and participate in community life (Mitchell, Shillington, 2002). Deficiencies in power, recognition, political capacity and required knowledge foster separations. Removing separations, such as those felt by persons living with poverty, is important for the improvement of the health of North Enders. Their voices must be heard.

> Whose favorite topics predominate? Who keeps being interrupted? Whose conversations are heard only when paraphrased by someone else? Who is too strident, beside the point, political, incomprehensible? Who is even permitted to be in the room? Whose language is used? (Fee, Russell, 2007; p. 188).

Segregation and divisions or social exclusions are difficult topics for dialogue.

6.6.1   Exposing Divisions

Some of the divisions, intentional or unintentional, within North End Halifax include those who are African Nova Scotian, Aboriginal, recent immigrants; those living with poverty, addiction, mental illness, homelessness; those who are members of Gay-Bisexual-Lesbian-Transexual-Intersex communities; drug lords; middle class or business persons. Within these separations are individuals with knowledge, skills, creativity and understanding to bridge those divisions; divisions that are largely built by society itself.

Poverty is a reality for many who live in North End Halifax. Economic disparities are a dismal truth in Canada. Ten percent of the most economically advantaged control 53% of Canada's wealth and have an average wealth of approximately one million dollars. Those in the top twenty percent control 70% of Canada's total wealth whereas the bottom twenty percent control none (Raphael, 2007). Study participants remarked on the difficulties of living in poverty. They experienced being judged, lack of choices, stress of maintaining food and housing security, and limited participation in community activities. Others noted feelings of deprivation, inadequacy and despair; loss of control over daily life; effects on their clothing and appearance; unwanted dependency on others; suffering chronic fatigue; being excluded and stigmatized; having little opportunity for relationships and friendships; and experiencing guilt for the hardships enforced on children (Raphael, 2007).

(photograph by participant #6)

Um, this is a picture of a graffiti tag on a wall. It says "YMK, homeless guy" and it ah, it struck me as an expression from, a very visible expression from an often times, an invisible population. I am here. And what's, is that not the basis of accessing your health when one first says "I'm here. I deserve health." (community member)

The history of slavery, expulsion from Africville and persistent discrimination still affects the lives of African Nova Scotians. Segregation, separations and discrimination are still a significant part of their lives as well as for people of Aboriginal heritage. Similarly, those living with addictions are often disparaged.

There are a lot of families in the North End of Halifax who can trace their roots to the 1700's, really. And it's fascinating the history of people in this community and yet the segregation that existed in the school system until the mid 50's in Nova Scotia has left this legacy of many families in the Black community not generationally acquiring a high level of education. And so what has happened is

173

that people have been left living pretty subsistent kinds of lives with low incomes and it becomes generational then, the spiral of making it very difficult to get out of that low income, low education, social economic bracket into improving your situation. (community member)

The media has contributed to perpetuation of divisions among those living in North End Halifax.

I think the media has done an amazing job at, um, villainizing people who use intravenous drugs and people who are homeless and people who are street involved. The media has portrayed folks in a way that is inhuman and so, so you could never, and also folks who are living in poverty and I think that there, that you cannot talk about housing in Nova Scotia without talking about race. (community member)

As noted elsewhere, there are separations and divisions among government departments, NGOs, non-profits and illness care services. These separations have impacts on the health of the community.

6.6.2   Understanding Impacts

Being patronized, being condescended to, you know. Those things bother me and I pick up on them. And I'm usually smarter than these people anyways. They're under the assumption if you're homeless, you have to be dumb. (community member living with homelessness)

Living with homelessness has many affects on health and on an individual's quality of life and feelings of self-worth. People who are homeless are often treated with disrespect, dehumanized, have their autonomy removed, are dealt with as children, lack control over their daily lives, have little chance for self-expression and have few opportunities to participate and contribute to community life (Miller, 2000). Most who come to homelessness must adjust and cope in a lifeworld quite different from what they experienced previously. As Miller, 2000, stated most "general explanations for how people cope with stress...ignore individuating characteristics such as gender, race, and class." (p. 17). Those living with homelessness must cope with lack of privacy, limited access to personal hygiene, little control over their day and few choices. Shelters provide minimal subsistence.

Real basic needs. We're talking they are no longer out in -30˚, they call this housing, I wouldn't call it housing. There was a man found dead there the other

morning, I know somebody else who was discharged from the VG here with cancer, transferred to this shelter, I know of somebody with a hip replacement who was transferred home to this shelter. Somebody last week fell out of bed who was intoxicated from the top bunk, hit his head, split it open, the same day somebody was found dead, didn't wake up in the morning. The lack of professional support to this population is well known. (health professional)

Others who are rendered invisible and separated from others are those living with addictions.

(photograph by participant #5)

It's, ah, it's the place where, if you're at Turning Point, that's, that's the little shortcut you take to get up to Brunswick Street Mission in the morning to have your breakfast. But it's also a place that you go around the corner and you're using, and you're drinking and you urinated and um, you know, it's like your private space, you know. It's like your living room I guess. You know, and so there's lots of things that make me feel sad about that. You know, it symbolizes how little privacy you have when you are homeless and how little space you can kind of call you own and so, you know, you find the cosiness of concrete, um, as that space. (health professional)

Other study participants told stories of people being shunned and excluded because of their race; ignored or taunted because of disabilities; judged because of appearances. They talked of being unable to participate in community events because of money, accessibility and/or membership in an unwelcome group.

Separations can also be physical separations.

This again, is about fencing and separation and neglect and then about sub-standard housing, the trailer, tree growing through a fence. You know, a paradox, whatever. We already discussed that, neglect on Gottingen Street. Neglect breeds neglect. (community member)

(photograph by participant #1)

And just like their physical counterparts, fences between people can be dismantled.

6.6.3   Removing Separations

We live in an agenda based world and a scheduled based world. Sometimes, you know, um, when you see the reality of everyone going off to work, and everyone having a, you know there is a purpose, it can often times motivate one to find a purpose and lift one out of, ah, lift one out of a, give one step up. Yeah, I don't know, ah, a psychic block I guess. Um, and also I think the other way around, when people who are relatively well off are exposed to a lot of people who don't have a flat screen TV, and such, it can certainly bring a check with reality and hopefully, a sense of a need to give back also. (community member)

Mixed housing is one way of decreasing separations. In this context, mixed housing refers to the planned interspersing of housing affordable to different socio-economic groups. As noted by study participants, the hope is that mixed housing would promote new social networks among those with different backgrounds, increase contacts that could potentially lead to employment, provide alternate role models and values, and increase understanding of another's lifeworld.

These hopes were also documented in a study by Sedlak, 2008. Unemployment, crime and other forms of violence, poorer education systems and poorer health were found to be increased in areas where people living with poverty were housed in concentrated numbers. Trust and effective networks were needed to reap the potential benefits of mixed housing (Sedlak, 2008). Sedlak also stressed the importance of building in ways to faciltate neighbourliness with places for informal meetings such as parks and squares.

176

She cautioned against cookie-cutter housing, which was also noted by North End study participants as undesirable. The response to and thoughts about the effectiveness of mixed-housing in achieving the hoped for benefits were diverse. Yet almost always mixed housing was associated with physical improvements to the environment and thus of benefit to population health. Mixed housing is in its initial stages in North End Halifax.

Community gardening was seen as one way of decreasing separations.

Anyways, I, it's just, the, the life thing, you know. It's vibrant and green and, you know. A, a lot of people put a lot of effort into doing them and here's my other angle here. I was leaning over this fence...But I, I just thought, you know, it's a fence but one that can be breached easily. It's not to keep people out, it's, you know. It's a friendly fence, which I do like. (community member)

Places where children gather are also a means of segregating and desegregating.

(photograph by participant #1)

So I like that reminder of kids in the playground. But also it's fenced in. I noticed that it's fenced in to keep the little children from getting out and keep the bad adults from getting in. So it's separated. Like a lot of things in our neighbourhood, there's separations, there's fences. And I understand the need for the fence. I'm not saying it should come down or anything, I'm just really aware that those running around children are segregated from the rest of us. But to see them running around in their little playground is a great thing. (community member)

And people who are open help decrease separations.

This area is a very, a lot of people in the arts live in this area, lot of folks who aren't so stiff live in this area and one of the attractions was the fact that you could sit out on your stoop at night and have a conversation with your neighbour. So they bought into that and I can still see that continuing. (community member)

177

(photograph by participant #3)

Examples were noted of organizations sharing skills and resources with others both within and outside North End Halifax. The MicMac Native Friendship Centre-

they provide emergency support to families and children and youth. They have a little bit of emergency housing. They assist people getting into school, getting into other training programs. They have a lot of cultural programs there and, of course, they have, they're the sponsors of a number of other programs including the needle exchange program and the methadone program for people who have drug addictions, not only from the native community but non-native as well…Increasingly, I think, I'm hearing there's more collaboration between the Friendship Centre and other organizations...And that's the kind of thing, I think, that's important. So that, as important as the work of the Friendship Centre is, that they not be isolated either in the larger community. Great facility. (community member)

In many ways these organizations enable community members to become active citizens in the endeavours to improve their neighbourhood.

6.7   SEEING NORTH ENDERS AS CITIZENS

Seeing North Enders as citizens incorporated the concepts of <u>adjusting our views</u> and <u>enabling participation</u>. These concepts captured a way of envisioning North End community members as able to work towards achieving community health. It contributes to the basic social process of *othering to togethering* by glimpsing a pathway through which to mobilize.

*So (*the*) vision for this area...is every man, woman and child knowing that they have a role to play in their community and agencies being more responsive to the needs and priorities of the people, not what they think residents need, and attracting resources to this area.* (community member)

178

Citizenship is another nebulous concept, a word with many associated definitions. In general, it is conceived as a role with rights and privileges <u>and</u> duties. It involves relationships with neighbours, being active within one's community, behaving in a manner dictated by social norms, and advocating for political actions. Westheimer and Kahne, 2004, identified three kinds of citizens: personally responsible citizens (acts responsibly within community, pays taxes, obeys laws, recycles, volunteers in crises), participatory citizens (active member of community organizations and/ or projects, organize activities, experienced with government agencies, aware of strategies to accomplish collective tasks) and justice-oriented citizens (critically assess community circumstances for issues of injustice, know about how to effect systemic change). As a very pertinent example, the authors noted that responsible citizens will donate to the food bank, participatory citizens will organize a food drive and justice-oriented citizens explore why people are hungry and act to solve root causes. All of these roles are important; however one might hope that as the justice-oriented citizens become more and more successful, the activities of responsible and participatory citizens would be re-directed. Within a community, individuals have different strengths and commitments that can be harnessed for neighbourhood improvements; albeit, some times those citizen activities may be in conflict. Carlisle, 2001, warned that social citizenship is unsustainable without an adequate social welfare safety net. People who are able to participate in the affairs of their community had positive impacts. Paired with improvements to the support system, members of North End Halifax have the potential to lead developments in their community.

6.7.1 Adjusting Our Views

All of us have the capacity to act as citizens, have a role within our community and possess ways we can contribute. Seeing others as active citizens requires adjusting our views away from the prevalent stereotype of an active citizen as a middle-class individual. Acts of citizenship include taking care of one's physical surroundings.

> *So, you know, um, on one street, on Gottingen, there's public housing and I'm always struck every time I walk by this block, the beautification that's occurred in front of it because I think that lots of people really, you know, their view of public housing is not about beautification.* (community member)

(photograph by participant #6)

Some organizations are inclusive in their embracement of citizens.

> *It's also the place (*Brunswick Street United Church*) that when they lose the people that we have loved and cared about in it, in the community, the folks that are homeless or street involved, Brunswick Street Mission often has a service, and so, that it is an accessible way for people to grieve and it is, um, it's their space. You know, it's not being done on someone else's turf. So it certainly, to me, is a source of health and hope and healing.* (community member)

And there were mentions of individual contributions as citizens, some of whom might have been considered unlikely because of past circumstances or unwarranted judgments.

> *X, who's an incredible heroine in my mind, she has championed the rights and the services that are needed for people who use intravenous drugs, for years and, um, she's really the only one that has focus like that on, on, on the radar. She's the only one that cheerleads that, that speaks to it, that advocates for it and ah, and, without her, this population of individuals would be extremely invisible in our community or be visible in ways that allowed for kind of, gave people the sense of entitlement to judge, to, um, to not offer service to etc, etc.* (health professional)

(photograph by participant #5)

Yeah! Yeah, and one of the guys that works on it (local construction site)*, um, one of the carpenters, his name is X and X, um, has this blue pick-up truck that he helped move two of our examination tables to, um, each of the shelters, and that, you know, so it feels really like, so it's just, you know, X is on the street and he's got a truck – do you think he'd move two? Yeah, sure I'll do that. So, it's, um, it, you know, the, the sense of small town community, if you will, is really, um, has been kind of the vibe from there.* (health professional)

To gain from citizen activities, every citizen must have opportunities to become engaged and participate as they are able. As with most things, members of the middle-class are more able to be involved in citizenship actions because they are the members of our society who have basically determined how things work.

6.7.2   Enabling Participation

Participation requires access (including language, acceptance, barrier-free locations, transportation), information (being invited, able to understand the issues by being given facts in a comprehensible way- oral or written as applicable), time (child care, time of day) and compensation (financial or by personal or collective gain from the efforts).

I think it's a very difficult thing to get people together unless they have a common purpose or a common goal. In numerous organizations I've been a part of...and I know that unless people have a common goal or a common end, or are on the same page and willing to walk forward, it's like herding cats, you can't get them to do anything. So to get a group of people together to take advantage of the NDP being in government would be like, that would be a very interesting exercise and you would have to, I think that you would have to headhunt. You'd start by headhunting. You'd sit down and make a list and go, who do we need on side on this. And if you headhunt three people, five people, to make a core, to be united in the goal and then you could fan out and get more people involved and then you just simply start calling up and take a meeting. The great thing about the NDP government is like you can jump right to the, I believe you can jump right to the "I want to take a meeting," as opposed to spending years writing letters, or lobbying, or protesting, or writing letters to the editor or whatever. Nuts to that, crack the phone, get a meeting. So I think it would be a really good, how you would do it? That's how I think you would have to do it. (community member)

*Also one of the bigger initiatives through the (*Black Business Initiative*) centre was Youth is Jamming. That was for young people, every summer, not just the summer, but through the year they would get young people together to start training about business and what it meant to be in business and they'd have a period of time and that at the end of the session those young people would have developed an idea for business. They would have put together all of the needs of the business, then at the*

end they were actually out there selling stuff, as an initiative to get young people interested in entrepreneurship. (community member)

(photograph by author)

Youth are an important and often untapped source of ideas and contributions. Within North End Halifax, youth lead efforts to increase acceptance of members of the Gay Bisexual Lesbian Transsexual Intersex (GBLTI) community; youth are leaders in camps and advocates to stop bullying. More opportunities for youth to develop the skills and knowledge to become active citizens will enable a better future for themselves and the community (Borden, Serido, 2009).

The ways that people can engage in citizen activities through helping a neighbour are countless and often of mutual benefit (gardening for someone who can no longer tend a garden and someone who has no other access to a garden; reading to someone who can no longer see and hearing from them stories of their past).

> *But then they go back to simple things, get to know your neighbour. We have this little thing, everybody can do something. Get to know your neighbour, and shovel the walk for your elderly neighbour, pick up garbage on the street, recycle. I mean there are some things if we could all just do a sort of basic citizens… that don't cost any money. It doesn't mean you have to join anything. Some people aren't joiners. Go visit somebody in the hospital. I mean, you always see somebody you know. There are certainly things you can do that just are, I think, being better human beings.* (community member)

Being settled in one's own home facilitiates neighbourliness and citizenship.

6.8   PROMULGATING HOUSING AS A KEY TO HEALTH

Each study participant was active in promoting **housing as a key to health.** A tapestry of the meanings of home were embedded in the elements of **promulgating housing as a key to health**. Sheltering consists of the basic roof over one's head, affordable safe housing moves closer to the idea of a family home, supportive neighbourhoods are environments facilitating health and social inclusion, and the built environment can provide structures that increase safety, activity and interactions. Within safe, enriching neighbourhoods, one can find security and understanding to move from *othering to togethering*.

Housing was a major concern for all study participants- from gentrification to shelters, from cars to couches to classy condominiums, from owners to transients.

> (He) *went through a period of homelessness and…he had a very happy smile on his face. And, ah, while* (it's) *a far too expensive room, as far as I am concerned, but it was a stable environment for him. It was a dry place for him. It was a place he could seek refuge from. It was a place that he said that when he is feeling a lot of pressure and he's feeling a lot of temptations, he knows now, that that's a place he can withdraw to basically.* (health professional)

6.8.1   Sheltering

There are many definitions of homelessness leading to complications in enumerating the number of homeless within a jurisdiction. For thinking about housing and homelessness, I found the description of the Australian Bureau of Statistics helpful (Zufferey, 2009). They outlined four types of homelessness - primary (without shelter), secondary (temporary accommodation), tertiary (living without own bedroom, bathroom or kitchen; as in a boarding house), and quaternary (people living at risk of homelessness or housing crisis; those living in substandard or unsafe housing; those for whom a very large portion of their monthly income is spent on housing). The definition of homelessness "can have profound consequences for policy, resource allocation, and parameters used to evaluate the success of homelessness initiatives." (Frankish et al, 2005). In Canada, only a small portion of those who are homeless fit the archetypical picture of a man with schizophrenia, panhandling, dishevelled and chronically homeless.

Metro Turning Point- men's shelter (photograph by author)

However, homelessness has a significant impact on health leading to increased infections (over-crowded accommodations), prolonged exposure to adverse weather, and the general risks associated with poverty. Alcohol and drug use, affective disorders, unsafe sex practices, injuries and violence as well as inadequate control of any chronic medical conditions lead to a higher mortality rate than in the general population (Frankish et al, 2005). As noted by study participants, some who are homeless do not have a health card, find it difficult to get and keep appointments, and suffer from lack of continuity of illness care.

In *A Report on the Health Status of Halifax's Homeless Population, 2009,* it was noted that 54% had less than a high school education (versus 32% in general population), 14% were African Nova Scotian (4% in general population), 12% were Aboriginal (1% in the general population), 12% were lesbian, gay or bisexual; 47% had accessed care in an emergency department and one third of individuals could not afford their prescription medications; 41% did not have a Medical Services Insurance card (@100% in the general population); 87% smoked cigarettes, 23% used street drugs, 45% had been physically assaulted, 80% had mental health issues. Forty-eight versus 6% of the general population rated their mental health as fair to poor; 55% said their lives were very stressful (versus 21%). Schizophrenia had been diagnosed in 6%. Of those in the survey, 42% were living on less than $200/month (@ $5000/month in the general population). In Halifax, it requires minimally $1000/month for a single bedroom apartment, phone, food, electricity and bus pass; the minimum wage in Halifax in 2009 was $8.60/hr and the living wage

was calculated as $12.48/hr in a 40 hour/week job. Twenty percent of those surveyed had been homeless for more than 3 years, 27% for less than one year and 54% for one to three years.

> To be homeless is to feel unsafe every minute of every day. It means that you are never truly able to stop looking over your shoulder or let your guard down. It means that you are vulnerable to frost bite, heat stroke, physical and sexual assault, verbal abuse, theft or arrest. It is a sustained violence that batters the body and tears open the soul. It leaves scars and takes lives. (Witherbee, 2008; p. 3).

These thoughts were echoed by study participants. Equally strongly expressed were sentiments of abdication of responsibility by governments.

> *That is the mentality I think of Nova Scotians. That is has been done for so long by church groups and non-profits who can hardly maintain, who are constantly fending for grants and sustainable dollars to think outside their own narrow board of directors I bet is a real challenge. I can't speak for that. But I can speak from the holistic responsibility of government that they do not provide the support of one agency then to or even to form a coalition of agencies to band together to meet the basic needs as well as the psycho-social needs of our homeless population. And it seems if they do give minimum dollars to a shelter or to a church that they have somehow done their duty. In my humble opinion, I think they are abdicating their duty when they don't, mind you we are talking 30 yrs now since the hospitals have started to close their (*psychiatric*) beds so this is not going to turn around easily. It's going to take a real sustainable coalition of people I think to change how the services are provided to inadequately housed mentally ill, I'm thinking of primarily.* (health professional)

Strategies to <u>end</u> homelessness differ from those used to <u>treat</u> or ameliorate homelessness (Barreto, 2007). The root causes of homelessness are poorly understood. Minimally they include societal failure to equitably distribute resources. Others include housing shortages, poverty, disabilities, joblessness, capitalism, lack of social welfare supports and family changes (Shlay, Rossi, 1992). The quest to end homelessness is a challenging one, fraught with potholes and potential for mis-steps. Attempts in the past included the USA federal program under Housing and Urban Development that utilized a continuum of care framework of outreach/ intake/ assessment, emergency shelter, transitional housing (job training, mental health rehabilitation, education, substance abuse treatment, family supports, etc), and permanent or supportive housing.

When well executed, clients placed directly into housing had decreased shelter use, hospitalization and time incarcerated; savings gained almost equalled the costs of the housing units (the housing first approach)(Barreto, 2007). The housing first approach was premised on the concept that if individuals were safely housed in places affording them dignity, they could better deal with other issues leading to their homelessness (Witherbee, 2008). Many housing first programs accepted individuals as long as they were no harm to others and that they contributed a percentage of their income to pay for their housing. To be effective, housing first programs looked at homelessness comprehensively; supplementing housing with other supports and counselling to enable those housed to thrive in their new environment. Core components were rapid housing, permanent housing with sustainable support services, prevention of harm and future homelessness, client choice and opportunities to participate, and minimal obstruction to eligibility (Cohen, 2008). Implementation was not without obstacles; leadership and adequate funding (funding that was not dependent on the vagaries of political parties) were imperative for sustainable success in undertaking a community-wide approach to prevention of homelessness. Broker organizations or "local intermediaries responsible for fostering and convening partnerships and networks among existing organizations" (Witherbee, 2008; p. 41) were helpful. They facilitated funding, public advocacy and media information. They appeared to be most effective when chosen by local consensus rather than appointed from outside (Witherbee, 2008). Such community linkers (or boundary objects) could build on the universal concern regarding affordable housing expressed by study participants.

6.8.2 <u>Affordable, Safe Housing</u>

Study participants were disparaging about the lack of governmental support for safe, affordable housing and the cutbacks of federal, provincial and municipal funding.

This is one is another development of social housing and again, in the business, and government call them a non-governmental organization. Anyway, it's for single adults and that's been a real issue for most of my career here that the fact that single people who are alone and who really are at the mercy of the rooming house landlords and it's been very unhealthy and there's still exists a small profits from very unhealthy rooming houses. This is the alternative to that. There're 20 units of

housing that will give people a safe and secure place to live and develop a sense of community. (health professional)

(photograph by participant #4)

In spite of the reduced funding opportunities and support, there have been efforts to increase affordable housing within Halifax.

Public housing is managed by the provincial government. It's the Department of Community Services, owns, you knows, owns it, manages the properties. Co-operative Housing is you and I...we could sell off our co-operative, you know, if we had any properties that we wanted to administer co-operatively, we could set that up and have like our own co-op family. You know, it's got, you'd have a board of directors and new members association, and all this, you know, all this, like there's no, there's rules about co-ops. And the difficulty is that there aren't, haven't been new co-ops built lately, because it was something, that you know, the federal government used to actually have. One thing is that they provided for proper housing to be built and then, you know, what, I don't know. However, wherever that money came from stopped flowing and so there hasn't been any new co-ops built in I don't know how long. (community member)

There are still some co-operative houses in existance.

I live in co-operative housing right now and the Halifax Women's Housing Co-op has three buildings in the North End, one on Fuller, one on Creighton, and one on Robie. (community member)

And there are efforts to increase availability of affordable homes.

Another good thing is that there are groups in this community, the Creighton and Gerrish Group Development, who are building affordable homes for people who use to live here but moved out and can't get back because of the price of the properties. They're building properties that they can afford so they are trying to encourage them to come back. The first offer for their properties is always, one of the qualifications is that you have to be from here, you have to have lived here or some connection, so that's first off, then after that of course is then it goes out to

187

the general public. Right across from the North Branch Library used to be a Sobey's store, but there's going to be 36 condominiums going in there and 12 one bedroom, 12 two bedrooms and 12 three bedrooms, all affordable to allow people to come back to the community. (community member)

Tenant participation in management of non-profit housing occurs to some degree in North End Halifax.

(I)t's best to involve the tenants, who live in the development, of the design of the building. One issue was, where is the laundry room, those who were going to be tenants would say well if you're going to have a laundry room, don't make it in some isolated room where there's no one around. That's intimidating. Put them in a central area. So just simple things like that. There were a number of things that people wanted and the architects came and met with people who were potentially tenants to talk about the design. All that facilitative management is all encompassed in that way of thinking. 'Cause if you do it yourself, it's totally different, it's amazing when you involve people in the process. (community member)

There are many literature resources available that explore tenant-centered and tenant-participation management outlining the benefits and the challenges (see Roder, 2008, for example). There is limited supportive housing available in North End Halifax.

The Housing Support Centre on Gottingen and Gary St...it's a drop in centre, it's a community, well for people for have been marginalized due to their poverty, addiction and mental health issues. So it's a gathering place for them. And they can go there and be welcomed there and get their needs or their issues addressed through support of the people there and our health centre is very active there, we have 4 or 5 staff that have a direct working relationship and collaboration with the staff in that organization. And besides being a drop in, the 2ⁿᵈ level of the building has actually 19 housing units, it was a response to a need of people who were actually dying in run down exploitative housing and conditions. (health professional)

With supportive housing in particular, landlord collaboration is critical and invaluable (Kloos et al, 2002). And perhaps helping or perhaps hindering, there are

those new ritzy apartments going up on the corner of Gottingen and - what would that be? It's where the old, anyway, they're going to be lovely condos, lovely. And it's in that, there are really old houses that's in there and it's going to be amazing to have, I think they're going to sell them about the $350,000 range so with more people with that kind of income around it's going to help. I mean, I realize there're still worries about driving the prices up. Anyway, I have very mixed feelings about this, but probably more positive than negative. (community member)

(photograph by participant #3)

And there are unfulfilled promises.

But it is a pity that that space is really wasted now. There was a picture in the paper of somewhere, um, Megan Leslie, our Member of Parliament, saying that affordable housing is going to be built there. Well, you know, and she turned the sod, but, you know, who's doing it kind of thing is the next (question). (community member)

And there are suggestions for improving the affordable housing now available.

But you know there are some, many things, I think, we could do to enhance the health of people who live in these buildings. First of all, just having secure housing that's safe, that's affordable, that's well maintained, is, I think, a big piece of providing sort of a core sense of well being for people who have no place to live, who can't afford where they're living, whose housing is crumbling around them. If the housing isn't healthy, if there's mould, if there's leaks, if it's cold, all of those kinds of things. (community member)

Other communities have established programs to repair and maintain the housing of elderly community members so they can remain in their own homes for as long as possible.

I had a series, just of new housing developments, um, that can either demonstrate a mixed income community, um, and the renewal of some areas or it can also demonstrate how economic pressures are making housing, in a once affordable neighbourhood, not very affordable for many. So I haven't figured out where the balance is going to be there. And there may never be, but, yeah. (community member)

Study participants wondered about the effects of gentrification and mixed housing on the affordability of housing in North End Halifax.

189

Yeah, yeah and I see that flowing both ways (mixed housing), very much so, flowing both ways. I've seen write-ups on it of, you know, mixed housing sort of bringing up the poor basically, you know, and, and developing a work ethic in the poor being very well, but I think there's always a work ethic, um, for a lot of people, but I think there is a belief that it is possible. That it is necessary also and yeah, I saw, I mean I see the benefits of a mixed housing situation definitely working both ways. Um, its, I mean it's, it's a complex issue to blame on and I'm not blaming one cause, but there is certainly a protection of, that affluence affords. And there are many things that one doesn't have to see when one doesn't want to. And there are many perceived causes of issues that ah, can be believed when one lives removed. (community member)

The availability of housing is influenced by the characteristics of the neighbourhood.

6.8.3   Neighbourhood

In North End Halifax, there are varied neighbourhoods. There are heritage buildings interspersed with modern structures.

And here is looking at the community, old and new. You've got Brunswick Tower, you've got your row houses, the church spire of St. Patrick's. Then behind it, you've got Cunard Court big apartment building, then the industrial office tower. You've got the school and the little tower with, then is going, going west of, of St. George's round church. (community member)

(photograph by participant #3)

There are well kept areas and those that are unkempt.

the house, the house on the south...and that there had been a fire in that house and, you know, and so routinely Unsightly Premises signs go up on the door and you know, whatever is the, whatever is the request, you know, and there's something painted up or fixes the railing or whatever. But those houses haven't been lived in.

190

Like, I mean, rumour has it, that people have been in and out. It's squatsville. (community member)

(photograph by participant #3)

Uniacke Square was a mess, in quite disrepair. We had a lot of drug problems in the community, a lot of prostitute problems, a lot of gun play, were a lot of issues in the Uniacke Square community. People were leaving, housing had begun to board up the windows, to go through it looked like a war zone, it really did. People did not want to live there, people were begging to get out. (community member)

Uniacke Square has been transformed as illustrated by this

little house and a nice little garden directly across the street from Hope Cottage, which is the, ah, area called Uniacke Square, and it's all public housing. And some of it is from 1988, a regeneration having been done of the buildings and built porches and everything up around them. Yet there was some, some of the houses, um, are pretty run down and there's plywood over some of the windows. So I thought this is very nice. That, you know, who ever lives here, you know, has this bright little flower garden and all the flowers in the front. (community member)

(photograph by participant #3)

191

Study participants spoke of friendly fences, caring for their surroundings, front stoops for watching the world go by and chatting with one's neighbours, the laughter of children playing together and the competitiveness of local basketball games. They spoke of people from many backgrounds and diverse interests.

> *Just pride of ownership, healthy mind, healthy body kind of stuff. Studies say when houses look like this instead of having papers blowing around, then it's a better neighbourhood for everybody. You just look at that and it looks like a place you'd want to live, raise kids, all that stuff.* (community member)

They spoke of neighbours helping neighbours.

> (B)*efore my mother went into a nursing home, one of her neighbours came to her and said, "will you do me a favour?" And at that point she wasn't doing any favours for many people, she was trying to hang on. And she said, "yeah." And she said, "would you let me tend your garden?" She said, "I'm a frustrated gardener, look at the size of my garden." Of course, my mother was thrilled and her house looked much better than it had started to look because she couldn't do it anymore. So, yeah, there's that kind of stuff, particularly in those small areas there are people who would love to have some more space. So if we could introduce that idea.* (community member)

Neighbourhoods are one component of the built environment.

6.8.4   Built Environment:

Billboards, buses and business complexes form our built environment. Parks, public places and pathways are part of our built environment as are roads, restaurants and residences. The built environment has largely resulted through the accumulation of many smaller decisions and rarely is designed intentionally. When it is intentionally designed, it is usually to meet the needs of middle class folk. Our cities and suburbs are slow to adjust to our changing lifeworlds (Jackson, 2003). How our environment is constructed has been shown to affect walkability, mental health, traffic safety, affordable housing, crime, policies and economics (Jackson, 2003).

The built environment can engender positive or negative feelings that in turn can impact on health.

> *This is a fence at the corner of Charles and Maynard Street and behind it is where the Harbour Hoppers live, which are these amphibious vehicles which go around town with tourists. I fucken hate the Harbour Hoppers and I have a personal, I hate*

them yelling, the custodians, whatever they are, the guides on them. And I always turn away. I won't look at them. It's like some kind of bad whammy superstition I've got. I will not look at the Harbour Hopper. This is a picture of a Harbour Hopper before it becomes a Harbour Hopper and there's a few of them parked there behind this fence. And what I find astonishing is that before they're Harbour Hoppers, these were vehicles that came out of, from the Vietnam war…And some of these, if you look at them, they have their little windshield still there in them, before they're made into Harbour Hoppers, with bullet holes in them. And people drove these vehicles in the Vietnam War and probably died on them. And I find it kind of obscene. (community member)

(photograph by participant #1)

I just took a picture of this house on Creighton Street because I liked the color. I always liked the color of this house. And there's a few houses in this neighbourhood where I feel better when I walk by them and look at them. And that's, probably my posture improves for a minute or I breathe a little more deeply for a minute or, you know, my mental health improves for 30 seconds, where I look at something where I go, oh, I really like that. (community member)

(photograph by participant #1)

Green space is an important component of our built environment and North End Halifax is fortunate to have existing green spaces (for example, the Commons) and potential green space (vacant lots). Study participants spoke of the need for easy access to

shopping for everyday needs (particularly groceries), of bike paths, of safe places to walk, and of local employment. They spoke of physical barriers for seniors and those living with disabilities; of garbage, dumpsters and gardens; and of pollution.

> *And here's the front of Turning Point. Ah, K went to a lot of trouble* (to plant these flowers)*. It's and plus, I, I went for the irony because here's the, you know, the sewage place, which doesn't smell that nice and then you have these that do, so. You know I thought and those, and these.* (community member)

(photograph by participant #2)

The built environment in North End Halifax includes physical activity resources such as the Y, Palookas', basketball courts and gym facilities for those who are homeless.

> (O)*ne thing that has come out of the local street health report was the fact the homeless have nowhere to look after their physical health, meaning exercise requirements through the day and because this church has a gym and the exec director has an interest in providing and maximizing the use of the space. It's going to open its door as a gym for the homeless and transient population. They're trying to get it organized to be manned by volunteers who have some background in training, physical training. So it's just a wonderful provision of the needs of this population.* (health professional)

Participants spoke of parks, pathways and efforts to have a greener environment. The elements of built environment of North End Halifax are strengths on which to work towards a healthier future.

6.9   CREATING A NEW FUTURE ON COMMUNITY STRENGTHS

Belief in **creating a new future on community strengths** was a thread through all of the study participant conversations. The stories of the area's past as recounted under the

theme of <u>community heritage</u> serve to provide context for the present, illustrating the community's resilience and diversity. The present <u>community diversity</u> is a resource for imaginative and effective community planning; past <u>community accomplishments</u> create optimism for future achievements; and <u>community children and youth</u> give hope for the improvement and sustainability of the area. Strengths revealed through narration and imaging demonstrate the basic ingredients needed to improve community health; a way forward that eschews *othering* and comprehends *togethering* as achieving benefits for all.

6.9.1   <u>Community Heritage</u>

North End Halifax has a rich heritage of which community members are justifiably proud. That heritage was chequered and included the Halifax Explosion and expulsion of citizens of Africville from their homes. The strengths of the community members, their resilience and wish for survival are evident in the following interview excerpts.

Aikens Cottage is found on Brunswick St pretty close to Cornwallis St. It's a historic building. It's one of our heritage buildings here on Brunswick St. It's a reminder, Aikens Cottage and those homes along Brunswick St, is a reminder of the affluence of Brunswick St at one time in the city of Halifax. The well to do and the rich lived on Brunswick St. As time changed, those folks moved their homes off of Brunswick and up to the South End of the city. But leaving behind some very significant houses. We've lost quite a few of them, but there still remains on Brunswick St some very significant, what would have been, estates at that time. (community member)

Little Dutch Church…You know, again real contrast in terms of what we have here. But again, that building goes back to the beginning of Halifax, it was built for the German population to celebrate their religion in that church and the graveyard that accompanies that goes back to the beginnings of Halifax, very significant building in terms of history of the city. But it's dwarfed by those Brunswick Towers. Brunswick Towers represents the thoughts of the day of modernizing Halifax and Halifax becoming a metropolitan area with all the new things. Just below Brunswick Towers is Barrington St and Barrington St at one time, was lined with old, really nice homes, all the way from Scotia Square, all the way up to the dockyard. And they were all demolished with the plan to run a major, major highway system through there…But the Little Dutch Church stands here as a reminder of our history here in Halifax and our humble beginnings. (community member)

(photograph by author)

Certainly, the 90's was a period of a real cultural and political and social renaissance of Black community, much of which existed around the North Branch Library. And that was when George Clark started writing, that's when "For the Moment" was performing, that's when David Woods was doing all of his work, that's when Cultural Awareness Youth Group was occurring, all of this was happening in the, from about '82-'97/'98 was the peak of this emergence and growth of the Black community as a social force seeking its own artistic, social historical, educational place in the community. (community member)

(photograph by author)

Well it's been used as a Common historically for over a hundred years, I mean, forever. And who knows, I don't know how they kept it from being encroached upon but they have. I mean, some people, there's that group, Friends of the Common. (community member)

Community diversity is apparent in the history of the community.

6.9.2 Community Diversity

The populations of North End Halifax have probably changed more over the years than other areas of Halifax and the present populations are far more diverse than elsewhere in the city.

I think that, what we know about urban development is classic in the trajectory is so obvious, so first you have a solid stable working class community, and then you have a working class people with upward mobility leaving that community and leaving it to its poorest members. The poor and the elderly, and then after that you have artists move back in and political types move back in because they are romantically attracted or politically committed to the more integrated lifestyle. And they move back in and once they move back in then they create this kind of artist community, a kind of bohemian environment that is extremely attractive and once they do that then the value of the properties go up and the businesses geared toward that community and so where we are now is in stage five. (community member)

North End Halifax has a variety of ethnic shops.

(photograph by author)

*I know this shop, Indian groceries store. I just think it's nice that in the neighbourhood there are some interesting little stores. We don't have very many ethnic people, let alone stores, in this city but we do have a couple in the North End. I've shopped there and bought stuff. You could probably get it at Pete's (*upscale fruit and vegetable store*) for a little more. Or a lot more. I just think it's great he can make a living selling that kind of stuff right in the neighbourhood...There's the one on the corner of North and Agricola, Phoenicia Foods, and it's great. Given that there's that Italian Culture Club there, you'd think there might be, well, there is, there's Brothers. I mean, there's an institution. So there are little places.* (community member)

The diversity of North End Halifax is a valuable resource for creative solutions and planning to improve community health.

197

6.9.3 Community Accomplishments

Community accomplishments or assets can be envisioned through a neighbourhood assets map or as different forms of capital: financial/ economic/ business, physical/ environmental, cultural, creative, information/ skills/ knowledge, social and human. Study participants gave examples within all categories, a few of which are given below.

> *The Mainline Needle Exchange is a, um, it a, ah, I have a lot of respect and a lot of appreciation for the work and the dedication and the commitment that, um, this agency, particularly the individuals that, that drive this agency.* (health professional)

> *I feel really lucky to have a neighbourhood drug store in my neighbourhood, a neighbourhood drug store in my community. And I don't just mean, it's not just geographical location because I think probably I'm a tiny bit closer to that giant Shoppers Drug Mart, which is not a neighbourhood drug store at all. It's a big anonymous warehouse. I mean, they've got lots and lots of stuff but the Pharmasave is a neighbourhood drug store. I know Sally at the front who sells the stamps and the candy bars. I know…my main pharmacist. I know…the owner. I walk in there, I get great service…I'm very, very happy that I can walk half a block from the North End Community Health Centre and get such great pharmacological – pharmacological is probably the wrong word – service…If I need $3.95 hair dye so that I can turn myself into a slutty blond carrot top, then I'll go to Shoppers Drug Mart. But for my medications, my serious stuff, I am privileged to be able to go in my neighbourhood…this place is a tremendous asset to the neighbourhood.* (community member)

> *I think* (Palooka's) *made everybody feel good about the community and that somebody's interested. Because I have been here almost 30 yrs and it's the first time that somebody from the private sector has contributed in a significant way to this community which is given the wrong end of stick all the time and is perceived as being the bad part of city that you wouldn't walk after dark and that kind of thing.* (community member)

Palooka's and the philosophy around the discipline of boxing is one investment in the youth of the community. There are others.

6.9.4 Community Children and Youth

Children and youth represent our future and optimism for better health outcomes. Early childhood development is one of the critical elements for life-long well-being. The community of North End Halifax has recognized and supported their children and youth in a number of ways.

(photograph by author)

The first year was last year (for the community garden) a small number of 32 children and a few adults in the local area, but she had such a commitment from other partners such as the George Dixon Centre, a couple of companies donated stuff, but this has taken off. Black Business Initiative provided a grant here to help the youth. This is taken off. It's like a seed that has taken rhizomes and grows by rhizomes. (health professional)

(photograph by participant #2)

The Cunard Street Children's Centre… It's a 100% subsidized child care centre. It makes a real difference to have child care here in the neighbourhood because we have a very large percentage of single parent led households and they're mostly female. Many of the women work and go to school and so for them to have child care is critical, child care they can afford. And for the kids it's fantastic. (community member)

The optimism embedded in children and youth mirror the potential for the North End Halifax neighbourhoods to move forward together to improve the health for its community members.

6.10 SUMMARY

As I read and re-read the incredibly rich input of the study participant conversations, I was struck by how I, and no doubt others, accept the many insidious and invidious standards, beliefs, values and norms of middle classism. Consciously and unconsciously, we as humans seem to separate ourselves by what we have (or do not have), such as food or housing (in)security; by failing to understand each other's everyday world; by building walls around ourselves; by foisting responsibility onto 'them'; by not actively concerning ourselves that there are many without housing let alone a home; we tend to have a stance of othering.

I was struck by how graciously study participants accepted me in my quest which must surely have appeared to be déjà vu all over again. I met people who I would, in the normal course of my life, only come to know if they were patients. And I couldn't help thinking of every one of the study participants, "here is someone I would like to know better"; how acceptance of another is based on exchange of information and communicating to understand. Threaded through all of the conversations were humour, optimism and identification of strengths on which to build. There was a spirit of 'let's work together' underlying many comments. The insight I gleaned from the grounded theory analysis of the interviews, limited though it is, led to the basic social process of *from othering to togethering* as a way to begin to address community access to health. Rather than conceding to the separations or othering that presently exist (or we perceive to exist), through accepting the intrinsic value and capacity for all to contribute, we can move together towards designing and achieving a better future.

The major points that I gleaned included:

- Health is a human right
- Housing is a key component of optimal health
- Those living in poverty experience greater adverse (inequitable) impacts from the other determinants of health (cumulative effect)
- Society created the divisions we see

- Greater benefit would be accrued from attempting to change society and its organizations than attempting to change individual's approach to health
- North End Halifax has a proud history and assets on which to build

This time of construction in the area is opportune for a re-look at how it could be better designed to facilitate the health of community members. The way forward, I believe, will involve:

- Building increased social cohesion and trust
- Active intolerance of health disparities
- Using the power of stories and pictures to change the image of the neighbourhood
- Development of parks and squares; gathering places and forums for conversation (places that are welcoming of those who presently hang out in front of the Salvation Army or Mainline for example)
- Treating people as if they mattered
- Justice-oriented citizenship
- Linkers and brokers
- Changing society's response to the determinants of health

CHAPTER 7   FEMINIST THEORY LENS

(photograph by author)

The background reading that I did to formulate my feminist theory lens became a subconscious blank burlap backing on which the picture evolving from the feminist theory lens-grounded theory analyses of the interviews was hooked. The warp and weft of that woven burlap cloth included the following strands. Relationships are central to feminist theory and within an ethics of care. Families are a paradigm of relationships and a micro-paradigm of relationships within communities. Participants in the study emphasized the importance of family - with respect to roots or heritage, as supports and responsibilities, as companions and carers, as stressors and saviours, as promoters and detractors for health. Within the context of a feminist lens, families and family membership are self-defined. Family, as idealistically conceived, engenders a vision of caring.

> There was a regular time to come over and have kids and the elderly people do activities. And I remember…I have a young friend who is about 22 or 23 who was a child in that daycare and his grandparents didn't live here. He had grandparents in Costa Rica and in Calgary. And he called all of the older people who came his grandmamma and his grandpapa. It was so funny. He would tell me and he would always have different grandparents every week. (community member)

Both African and Aboriginal nations emphasize family and community; some are matriarchal (although the Atlantic Provinces Mi'kmaq culture is not). Historically, within

Indigenous cultures, women were highly respected. Creation was believed to be gyne-centric beginning with Thought Woman "whose thoughts preceded creation, and from whom all else was born" (Reeves, 2008). Women were valued for their economic contributions as well as their positions of authority and place within rituals. However, colonization contributed to life style changes that are more sedentary, to alcoholism and to drug addiction. All of which, in turn, are related to higher incidences of diabetes, obesity, cancer, foetal alcohol syndrome, suicide, homelessness, poverty, HIV/AIDS, sexually transmitted infections and smoking among Aboriginal women (Reeves, 2008).

This history serves as a cautionary note for future endeavours to improve the health of North End Halifax community members - imposing through assimilation the norms and values of the dominant population has done harm to both those assimilated and those leading the assimilation (Restoule, 1999). All cultures can learn from one another, changing how we view the world. Integration (preservation of one's own culture and participating within the dominant [and others'] culture), was seen as preferable to assimilation (adoption of dominant culture and suppression of own culture norms and values)(Restoule, 1999). Study participants implicitly agreed with the philosophy of integration rather than assimilation through references to resentment when others tried to make abstinence a requirement for shelter, writing contentious treatment of African Nova Scotians out of our history, and pressures for conformity to the Euro-Nova Scotian middle-class ways of doing things. As quoted in Marmur, 2002, "the more one attempts to identify with those who have labelled one as different, the more one accepts the values, social structures, and attitudes of this determining group, the farther away from true acceptability one seems to be. For as one approaches the norms set by the reference group, the approbation of the group recedes." (p. 4).

Women are more likely to have the major responsibility for care of children and elder relations; are more at risk of living in poverty. They have a lower median income than men, and positions held by men on average have greater power and prestige. Within the illness care system, there persist many gender related discrepancies with women more likely to be nurses, occupational therapists and social workers; men are more likely to be

physicians or biomedical engineers. Gender-based differences exist in health and in illness care. As stated by Spitzer, 2005, gender "intersects with factors such as ethnicity, sexuality, age and disability in dynamic and complex ways" to determine health (p. S78).

For women, "health inequities emerge from the demands of multiple gender roles, environmental exposures, the threat and consequences of gender violence, workplace hazards, economic disparities, the costs of poverty, social marginalization and racism, aging, health conditions and interactions with health services and health behaviours." (Spitzer, 2005; p. s80). Although women live longer than men, they experience greater morbidity and chronic disease (Pederson, Raphael, 2006). With respect to healthcare services, Jackson et al, 2006, noted that in Canada, although women have twice the rate of osteoarthritis as men, they were less likely to discuss total joint arthroplasty with their physician or to be referred to an orthopedic surgeon, thus compromising their surgical outcome through delayed procedures. Indeed, women of color have higher rates of knee osteoarthritis than White women and were even less likely to undergo joint replacement.

The particular vulnerability of women around the time of pregnancy was acknowledged (Braveman et al, 2010), as well as the greater risk of domestic violence and abuse of women who were homeless (Richards et al, 2010). All gender-based disparities tend to be heightened for Aboriginal, African Nova Scotian and immigrant populations. Sexual health and healthy sexuality have been re-defined to include emotional, physical, cognitive and social aspects; to include individual, family/ community and systemic impacts; embracing personal experiences, social position, social scripts of one's group (norms - behaviours, rules, expectations) and cultural worldview (Reeves, 2008). Our lives, communities and larger environment tend to be a culmination of the accumulation of many small, everyday unconsidered things. The use of a feminist lens helped to illuminate some of these.

Through using a feminist theory lens, *adopting an ethic of care* was identified as a basic social process for the achievement of health for North End Halifax community members.

7.1 ADOPTING AN ETHIC OF CARE

Adopting an ethic of care emerged as the basic social process that tied together the substantive codes developed from community member interview analyses through a feminist lens. For me, the ethic of care embraced the concepts of connections, relationships, communities, nurturing, reciprocity and concern for inequities. It included the feminist theory precepts of situated knowers, circumscribed autonomy, self-definition, empowerment and non-domination.

Nine components of adopting an ethic of care evolved from the data- **exposing inequities** highlighting the reasons for examining access to health (concern for inequities), **problematizing the everyday world of the middle class** to shift the emphasis from changing the unprivileged to changing the privileged (non-domination and concern for inequities), **understanding the everyday worlds of community members** to provide context for change (connections, community), **forming relationships/ alliances** to work together for change (relationships and reciprocity), **shifting the paradigm of helping** to learn effective supporting (self-definition, non-domination, reciprocity, empowerment), **reconceptualising health care** away from the biomedical to a holistic approach (connections, relationships), **building capacity** for community development (empowerment, nurturing, situated knowers), **ensuring food security** (nurturing, circumscribed autonomy) as one way of **redressing inequities** (concern for inequities, connections). These concepts are presented in **Figure 4** and discussed further below.

Figure 4   Feminist Theory Lens Analysis Concept Map
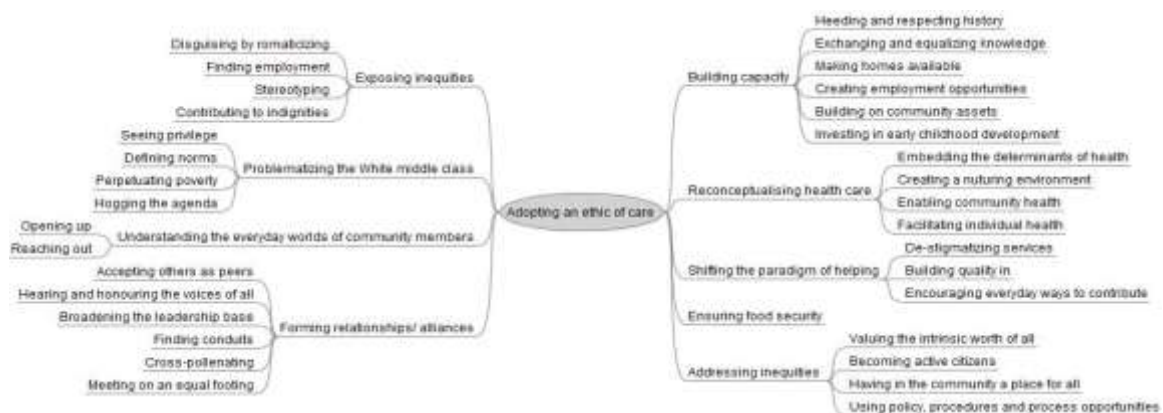
7.2   EXPOSING INEQUITIES

Exposing inequities came together as a substantive code composed of the concepts disguising by romanticizing, finding employment, stereotyping and contributing to indignities. Disguishing by romanticizing conveyed the import of not permitting the strengths of the community to obscure the reality of persisting inequities; finding employment was noted as an area where discrimination and inequities were expressed and an area where, if redressed, could help to decrease inequities; similarly with stereotypes; contributing to indignities highlighted how we all are aiding ongoing inequities. These strands, when braided together, form a piece of the mosiac of *adopting an ethic of care*.

7.2.1   Disguising by Romanticizing

Whereas there were stories of individuals whose lives turned around following supportive services from agencies such as Direction 180, the Methadone Clinic, Turning Point and supervised housing, many had to be turned away because of inadequate resources. These agencies and the work they do are critical building blocks for the future health of community members, but they are woefully insufficient. Threads that ran through the stories told by participants included strong Black women, resilience and survival in adversity; they were imbued with the philosophy that 'God only challenges you with what you can handle'. Yet, the question of why should community members have to face such obstacles was never asked. The many stories of resilience and survivorship from the Halifax explosion, Africville and mistreatment of African Nova Scotians are undoubted strengths yet camouflage the lives of many who have not thrived.

> *Centennial Pool 1967, to me is significant because in 1967 they were tearing down my church in Africville at the same time they were building this building to commemorate 100 years of confederation, they were destroying the community of Africville...It's a reminder of on the one hand we are celebrating our history and on the other hand we're destroying it.* (community member)

Remembrances of the days when Gottingen Street was THE place to shop rekindled visions of economic revival. Recollections of community activism and accomplishments harboured wishes for return of an era past.

(photograph by participant #1)

I think the North End Library and I think the North End Clinic can continue to provide good service to this community and should but I don't think they can rebuild this community. And I don't think those institutions can re-empower. And I think most of us who work and participate in those places do so for the kind of longing of the past. Kind of romanticized notion of what could be from what was. You know, breaks my heart. I don't think there's anything the matter in wanting that, but I don't think it's a realistic assessment of what's actually going to improve the quality of life of the most poor people in this community. (community member)

Yet that heritage and spirit are assets for future change. Being able to live safely, shop and be employed in one's neighbourhood has appeal for many.

7.2.2   Finding Employment

There's been no economic development of any significance in this community, and it needs to be, and people would like to live where they work. (community member)

Employment is felt to benefit individuals by imposing a time structure to the day, compelling social contacts and shared experiences with non-family members, developing collective goals, bestowing status and identity, and enforcing activity as well as a way to obtain a living wage. Subtle forms of discrimination in acquiring employment still exist. Among the unemployed of North End Halifax are individuals whose life chances have not permitted them to gain the education and skills needed for achieving employment.

There are controversial forms of employment in North End Halifax. Organized crime is known to exist in North End Halifax. Work in the sex trade (or survival sex) and in the

207

drug trade were not viewed favourably. Both survival sex and survival drug trafficking were variably viewed as victim's responses to poverty, or a poor choice for temporary gain or relief with disastrous long-term consequences. In a study of twenty-eight women living with homelessness, Ryan et al, 2009, noted that their lives were more likely to be complicated by drug and alcohol use, violence and risky sexual practices. The decision to have sex for money was influenced by emotional bonds, craving for relationships and /or a need for drugs or food and shelter. A history of abuse and coercive partners who encouraged participation in the sex trade was common in those engaged in street level sex work (Harding, Hamilton, 2009). Greater freedom of choice is likely for women who participate as escorts than for those who are paid for sex by strangers found through pimps or streetwalking.

> *My feminist politics is get us out of the fucking sex trade. It's dangerous, it destroys our lives, it destroys our children ... No my life is really good 'cause I'm not engaged in prostitution. Your life isn't 'cause you're engaged in prostitution. It's not much as a moral judgment, as an appeal to your own empowerment. Can we talk about a strategy to get the hell out of this situation? You know, that is completely apart from the gorgeous young law students who make $2000.00 / month being called Call Girls, like whatever. If you can do it, fill your boots. That's the myth- that women are empowered, that if they want to sell their bodies, let them sell their bodies. But among poor women, it's turning your life into hell. Absolute hell.* (community member)

Study participants noted there were few opportunities to gain employment (and an adequate living wage) locally. Some of that failure to gain employment is linked to stereotypic beliefs.

7.2.3 Stereotyping

There is a tendency for us to define people by their circumstances rather than their individualities, assigning to all members of a group similar characteristics. Stereotypes mentioned included those who are homeless (unkempt, smelly and odd versus the reality of many who are well groomed, employed, everyday people indistinguishable from 'us'), Black youth, those working in the sex trades, homosexuals, drug traffickers and those with mental illness. Youth, those who are homeless or Aboriginal in particular, are ill served by our system. Mental health was a significant issue identified by most interviewees. Mental illness was associated with being different, poverty, homelessness,

unemployment, isolation as well as challenges to other aspects of health. Many who might benefit from mental health interventions felt alienated by, lack of access to or discomfort with available mental health services. Although many of us have relatives or friends with mental illness and understand there are biologic or genetic causes of mental disease, we often find it challenging to work alongside or have social or other relationships with people living with mental illness. Whereas we would rarely chastise an individual with osteoarthritis of the knee for limping, we may expect a person living with mental disease to behave normally.

> *Local residents and business people often have a negative impression of that clientele. But little do they know the personal stories behind each one of those clients. 'Cause anyone of those clients can be our cousin or family member who has had a very difficult time and who has hit rock bottom.* (health professional)

> *I mean, you know, I'm, I'm certainly projecting that among I don't know how many individuals living in the townhouse across the street from Brunswick Street Mission understand its, its open house. It's, um, kind of, its contribution to the community of people who don't have the resources to be able to live and have safe housing. So, just, you know, that the two kind of, the two have, the two are in, kind of the open house and the different meanings of it. I'd like to see some of the gents I know, go in and take their shoes off at the door and see how well they would be received.* (health professional)

We carry with us images of poor children in ragged clothing, mumbling men with mental illness, illiterate Blacks, glassy-eyed addicts, immigrants in strange clothing that have little basis in reality that nevertheless affect our relationships and actions.

> *I think another thing that might be said to the rest of the population, the White population, middle class Haligonians, is that we don't want to assume that the Black population that live in this end are all illiterate and poor and impoverished, because of the education they have or lack of.* (health professional)

> *The general public is intimidated by a crowd of five or six young Black kids walking down the street and wouldn't be if it were five or six White boys.* (community member)

> *I'm at this meeting and they had a really good poster for it; and they showed this picture and in this picture they showed a pathetic looking little child with torn clothing, saying Demonstration Against Poverty, I said I sure as hell hope that you don't think poor people are going to be attracted to that poster? Well what's wrong with it? Well the poor people I know don't dress their children that way. And if they do, they don't want anybody to know that. And they don't even want to*

209

acknowledge that so you're actually insulting the poor people in this neighbourhood by putting up a poster like that. (community member)

Stereotypes continue to haunt us and contribute to indignities foisted on others.

7.2.4   Contributing to Indignities

Through society's complicity in tolerating shelters and soup kitchens that ameliorate or render more invisible poverty, housing insecurity and food insecurity, we are colluding with governments in their abdication of responsibility. Similarly, we are condoning indignities experienced by fellow human beings. Some of those indignities were (and are) flagrant.

> *When I visited to the dorm, I think there were 65 or 67 bunks in the dorm and when they opened the room I almost got nauseated because of the foul odour of body and just probably unwashed clothes; basic living odour was what you were smelling.* (health professional)

Others are less so.

> *Some of the buses still have steps, which makes it difficult if you've got a stroller and kids and so on. So they don't want any buses with steps. And when service providers offer programs they want to make sure that there's a place to park their strollers. So like, we're told that bus drivers… that you can't take many bags of groceries onto a bus.* (community member)

Study participants spoke about being talked down to, ignored, herded like cattle through line-ups, treated as stupid and regaled to reform. Hoffman and Coffey, 2008, in their study of 500 interviews of people experienced with homelessness, identified similar interactions as objectification and infantilization. An attitude of marginal resources for marginalized people seems to prevail within the bureaucracy and middle class citizens of the municipality of Halifax.

7.3 PROBLEMATIZING THE EVERYDAY WORLD OF THE WHITE MIDDLE CLASS

The substantive code of **problematizing the everyday world of the White middle class** grew out of the concepts of seeing privilege, defining norms, perpetuating poverty, and hogging the agenda. These concepts, in turn, were exposed through seeing the interviews with a feminist theory lens that embraced the ethic of care. Seeing privilege enables us to appreciate subconscious domination as does defining norms; our failure to see our inter-

relatededness and connectedness leads to, albeit unintentional, <u>perpetuation of poverty</u>; and <u>hogging the agenda</u> has allowed little space for other than Euro-Nova Scotian, middle class men to dialogue in places where the status quo can be influenced. **Problematizing the everyday world of the White middle class** reframes the challenge about who needs most to change to achieve optimal health for North End Halifax community members, a pathway to which can be enabled through an *ethic of care*.

The White middle class are largely responsible for the federal, provincial and municipal governments that are elected. The values of the dominant classes are ultimately the values that become reflected in government transactions.

> *I've come to the conclusion that government policy around social housing is intentional because they don't want to be in it* (housing). *They look at the high density housing projects and the cost, they just put people into them who are absolutely poor and have no resources, got no home, dysfunctional families. You just keep putting people in who are poorest of the poor and that's wrong.* (community member)

Health professionals have largely designed the acute illness care system to meet their needs and standards. These are privileges that are rarely acknowledged.

> *I mean, I have experienced it with the eye clinic and trying to get this man who was assaulted, who had some orbital damage, um, in to get checked out. So, they supply me with appointments next day. He has no phone. We don't have an address on him – he just happens to come to Turning Point once in a while. So, finally I got the booking person understanding and she called me, you know, that, I, I've said no enough that she gets it now, that she, she called me the other day and said "Okay, in two weeks can you, do you think you could track him down in two weeks?" Yeah, I can do that!* (health professional)

Power, as manifested by the dominant population, includes the capacity to begin and end relationships (such as collaborations and partnerships) and to define them; they have the power to significantly influence what we see. Usually flowing from a stance of independence and autonomy, the challenge lies in reframing how we live as Haligonians in terms of inter-relationships and inter-dependencies; of acknowledging privileges and thus strengths to share with other community members.

211

7.3.1 Seeing Privilege

People who are White and middle class daily experience, consciously or unconsciously, privileges denied others; whether because of race, socioeconomic status or gender; whether because of disability, poor physical health, mental illness or unemployment. These privileges are largely inherited, based on rationales and beliefs no longer valid or appropriate. Individual success is contingent on, and attributable to, the receipt of these largely unearned privileges (Raphael, 2009). These privileges include having a louder and more influential voice, more opportunities for input in daily lives as well as the world around, greater access to health and many other venues or possibilities, greater freedom to choose, bigger impact in decision-making, more mobility, greater political clout and, sometimes, being more knowledgeable. Anglo-Saxons are able to largely ignore all other languages except English.

> Privilege refers to the structural advantages (e.g. ideological, material, cultural, legal) given to some social identities or groups at the disadvantage of others; whether or not these are advantages readily perceptible, actively sought after, or even desired. Everyone within the system, both those more and less advantaged, contributes to reproducing these power relationships...The most privileged, those who are given accumulated and intersectional assets (e.g. able-bodied, wealthy, American, White, heterosexual, male), are more likely to profit from the prevailing institutional structures because of the frequency with which their identities (separately or in combination) become socio-contextually prominent, beneficial, or useful. (Stoudt, 2009; p. 8).

(photograph by participant #2)

Expressing privileges includes evading responsibilities.

212

This is like one of the houses owned by the X brothers who are like cantankerous crazy guys who own these buildings that are unfit for human habitation and won't do anything with them, won't tear them down, won't fix them up, won't paint them, 'til they're ordered and reordered and reordered again by the city to do it. (community member)

Being privileged includes defining norms and expectations of behaviour.

7.3.2   Defining Norms

White, middle class men in particular have had a major influence on expected norms within our society. They designated appropriate behaviours, expectations, morals, ethics and worth. They determined the standards for work ethic and the position of women's work within that standard. We, as a society, became comfortable with the unfortunate inevitabilities of poverty and homelessness; their existence became acceptable and tolerated. Counter to those norms, study participants viewed others through alternate lenses, perceiving the intrinsic value of people.

But he's my best friend and he's, he's a good guy. I didn't want to do a black and white photo because he's, he uses crack and spends immense amounts of money on it, yet he's a kind and gentle and gentle human being and so on. (community member)

Norms referred to included being employed, adhering to schedules, behaving with decorum, not interfering with others and graciously accepting what one was given.

When I was a kid and you were a kid, you know, we hid our problem children. Our uncles and aunts who, you know. Everybody has an uncle or an aunt that, you know, and so on and so forth. Everyone had a son in the family that was, you know, not enjoying good mental health. But now, it's like, it's a business (the medicalization of some behaviours). (community member)

Homelessness is usually problematized as a lack of safe shelter rather than as a failure of society, or as insufficient attention to root causes, or need for prevention of homelessness. Providing services and shelter are seen as adequate solutions (Wasserman et al. 2009). Indeed, as these authors pointed out, we've medicalized homelessness along with birth, death and much in between, thus shifting emphasis to addictions and mental illness. With medicalization, there is a push for counselling, abstinence and assimilation of proper behaviours. As one study participant noted, we have also industrialized homelessness.

I just, I have a problem with making homelessness and homosexuality an industry ...I just find, I find it extraordinarily crass. (community member)

And, as Wasserman et al, 2009, reiterated, this gave the shelter and other service provider's power of position and patriarchal decision-making. With rules and policies that eschewed addictions and required steps to be taken towards abstinence and achievement of other norms, agencies and workers attempted to mould those for whom they provided services.

The norms of cultures other than White, Eurocentric, middle class are different and sometimes not considered. Spirituality is deeply important to many African and Aboriginal Nova Scotians.

> *What I've learned is that historically when the Black population were not allowed to write or have books, they told their stories through song, so thru generations, rightly or wrongly, stories are passed on through voice through music...I've learned that their spirituality is deepened through song so the beginning of most meetings is started with a song, a prayer that's voiced in song. And so I commonly, I see spirituality in their music as well.* (health professional)

Defining norms impacts how we see poverty (the major influence on health) and thus how we feel about our responsibilities and how we believe that poverty can be ameliorated. Envisioning ourselves in a web of community connections can provide impetus to each do our part to end poverty.

7.3.3   Perpetuating Poverty

We, as Nova Scotians and as Canadians, are in a large part responsible for the continued presence of poverty within our province and neighbourhoods. Because of our scarcity mentality, the presence of perverse incentives, the relative invisibility of poverty within our daily lives and a fear of what it would mean for us as individuals if poverty were truly redressed, we have failed as a community to unite to extinguish poverty. This responsibility has been highlighted in other Chapters.

> *The way the province funds the various social service related agencies sets up a competitive nature with each other as opposed to rewarding us for working collaboratively.* (health professional)

Part of our failure has been related to filling the agenda of our individual and collective lives with items of more direct importance to ourselves than others.

7.3.4   Hogging the Agenda

Recent developments within North End Halifax have been largely orchestrated by the middle/ business classes to meet the needs of wealthier, more lucrative economic prospects. This domination by those of higher socio-economic status has forced a change in the demographics of the area through financial inaccessibility and exclusion of prior residents.

> *You know Gus' Grill somehow managed the transformation from the poorest most suffering depressing working class pub in the city to, you know, high end chi chi movie you know, Four Inch Nails type bands every Friday and Saturday nights packed, lined up you know.* (community member)

(photograph by author)

> *The co-operatives in this area, are dwindling and disappearing, because the first generation co-op folks, when they left, because their income improved, new folks going into those co-ops were not interested in managing the co-op. They just wanted to rent. And so what's happened is a lot of those co-ops have gone to private management companies now or they have come completely bought. So that housing stock that allowed a person an opportunity to move from public housing, to one day to home ownership, is completely wiped off.* (community member)

(New gentrified condominiums)(photograph by participant #5)

Note was made by study participants of gentrification, upscale shops, entertainment facilities and recreational opportunities that cater to the higher socio-economic strata. There continue to be many unheard voices in the many disparate efforts seeking to improve North End Halifax. The definition of improvement itself is implemented through everyday worlds of the White, middle-class. Actively or passively condoning the circumstances which engender a change in the neighbourhood demographics suggest the interests of the entire community are not being heeded. Sometimes cleaning up the neighbourhood becomes a euphemism for ridding the area of undesirable (socially defined) community members (Picton, 2009). Yet greater understanding of the lives of others might help to embrace varied and diverse populations; to develop and strengthen connections to gain new knowledge.

7.4 UNDERSTANDING THE EVERYDAY WORLDS OF COMMUNITY MEMBERS

Understanding the everyday worlds of community members was built from the concepts of <u>opening up</u> and <u>reaching out</u>. <u>Opening up</u> is necessary to permit relationships, <u>reaching out</u> is indispensible in developing connections and thus **understanding of the everyday worlds of community members**. This, in turn, enables one to envision *an ethic of care* as a framework for improving the health of North End Halifax community members.

We all would benefit from accepting the invitation to "walk for a day in another's shoes".

So a journalist decided to try to live on a waitress' wage. In ninety days she bottomed out. She couldn't keep up with anything. She couldn't eat right. She couldn't pay for her phone. She couldn't pay her cable. She had to cut off her, maybe it was metaphoric, but she couldn't use her Visa. So in ninety days, this woman, you know, making eighty-five as a journalist and eight thousand as a waitress, even with tips, could not maintain a bachelor apartment. She couldn't put gas in her car. (community member)

7.4.1 Opening Up

This one, it's, it's very blurry but it's the alley way between Brunswick Street Mission and Metro Turning Point. And Yeah, I think, it's blurry but, um. This one for me is... I find it, you know, I find that, I, I, I have lots of different emotions around that one...And it's, it's like the narrow, like the other part that struck me. That it's the narrowness. Like the narrowness of all kinds of things? Like the narrowness perhaps too of society, right? (community member)

(photograph by participant #5)

The concept opening up refers to all of us allowing space to see, hear, empathize and learn with others. One group that received less attention by participants are people living with physical disabilities; they were only peripherally mentioned. Silvers, 1995, noted that people living with serious disabilities were generally an invisible population who suffered exclusion through employment practices, lack of wheelchair accessibility and absence of personal sound amplification devices in theatres, for example. She wondered "what social arrangements would be in place were persons with disabilities dominant rather than suppressed" (p. 48). Such a wondering is of value when attempting to understand impacts on others' everyday lives.

217

Women who have experienced spousal abuse have been viewed as undeserving, yet their lives are almost always complicated by factors over which they have no control (Goodlin, Dunn, 2010).

> *When Bryony House opened; it was the first women's transition house with shelter in the province so prior to that, women had no alternative. The attitude was that if someone is in that kind of relationship they must want it, somehow it's their problem. That kind of attitude exists within the mental health and addiction community now.* (community member)

Greater empathy for the circumstances of these women permits more appropriate opportunities to address. Kiely-Froude and Abdul-Karim, 2009, reminded us that in this, as in all things, cultural norms and comfort must be incorporated in any response. Similarly, persons who are homeless have lives that are incomprehensible to many; from the obvious insecurity, to the countless indignities and challenges, to the lack of freedom of choice.

> *At Turning Point, people are, there is very much a schedule that people have set up for the 7 o'clock breakfast, um, when you can come back to dry out a little bit, um, but you've got to get, you know, then you've got to be in line for the 10 or 11 soup and sandwiches at Hope Cottage, okay? And then you can sort of try and do some appointments. You can do some apartment hunting, but you've got to be, with your apartment hunting, with any appointments in general, you have on the go, you have to be cognizant that you've got to be in line again at 20 after 4, or 4:30 for Hope Cottage. Um, and its, ah, I'm try to, just remember where it's at people have used before and the disjointed feel of not having an agenda that you can carry through for the day.* (health professional)

For others, there are issues of impoverished housing and unsafe or unsightly neighbourhoods.

(photograph by participant #3)

So this is pictures of abandoned properties that used to be rooming houses and so, like...some days they'd have cold water but some days they didn't, you know. And sometimes the toilet flushed, sometimes it didn't. You know, it's like barracks, very rough inside. (community member)

Study participants had many stories of the neighbourhood from their perspective, exhibiting their challenges and triumphs. Their stories, and the stories of others, can help all to better understand each other. Listening to another's stories is but one way to reach out to form connections.

7.4.2 <u>Reaching Out</u>

Whereas there were examples of reaching out, there were other stories of failure to extend a hand. The North End of Halifax is one area where recent immigrants first settle. Although there are services available in Metro Halifax to assist new immigrants, there is no concerted plan to help newcomers settle safely and productively in North End Halifax.

> (There was) *a young couple from Bangladesh who were students at University X and she got pregnant and dropped out and he had just finished his program and they were living in an attic and they had nothing. Their baby was 5 days old. Their visas were expiring.* (health professional)

There were very limited resources available to help this young couple as they faced unexpected parenthood in a foreign country, with no family or friends or social support network.

There were a significant number of examples of reaching out to deliver healthcare (as well as laments that they were insufficient to meet the needs). These include the Mobile Outreach Street Health program and others such as health professionals seeing clients in shelters and public or subsidized housing or other gathering places such as soup kitchens, Mainline and Direction 180.

> *Because someone who lives on the street and doesn't have a home, doesn't have a watch, isn't going to end up at the IWK or the QEII for a 2 o'clock appointment with so and so. We have to be there and when they're ready to walk in and drop in, ready to offer the care they need, at least for primary health, screening and that.* (health professional)

> *I just thought, it's ironic compared to our government agencies that care for poverty and the poor and how they operate compared to how this service does*

(Halifax Coalition Against Poverty). It's so close to the street. Yeah. And yet more likely people would be to walk into there than they would be to walk into the Joseph Howe building downtown. (health professional)

The Friendship Centre is an example of an organization that extends a caring hand out into the community. Most of the Aboriginal population in Halifax lives in the North End. The increased birth rate of Aboriginal peoples and the transitioning of many youth to urban locations have provided both challenges and opportunities to learn from these very old cultures.

The Friendship Centre is the, every major urban centre in the country has an Aboriginal friendship centre for First Nations people who live in the urban community away from their generally rural Aboriginal communities. And it becomes a real gathering place for Aboriginal people and our Friendship Centre – the Friendship Centre on Gottingen Street – very much fulfills that role. (community member)

(photograph by author)

Several participants noted that the Friendship Centre was a good neighbour to Direction 180 (the methadone clinic), a population not often welcomed by others. The philosophy of the Friendship Centre itself is one of harm-reduction rather than abstinence.

As referred to elsewhere, Aboriginal cultures have health beliefs that differ from those which guide our health (illness) care system. Mental health or illness is culturally and socially defined. Mental health is a significant issue for Aboriginals who have moved to the city from their traditional homes. For Aboriginal youth, suicide, abuse and neglect,

and addictions are challenges. Within metro Halifax, there has been little collaboration between indigenous healers and psychiatrists or psychologists to assist youth facing these challenges. Resolution will require family and community participation. Syme and Mussell, 2001, stressed the importance of balance embodied in the medicine wheel and the root causes of mental illness experienced by the Aboriginal populations (intergenerational trauma, poverty, unemployment and lack of housing).

> *Mental health is really important for that group...(and) homeless youth, I mean even if it wasn't what called them to be out on the street, then the stressors and the things you have to do to stay on the street could be so much at risk that it's almost an addiction...If we had a way to get these kids sooner, because if you tell them they're homeless, they* (the formal health care system) *may not see them or they may not see them for three months.* (health professional)

Youth who are homeless are often stigmatized by their panhandling, appearance and tendency to form gangs. Many have a history of family violence and personal abuse. Homelessness places youth at increased risk for unsafe sex, drug and alcohol use, street violence, theft, stress, depression, diminished self-esteem and life-long consequences of turmoil (Kidd, 2007). Finding venues to reach youth was identified as important.

(photograph by author)

> *Youth Net...It started to bring more youth access to services, youth friendly, a more of a drop in place and Youth Net St Georges is not so much health based, whereas the Youth Net that went across from Ottawa that came here was more of a health based program for youth to access health. But this is the only one I know of that is a drop in for youth that you don't have to be referred, you can actually go and they will actually help those youth that are really struggling... So I guess we need more of that. A drop in place for youth, 'cause youth don't really work on the having an appointment in 6 months model, they need help, they need help now! And if they don't have a safe place to do it, they may find another avenue to seek help.* (health professional)

221

Other ways of reaching out include working towards creating a safer neighbourhood; a neighbourhood that generates community connections. Study participants spoke of the harm reduction effects of local policing, a fixing broken windows philosophy, acceptance by shelters of people misusing alcohol and/ or drugs, and neighbourhood watch. Mainline Needle Exchange is an example of an organization that reaches out to those living with addictions, people often shunned by others.

> *They were seeing people that didn't want to use needles anymore; that wanted to have this stopped in their lives but had no other options and, except abstinence. You know, that totally withdraw and don't use anything. And not that methadone is used in that way. Methadone is a treatment. Um, but the only treatment available to people was to just stop. And, and so that wasn't working for a lot of people and it wasn't working for people who still had other things in their lives that they weren't prepared to give up. So, you know, maybe they weren't prepared to give up crack but maybe prepared to stop using needles and stop using Dilaudids.* (health professional)

> *Mainline Needle Exchange is on Cornwallis Street. Um, the very obvious harm reduction stuff they are doing includes, um, needle exchange, ensuring that, um, drug users will only use clean needles. They also do needle sweeps. They're going around, ah, around Turning Point. They're checking around some areas in case there are any needles left. But their, most of their policy is, is an exchange of needles so that people who get needles, give needles back to get needles and that tends to help things a whole lot.* (health professional)

Reaching out is a way of forming relationships and alliances.

7.5   FORMING RELATIONSHIPS/ ALLIANCES

Accepting others as peers, hearing and honouring the voices of all, broadening the leadership base, finding conduits and cross-pollinating came together under the umbrella of **forming relationships and alliances**. Accepting others as peers enhances relationship building, hearing and honouring the voices of all respects diversity and facilitates connections, broadening the leadership base acknowledges that everyone has useful knowledge and skills to lead portions of improvements for community access to health, finding conduits relates to boundary objects or linking people together, and cross-pollinating builds on the strength of diversity, to learn from others to make possible equitable access to health. **Forming relationships and alliances** is a key construct within *an ethic of care*.

A strength of the feminist approach is creating collaborative relationships instead of the more prevalent competitive stance of business and governments. Study participants identified, in spite of a dearth of positive incentives for collaboration among agencies and groups, there were helpful partnerships and alliances formed.

> *And that's how a lot of partnerships and collaborations get started. It's these chance conversations but it's also being very intentional about having conversations...it's in relationships. It's all about relationships. And keeping those relationships healthy and alive and when we disagree, to air the disagreements and sort through it...if you want people to collaborate, you have to have somebody whose job it is to nurture the collaboration, bring the people together.* (community member)

Benefits of collaboration include sharing of limited resources for mutual benefit, increased visibility for the issue being addressed, improved intersectoral relationships, comprehensive analysis and solutions, easier acceptance and greater willingness to implement. Factors influencing collaboration include history, environment, political and social climates, mutual respect, willingness to view from the standpoint of another, power dynamics, communication, purpose and resources (Barreto, 2007); these were also mentioned by study participants. North End Halifax presently has no natural gathering place or leadership/ oversight group.

> *There's never been a social client counsellor in this municipality. We don't have members or executive directors of the various organizations meeting together on a regular basis to talk about what's one problem or area significance in this community that we can/could put a dent in. We'll all focus on it and make a small contribution. Why the hell aren't we doing that??* (community member)

A key ingredient for developing collaborations is accepting others as peers.

7.5.1 Accepting Others as Peers

A peer is a person of equal standing with another, colleague, contemporary, friend and/ or cohort member. Each of us has a body of knowledge that is incomplete but can complement or supplement or be supplemented by others' knowledge. In the natural or usual course of events, the knowledge of professionals, bureaucrats and merchants is privileged. In a peer relationship, respect for another's everyday life, philosophies and actions can open eyes to new, and often better, ways of viewing what we have come to

see as just how things are. Both African and Aboriginal cultures stress the significance of family and community and the importance of care of others (Jegede, 2009). In contrast to the North American emphasis on autonomy, African cultures espouse "cohesion and communal responsibility" (p. 240); the boundary between "the individual as a member of society from his/ her person as both relational and embodied being" (p. 244) is hazy. Most African cultures are patriarchal; individuals exist through the community; community interests supersede individual interests; "respect is the basis of social relationships" (p. 245). The African Nova Scotian regard for family and community was apparent in the interview data. Respect for capacities of individuals engenders empowerment for all involved; sharing control is mutually beneficial.

> *It's been great, so Mainline, I think is a real source of health for this community in general because she is a great collaborator, and partner. Um, she's quite an exceptional woman in fact. Um, there are very few like her…(she) comes to this position as a woman who was also, a person who was drug abuser in the past. She's a remarkable woman. And so all the staff that work there are individuals who are in recovery and who've had a good amount of clean time and are really headed on the path of wanting to give back and help and, that's the model they use..I mean, it's very, it has the right level of professionalism and um, sensitivity that you could ever ask for, really. Yeah, it's quite, quite remarkable.* (health professional)

Attention to creating space where there is mutual respect for each individual's strengths, skills and knowledge; space where individuals feel free to speak and be heard; space where all knowledges are valued; space where traditional power differentials are muted is critical to obtaining the best steps forward for North End Halifax and building on the present community capacities.

> *It's also the place that when they lose the people that we have loved and cared about in it, in the community, the folks that are homeless or street involved, Brunswick Street Mission often has a service, and so, that it is an accessible way for people to grieve and it is, um, it's their space. You know, it's not being done on someone else's turf. So it certainly, to me, is a source of health and hope and healing.* (community member)

Within the context of health and health care, health professionals generally adopt a provider: receiver relationship with patients. Yet there are others, 'non-professionals', who are often more helpful for those facing issues with which most health professionals have had no direct experience.

*They (*Mainline*) have peer counsellors there, there's a lot of respect for counsellors that have been there. They have the same challenges as those that are receiving treatment.* (health professional)

The above quote reminds us that there are many valuable voices that are not heard or are not viewed as credible; those individuals remain disconnected from the community web of inter-relationships.

7.5.2   Hearing and Honouring the Voices of All

As in other communities, there are advocates for greater attention to first voice expression and community member participation in decisions related to the neighbourhood. People who have, and are living with, the challenges and opportunities of their neighbourhood are in an ideal position to provide input and to work with others towards needed changes.

A lot of the staff who work at different shelters and agencies actually live in the North End, and have very astute awareness of the needs. (health professional)

People may require encouragement and support to lend their voices.

'Cause they recognized that the people who lived in Uniacke Square, on the most part, the majority of people were good people, but they were being intimidated and were afraid to speak up. (community member)

In the 1970 and early 1980s, radio phone in shows were an invaluable asset to enabling many voices to be heard.

There was a meeting that was held in the basement of St. Pat's Church around the…tearing down of the old school and there were some 300 people that came to that. All you had to do was go onto the CJCH talk show and say there's going to be a big meeting tonight to vocalize and that's it, they'd be there. (community member)

These opportunities have decreased. In the past, the Derby (a lunch pub) served as a gathering place for exchange of ideas and building alliances for addressing issues; to some extent the library and the Dixon Centre are present day gathering places. Community organizers in other areas have been more active in seeking input.

We wanted to make sure that we heard from all different kinds of voices, so rather than calling a big public meeting and hoping different kinds of people would come, we did small group meetings. So we heard from businesses; we went and talked to people who use food banks; we talked to parents in the school in a public housing

neighbourhood; we went to environment groups…It's, you know, a variety of, we heard from church people. And so any one group was fairly homogeneous but we got diversity between the groups. So that was very important to us. (community member)

Participation can be enabled for women through child-minding and designing meeting times of forums for dialogue around family life. For others transportation, comfort with surroundings, cultural sensitivity and language support can increase input. For North End Halifax, both broadening the leadership base and developing gathering places could facilitate first voice input and community participation by all members.

7.5.3 Broadening the Leadership Base

There are many North Enders who have offered leadership for particular areas of interest and need - for example for Mainline and Direction 180, Parker Street Food Bank and Black Heritage preservation.

There's a network of people that everyone knows. So if you have an issue or concern, it's not hard to get people together. It's not hard to bring the groups, all of them together and say ok, here's what we're facing, what can we do about it? Then everybody will chip in and it gets results. (community member)

Nevertheless, there is no apparent leadership for the overall direction of the neighbourhood, leadership to understand all of the many separate endeavours; to encourage alliances and collaborations; to envision an interwoven whole developing from the many single, sometimes entangled threads; to guide the willing towards that end. Conduits presently in place can be built on to spin a web of communication from which to find and develop future leadership.

7.5.4 Finding Conduits

Radio talk shows served as conduits in the past, but are less so now. The topics and the participants have become more middle-class and there is less social advocacy. As noted above, the Black Business Initiative is an example of a conduit. Conduits are not only supportive for community development, but also for health and health care.

Um, a picture of Barry House. Ah, a service that is a shelter for women and children. Um, a service that, uh, has connected to many other services also and

provides a base for many women and children in crisis. And provides a, not only a base but a conduit to other things also. (health professional)

(picture by participant #6)

Mainline Needle Exchange is a conduit for people living with drug addictions.

Mobile Outreach Street Health (team of health professionals and homelessness peer representative) *has a presence with Mainline* (addictions services) *and we go with them on a, a van outreach that they do. And they've just been a conduit to making services accessible and practical for people, in the midst of addiction, are pretty crisis oriented sometimes.* (health professional)

Conduits and cross-pollinating are ways of connecting and sharing; of building relationships and alliances.

7.5.5   Cross-Pollinating

Individuals, groups, organizations and communities often learn best from each other. Such learning is empowering, increases involvement and establishes new relationships.

So it was the commitment of community partners who recognized the unmet needs of health care of clients in this end of town. (health professional)

How did Creighton and Gerrish Street Development come about? Just some interested people seeing that there would be affordable housing in this area and it's really been championed by Grant Onesella who was the Director of the School of Architecture at Dal. He is the main proponent of it. Harbour City Homes is a member of that; Metro Not for Profit Housing is another group that's been a part of it. (community member)

227

Umm, this one was the Mi'kmaq Child Development Center and the North End Community Health Center. I just wanted to show the proximity and connection. There is a lot of outreach by other organizations. Yeah. Yep, lots of cross-pollinization. Yep. (health professional)

(photograph by participant #5)

Cross-pollinating and relationships are mutually reinforcing. Relationship and alliance building are more difficult in the presence of power differentials. To some extent, power differentials can be ameliorated by capacity building.

7.6   BUILDING CAPACITY

Heeding and respecting history, exchanging and equalizing knowledge, making homes available, creating employment opportunities, building on community assets and investing in childhood development grew into the substantive code of **building capacity**. Heeding history is both a way of honouring those who helped build the community and respecting the lessons they learned, exchanging and equalizing knowledge recognizes the power in knowledge and situated knowers, creating employment opportunities is a pathway to equitable relationships, building on community assets engenders involvement not distance and investing in childhood development increases the probability of future community integration. **Building capacity** enables empowerment, forms connections, creates openings for reciprocity and challenges inequities to facilitate *adopting an ethic of care*.

North End Halifax has a strong foundation of resources and skills on which to build greater capacity. However, Chino and DeBruyn, 2006, noted that for capacity building to

be effective, it must be culturally comfortable. Such comfort includes definition of success and desired benefits, language, place, ways of knowing and issues of identity. These authors' approach, originally suggested as applicable for indigenous peoples (building relationships, followed by building skill, then working together and promoting commitment), seems well suited to North End Halifax; it is one that respects the history of the neighbourhood and is compatible with an ethic of care.

7.6.1 Heeding and Respecting History

North End Halifax, as a major port town, has a wonderfully varied past history.

This is the military base, dry docks and so the navy is such an identity of our city still, not just the North End, but our city and I can never look at this part, without thinking what the North End has been through historically, because of the Halifax explosion involved a military ship. No other part of Halifax had to survive anything like that really. (community member)

(photograph by author)

As the centre of naval activities, the North End acquired pubs, drugs, and the sex trade.

There is a long heritage of African Nova Scotians living in North End Halifax.

And I remember my grandmother, she used to be a post mistress in Africville, and she would have to come into this post office to do her business, cause this was the bigger post office, and I can remember coming into town with my grandmother and walking along Gottingen St and White people would be approaching us and she would grab my hand and make me stand to the side to let them pass by. That's why I picked this picture up. Because that's the way things were done back in those days. (community member)

Study participants spoke about and photographed heritage buildings in the area.

(photograph by author)

Heritage Nova Scotia is quite active in trying to preserve our historic buildings, but the focus hasn't been in this particular area of the city. Even though we have some significant buildings. Like I said we've lost a lot unfortunately, but they need to save those buildings, absolutely. (community member)

North End Halifax has a past history of activism and strong community spirit as well as many heroines and heroes (Pachai, Bishop, 2006).

(photograph by author)

(This monument is) *erected in front of the library which has a symbolic meaning that the library means help and hope and independence, maintaining ones independence through education and literature and the statue of one man pulling another man up I think has significance of this population, this community so willing to help one another, it's so valued in community spirit that who ever devised this I see it in my everyday living of how community members help one another through various severe challenges.* (health professional)

This spirit of history and heritage can be leveraged for achieving equity in knowledge.

7.6.2 Exchanging and Equalizing Knowledge

Knowledge has often been framed as power, thus engendering reluctance for one group or individual to share with another. Although the following quote refers to Aboriginal populations, it is applicable to all groups and cultures.

> The experience of many indigenous people has been that focusing on similarities between their beliefs and beliefs grounded in Eurocentric knowledge does not lead to significant change. Rather, this perspective is often guided by an interest among those with power to maintain the status quo by disregarding, minimizing and devaluing the fundamental differences between the knowledges. Focusing on similarities does not require that the person in power shift from their place of privilege and let go of that power. With their power still intact, they can still comfortably define the reality facing them. This stance rarely leads to significant changes or improvement if at all...it has usually resulted in a misappropriation of this knowledge for the benefits of non-Indigenous interests. Indigenous practices are blended into Eurocentric schools of thought and practice to further perpetuate their position of power and privilege...there is rarely a genuine interest to support Indigenous self-governance over their own lives and knowledge. (Sorin, 2006; p. 122).

Dialogue to achieve a balance between retaining differences and building on similarities in goals and common benefits fits well within a feminist philosophy and an ethic of care. The integration of experiential and scientific knowledge can further community health.

The North End Library was noted as a source for knowledge and information; a place to enhance literacy and open doors to employment opportunities; to meet and exchange ideas; to access the wider world through books, tapes, DVDs and the internet; accessible and open to all. It is a nidus for the exchange and acquisition of knowledge.

I took this picture of some of the health books at the North Branch Public Library because the library is a huge part of my health care. (community member)

(photograph by participant #1)

The North End has a proud history of promoting education.

That's why I talk about the Black Report (and the Black Educators Association). *It took a look at the quality of education. Finding out that the quality of education was far below that of the White students in the schools, both from a resource point of view right up to the actual teachers themselves. A lot of cases they weren't professionally trained teachers, they were someone from the community who might have had grade 10 but they were hired to teach children. So the quality of education was lacking and so that's the work that they're, and it's an ongoing piece of work that they're continuing to work on.* (community member)

The Black Report and the Black Educators Association stressed both the importance of education and that <u>all</u> children (and adults) were deserving of high quality education as a means to level the playing field and to open up more opportunities in the future. Another important aspect of levelling the playing field is having a secure home.

7.6.3   <u>Making Homes Available</u>

An important component of housing security (the most prominent concern for all interviewees and a clearly identified issue irrespective of lens used) was its multi-dimensionality. It not only meant shelter against the weather and a place to eat and sleep; it meant safety, predictability, a sanctuary, a place of peace and renewal, a means of self-expression, an opportunity for solitude or company, greater ability to set one's own agenda and a space where one was free to be oneself.

I can't help from what I see, I can't help but see the differences in a person's whole outlook on life, in a person's whole psyche, in a person's whole ability to access health, um, attitude to thinking they deserve, to wanting to help themselves, comes from having a place you can find peace. One little spot where you can feel safe and dry… I really have a much deeper appreciation of that, just that little piece of peace and safety, even more so than being dry, that is needed to help reframe someone's priorities. (health professional)

Participants in this study pointed out the inequity of housing security with respect to the burden for women, especially those in single parent families, and the often greater invisibility of women struggling with housing security. Women are disadvantaged by generally lower salaries, and higher risk of abuse (physical, sexual, psychological, financial and emotional). Women whose social networks include users of drugs and alcohol are more likely themselves to use drugs and/or alcohol (Wentzel et al, 2009).

Participants spoke of the disempowerment of homelessness or struggling to retain their home; the indignities of shelters with crowded accommodations, lack of privacy, line-ups for the shower and inadequate supplies for personal hygiene. They spoke of how a person without a fixed address becomes a non-person. They spoke of how we arbitrarily categorize people into deserving and undeserving poor. They spoke of government and society acceptance of the many Canadians lacking housing security. They spoke of a lack of a preventative approach to housing insecurity and homelessness.

There are many inequities associated with housing- those who are homeless or at risk of becoming homeless are often unprepared or ill-equipped to deal with landlords, some have not yet acquired English as a second language, some are prone to unacceptable behaviours (as defined by White, middle-class, employed males), or are involved with the sex or drug trades, have addictions and/or are not heterosexual. These differences complicate acquisition and retention of secure housing; prejudgments shape expectations. But, changes are happening.

> *Another good thing is…the Creighton and Gerrish Street Development who are building affordable homes for people who use to live here but moved out and can't get back because of the price of the properties. They're building properties that they afford so they are trying to encourage them to come back. The first offer for their properties is always, one of the qualifications is that you have to be from here, you have to have lived here or some connection, so that's first off, then after that of course is then it goes out to the general public. Right across from the North Branch Library…there's going to be 36 condominiums going in there and 12 one bedroom, 12 two bedrooms and 12 three bedrooms, all affordable to allow people to come back to the community. So I think that's going to go a long way in protecting that sense of community and keeping it alive and vibrant.* (community member)

HRM by Design (www.hrmbydesign.ca), a branch of the Halifax Regional Municipality, has as one of its objectives

> (i)n addition to a greater variety of housing types, housing opportunities for residents with a variety of income levels must be accommodated. Therefore, affordable housing will be encouraged through the bonus zoning provisions of the Plan…Three important changes from existing policy made in the new Land Use By-law that will improve affordability are: a. No minimum unit size, b. No maximum residential density per area, c. No disincentive to larger units through extra landscaped open space requirements.

But is this what will serve better health?

The Affordable Housing Functional Plan is not yet available. Housing is clearly an area that requires a fresh approach, one that could incorporate connections, relationships and interdependencies. Creating employment opportunities could enable more community members to find housing security.

7.6.4   Creating Employment Opportunities

Some businesses have remained and others have moved into North End Halifax within the past decade, exhibiting optimism and belief in the community, and valuing the diverse populations of the area. Their investment in the community manifests comfort with the community demographics.

> *The next photo is the Jack Nauss bike store...it as a real community business that has been around in the family for years and I think the North End has a few of those that are real classic Halifax businesses that are the essence of Halifax.* (community member)

(photograph by author)

> (This picture) *is really of a little coffee shop, but there're probably three or four of them along the street. Since I've been here, these small entrepreneurs have really been the only economical development in the community. There's been no other economical development. They took a chance and invested and came into the community and opened shops and they're surviving and doing okay. They seem to be satisfied and not closing out. For me, that's something that matters, people will come in and open up a shop and run a business in this community and not be scared off by the negative kind of reputation that the community has.* (community member)

(photograph by participant #4)

Staples was mentioned as hiring locally as does one construction company. The Black Business Initiative has sponsored programs for youth and adults to increase the employability of participants. Further economic development of the area, as well as a philosophy of encouraging local hiring practices, are required for a thriving neighbourhood. The potential for economic development exists in within the community's assets.

7.6.5 Building on Community Assets

There were numerous community assets pointed out in study participant's conversations. Some examples are given below.

> *I think it* (the monument outside the Library) *was an acknowledgement of the historic roots of this community and the people that are in it and it's kind of a helping hand and help people support one another. It does name individuals on this plaque as well as streets and street corners where issues of some of the events have happened over the years. It's kind of a reflection on this part of the community that is nurturing and where there is a sense of commitment to each other and community embracement I guess.* (community member)

> *They* (Black Business Initiative) *have been quite successful in terms of not only helping Black businesses get started, but sustainability of Black businesses I think is the most important thing that the Black Business Initiative has been able to accomplish. Building partnerships with existing financial institutions in the city, the banks, lending, co-op, department of economic development. And being a conduit for Black businesses to be able to access the services provided by those other service providers.* (community member)

> *So Brunswick Street Mission is really a spot of health and hope, in my mind. They serve foods, so they nourish the soul. They, in lots of ways, they nourish it through, through food. They nourish it through spirituality. They, the trusting relationship*

with people, so that people can have their housing and get their bills paid because maybe they haven't got anyone to manage that in the past, you know. They have a food bank there. They, um, they, they do, they do a lot to, they open their doors on a regular bases to all of the community to use the sanctuary. (community member)

There are potential green spaces and housing available for renovation to decrease the gap of affordable homes; there are vacant shops for new businesses; there are many people with skills, knowledge and understanding of the community; and there are children and youth with the potential to develop a better future.

7.6.6   <u>Investing in Early Childhood Development</u>

Many study participants expressed concern for children and youth of the neighbourhood. There was a general understanding of the importance of early childhood development supports. Children from low socioeconomic status families are disadvantaged at the time of entry into kindergarten, often having lesser reading, math, general knowledge and social skills than their more privileged counterparts (Barnett, Belfield, 2006). This disadvantage persists during life and significantly limits opportunities to escape from the vortex of poverty. Early childhood interventions have been shown to produce at least temporary improvements in IQ points as measured by tests standardized to the norm of middle class children's culture and development. Barnett and Belfield, 2006, reviewed the literature on evaluation of effectiveness of early childhood interventions. They determined that young children participating in such programs had lower rates of teenage pregnancy, greater feelings of well-being, fewer addictions, lower rates of criminal activity and greater earning potential as adults. However, the interventions that lead to these results were from programs with highly qualified, well-paid teachers leading intensive classroom or individual tutoring sessions begun before the age of three and lasting until kindergarten. Such programs are not yet available to North End Halifax preschoolers. Yet, there are other benefits of early childhood programs.

The North End Parents Resource Centre, one of the big positive aspects of the Resource Center has been the peer support that has come out of the programs that run out of there and how dependent the success of that is on peer support and peer acceptance. It offers services, um, a cooking class out of there...they offer a babysitting service for people who are going for appointments. There is a clothing swap there. I've been, I've done educational sessions there, um, around child development, around eating, around infectious control, control of infectious disease

control stuff. So, they, they've brought in professionals. But it's basically a supportive peer environment. (health professional)

(photograph by participant #6)

Marmur, 2002, advocated for children eating together to develop a community spirit (for example, as in Sweden where all children are given free nutritious lunches independent of their parents' incomes); learning together to equalize opportunity; learning of the life of others to appreciate; speaking in a way that all can understand; expecting students to teach each other; and fostering each child as an individual. Emphasis on establishing comfortable relationships with peers and others early in childhood and youth facilitates collaborative relationships later in life. Children and young people who develop a spirit of community and a sense of belonging are more likely to become active citizens and work towards community health (Nitzberg, 2005).

7.7 RECONCEPTUALISING HEALTH CARE

Movement away from our conception of Canada's healthcare system (fundamentally an acute and chronic illness services delivery) to **reconceptualising health care** and the required health system is mandatory for achievement of healthy populations. Concepts emanating from participant conversations were underlining the determinants of health, creating a nurturing environment, enabling community health and facilitating individual health. These concepts reflected the concern of study participants with the quality of their day-to-day life (and the quality of life of other community members).

The spectrum of health care must be expanded to enable greater access to health for Halifax North Enders. As stated by Howell-Jones, 2005, Western medicine and our health care system are focused on disease, disability and disorders; on distancing oneself from patients (professionalism); on rigid timelines, protocols and guidelines. It is individualistic and fragmented; rarely optimizing the benefits for either individuals or populations. Evidence-based decision-making and stress on objectivity have made it easier to avoid addressing issues related to the determinants of health where the evidence is more nebulous than that for biomedical markers for example (Jensen, Kisely, 2005). As individuals, in common with Aboriginal cultures, looking for "connection, belonging, integration, self-acceptance, understanding and balance" (Jensen, Kisely, 2005; p. 142) resonated with study participants. Embedding attention to the determinants of health is critical to reconceptualising access to health.

7.7.1 Embedding the Determinants of Health

Well, I think that the more of this we do (referring to the community garden)*, potentially the less issues around mental health and the true mental illness issues will surface in the appropriate ways and will get treated through a medical model, which in fact they should. But when you talk about sense of community and just wellness and how people feel, this, it's this kind of work that will be a mental health program. Not referring somebody to the therapist and making sure, and "how come they didn't make the appointment"?* (health professional)

Within some African and Aboriginal cultures, the determinants of health have been embedded implicitly or explicitly in their philosophy and approaches to health. Sorin, 2006, noted that most Aboriginal cultures see healing (rather than just treatment) intertwined with identity, spirituality, knowledge, learning, assessment, space, and time for a holistic, pluralistic, contextualized view of health. The Aboriginal medicine wheel includes the concepts contained in the determinants of health at the person, family, community and global levels (Bopp, Bopp, 2006). Many indigenous people believe an individual cannot heal independently from her or his family and community healing (Sorin, 2006). We have much to learn from these cultures. A cynic might point out that these populations are among those with the poorest health states in Canada. Yet it is highly probable their disadvantaged states of health were profoundly affected by decisions and actions of the dominant middle class, Euro-Canadians, historically and to

this day. As discussed in other Chapters, study participants had an intuitive understanding of the importance of the determinants of health for their own and their community's health. One important determinant of health is a nurturing environment.

7.7.2 Creating a Nurturing Environment

Gardens are a natural embodiment of nurturing; gardens, gardening and community gardens were an important theme within the interviews.

> *Well I think the idea of community gardens is an excellent idea, both to build social capital and to grow vegetables and to improve people's diet and to work together to potentially teach about food and cooking, better eating. There're tremendous possibilities in a community garden.* (community member)

> *North End Community Garden...This is a happy picture. I chose this because it represents many things. But what it represents for me is a transition of ideology of health care being simply a medical issue that one comes into a clinic/centre and receive medicine from a stereotypical doctor, whereas this represents health promotion to the fullest.* (health professional)

> *This was a little oasis of trees and gardens and just very definite form of self expression in, um, a row housing of subsidized housing, of houses that were very much the same, but in amongst these trees was a great little garden area that someone had planted right next to the sidewalk and it was untouched and undamaged and I've admired it many times going by and I'm sure many other people have also.* (community member)

(photograph by author)

Gardens were variously described as sources of beauty, joy and sharing; ways to learn working together; examples of entrepreneurship; suppliers of nutritious foods; creative outlets; spiritual endeavours; places for informal education; chances to be outdoors and

develop new relationships with others. Community gardens have been documented by others to revitalize neighbourhoods, enhance conservation endeavours, increase sense of community, bolster community activism and engender voluntarism (Ohmer et al, 2009). Community gardens "foster norms of reciprocity and trust" (p. 382), foundations for caring and citizenship.

Opportunities to be creative in other ways are believed to enhance health.

(photograph by author)

Like I think art can have so many uses and when I see...There's been a few things over the past few years about art therapy and arts and health care. And I remember thinking, "cool."...Yeah. So, you know, it's...I mean, again, it's any age group. I think everybody has some kind of artistic ability within them and I just think it's very important interest, somebody who, I don't know, say they're lonely or sort of puts you in that creative world. It's like....I don't know how to describe it. It's like something there, it fosters self-esteem, it's just...anyway, I'm just very pro art in health care and creativity and just the general importance of it for whatever, spiritual growth. Like, it's everything. (community member)

Green spaces and attractive surroundings promote physical exercise and decrease stress.

And this is the common and I live near it. It's an amazing green space to have right there. You can go out and you see cricket and baseball and football and Frisbee and just everything. I just think it's a tremendous resource in the middle of the city. And it seems to be well used and you can even ride your bike across it which is nice. (community member)

And people should feel good about the area they live in. And there's so much out there about...you know, if you live in derelict and yucky garbage. You know what I mean. If you live in that kind of surrounding, it affects your mental health and that affects so many more things about how you feel about yourself and being positive. (community member)

(photograph by author)

The playground - a green place, a place where children can be safe and play and do things kids are supposed to do. I think there are some nice playgrounds around the city. I do think there's some lovely playgrounds and in the North End too. Yeah, it's just a pleasant place to be. (community member)

Safety issues for women were noted by study participants related to walking and cycling - areas where the built environment could better enable community health. Note was made of the need for a barrier-free environment for the elderly and those who have disabilities. Nurturing of the body, spirit and soul were important for study participants. That nurturance could be found in the churches of the neighbourhood, the music and arts. The built environment can be created to welcome people from all walks of life through art, music, shops, recreational venues and gathering places.

7.7.3 Enabling Community Health

Emphasis in the past has been placed on individual health promotion through lifestyle changes. However, the ability of an individual to influence their health through lifestyle changes is limited, particularly for those not advantaged socio-economically. Coping with mental illness, living with homelessness or poverty, being unable to speak the dominant language or having a disability all curtail opportunities for a healthy lifestyle. Rutten, 1995, developed a complex model of health promotion in which individual lifestyle choices are bolstered by facilitative policy implemented at multiple, complementary levels. Most health promotion efforts within Nova Scotia are still aimed at individual lifestyle changes. Exceptions include bike helmet legislation for example.

Promoting a green environment through recycling of clothes, furniture, material items and food; through bicycling, walking and using public transit rather than cars; through fuel efficiency initiatives; and through maintaining green spaces, playgrounds and gardens was a common theme.

> *Jessie and the Halifax Walkers and community garden. And Jess is really good with the garden because I guess one person can't have a piece of it themselves. So she set it up so you have to do it with somebody else or your family, so it's not just you. And she has all kinds of kids doing it and the kids so last, sometime last week they had harvested everything and they were selling salads in front of the library and then they also made salsa. And so it was not only like growing stuff and seeing stuff grow and harvesting it and doing all that kind of stuff, it was also standing out there selling it. I think she's amazing.* (community member)

And quixotically,

(photograph by participant #1)

> *This is a billboard again right next to People's Park and across from the library. Beware the Idler. I think that this is a great thing...you know, we're in the throes right now of people learning to turn off their car engines when they're in line at MacDonald's or whatever and I'm appreciative that they've put this reminder up in our neighbourhood because it's a huge education campaign. Because 99 out of 100 people do not want to turn their car off for 30 seconds.* (community member)

The built environment can influence individual health.

7.7.4   Facilitating Individual Health

Study participants spoke about the recreational facilities available- Palooka's, the Y, Centennial Pool, basketball, horse shoe pitch, playgrounds, green space and the commons.

(photograph by participant #4)

It's preventative health care really is what it is. He's training young kids to be disciplined at, to respect their bodies and to focus on being the best at what they can be. It's more about the discipline and mindset than it is boxing. (community member)

(photograph by participant #6)

The basketball court out in front of the Dixon Center. Um, quite a hot spot of activity. I was surprised to see it empty on a sunny day. That was, that was about school time though actually, that was the beginning of school I think when I took that picture, but that's been a hangout spot; that's been a growth spot; that's been a physical activity spot, it's…basketball is taken pretty seriously in this neighbourhood. (community member)

Sometimes healing and health promotion come from unexpected sources.

He proceeded to tune that guitar down to "dab gab" tuning and played some mean Delta Blues. And just immediately took the mood of that corner and you can see the three people just sitting next to him and it's just, the man could play. And, ah, that did far more to brighten the atmosphere of those, there were about 15 – 18 people around at that point, than anything that I could have done. And anything that I

243

thought was just; yeah it was just the power, the healing power of music. It was pretty strong. (health professional)

Less attention has been paid to enabling community members to take advantage of these opportunities for physical activity. Though dependent on personal life-style choices, the ease with which an individual can participate is frequently impacted by elements beyond her/ his control- financial, access, time, etc.

For illness care, many hurdles still persist.

> *So if I have a bad tooth and my choices are between $900 or a $1000 for a root canal or $95 for an extraction, of course I'll go for the $95 extraction a) but b) to add insult to injury, Quick Card does not cover the entire cost. I forget what it was the last time I had a tooth extracted but I think it was $95. That was the charge from the dentist and Quick Card only paid like $60 of that. So the other $35 had to come out of my little poor urchin welfare pocket.* (community member)

Interestingly, Treadwell and Northridge, 2007, noted that oral health was a measure of a just society and one's social economic status could be deduced from the condition of one's dentition.

Life-style choices are not true choices for some; illness care is not at the same standard for all in spite of our Canadian Medicare. To move towards a more equitable community, the need for help of others is inevitable; but the how and what of that help must be respectful of the community and its members.

7.8   SHIFTING THE PARADIGM OF HELPING

Shifting the paradigm of helping is a key component of *adopting an ethic of care*. This theme addresses some of the discomfort both feminists and others have expressed with the ethic of care. My understanding of a feminist ethic of care envelopes reciprocity and responsibility, community and citizenship, partnership and participation, connection and interdependence, and justice and equity; it eschews paternalism/ maternalism and parochialism of the mother/ child metaphor for the ethic of care (Meagher, Parton, 2004). It refutes some historic associations with care such as welfare, being looked after, dependent, needy or incapable/ incompetent; it enables choice and control over one's life

(Meagher, Parton, 2004). The interdependencies and connections are among individuals and groups/ organizations. Care becomes bounded by one's reach or "resources of time, skill, and goods, as well as by actual contact. The focus of care is also upon needs, rather than interests." (Liedtka, 1996; p. 196). Care should be growth-enhancing and autonomy respecting for recipients (Liedtka, 1996).

De-stigmatizing services reminds us that we as a society have created the circumstances whereby some have a more than adequate income whereas others don't, building quality in discourages bandaid or uncaring responses to needs, and encouraging everyday ways to contribute highlights how, through our interconnectedness, we all can contribute to others. Together these concepts are elements of **shifting the paradigm of helping** which in turn is a component of *adopting an ethic of care*.

As quoted by Cockburn, 2005, "help-givers chose how they are willing to help, but help-takers cannot choose how they will be helped, for in choosing to reject proffered help one withdraws from being helped as well as from being in a helping relationship." (p. 81). Yet being in a position of requiring help is often stigmatized (in spite of the reality that none of us is self-sufficient).

7.8.1   De-stigmatizing Services

Stigmatization usually occurs when an individual belonging to an identifiable group is judged as if she or he epitomized the stereotypic characteristics of the group (usually the undesirable characteristics) and thus becomes devalued and prejudged. Stigmatization maybe subliminal; those stigmatized begin to act in the expected stereotypic ways (Stuber et al, 2008). As a society, we may disparage those who use donated clothing or food because of their poverty. Community members saw these services in a different way.

I'm a big supporter of Salvation Army because it's the only place I shop. I think the Salvation Army now is more popular than it's ever been. So, I would walk my kids over and I discovered it and it was a way that I could get things for my kids, books, clothes, toys, and support this place. And I got so much more out of it than they got out of it. And still I'm getting stuff out of it because when you go in, you have this like a sense of peace, in a way, when you go in. Like it's, you see lots of, you never know what you're going to find. And I don't think it's like being in a church but

there're all these different characters that go in. I always say it's my bar because I go in and I just have this, you see these different people and the way that they talk and the staff are incredible, both in the North End one and the Green Street. You're kind of, it's like you're Norm in Cheers, you go in and you talk to them, "how are you doing," they ask about your kids. It embodies community. It's awesome. I love the Salvation Army. (community member)

(photograph by author)

It's a place where people with mental illness get paired with other people and get to live in an apartment and are basically supervised so that they can live independently. It's a great service. Yes, it is. And then the people who get paired are often people who don't have a lot of money and they get free rent and then they have, they can get paired up and they move on. Like I know people who have moved on from this service and are living good, healthy, independent lives now. (health professional)

And there are organizations who strive to make available services without judgment of those who use and need the service.

(photograph by author)

*This is an organization (*Parker Street Food Bank*) that is very dedicated to people who are very poor and very disadvantaged, who live on really small incomes in the community. And they provide more than emergency food and helping people get*

some of the basics when they are setting up a household. They provide, I think, a very non-judging environment in which to get support and material things. And that can be very tough to find in our, you know, the context in which services are provided. They don't engage in a lot of application filling out. (community member)

As a part of receiving services, some participants felt that they were being lectured to reform. They felt that health care professionals must separate their professional functioning from moralizing. They also suggested that quality should become a more important part of helping organizations.

7.8.2 Building Quality In

There were several comments about the benefits of building in quality – in housing, with respect to food and for other services provided. Quality was envisioned to include accessibility, cultural appropriateness, safety and sustainability.

(photograph by author)

Ahern Manor. Built probably, 1970 somewhere in that era. It's a family building, high-rise, 10 stories high, public housing, it has housed families there from the time it was built and right now we've got 3rd generation people living in there. It's a quite significant building. People had raised families there and a lot of good things happened. It goes to show when you build a quality building, it can last quite awhile and serve the needs of the community. (community member)

Improving the quality of food in food kitchens and food banks is one area where everyday ways to contribute could make a big difference.

Like you see people staggering out of the food bank with these 18 by 24 inch giant slab cakes from, that have been donated by Costco. Or there'll be a box of 24 cinnamon rolls. And it's like, for someone like me to go home with a box of 24 cinnamon rolls, it's like deadly on so many fronts because cinnamon rolls are one

among many things I am unable to portion control. So the sodium would kill me and then the trans fat will wipe me out in case I survive. And so you can eat from the food bank but no, I don't think you're going to grow good bones from it. (community member)

7.8.3 Encouraging Everyday Ways to Contribute

It is sometimes difficult to see how an ordinary citizen can make any difference when facing such seemingly overwhelming challenges as those of North End Halifax. As study participants noted, anyone can help by sharing their own particular talents.

Well, one of our other projects is time banking. Have you ever heard of time banking? Well, the Nova Scotia Department of Seniors is interested in seeing time banking across the province. And the folks mainly are seniors. It's about neighbours helping neighbours. So if you bake a cake for me and I give gardening advice to someone else and that person puts oil in his car over there, it all gets recorded...This is a way of encouraging natural neighbourliness in a more intentional way. (community member)

These small deeds can facilitate new understanding, relationships and alliances.

7.9 ENSURING FOOD SECURITY

Nurturing is one paradigm of care; **ensuring food security** was second only to housing security as a concern for study participants although both are inextricably intertwined. We, as Canadian citizens, have not demonstrated an ethic of care as we continue to tolerate poverty and its associated food and housing insecurity.

Food security has been defined as physical and economic access to safe, nutritious, culturally acceptable foods in sufficient amounts to lead a healthy and active life (Riches, 2002). Wicks et al, 2006, amplified this definition to include "four core constructs: the quantitative construct of having enough food; the qualitative construct concerning the quality and diversity of accessible foods; the psychological constructs that includes feelings of anxiety and restricted choices about the quantity and quality of accessible food; and the social construct of food practices, food sources, and roles and interactions with other people" (p. 921). Components designed to enable food security are generally treatments of the symptom rather than addressing the underlying issue of why individuals live with food insecurity. Such components include food banks, community kitchens,

food stamps, community gardens and food boxes. Which raises the questions: Why do we need food banks?, and "who is benefiting and why from food banks?" (Riches, 2002; p.650). According to Riches, 2002, the first food bank in Canada was established in Alberta in 1981 to meet a need generated by the collapse of the oil industry, increased unemployment and perceived inadequacy of government response; the first in the USA was set up in 1967. Subsequently, food banking has been industrialized along with homelessness.

In spite of Canada's signing on to the International Covenant on Economic, Social and Cultural Rights in 1998, (a covenant that stated everyone has a right to an adequate standard of living, inclusive of food, clothing and shelter and to be free of hunger); Canada has no national and Nova Scotia has no provincial nor has Halifax a municipal plan to ameliorate food insecurity, let alone address its root causes. As identified by study participants, food banks and community kitchens "permit the state to neglect their obligation to protect vulnerable and powerless people. They encourage the view that food poverty is not a critical public policy issue. They allow the corporate food industry to be viewed as responsible community partners." (Riches, 2002; p. 654). They also allow those responsible for and working or volunteering with food banks and community kitchens to be viewed as responsible citizens. The attitude of well at least we are doing something may unintentionally perpetuate food, housing and economic poverty. As highlighted in the section indignities, people who must rely on food banks and community kitchens find the experience disrespectful of them. The failure to provide quality, nutritious foods in food banks and soup kitchens was one area where there was unanimity of study participants. Both the literature and study participants stated that the supply of food is significantly less than the need. The photovoice study of Valera et al, 2009 poignantly illustrated the inadequacy of supplies and the poor nutritional value of much of what is available.

> *Then the vast majority of what you can get, which is a sure thing, is, of course, the canned food stuff because it has such a long shelf life. But, as we know, processed food like that, it's, you know, the sodium alone could kill you, let alone whatever else they use to process the food. So sometimes it's a treat to get it. Like if you end up with a can of ravioli, it's like, whoa, that's like such bad business I don't want anyone, it's so bad for you but it's such like a nasty good treat. And sometimes*

there will be staples, flour, sugar or something. But it's a, what you get will never hold you for three weeks, it's only an adjunct to what else you might buy or get from somewhere else. So, unfortunately, no, I would say you cannot get a healthy, be a, eat in a healthy manner by eating only what you get at the food bank. (community member)

(door to Parker Street Food Bank)(photograph by participant #1)

One of the dilemmas is lack of control over the source of the foods distributed.

(S)ometimes you would get, at harvest time sometimes we would get a truck load of turnips or something, or apples. But most of the time, you're right, it's Kraft Dinner and tuna fish and pop and stuff like that. And some of it's so dreadful. And I realize some of it comes from the warehouse when they've dropped a pallet and something breaks and everything is sticky, so they say, "we can't put this on the shelves, that's what goes to the food bank". So you can't blame the forklift driver, he doesn't know what he's going to drop. But I agree with you that money is a lot better because then you can say let's buy everybody rolled oats instead of sugar cereal, that kind of stuff. To be fair, I'm sure they'd like that too. But some really awful stuff comes through there. (community member)

Teron and Tarasuk, 1999, randomly examined Toronto food banks to determine the quality of the donated food. They found that 80% of donated items were either unlabelled, outdated, had damaged packaging or were dented. They showed that the food boxes issued were nutritionally inadequate. Although some food is donated by the public and some funds are donated to organizations such as Feed Nova Scotia, the bulk of the food received by food banks is through food corporation unsaleable products. As Tarasuk and Eakin, 2003, highlighted, "reliance on donations promotes a system of food distribution that is disassociated from clients' food needs." (p. 1506). In many food banks, clients are given a pre-packaged box or bag of food. However, Parker Street Food Bank has taken a more customer-oriented approach.

It's one of the few places where you go into, where the people who have a need for food, get to actually pick what it is that they're going to take away rather than just be given a bag with what's been picked for you. And I've always found that really just a fabulous way. And, you know, people don't abuse that, that opportunity. They go, if they don't like molasses and beans, they pass it over and they'll take the chicken noodle soup or whatever. And Parker Street has been, they have a very respectful way of dealing with people. It's, I think, really important for people's spirits, you know. (community member)

Children are particularly vulnerable to both short-term and long-term effects of food insecurity. In Canada, in 1999, one in five children lived in poverty; yet there are no federally legislated school feeding programs (Raine et al, 2003). Within North End Halifax, there are scattered school children's breakfast and lunch programs.

(photograph by participants #3)

And this is Cornwallis Street Baptist Church. 'Cause this is, cause this is, this is, you know, where things go on and if you go in through there, like, um, you don't, you won't realize it, but they have a little lunch program, you know, for children, that you know, they just know, they know to go there, get a hot meal. (community member)

Raine et al, 2003, noted that both children and parents, particularly parents, felt a stigma attached to having their children in a school food program. While there may be a valid argument for targeting programs in times of resource constraints, all children benefit from the socialization, and programs inclusive of all children remove the humiliation felt by being needy. Yet these programs are dealing with the symptom and not the disease.

(photograph by author)

Hope Cottage. It makes me, I like to look at it. I think it's a really sweet looking little place. And to go and have a meal there, I would love to go and have a meal there. And I've been in the door to bring in some, we'll do stew each year, like a great big beef stew as a part of our neighbourhood which is, and I bring a few things down from time to time but probably not enough. But when I go in, it's just a really nice place to be inside. It's clean and inviting and there's the bench kind of seating. I think there's bench seating. And no, it's not solving the problems of poverty because some people think that it's a Band-Aid approach. I mean, you could argue that, but I just think it is a nice pleasant place to eat. (community member)

This is in stark contrast with the comment on community kitchens or soup kitchens below.

I said to the staff "How about you go in there and eat mashed potatoes that are turning yellow because, you know, free radicals have started to work on them and, and a bunch of fish bits. Is that what you had for breakfast today at home?" And why would you expect these guys to want that crap? Like no cereal. There's no real milk, it's powdered milk. It's the poorest quality coffee. One spoon, and sometimes two, for fifty or sixty guys for breakfast. It's disturbing. God, so now you have a biohazard and a carrier. The spoon now becomes "Here, have my disease". And the sugar in which it's dipped now becomes a toxic wasteland of bacteria. And I'm thinkin', I'm not, you know you don't have to have a degree in food science and you know, be a, a person that, you know. I'm saying you don't have to have a degree to figure out that this is not healthy. (community member)

In North End Halifax, as well as other urban areas, homeless youth are an increasing population with many vulnerabilities including food insecurity. For these youth, soup kitchens provide some nourishment to supplement what they are able to buy with their

252

street earnings. The soup kitchens (and shelters) also provide a sense of family and social contacts.

Overall, it can be concluded that food banks have inadequate amounts of food and what they have is often of poor nutritional value. Access is limited through limited hours of operation and through rules and policies about food distribution. Yet a common attitude as expressed by a participant in Tarasuk's and Eakin's study, "at least we know they will have something, and it's better than nothing." (p. 1509). However, Tarasuk and Eakin, along with participants in this thesis study, suggested food banks help to mask or dampen the extent and magnitude of food insecurity, its long term consequences and failure to address the issue systemically. "As clients' food needs are obfuscated through the everyday practices of food banks, there is little impetus for either community groups or government to seek out other solutions." (p. 1513). The use of food banks and soup kitchens is often a first step in a journey to homelessness (O'Toole et al, 2007). Food security is one of the pervasive inequities of our present day society.

7.10 ADDRESSING INEQUITIES

Adopting an ethic of care entails **addressing inequities.** Valuing the intrinsic worth of all provides motivation to **address inequities**; dealing with fears and myths enables us to more clearly see others as worthy of respect; becoming active citizens offers a way to work together; having the community a place for all honours the gifts we all have that can be combined to effect transformation; and using policy, procedure and process opportunities presents a pathway through which to engender and embed changes.

Addressing inequities begins with respecting and valuing the intrinsic worth of each individual.

7.10.1 Valuing Intrinsic Worth of All

People crave being treated with respect. In this context, respect encompasses valuing individuals regardless of ability, social status or group membership; it means recognizing the inherent worth and equality of all people; it means accepting others as they are; it

means willingness to hear their view; it means being authentic in trying to understand others and their situations; it means sharing information; it means sincerity in interactions; it eschews discrimination and it honours privacy (Browne, 1995).

> *And another thing about the picture that I took of Direction 180 through the, um, scaffolding is that, um, this building next to it has been really, an interesting, ah, project in the, in its unveiling, you know. There have been these stages that have been an extremely entertaining and kind of chuckle-like in a way with things that were found in the building, hung, you know, as trophies on the outside. Um, there's also, there's, there are individuals that work in that building that have been stringing it together, that have had a lot of patience for sometimes the folks who hang around in this community who don't necessarily, um, have many other places they can go during the day and so, they have, kind of taken people in and put them to work and I'm sure people feel quite, um, that's there's a regular purpose in their lives on, on certain days.* (health professional)

(photograph by participant #5)

Devaluing another can be subtle. Several study participants remarked on the presence of unexpected surprises of beauty, of hope, of compassion and of giving; yet, why should they have been considered unexpected? These were all created by ordinary folk, some of whom belong to groups discriminated against. They illustrate that we all have value and the right to health. It also serves to remind us that many of our beliefs are founded on unwarranted fears and myths.

7.10.2 Dealing with Fears and Myths

North End Halifax includes people living with homelessness, engaged in the sex trade or drug trade and those affected by addiction. There have been violence and occasional gun

shootings in the area. The risk and the magnitude of realistic concern are small, yet have an impact on how people might react to others.

> *I was thinking why would you walk by someone who has fallen? Why wouldn't you stop to help them up? Are you afraid that they will rebuff you, afraid that you won't be able to help, are you afraid that they're harmful? That they would hurt you?* (community member)

> *And there are lots of myths about the North End but some of it's true. I mean, there are some nights I'm like sitting there minding my own business and I think, "Fuck, was that a gunshot?" And then I go, "well, jeez maybe." And then I go back to what I was doing. But as I say, so maybe there is gunfire once in a while in the North End. And people are inhibited but you have to work against that. I think, particularly for women being told like only go out in groups at night. Well, frig, what, do I have to get chaperones so I can go out at night? I'm 55 years old, I'm going to go for a walk or, especially these summer evenings where they're absolutely beautiful and there's a little bit of wind in the leaves and the streetlights illuminating them and maybe there's a cat sitting out on the sidewalk. There's absolutely perfect nights for walking and so I think the more of us that are out on the street, the more of us that are sitting on our porch, or that are tinkering with our car, or are walking around our neighbourhood, the better it is.* (community member)

Community members can learn more about each other as they strive to become community citizens.

7.10.3 Becoming Active Citizens

Engaged citizens are important for asset-based community development (Mathie, Cunningham, 2003). Active citizenship involves being accountable for health, healthcare and related public policy on more than an individual level. As Kenny, 2006a, stated "(m)eaningful, deliberative citizen engagement is a crucial requirement for accountability at every other level." (p. 68)(government, hospitals and health centres, healthcare professionals [particularly physicians] and patients or users of health and healthcare resources). Accountability can be defined as "the obligation to answer for the discharge of responsibilities through explanation, to those having a significant legitimate interest in what decision-makers intend to do and have done." (Kenny, 2006a; p. 69). In turn, responsibility can be understood as "the obligation to act in a role or duty to the limits of one's power or authority and to cope with constraints." (p.69). Caring and citizenship are complementary (MacGregor, 2004).

So there needs to be another trajectory that rekindles the idea of agency and citizenship and political mobilization and if I knew what that was, I'd be out there doing it. You know I'd still be going to the meetings but I don't know the answer to the question (how to increase community members' participation in endeavours to improve community health). *I know it's the single most important question, but I don't know the answer to it. I don't.* (community member)

Examples of citizen engagement were noted in the interviews.

(photograph by participant #4)

The first picture I took is of the Housing Support Centre on Gottingen and Gary St. The reason I took the photo of this particular building is a, it represents to me, a lot of the engagement that I've had on housing and homelessness issues and looking at housing as a determinant of health and how the focus of this building and the organization reflects community response to the issues. (health professional)

Interviewees demonstrated a deep understanding of their community, its strengths and the challenges it faces. There were stories of how community members banded together to fill gaps in agency services. Examples included a winter shelter that accepted both men and women irrespective of their state when the prior harm reduction philosophy shelter was closed; neighbours helping neighbours when one was discharged from hospital with insufficient planning for transfer home. Souliere, 2004, noted in her literature review of community engagement, norms of trust and reciprocity are necessary to unite community members in action. For North End Halifax, issues of trust must be addressed. Issue awareness, feelings of efficacy, sense of community, value congruence, organization supports, and value of expected outcomes increased citizen involvement (Souliere, 2004). Discomfort with issues, surroundings, support or welcome decreased participation, as did barriers such as lack of childcare facilities, unavailability of parking vouchers, inconvenient scheduling of events, and failure to acknowledge and appreciate individual

256

contributions. Levels of involvement can vary from being informed of developments to consultation to input into decisions to collaboration and partnering to final decision-making.

Souliere, 2004, outlined the principles of engagement as "clarity of purpose, commitment, communication, evidence, flexibility, responsiveness, timeliness, inclusiveness, collaboration and continuous learning" (p.17). "To be successful, engagement must be based on vision, relationship building, knowledge and learning, and action." (p. 17). These concepts are compatible with a feminist approach. Citizen's panels (group of citizens engaged in discussing issues on a regular basis over a period of time; input used in decision-making), citizen's juries (members meet over a period of days to examine a particular issue by reviewing evidence and interviewing experts; input used in decision-making), planning cells (group of about 25 members divided into sub-groups [cells] for deliberations; input used in decision-making), deliberative poll (survey followed by presentations and discussion, then re-surveyed; information used in decision-making), scenario workshops (participants gather for a 1-2 day meeting using the scenario as a starting point for developing solutions and recommendations; input used in decision-making) and consensus conferences (dialogue between experts and citizens; citizens lead the conversation; experts give opposing views; may lead to relationships building; may or may not have impact on decision-making) have been used to engage citizens (Abelson, Gauvin, 2004). Whereas there is little evidence of the value and effectiveness of these reciprocal accountability approaches, all are feasible within the context of North End Halifax, albeit requiring resources.

To become equitably engaged, people from all of the diverse populations within North End Halifax must be encouraged and supported to effectively participate. "Citizen engagement processes, by definition, wield their accountability through the formation of strong relationships that are built upon trust, openness and responsiveness between citizens and government or public institutions." (Souliere, 2004; p. 15). The importance of government (municipal, provincial and federal) participation and accountability was stressed by study participants. Examples were given where government at the municipal

257

level took social housing units and converted them into space for agencies, occasionally assigning two or more agencies with the same mandate, thus hampering collaboration and usurping potential safe housing opportunities.

> *But I can speak from the holistic responsibility of government that they do not provide the support of one agency then to, or even to form a coalition of agencies, to band together to meet the basic needs as well as the psycho-social needs of our homeless population. And it seems if they do give minimum dollars to a shelter or to a church that they have somehow done their duty in my humble opinion, I think they are abdicating their duty when they don't.* (health professional)

In a Caledon Institute of Social Policy publication (Torjman, Leviten-Reid, 2003), potential social roles of local government were identified. They included promotion of awareness of pressing social needs and the importance of social investment; fostering of a sense of responsibility for social well-being of all community members; helping build relationships; and assisting with effective integration of services. Local governments could become exemplary employers, service providers, investors, leaders, partners and champions. They could provide employment to those living with disabilities, and from Aboriginal communities or other groups disadvantaged in the employment market.

Trust among community members and agencies is required for people to engage as active citizens. Building of trust will entail decreasing prejudice. Paluck and Green, 2009, reviewed the literature on prejudice reduction. They concluded that cooperative learning through working together on collaborative projects that have meaning for all involved was the most effective approach (however, they determined that there was scant literature addressing the subject). As discussed under *bonding, bridging, linking and mobilizing*, there are already established relationships in North End Halifax as a foundation for future citizenship endeavours. However, there are many challenges.

> *We don't have to be a large multi service agency, it can be a mixture of various programs and if people have to see each other as they walk into work, then they'll develop relationships and do partnerships if they're using mutual spaces for various programs. We desperately need that kind of government here. We haven't been great at it. But the community on the whole, unless they're being a part of it, kind of meeting on equal footing level and let's do something about the particular relationship.* (health professional)

So it's just, we are not doing a good job. In that area and I just, it's just something I really want to do ultimately. Find out what they're doing and how could, you know, even one person starting to do something will make a difference. (community member)

In communities with active citizens, officials and agencies led by "stepping back" (Mathie, Cunningham, 2003; p. 476). Expression of community citizenship is one way to build a community with a place for everyone.

7.10.4 Having in the Community a Place for All

Many of the study participants felt that it was important to retain the many faces of North End Halifax and provide a place for all (with the exception of drug lords) - artists, those living with poverty, Aboriginals, African Nova Scotians, recent immigrants, those living with drug or alcohol addictions and/ or mental illness, members of the GBLTI community, Euro-Nova Scotians and people from the spectrum of socio-economic status. They saw their eclectic community as one that could grow even more vibrant and healthy with contributions from and for all. Study participants were envisioning integration (retention of cultural distinctiveness; group and individual uniqueness) rather than assimilation (or adoption of the dominant culture). The cornerstones of community inclusion encompass value, recognition and respect for community members; opportunities for development and nurturing of talents, skill and knowledge; involvement and engagement in community affairs; sharing of social and physical space to interact and form relationships; and having access to resources (Marmur, 2002). These dimensions were also identified by study participants. Where one lives has enormous impact on one's life choices, health, education and economic circumstances (Duke, 2009).

In spite of the belief that everyone had the right to live in a safe, thriving, low poverty neighbourhood, there was dissention about whether mixed income housing could be comfortably achieved. Sequestering populations limits physical, political, economic and social space (Duke, 2009). During a visit to Cambodia, I asked how the people who lived in sumptuous houses sprinkled amongst people who lived in shacks without electricity and indoor plumbing co-existed. The answer from those who were wealthy was they had earned their wealth and comfort and those living in abject poverty did nothing to deserve

such splendour; those living in the hovels said this was their fate. The two populations co-existed without communication or interaction. This is clearly not the objective of mixed income housing! Yet there is a dearth of research on the long-term effectiveness of mixed income housing and the evidence available is equivocal (Duke, 2009). Importantly, the "underlying discrimination, race and class based, that has sustained neighbourhood segregation" must be coincidently addressed (Duke, 2009; p. 108).

(photograph by author)

Oh, I don't think that will ever happen because I think that, um, people have a fear, um, an unreasonable fear of, um (potential neighbours). (community member)

I keep going back to that, but co-op housing in particular has a whole lot of mixed income and mixed levels of employment involved. Um, and from my very limited and probably biased perspective, I guess it, it creates, I was trying to articulate a little better than a level of reality for everyone involved. You know, um, sequestering, a whole bunch of unemployed people together can certainly create a feeling of despair and hopelessness and, and a removal from the reality of the world, um, and also I think the other way around, when people who are relatively well off are exposed to a lot of people who don't have a flat screen TV, and such, it can certainly bring a check with reality and hopefully, a sense of a need to give back also. (community member)

Provide incentive for those people to live in the projects and again it goes back to if there's a mix, there's opportunity. 'Cause people get to know their neighbours and if there's a job come up, it's a way communities are helped, with a mixture. It's not just put all the poor people on one road and forget about them. It's an example of the mixed housing and it's not in the projects, but it's on the outskirts of the projects. I believe we should be putting moderate income families in the projects

with a rent incentive. But what they do now is if you live in the projects and you get a job, your rent goes up. (community member)

Thriving neighbourhoods have easy access to decent shopping (including grocery stores), child care, schools, health services and recreation (Duke, 2009). With the recent increase in gentrification of North End Halifax comes the fear that the newcomers will dictate the norms and expectations for the area, and determine who will be able to use community resources and participate in decisions related to community development.

7.10.5 Using Policy, Procedure and Process Opportunities

As reviewed in other Chapters, policies, procedures and processes are tools for change.

> *However, governments still have accountability and responsibilities at all levels around quality of life, it's in the communities; and municipality ought not state that it has nothing to do with social housing, when it builds these damn condos, left, right and centre and pushes poor people out when it has a commitment to the people in the community regardless of their income level and find a way to show leadership and show people how to secure their housing.* (community member)

> *Progressive parks let people walk and then they put the paths in. That's how I think social policy needs to happen.* (community member)

An organic, community-centered, community-owned approach to change was favoured by study participants. The concepts presented above are all improved within *adopting an ethic of care.*

7.11 SUMMARY BASED ON FEMINIST THEORY LENS QUESTIONS

1. What embedded assumptions/ biases/ values can be detected in the information presented-particularly related to positioning of women and the knowledges and experiences of women? Were these biases or inaccuracies expunged?

The embedded assumptions, biases and values were an intricate mix of the dominant Euro-Nova Scotian middle class countered by those of other sections of the population. However, the foundations on which the area was and is being constructed are those of the dominant population. There were centuries of history of disrespect for African Nova Scotians and, more recently, for many of the people who have settled in the area. Many of the approaches to supportive services such as those to deal with housing or food security are still based on the perspectives of White, middle class professionals. The women living

in the area tend to have low paying jobs and the difficulties of single mothers were noted. However, the Member of Parliament and the Member of the Legislative Assembly were mentioned and both are women and both are active members of the community. Other women have been leaders in the past and in the present (for example, Mainline/ Direction 180) as well as some highlighted by Williams, 2007. <u>Problematizing the White middle class</u> rather than the traditional problematizing of marginalized or vulnerable populations was, for me, an extremely important concept.

Study participants expressed sensitivity to the particular vulnerabilities of women related to poverty, homelessness, abuse and safety; to wage discrepancies and caring responsibilities; to expectations of stoicism and resilience. Especially within the Aboriginal and African Nova Scotian cultures, wisdom of elders and women was respected. Stereotypic views of women and other populations (those living with homelessness, addictions or mental illness; Black youth) were largely avoided by the study participants, but noted as viewpoints of others. Individual members of groups (African Nova Scotian, Aboriginal, living with homelessness, living in poverty, living with drug addiction, living as a non-heterosexual) stressed their particular knowledges, beliefs, values and experiences. And they felt these worldviews and their everyday lives were legitimate and of value.

> *This across the street from here, it's a very nasty neighbourhood and a friend of mine was killed across the street from here and this is the last place he was. My friend X, he would have been a nurse. He was in his last semester, so he would have been doing his on the job training in what. Unfortunately, he's schizophrenic and that was holding him back because, you know, you know, it's hard to study when you have a problem such as that.* (community member)

Expressed values included taking care of your property, sharing with neighbours, and the basic rights of housing/ food security and a high quality education.

2.   Have the differences in power been acknowledged? Their impact?

Study participants were very aware of power differentials in many aspects of their lives- both those ostensibly with power and those ostensibly without. These power differentials had impact from giving to receiving respect, gaining access to resources, being perceived

as credible and endeavouring to better one's lot. The power differentials included who was stigmatized and who was seen through a stereotypic lens. Power differentials were expressed through the implicit and explicit norms, values and ethics. They were exhibited in how the illness care system was designed; in how agencies, organizations and governments functioned; in the ability to lead the development of relationships and partnerships; and in funding.

Direction 180…represents one of many non government grant funded programs that are highly needed in the area that services clients in the North End…They have many challenges in maintaining ground to making funding, to maintain sustainability in their delivery and I admire the work of that executive director who has continued and fought in spite of all odds to maintain and create a service for this population. (health professional)

(W)e really need a staff person who can help do this, who can help us do this, because too often the kind of collaborative work that needs to be done is on the edge of somebody's desk, on multi people's edge of their desk. And so often the first thing that falls off. And we've also heard stories mostly at the federal government level of staff people who have collaborated with other departments and then had their wrist slapped because it wasn't part of their job description. (community member)

3. Have the political aspects been recognized?

Study participants implicitly expressed that all is political. They explicitly and scathingly chastised the governments at all levels for abdicating their responsibilities.

The city doesn't do anything for people, it provides services. But not for people. So fire and police and recreation…(We) were talking about today was a volunteer centre and that's certainly about people but it's not fixing them, it's not providing any health or social services or anything like that to them. That's now the province's responsibility. The city has no responsibility for housing even though they have full responsibility for development. I'm more and more convinced that that exchange of services was just the worst thing because it let the city off the hook for things that should fall within its mandate. I mean, housing? (community member)

Politics dictated how poverty was viewed, how people with alternate lifestyles were treated. Politics determined responsibilities of the general public and the agenda for action. Politics reinforced society's complacency.

4. Were "women-centered efforts to improve the quality of life for those who are oppressed" identified?

Women have been as active as men in efforts towards betterment of North End Halifax and the health of those who live there. Notably, they have led the development of Direction 180, Mainline and the North End Community Health Clinic as well as

a couple of young ladies who lived in Uniacke Square who had just finished going through a personal empowerment program and self awareness about who they were and they were quite keen on making a difference in their community, they wanted to make a difference...They said we want to form an association, we want to get people involved, we want to make people excited about Uniacke Square...There was a lot of backlash, they all came from the criminal element that lived in Uniacke Square. But these two girls were determined that they weren't going to be, they weren't going to be turned away, they weren't going to be discouraged. They would take all the heat and they did. Those folks that weren't comfortable left and as I knew they would. They'd leave, you can't conduct business anymore. Drug dealers left, no more guns, very few you know. It's been working. Uniacke Square has really, really changed. Changed back to what it was intended to be and what it was. (community member)

Women-centered efforts include child development, support for single parents and Barry House.

5. Was improvement to society through eliminating constraints based on gender sought?

Although acknowledged, issues of gender constraints were entangled with other questions of inequity. In general, the expectation appeared to be that improvement in the circumstances of all of the marginalized or vulnerable populations (those underserved by our health system) would inevitably lead to improvement in the lot of women. The ethic of care in many ways emphasizes the viewpoints of women, at least as expressed by study participants. An ethic of care would facilitate the design of a system for health from an inclusive perspective.

Generally in the morning you see numerous people standing in front of this building, they are the clients waiting for the door to open for their methadone and local residents and business people often have a negative impression of that clientele. But little do they know the personal stories behind each one of those clients. 'Cause anyone of those clients can be our cousin or family member who has had a very difficult time and whose hit rock bottom and all I can say is we are very fortunate to have a centre like this that provides the holistic treatment. (health professional)

264

6. Was how culture may have shaped the behaviours/ results conveyed?

Study participants spoke about the history of the area, the cultures (predominantly African Nova Scotian, Aboriginal and White working class/middle class) and how these cultures shaped the demographics of the community and its present circumstances.

The traditional culture of helping and helping professionals/ agencies was experienced by study participants. As exemplified by the approach to food insecurity, the related efforts perhaps served the helpers more than those requiring food security (albeit inadvertently). However, community members have helped to institute significant change.

> *When I lived in Uniacke Square, it was a community right, we never thought about guns and shooting lights out. When we lived there, we were very protective of the neighbourhood. Who are you, what are you doing in our neighbourhood? Oh, okay, so you're going to visit Mrs so and so, well, okay she just lives right there. But then it changed, it just suddenly switched. Now it's back. It's back to being a community again. And a safe, safe community. So you're right, broken windows, you fix them, broken doors, you fix it. Plant gardens, put flowers in, put up nice little fences, allow people some privacy, allow them dignity. Give them dignity. They'll take care of it themselves. They'll come out and rake, clean up. It does make a huge difference.* (community member)

7. Were conceptual frameworks and standpoints clearly identified?

Study participants universally valued the framework of determinants of health. They expressed an astute awareness of the impacts of the social determinants on the health and lives of individuals to an extent rarely seen within the acute care health system. Study participants clearly identified there were many valuable knowledges that were not those of White, middle class males; they understood the worth of relationships. The enacted standpoint was one of feminism expanded to include all vulnerable, marginalized or oppressed people; an emancipator view.

> *They serve a population that, in my humble opinion, is at the bottom of the barrel in our health system. That general delivery of health care is not open to this population. This population is at the bottom of the barrel both in the health system and in their own lives often. They have hit rock bottom with regard to their addictions and often having dual diagnosis often a mental illness of some sort. So have the staff who are providing a caring, holistic, non-judgmental harm reduction philosophy of a health care; it is absolutely wonderful and needed in our health system.* (health professional)

Undergirding frameworks were the governments (local, municipal, provincial and federal) had the fundamental responsibility for a health system; that the definition of the problems/ opportunities and thus the definition of improvement have been determined by those with power due to wealth and /or position.

The major points I gleaned:

- The importance of problematizing the dominant middle class populations
- The potential of mixed housing when approached empathetically
- The benefit of integration versus assimilation
- The usefulness of an ethic of care to reframe pathways to achieving community health (and the metaphor of meals through which to envision the reframing)
- The need to reconstruct our perceptions of helping and the helping professions and agencies

The way forward, I believe, will include:

- A balance between exposing inequities and changing the image of North End Halifax
- Linkers or connectors to weave relationships within the community to facilitate emerging leaders to work together towards a collective goal (potential rallying cry of "health for all!")
- Designing a future from the perspectives of those poorly served through inclusion and visualization of their lifeworlds
- Active multi-sectoral government engagement and partnerships with community-directed action groups

CHAPTER 8   CRITICAL SOCIAL THEORY LENS

Through using a critical social theory lens to examine interview data, *enriching the community to enrich us all* was identified as a basic social process to increase access to health for North End Halifax community members. The realization that we are all affected by the communities in which we live, and by the quality of life of all community members, can enable each and all of us to assume responsibility and accountability for the health of the community. Eight components of *enriching the community to enrich us all* evolved from the data - **walking the talk of diversity and inclusion** requires compassionate attitudes and behaviours towards all community members, **eschewing judgments** facilitates collaboration, **mitigating power differentials** enables broad participation for community development, **shifting political emphasis** becomes the way to achieve community goals, **securing basic rights for all** underlines that we as fellow citizens have not heeded our responsibilities for community health, **grounding activities within the community** recognizes that the community itself knows best how to achieve community-defined changes**, recapturing business and economic development** provides a financial foundation for future efforts, and **rendering healthy lifestyle resources accessible** makes it possible for community members to adopt a healthier lifestyle. The map below illustrates these concepts.

Figure 5   Critical Social Theory Lens Concept Map
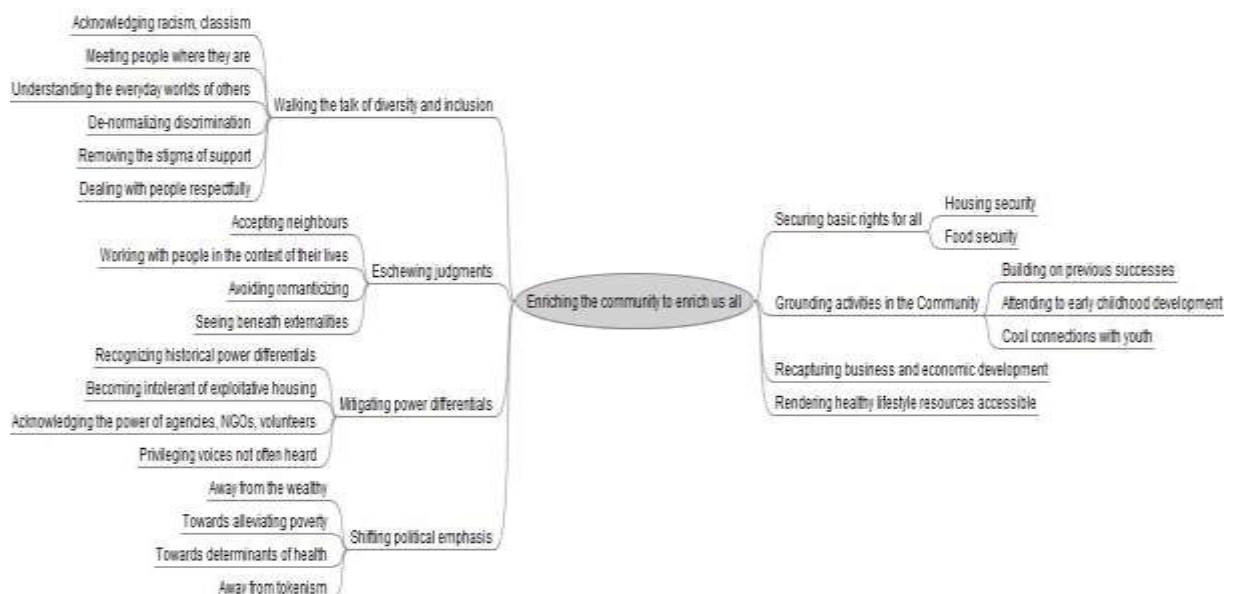
8.1   ENRICHING THE COMMUNITY TO ENRICH US ALL

There are many aspects to this basic social process- it includes better health for the community as a whole and for individual community members; it embraces the principles of the determinants of health. It stresses developing communal values of the common good and collaboration; it sees the individual enmeshed within the community. In North American culture, autonomy and individualism are emphasized; the "African worldview demands an ethic that supports order, cohesion and communal responsibility" (Jegede, 2009; p. 240).

> If there is no peace in the community, it affects its individuals. This means that the health of individuals is grounded in the health of the community and vice versa…peace of the individual member is the peace of the community, affliction to one member is affliction to others. (Jegede, 2009; p. 246, 249).

This worldview is shared by Aboriginal peoples' philosophy that it takes a village to raise a child; community interests take precedent over individual interests (Souliere, 2004). Martin Luther King claimed that racism harmed Whites as well as Blacks and, although laws and policies may not necessarily change attitudes, they can decrease or prevent racist actions (Rogers, 2004).

> The voice of the organic whole, speaking through representatives who see the needs and correct relations of the different individual groups, demands that one class in society who will not voluntarily give up privileges which their position in society enables them to get, must be compelled to act as if they saw the good of others and the true interests of all classes. (Rogers, 2004; p.79).

The health of a community can be seen as a communal good; health facilitates all aspects of our lives including productivity, creativity and economic well-being (Filho, 2008). Each of the components of the basic social process *enriching the community to enrich us all* is presented below.

8.2   WALKING THE TALK OF DIVERSITY AND INCLUSION

Walking the talk of diversity and inclusion enveloped the concepts acknowledging racism, classism, heterosexism and other 'isms' and meeting people where they are. Acknowledging racism, classism, heterosexism and other 'isms' provides an incentive to move to the construction of a more communal sharing of power; meeting people where they are paves a pathway of empowerment towards *enriching the community to enrich us*

all. Inclusion of all community members in working towards equitable access to health is imperative to meet the needs of diverse populations. The Nova Scotia Department of Health has an established diversity, social inclusion and cultural competence initiative, the need for which was reinforced by comments made during participant interviews.

8.2.1   Acknowledging Racism, Classism, Heterosexism and Other 'Isms'

Acknowledgment of injustice to others is an initial step towards redressing inequities. Racism can be expressed at a personal level (conscious or unconscious attitudes), interpersonal level (biased assumptions about self and others), at an institutional level (embedded institutional practices that unfairly treat some) and at a cultural level (defining European-American-Western culture as right or the standard on which all is based)(Nsiah-Jefferson, 2006). Examples of racism at all of these levels as expressed by those interviewed included:

> *So there's lots of prejudice and lots of stereotyping that I think exists in a, in the fabric and the DNA of people that, and when I say the DNA, I don't say that to take them off the hook, to say they can't help it. But I mean, that, you know, people are really, um, I think in general, philosophically can speak of this feat* (respecting diversity and inclusion)*, but I think when it comes down to it, um, we have a hard time living and walking the walk.* (health professional)

> *I've watched these little toddlers* (African Nova Scotian) *in kindergarten, then growing up and becoming preteens and you can see those big smiles on their face change to anger over the years and they are not happy; there's a lot going on and this is one way which it takes a village to raise a child kind of approach but we can always say "it's the parents" and that is significant. There's a lot of dysfunction going on when people are deprived and there's all kinds of layers of issues of racism. I think what we don't do as a general public is we are not as vocal as we can be about addressing racism. We behave in a way, the majority of us that wouldn't be a positional type acceptance of racism, but we are not as proactive as might be to embrace the Black community in a way that we want to share a bench with them. That's all, anybody is really asking; doesn't matter who you are. People just want you to move over a little bit.* (community member)

The following interview excerpts illustrate other prejudicial attitudes. Referring to an advertisement for a GBLTI entertainment event,

> *Oh, this is like a sideshow at a friggin' circus or fair, you know. "Come see the queers", you know, real, that's, I just, that's how I looked at it. I just thought, you know, it's a sideshow, and, and I have, you know this is cliché. I have friends that are gay and they're my buddies and, and they have been. But when it turns into a*

sideshow or "Oh, look Mommy. Look at that guy. He's dressed like a girl". You know, ah, transsexuals, transvestites. (community member)

(photograph by participant #2)

Or persons living on the street or with addictions,

I still get things like "You don't go out alone? Are you scared to be doing it"? Like, why should I be scared to do the work that I do? Why, why would I need to be afraid of that, you know? I might, you know, when I need to, what I need to be careful about is that, yeah, I am around people who use drugs but often people who are using drugs aren't interested in any kind of violent activity but the people who are often selling drugs might be. So, you have to be, you know, but that's not who I'm really there for. So, you know, that's not who I see. (health professional)

We need to move beyond acknowledgment.

Strikingly, acknowledging a kind of White privilege is a form of entrenching White property by extending formal equality through the hyper-individualized discourse of liberal self-awareness. This self-awareness is limited, however, because it is not accompanied by a structural awareness. The very nature of legitimation *(sic)* is that it is deceptive. The formal equality that legitimates systems confuses superficial change at the individual level with structural transformation…Awareness is collapsed with change. Difference is conflated with deficiency. Equality replaces equity. And, White privilege is countered by Black 'racism'. (Vaught, Castagno, 2008; p. 107-108, 111).

We must engage in structural changes, inclusive of enabling public policy. Part of engagement in structural changes requires meeting people where they are.

8.2.2   Meeting People Where They Are

Although the following quote refers to residents in a senior's care facility, it equally applies to the rest of the community.

> *One of the things that I've learned over the years is that there are many different ways that people approach their lives. And there are some people who really love the idea of a community; communal, more social activities. And then there are people who really love the anonymity of living in the city in the urban environment and in a big building. They like that, they like coming into the big building, getting on the elevator, going up to their unit and that's it. They close the door and that gives them a sense of well-being. And they don't necessarily want to be social with other people who are in the building. And sometimes some of the social, some of the government services start with this idea that everybody should be involved in the social activities without recognizing the diversity of opinion that exists…The people who live here are not homogenous. They come from lots of different backgrounds, lots of different levels of education, lots of different life experiences, lots of different cultural experiences, and just getting harmony to rule spontaneously is not an easy thing to do. You have to really work at it.* (community member)

(photograph by author)

There are examples of health professionals reaching out to where those poorly served by the traditional illness care system can be found.

> *Umm, infections there, "I want it treated now." "Okay." "You know, I'll assess that now." "There's no-one here right now and I've got other things to do at this point." But one of the other big things I'm seeing Mainline do is just maintain a relationship, maintain the dignity. Um, maintain a contact with people so that when people have reached a point in their life; they provide a pretty healthy springboard to accessing services in a more traditional manner and advocacy. And it's, it's a coaching also that, that's sort of a long term coaching that they do that basically tells people, um, you know, you are deserving of health care and ah, and this is one where you can do it.* (health professional)

"Meeting people where they are" was understood to mean both physical location and within their everyday world and situation.

8.3 UNDERSTANDING THE EVERYDAY WORLDS OF OTHERS

De-normalizing discrimination, removing the stigma of support and dealing with people respectfully were ideas embraced within **understanding the everyday worlds of others**. De-normalizing discrimination enables seeing systemic inequities that can be reframed as goals in common; removing the stigma of support serves as a reminder of our role in creating the need for help; and dealing with people respectfully allows us to hear the stories of others, to **understand their everyday worlds**. **Understanding the everyday worlds of others** is an important facet of *enriching the community to enrich us all* for without it there would be no motivation for inclusive improvements.

Much in our lives is socially constructed from the viewpoint of middle class White men. Smith, 1990, emphasized the importance of the everyday world to gain understanding of the lives of others. There both positive examples, and pleas for understanding, of the varied everyday worlds of North End Halifax community members.

> *Pharmachoice has been a neighbourhood pharmacy and they have been particularly cognizant of, um, of people on social assistance and in the process going through co-pays and have been certainly helpful to me and helping sort some of that out sometimes. And they've been known to carry a few people; probably far longer than some other pharmacies might have and just having faith in some people, while still maintaining a small business.* (health professional)

(photograph by participant #4)

But, you know if you get impatient, or if you huff and you sigh and you say "Where the fuck is the doctor?" to the receptionist, all of a sudden you are difficult and you need to, you know. But if I've, you know, if my day went something like this – I woke up. I got a phone call from the creditors. I had to get my four kids off to school. I don't have a partner. I had to try and make as much as I could for lunch for them to take. I walked them to school and it was pouring down rain. It was wet snow and then I had to walk back. And then when I got back the mail was there but my assistance check wasn't it and I called my assistance worker. It's 11:30 only to find out they only return phone calls between 9 and 11. You know, I'm probably really not going to get the 45 minute wait or the hour wait or the whatever. And I might say "what the fuck". (health professional)

(photograph by author)

This church, the Black church - the Revival Tabernacle Church - is a church that's made up of families that are generally very low income families. (They have a) *camp out at Miller's Lake every summer. It's phenomenal for a whole variety of reasons, including the fact that the kids have meals there that are just to die for. They have…these children have never eaten home cooked meals from scratch that didn't come out of boxes and cans…They love it and it's really quite amazing. And they do so many kinds of really good things for kids. They have lots of games and lots of competitions. But nobody is left out. Everybody wins. Every child is a winner in a competition. It's fabulous. It's amazing. And the kind of joy that engenders in these kids when you go there is just unbelievable.* (community member)

Mental health, a significant issue identified by most interviewees, was associated with being different, poverty, homelessness, unemployment, isolation as well as challenges to other aspects of health. Many who might have benefited from mental health interventions feel alienated by, lack of access to or discomfort with, available mental health services. Youth, those who are homeless or Aboriginal in particular, are often invisible or ignored

273

with respect to access to health. Persons living with disabilities challenge our comfort with difference where difference is often perceived as strange or deviant resulting in a negative bias within social relationships (Silvers, 1995). Persons living with disabilities (mental, physical or other) are amongst the forgotten or invisible populations. Our social construct of disabled versus able-bodied is often achieved through looking away rather than interactive exchanges with an individual having a disability.

> *I witnessed a person falling who looked like he was having difficulties and looked like he could have been intoxicated. Five people walked by and watched him slip in the grass, he was just confused and lost and he had a phone number in his hand.* (community member)

Oppression may become evident when individuals are daily exposed to a racist, sexist, ablest, classist and homophobic society (Campbell, 2008), emphasizing the need to de-normalize discrimination.

8.3.1   De-normalizing Discrimination

> Discussions about visibility and assimilation indicate that the notion of 'community' is furthered *(sic)* problematized by the complexities between rejecting and holding on to identity. Whilst some participants seek to move beyond the identity of 'trans' and to assimilate into a gender binary system as women or men, others argue for a politics of transgender visibility that problematizes the gender binary and seeks to recognize gender diversity. (Hines, 2007; p. 482).

Heterosexual, middle class, White individuals and families are the "uncritical assumption within the literature of universality and desirability" (Hines, 2007; p. 464), yet what one might consider standard for some appears unattainable for others.

(photograph by participant #1)

This is the other side of the Joseph Howe School. Look at this little playground down here. The fenced one is for the little baby kids, right. They're all looked after. This is for the kids at recess. Right behind the dumpsters with the garbage strewn about. And if you walk down there, there's syringes and gloves on the, in here, and condoms, just right here in this kids ground. I bet every school ground in Halifax doesn't look like that. But I accuse the School Board of ignoring some North End schools and that's one of them. (community member)

*One of the tragic jokes that I still tell people today, 'cause I still think is true, and one of them is that if you are, if you're bad and you're poor or you're Black and you live north of Quinpool Road, you go to jail and if you're bad and you live south of Quinpool Road you go to the IWK (*Health Centre*). I don't think that's changed you know, so I think what I'm saying is that, what that meant is that the degree of oppression in this community and the degree of class, of dramatic class difference, gave the North End a quality, a class quality, and homogeneity experience certainly not a homogeneity between races, but homogeneity of class experience, that was hundreds of years old and very identifiable. That's my theory. And reinforced by the explosion and reinforced by the geography of this city, where the Commons breaks the city in half, and reinforced by its British class history.* (community member)

As noted previously, within the traditional illness care system, we do not always recognize how abnormal a context it places individuals in, and that we consciously and unconsciously discriminate against those who do not fit within that health professional worldview. Persons who are discriminated against may also experience the stigma of support.

8.3.2   Removing the Stigma of Support

Stigma separates individuals based on judgments that they are tainted or less than others (Pescosolido et al, 2008). Taking the step of admitting that one requires social services; financial, housing or food or other help is difficult and often traumatic. It may engender feelings of inadequacy and failure. In their study of Atlantic province school children, Raine et al, 2003, found that parents may fail to enroll their children in school food programs because of the stigma attached. Yet, we, the members of Canadian/ Nova Scotian society have repeatedly (both consciously and unconsciously) contributed to the system that forces people to seek assistance. It is our failure more often than theirs.

People have to identify as poor to be mobilized; but in this community people could be identified as North Enders that would make it less humiliating. (community member)

The Parker Street Food Bank, up on Maynard Street, food and furniture bank… This is an organization that is very dedicated to people who are very poor and very disadvantaged, who live on really small incomes in the community. And they provide more than emergency food and helping people get some of the basics when they are setting up a household. They provide, I think, a very non-judging environment in which to get support and material things…They don't engage in a lot of application filling out. There's a little bit but it's minimal…So, I think they fulfill a really important role in that kind of continuum of services that people need and, especially, for people who are put off, upset, intimidated, and really alienated by the more formal kinds of organizations. (community member)

In the same way that we feel no compunction seeking acute health care services as our basic right (a normalized action), asking for assistance to achieve access to other basic rights should become a de-stigmatized request. This is one way through which we can begin to treat people with more respect.

8.3.3   Dealing with People Respectfully

Being treated with respect is something we all wish for ourselves. Yet we may fail to treat others with the respect we all merit as human beings. Self-respect enables us to more readily act respectfully with others and vice versa. Participants identified both how respect was not always given and how that disrespect further hampered self-respect. In this context, respect was being treated as a human being, having intrinsic value as such. Such respect does not require agreement with the individual's values, behaviours or attitudes. As stated by Dillon, 2009,

> The attitudes of respect, then, have cognitive dimensions (beliefs, acknowledgements, judgments, deliberations, commitments), affective dimensions (emotions, feelings, ways of experiencing things), and conative *(sic)* dimensions (motivations, dispositions to act and forbear from acting) some forms also have valuational *(sic)* dimensions. The attitude is typically regarded as central to respect: actions and modes of treatment typically count as respect insofar as they either manifest an attitude of respect or are of a sort through which the attitude of respect is characteristically expressed. (p. 7).

Regarding local shelter facilities, a study participant stated

I was aghast at this practice of basically herding humans in like cattle, closer and closer together, not only for the lack of humanity but for the sake of transfer of respiratory illnesses. Things like tuberculosis, just basic dignity…And so different people, a group, were allowed to sleep over the winter months in the basement area that was a little bit more humane. They called it something like "the suite" where

special people got to the basement, but anyway, it's sad you know, when you think of what people perceive as acceptable housing. (health professional)

And referring to community kitchens,

You know, you're not supposed to throw stuff at someone and go "This is it" or "We've run out". Run out? Breakfast has just been on for half hour, you didn't. So, possibly, bringing a little more bread, or "Oh, no we have to save that for tomorrow" so several guys every day don't get to eat because there's not enough. But, you know, if you're going to have a kitchen in which guys that have next to nothing go to eat, don't, don't insult them by throwing at them. We're not dogs. You don't throw scraps at human beings. They have self-esteem issues as it is. Why would you further that negative pathway by not giving a shit what you're giving them to eat? (community member)

Redressing inequities related to diversity, prejudice and exclusion is challenging. Few interventions are proven to substantially change discriminatory beliefs and actions. The most encouraging are cooperative learning (performing tasks within groups that are culturally, socially, sexually, etc diverse) and contact with others in situations where people are seen as having equal status, where goals are shared and where competition is absent (Paluck, Green, 2009). Eschewing judgements is another aspect of facilitating inclusion.

8.4   ESCHEWING JUDGMENTS

Accepting neighbours, working with people in the context of their lives, avoidance of romanticizing and seeing beneath externalities contribute to **eschewing judgments**. **Eschewing judgment** is an important part of coming to accept one's neighbours and accepting one's neighbours creates an opening for learning another's lifeworld and becoming less judgmental. Working with people in the context of their lives allows appreciation of the challenges they face; avoiding romanticizing provides a realistic view with which to plan a better future; and taking the time to see beneath externalities prevents premature conclusions. **Eschewing unwarranted judgments** facilitates people working together *to enrich the community to enrich us all*. Judgments of others often are based on dominant or powerful population norms.

Myths and mysteries have been promulgated about North End Halifax, largely through unfavourable media reporting, unbalanced by coverage of stories of community strengths and improvements. These myths and misrepresentations have hampered community members from accepting their neighbours.

8.4.1 Accepting Neighbours

Housing for individuals living with mental illness has been an issue since the closure of the Nova Scotia Hospital as an inpatient psychiatric facility. Following the pattern seen elsewhere (Zippay, Thompson, 2007), and benefiting those unwilling to have such housing in their backyard, many are living in North End Halifax, homeless or in supported housing. Many live in a "milieu of disadvantage" (Zippay, Thompson, 2007; p. 393) - social isolation, segregation and decreased access to employment. "Segregation limits the right people have to space, not only physical space, but political, social, and economic space as well", and the right to change their community as they would desire. "Physical integration, often seen as a panacea for public housing residents, might not be sufficient." (Duke, 2009; p. 101). The right to the city includes the right to appropriate space, the right to participate in the design of urban space and the right to diversity (Duke, 2009). Opportunities and well-being are profoundly influenced by where one lives.

So I moved into this neighbourhood because of the desire to be integrated but a desire to be integrated doesn't make you integrated. Integration is actually extremely difficult so I would say that people I know in this neighbourhood are middle class people, after 22 years people I know are middle class. The neighbours I know next door…not in a positive light. I don't know them. I knew some of the people who used to live in the neighbourhood who were poor; when people talked to each other real regularly, but I don't know. And I think you see, because, people's housing is a more selfish place than people's politics I mean, it stuns me after all these years the degree of racial and class segregation that continues to exist to this day. (community member)

No frigging way – it's (mixed housing) *not going to happen. Human beings tend to be very narcissistic and we see the world in the people who look like us and talk like us and dress like us – so no – common cause in people who are currently living on the $300,000 row houses on Brunswick with people in Uniacke Square? Oh my god it's not going to happen.* (community member)

The assumption of mixed housing is the exposure of individuals and families from different socioeconomic backgrounds will redress some aspects of poverty and perhaps be mutually beneficial to those who are better off.

> *Co-op housing in particular has a whole lot of mixed income and mixed levels of employment involved…You know, um, sequestering, a whole bunch of unemployed people together can certainly create a feeling of despair and hopelessness and, and a removal from the reality of the world.* (community member)

However, there is frequently opposition because of fears of decreasing property values, safety or quality of life from the proximity of undesirable neighbours (Duke, 2009).

> *And in fact, on the other side of Mainline on Cornwallis, there are townhouses, condos, whatever, called Theatre Lofts, or something I think, going up there, or have gone up and, um, you know, there have been times in which the developers have, you know, gone to the municipal and provincial government and wanting, you know, complaints and concerns about needles be around or the kind of people that hang around or that type of thing. And so, you know, it's a constant struggle for us and the composite of the Direction 180 and Mainline to manage their neighbours, plus allow people to be who they are. It's been very, very hard and they have had huge challenges with that.* (health professional)

In North End Halifax, differences socioeconomic class, race/ ethnicity and lifestyle led to separateness. Challenges of mixed housing included real estate marketing discrimination against certain populations, perhaps removal of attention from the issues of poverty and racism, and the expectation of the formerly segregated people to conform to the expectations of the dominant group (Duke, 2009). To counter this, a neighbouring town is investing in activities that encourage neighbourliness such as time banking.

> (T)*he Nova Scotia Department of Seniors is interested in seeing time banking across the province…It's about neighbours helping neighbours. So if you bake a cake for me and I give gardening advice to someone else and that person puts oil in his car over there, it all gets recorded. We asked people, what are some ways you could help other people and what are some ways you might need help…the young people had four times as many ideas about ways they could help others and five times as many ideas about help that they could use. Isn't that amazing! So that might be like running errands, or going to get groceries could be something that could be banked in a time bank.* (community member)

Not only are people in general hesitant to be neighbourly, we as health professionals fail to consider how our relatively ordered world (a world ordered to our benefit) disadvantages others.

8.4.2 Working with People in the Context of Their Lives

We can be hasty to judge others and their actions, unknowing of their circumstances. An understanding of the situation of others might not only assuage our judgments but might also allow us to see more clearly how we could work together for improvements in the health of community members.

> *My addiction is physical. I'm physically, I'm physically dependant on opiates. But I, I don't have any track marks. I don't use beyond doses prescribed and you know. In the second stage of addiction, you know, continued use despite harm to subject. I've never, I got injured and I use pretty much every pain med that's prescribable, you know, and then I quit for two years and but still had the pain. So, I, I use small quantities when necessary and that's just the way it is, you know. I'm, I'm not a social burden and a, you know, a buffoonery that goes on with someone drunk on the street and you know there's a lot of that down there, at Turning Point. But anyways, you know, I'm at one end of the scale and my buddy with, ah, puncture marks in his neck. Well, that's how bad it can get, you know. I, I, I mean I'm not preaching or testifying, just there's things that can be done and they're not going to be done because number one, politicians gasp when they're offered a suggestion how we can take care of things.* (community member)

> *You know, it symbolizes how little privacy you have when you are homeless and how little space you can kind of call your own and so, you know, you find the cosiness of concrete, um, as that space. And I think that that is the sort of thing that people don't understand about living, you know, living in a shelter is the, um, the lack of kind of...You're on, 24/7, like you're on, you're needing to just be on and you have no downtime and you have the, you know, the whole concept of relaxation, privacy, um, is completely stripped of you, so that space is an odd space to me. Okay, so I feel, yeah it does give some of the guy's privacy to go and to use* (drugs in the alleyway) *and then on the other hand, ah, I think, you know, how sad it is, that there's so little privacy. And it's one thing that we don't, we don't do anything about. We haven't really figured out how to address it.* (health professional)

Knowing the context of the everyday world of people with different life worlds than our own prompts one to pause and contemplate how she or he would act under similar circumstances, knowing that previous life experiences will either hamper or help in our ability to imagine.

8.4.3 Avoiding Romanticizing

There is a tendency for those of us in our comfortable pew to remark on the resilience of community members, the strength of Black women (Etowa, 2005), the hardiness of the

homeless in surviving the winter and the past history of this remarkable community. Such romanticizing can create complacency and failure to see and strive to address root causes of a basically unacceptable situation- the vast inequities present in North End Halifax.

(photograph by author)

You know, this church was struck by fire and it became a national incident and the fundraising efforts were made to rebuild this church and thank goodness people contributed and were able to restore St. Georges. The other significant thing is the old structure, in the balcony, had leg irons. So when those affluent people on Brunswick St. brought their slaves to church, because they were good Christians, and took them to the balcony and the leg irons were put on them so they wouldn't run away. But they didn't restore the leg irons with the restoration of the church, which they should have, because it's history. What a reminder that would have been! (community member)

Nobody should romanticize what's going on in the North End, I'm mean there's shootings, there's knifing, there's death, there's assaults, there's a quiet drug trade, so it's important to validate without romanticizing what's going on in this community and there's some very dangerous shit happening, very dangerous. And whenever there's a demographic shift in the larger population or shift of sort in social morals and expectations, those things always affect poor and marginalized groups even worse. (community member)

I remember one day in the 90's somebody walking down the street and saying to me as I was out gardening "don't we live in a wonderful community" and I said "yeah we do and we've really been blessed." In fact this was in '94, when Nelson Mandela was released, and he said to me "you know we should rename Fuller Terrace, Nelson Mandela Street." and I said "no we fucking shouldn't because Nelson Mandela would be really pissed that people like us moved into this neighbourhood and driven everybody else out to Spryfield." Even though we have a

281

very nice community, we should not forget for a minute that it's privilege that got us in here, not solidarity. (community member)

Depicting the past and the present resplendent with people overcoming adversity can mask the obvious question of "why should people have to face such challenging circumstances?". Digging deeper into issues also requires seeing beneath externalities.

8.4.4   Seeing Beneath Externalities

There were two broad categories of this component - (a) seeing people as worthy of respect without judgment based on appearances and (b) exposing the deceit of cosmetic corrections to housing. For people, externalities such as the faces of homelessness and poverty, alcoholism and mental illness, physical disabilities and race or ethnicity may deflect us from seeing the worth of the person "underneath the skin".

Yeah, there is much more that happened before, before their first haul off a crack pipe that nobody paid attention to. I mean, you know, a lot of the women that I've met with addictions, I don't know that I've met one yet, that doesn't, has not shared some form of childhood sexual abuse or abuse, you know. So, so where were, where were all of these, where was all of this judgment then? You know, where was the community of morals that, get, the more high road then? And it wasn't there for a number of these women. Not only were they victims of child abuse often or sexual abuse, but often their lives were, you know, they're maybe suffering through generations of, of inconsistence or living in poverty and so, again, we, there are people, and, and I think that, you know, that as health care providers, we get, we have a, a kind of standard of which we feel that people should, how people should interact, you know in certain, in, in other settings. (health professional)

I have a bit of a problem considering it unhealthy because he's not in denial about it (his drug use) *and, you know what I mean? He's, it's not a proud thing, it's just, you know, he's, he's a sensitive young man and I, I just, ah. I think a lot of him. He's, he's a, a good dude.* (community member)

With respect to building externalities and misplaced emphasis,

So an example of a policy I'm thinking of is what's called Frontage or something. So you are not allowed an eyesore of a house, an example an elderly couple who are clients here, whose roof was leaking, and were as you know, on a fixed income, limited income, and were saving their money to have their roof repaired in the spring, and the wife had COPD and a pneumonia infection, and was being monitored by staff at our centre and were told by this couple that the money they were saving to have the roof repaired had to be spent to paint the front of their dilapidated house because they received an eviction notice that the site of their house was an eyesore and that if they didn't have it painted or repaired in X

amount of months, or repaired or to a degree upgraded they would be slapped a fine. So they used the money that they were saving for their roof to have their house upgraded, but the roof continued to be leaking so there was damp and mould building up inside the house. (health professional)

Externalities are often important in power relationships, designating or signalling the façade of a person with power.

8.5   MITIGATING POWER DIFFERENTIALS

Mitigating power differentials first requires understanding their <u>history</u>. Other elements include <u>becoming intolerant of exploitative housing</u> as a power differential that undermines obtaining or keeping a basic security; <u>acknowledging the power of agencies, volunteers and NGOs</u> emphasizes an often overlooked power differential and control by those who have versus those who do not; and <u>privileging voices not often heard</u> indicates a way of beginning to **mitigate power differentials**. In turn, **mitigating power differentials** eases the challenge of engaging in *enriching the community to enrich us all*.

As stated by Townsend, 1994, "people's experience of power is organized by processes and practices which invisibly coordinate and control everyday life." (p. 6). Those in positions of power have the ability to give and to take away; to make choices denied those without power.

8.5.1   <u>Recognizing Historical Power Differentials</u>

As stated by Campbell, 2008 "oppressed people are routinely worn down by the insidious trauma involved in living day after day in a sexist, racist, classist *(sic)*, homophobic, and ablest society." (p. 155). For North End Halifax, such historical power differentials have included persons who are living in poverty, who are homeless, who are Black or Aboriginal or immigrant, who speak a different language, who are unemployed, who live in single-parent households, who live with mental illness or who live with addictions.

"Family violence occurs all across the class lines and bad behaviour in children occurs all across the class lines and drug and alcohol abuse all across the class lines," well there's an element of that that's true but the danger in making those statements is not acknowledging the poverty and racism are huge risk factors for social collapse and personal and emotional distress, and the incidences much

higher…To say that tells us that poor people or Black people or Aboriginal people are bad or badder people, no, it says that the stress, the struggles and the issues that are going on have a disproportionate impact on their lives. (community member)

Disadvantages from these historical power differentials are almost impossible to obliterate yet we can narrow the disparities through consciously considering the circumstances of all involved. One area where those power differentials are played out is in exploitative housing.

8.5.2   Becoming Intolerant of Exploitative Housing

Compared with the power of people with low incomes seeking affordable housing, that of landlords and real estate owners is daunting.

A lot of rooms are going for $535 which is the allotted allowance from a Social Assistance Benefit when one is on a medical disability…There is, again, I never had the chance to confirm this, but basically from R, he said he was paying $630. That meant, for him, that he used up all of his food allowance to cover his rent. And he was completely dependent on outside sources for food, and bottle collecting for food. But his rationale for paying that extra rent was that it took him away from a high drug use area, an area he used to use a lot of drugs in. So it took him out of that area and it took him away from temptations. And it took him away from old animosities and old pressures, to a fresh start. (health professional).

(photograph by participant #4)

This is one is another development of social housing and again, in the business, and government call them a non-governmental organization. Anyway, it's for single adults and that's been a real issue for most of my career here that the fact that single people who are alone and who really are at the mercy of the rooming house landlords and it's been very unhealthy and there's still exists a small profits from very unhealthy rooming houses. This is the alternative to that. (community member)

Underpinning the more obvious examples of exploitative housing is failure to make affordable, safe housing available.

> *Bring back, rent, you know, rent control and we'd just like affordable housing…I'm not sure what percentage builders have gotten for their money to, you know, help build those places, with the understanding that, you know, some of the units will be not market rent but subsidized amount. But if you don't tell anybody that you have that, you know, how are they going to know? Who's going to move in? You know, I mean, you advertise that you have, you know, three houses or apartments, you know, from $985 to $630 to $580 kind of thing and, you know, this is what's available and you go on the internet so that people all over Canada are looking at it and calling you up…But you're not saying, if you likely to apply for a subsidy and you know, when you come, whatever the rent $300, you know, and something, so. So, you know, just knowledge is power but, you know, if you don't know who you're supposed to give the knowledge to and, you know, it's not a standard procedure that you would know.* (community member)

Failure to address exploitative housing is our failure as a society. As insidious and invidious is the lack of acknowledgement of the power of agencies, volunteers and NGOs.

8.5.3   Acknowledging the Power of Agencies, Volunteers and NGOs

Whereas agencies, charitable associations, volunteers and non-governmental organizations have assumed critical roles to cover gaps in our support services, they may also perform dis-services. By not facilitating means for communities and individuals to escape from the vortex of poverty and disadvantage, they perpetuate the circumstances that their services/ supports are meant to alleviate. They indirectly reinforce the negative images of communities and individuals, an image the community comes to believe as true (Kretzmann, McKnight, 1993); they reduce incentives to move on from basic subsistence. It was the dis-services that study participants emphasized.

> *I know Ayn Rand, the author. I didn't like what she read or wrote but I read her but one thing that sticks in my mind about the author and that is "the unearned is undeserved". So, you know I thinking, well here is a perfect application of that, you know. You didn't work for this food so you're going to eat whatever we throw at you, you know. And whatever is simplest for us, that's what you're going to get.* (community member)

Tarasuk and Eakin, 2003, noted that the "framing of food assistance as a supplement also served to lessen the importance of the particular selection of foods distributed as there

was no illusion that the assistance was intended to completely meet the clients' food needs." (p. 1509). Clients were expected to be grateful for whatever they received. Silvers, 1995, believed that "the very structure of helping or caring relationships invites the marginalization of whoever is consigned to the position of dependence." (p. 40).

> …helping relationships are voluntary, but asymmetrically so. Help-givers choose how they are willing to help, but help-takers cannot choose how they will be helped, for in choosing to reject proffered help one withdraws oneself from being helped as well as from being in a helping relationship. To relate to others primarily by being helped by them, then, implies subordinating one's choices to one's caretakers, at least insofar as one remains in the state of being helped. Of course helping need not be repressive, for bonds of affection encourage mutual helping, and bonds of respect support reciprocal helping (Silvers, 1995; p. 41).

As noted by Raine et al, 2003, school-based programs often left the parents out of any decision-making, thus removing some control and power over their children's lives. A social justice approach, rather than a charitable services approach, would attempt to reduce dependency by concentrating on eliminating poverty and social inequities. Similar concerns have been expressed about supportive housing for people living with serious mental illness (Chilvers et al, 2009). Such housing associated with professional resources, while beneficial, may contribute to prolonging dependence and exclusion from other components of the community.

> Ironically, sheltered work, special recreation, and special benefits limit inclusiveness while they simultaneously support the deinstitutionalization of people from mental asylums. On the one hand, these processes create positive opportunities…on the other hand, sheltered work, special recreation and special benefits divert attention from the stigmatization and marginalization which people with long standing mental difficulties continue to experience. The contradiction appears to lie in society's commitment to an ethic of philanthropy rather than an ethic of inclusiveness. (Townsend, 1994, p. 218).

In addition, the attitude expressed through the charitable acts provided illustrate, albeit unintentionally, the power of the giver over the receiver.

> *You know how, you know how, you can have two people doing the same thing for the homeless, or for people that have fallen on hard times and someone will say "This is a good person doing a good thing" and they look at the other one and say "They're a do-gooder. They're, they have a motive for doing this". Well, I, I, I have those, there's even someone in this office with whom I have an extreme problem with because I can see that person a do-gooder and, and shallow, and I, I, I just can't get along with the person.* (community member)

286

Communities can be denied the chance to own their community development.

> If the practice of ABCD *(asset-based community development)* is co-opted by the NGO *(non-governmental organization)* sector and delivered *to* communities, there is a real danger that the strategy will be discredited as a self-serving initiative for the external agencies. An important challenge to government and non-government agencies is to avoid this trap by genuinely stepping back, while fulfilling social obligations that are inherent in a government-citizen relationship. This may require radical changes in the culture and practice of these agencies, the institutions to which they are accountable, and the public they serve. (Mathie, Cunningham, 2003; p. 484; italics inserted).

Riches, 2002, noted that charitable organizations sanction the government's abdication of responsibility for all citizens, especially those facing challenges fundamentally created because of government inaction or mis-action.

Those who volunteer were more likely to be active citizens and to have developed knowledge and skills useful for community development (Wilson Musick, 1999). Volunteerism has been positively associated with social networks, norms of reciprocity and trust, and collective community action (Lipford, Yandle, 2009). Boundary objects (discussed in Chapter 6) can serve as valuable instruments of communication between community members and organizations active in the community. However, these boundary objects must be co-created and privilege the voices not often heard to prevent these objects from becoming objects of power for those who are dominant (Oswick, Robertson, 2009).

8.5.4 Privileging Voices Not Often Heard

There are many voices within the North End Halifax community that are not clearly heard. These include the voices of the homeless, youth, children, sex workers, drug and alcohol addicted, and particularly, those who are living in poverty. "Privilege refers to the structural advantages (e.g. ideological, material, cultural, legal) given to some social identities or groups at the disadvantage of others; whether or not these are advantages readily perceptible, actively sought after, or even desired." (Stoudt, 2009; p. 8). In the instance of privileging voices not often heard, it becomes a counter-action to the norm.

> *The Halifax Coalition Against Poverty, this little coalition evolved out of a federally sponsored program- the community action on homelessness, it originated*

with federal dollars in the 1999 / 2000. That organization sponsorship project has worked again by annual grants to do tremendous amount of work against poverty and homelessness. They have in some ways become the voice of the voiceless, the voice of those who are in poverty, mentally ill, homeless. They have done some great work including taking the lead on developing the Nova Scotia strategy against poverty, not only in Halifax but across the province and they speak and sit on national committees so as I say this little picture representing the coalition against poverty has evolved out of several years of consistent work to address some of the needs of the homeless. (health professional)

Reaching out, creating venues of comfort and conversing in a common language can help to have other voices heard. These voices are needed to help shift political emphasis.

8.6   SHIFTING POLITICAL EMPHASIS

Concepts forming **shifting political emphasis** were moving attention <u>away from the wealthy</u> and their traditional dominance in politics, ensuing policy and control of resources <u>towards alleviating poverty</u>, a pivotal component of the <u>determinants of health</u>. <u>Away from tokenism</u> calls society to task for its failure to redress inequities, often based on historical power imbalances.

> The growing gap between the rich and the poor has not been ordained by extraterrestrial beings. It has been created by the policies of governments: taxation, training, investment in children and their education, modernization of businesses, transfer payments, minimum wages and health benefits, capital availability, support for green industries, encouragement of labour unions, attention to infrastructure and technical assistance to entrepreneurs, among others. (Raphael, 2002; p. iii).

Although governments and communities advocate social integration, empowerment, equitable access to health and social justice for disadvantaged groups, they simultaneously limit the means required for their achievement. Policies have been conceptualized as a means to change resource utilization (Thurston et al, 2005). Yet alternate programs are controlled through government policies, budgets and legislation, favouring those already funded by government (Townsend, 1994). Although not without challenges, expanding the scope of health policy and facilitating inter-sectoral collaboration (and inter-departmental financing of ensuing collaborative undertakings) are two ways the provincial government could enable equitable access to health (Lurie, 2002).

Those benefiting from the present health system include governments, health professionals, people of higher socio-economic status, businesses and, to some extent, the non-governmental agencies and volunteers who provide support to the health system- "recipients become dependent on the largess of government while the government requires them as recipients of its beneficence as proof of its morality" (Reitz-Pustejovsky, 2003). Developing and implementing policy designed to ameliorate inequitable access to health requires stepping away from the usual incrementalism calculated to maintain status quo, comfortable information that is readily assimilated into current policy approaches, to breaching areas of specialization to "multiplicity of intervention levels" that are contextually appropriate (Rutten, 1995; p. 1634). Public participation in regional health policy is particularly essential when many of the community members are not represented by the middle-class, White, heterosexual male viewpoint (Thurston et al, 2005). The shifting of responsibilities can be either a potential or liability in shifting priorities away from those of the wealthy.

8.6.1   Away From the Wealthy

Canadian politics have been characterized as Liberal Anglo-Saxon with a strong capitalist class and a relatively weak labor class, largely market driven where benefits are accorded based on proven financial need rather than a right of citizenship as in Social Democratic countries such as the Nordic countries (Navarro, Shi, 2001). The Social Democratic countries are generally the countries with the narrowest range of individual wealth disparity. By our disproportionate allocation and distribution of money and rewards, Canadians gave the decision-making power to the dominant society (White, middle class). "While sharing of affluence is desirable, it is not sufficient. In its most debilitating sense, poverty is a lack of power and not merely a lack of money." (Deutsch, 2006; p. 32).

Study participants wished to exert power and become influential within their community.

8.6.2   Towards Alleviating Poverty

Poverty adversely influences every stage of human life, from conception to death, creating an existence never consciously sought (Meier, Fox, 2008). In spite of the devastating effects of poverty, society has done little to alleviate it.

And the thing about being poor that's different from being a woman and different from sexual, racial identity, is that women want to be more of who we are, Black people want to be more Black, gay people want to be gay, poor people don't want to be poor. So as soon somebody becomes a leader and has a chance to get the hell out, those of us who are poor go "oh my god that was really opportunistic of them" no it wasn't, their goal was not to be poor. So nobody mobilizes around poverty in order to stay poor. But people mobilize around these other issues to retain identity. So there's a real psychological and sociological issue there about mobilization around poverty and class that is qualitatively different than other kinds of mobilization and even working class people want to stay working class, they just want get paid a really good salary, but poor people don't want to be poor.
(community member)

(photograph by participant #1)

(T)here's a social problem and they're relying on other people's money and time and effort to fix the problem. They don't care if you're Democrat or Conservative. You know Democrats haven't been doing this 'cause the moment they say "Well, we're going to enact a tax, that will go to low income people, maybe two percent more if you make over a hundred thousand dollars a year; maybe four percent". And this money will be funnelled into programs and this and that. "And, oh no, we're not. No. Don't". So, we have a tax revolt and it will come out, "We don't like poor people except that they'll work for minimum wage jobs." Oh, there's lots of jobs in Nova Scotia. Yeah, if you want to work for seven fifteen an hour.
(community member)

Although ostensibly referring to developing countries, it is equally applicable to North End Halifax, as emphasized by Mathie, Cunningham (2003),

(i)f civil society is to flourish, however, it requires the acceptance of basic rights of freedom of association and information, and of the rule of law…Enhancing the capacities of people who previously have been excluded from participating in decision making and from enjoying the rights of citizenship is also essential, as is creating the institutional mechanisms for their voices to be heard. (p. 483).

Amelioration of poverty will require changes in attitudes of citizens as well as intensive collaborative efforts amongst usually siloed agencies, sectors and organizations.

For one thing, housing in this government is outside of health care, so if they talked about the Department of Primary Health, first they would have to include the Department of Housing under the Department of Primary Health to help people appreciate the association between housing and health and poverty. And from there, both from the provincial level and the district level, to assume responsibilities, forming some sort of coalition or a directorate. The Department of Primary Health really should be shouldering this responsibility. And even to see that the Department of Health, Community Services and the Department of Health Promotion and Prevention have all separate ministers and therefore portfolios, therefore turfs, therefore silos, so how can we break down those silos to ensure that policies are addressed across the board. That policies aren't just approved just inside each Department, if they affect, I don't know, it's a big question and big issue. It will continue as long as the departments are separated. (health professional)*

Examining how to alleviate poverty becomes a significant step towards embracing the determinants of health as critical to health improvement.

8.6.3   Towards Determinants of Health

Interviewees made little mention of the acute care health system; rather they emphasized several of the determinants of health that had particular relevance to their circumstances and everyday lives. Although the importance of the determinants of health has achieved wider appreciation, there is little recognition of how organizations, society and governments influence the determinants through distribution of material resources or the political, economic and social forces behind social practices (Raphael, 2006).

At the communal level, widening and strengthening of hierarchy weakens social cohesion- a determinant of health. Individuals become more distrusting and suspicious of others, thereby weakening support for communal structures such as public education, health, and social programs. An exaggerated desire for tax reductions on the part of the public weakens public infrastructure. (Raphael, 2006; p. 658).

We live in a society that emphasizes the rights and freedoms of individuals. Although the Canada Health Act and Medicare were founded on valuing universal access to health services, the lens of individualism predominates in decision-making. With our present "medicalized concept of health, rooted in the post-War era, the right to health was created simply as a right to the individual medical treatments then thought to be singularly necessary for achieving the highest attainable standard of health." (Meier, Fox, 2008, p. 298). As Raphael, 2006, pointed out, the current system benefits health professionals, the wealthy, businesses, institutions and governments. Within North End Halifax, there is likely a greater understanding of the importance of the social determinants of health; yet the problem remains, for the most part, ineffectively addressed.

> *But what it represents for me* (a picture of the community garden) *is a transition of ideology of health care being simply a medical issue that one comes into a clinic/centre and receive medicine from a stereotypical doctor. Whereas this represents health promotion to the fullest, it represents the delivery of health care by other disciplines, in this case dietician. This picture represents her ideology of moving outside of bricks and mortar to delivery health care. She wants to bring health to the residents within their community setting through naturalness of teaching, entrepreneurship, and economically being able to eat and thrive on healthy food within a budget. So the North End Community Garden exemplifies health promotion to an area of North End of Halifax starting with children and youth teaching them entrepreneurship of business where they would talk gardening and yielding and forming a business of salsa. Cooking salsa and selling it. But more so, the intent was to bring community together through the productivity of life, of growing a garden. Her dream was to see soil that was not used, that was left unmanaged, un-manicured, to bring it to life and her dream is coming true.* (health professional)

(photograph by author)

The social determinants of health featured prominently in the conversation of study participants and many felt the efforts to address them have been token only.

8.6.4   Away From Tokenism

Many study participants felt that the governments at all levels had abdicated their responsibilities to create policies, develop applicable legislation and provide appropriate funding to improve community health.

> *That is the mentality I think of Nova Scotians. That is has been done for so long by church groups and non-profits who can hardly maintain, who are constantly fending for grants and sustainable dollars; to think outside their own narrow board of directors I bet is a real challenge. I can't speak to that. But I can speak from the holistic responsibility of government that they do not provide the support of one agency then to, or even to form a coalition of agencies to man together to, meet the basic needs as well as the psycho-social needs of our homeless population. And it seems if they do give minimum dollars to a shelter or to a church that they have somehow done their duty in my humble opinion, I think they are abdicating their duty.* (health professional)

> *Well, I think, currently we're going through a terrible downloading and it started years ago when the feds put it onto the provinces. Not the provinces, but the municipalities. And it's all ending up in charities; the demands could be just so far, so far behind with what the dollars are. And it's, yeah, I think it's terrible. Everything, all the social ills, etc., when it comes back to it, it comes back to poverty. Why is there crime, why is there whatever? It's because of poverty. And to have charities having to look after that instead of the government, just doesn't make sense.* (community member)

Our municipal and provincial governments are optimally situated to promote awareness of social needs, particularly within the framework of the determinants of health. Torjman, Leviten-Reid, 2003, outlined the need for local governments to foster a sense of responsibility for social well-being among all sectors and citizens, build relationships with diverse participants and organizations, more effectively integrate their services, and become exemplary employers, service providers, leaders and partners in order to conquer major issues such as poverty and its associated housing, food and educational insecurities. In an ethnographic study of food banks in Ontario (Tarasuk, Eakin, 2003), the researchers concluded that "food giving was essentially a symbolic gesture, with the distribution of food assistance dissociated from clients' needs and unmet needs rendered invisible. (They) conclude that, structurally, food banks lack the capacity to respond to

the food needs of those who seek assistance. Moreover, the invisibility of unmet need in food banks provides little impetus for either community groups or government to seek solutions to this problem." (p. 1505). Food insecurity is but one example of where basic rights have not been achieved.

8.7 SECURING BASIC RIGHTS FOR ALL

The two major basic rights for study participants were <u>housing security</u> and <u>food security</u>. These rights are implicitly undergirded by economic security. These two securities are foundational for achieving health. Seeking to **secure basic rights for all** is one path to emancipation and is a key ingredient for *enriching the community to enrich us all*; an ingredient that builds on the concept that benefit for one leads to benefit for all.

> A rights-based approach to health means using human rights as a framework for health development. It means making principles of human rights integral to the design, implementation, and evaluation of policies and programs. And it means assessing the human rights implications of health policy, programs, and legislation...Human rights ...include economic, social, and cultural rights, such as the right to work, social protection, an adequate standard of living, the highest possible standards of physical and mental health, education, and enjoyment of the benefits of cultural freedom and scientific progress. (Rioux, 2006; p. 86).

The World Health Organization established the *right to health* as a fundamental right of all people (Meier, Fox, 2008). Housing, food and income security are all extremely dependent on socioeconomic status through their effects on relationships/ contacts, income, quality of early life, education, employment and work-life. Socio-demographic factors predict 56% of variation in life expectancy (compared with 1% variation secondary to obesity rates)(Raphael, 2006). Nations with social democracies are among those with best health outcomes (McGibbon, 2009). However, in spite of a number of international statements, national policies and promulgated ethics, poverty in Canada and disparities in incomes continue to increase.

> The health sector has been relatively slow in grasping the connections among human rights, social injustice, and how everyday life unfolds for patients. (McGibbon, 2009; p. 320).

Whose responsibility is it to ensure basic rights are secured for all? As stated by McGibbon, 2009, (p. 331), "there is no nationally developed protocol to which the health

system must be held accountable.". There were many references to the abrogation of responsibility by all levels of government (federal, provincial and municipal) in the study interviews. Yet, we are our governments. As outlined by Cockburn, 2005, a rights-based approach to achieving equity has draw backs in

> that it adheres to a universalism; that it fails to apply ethics to context; that it is adversarial; that it conceptualizes persons as autonomous rather than relational; that judgements in search of objectivity and rationality elide aspects of experience; and finally, that these concepts are premised upon disembodied rationalism. (p. 73).

Study participants appeared to have implicitly understood these limitations and placed them in context. Yet a rights based approach can reframe policy decision-makers focus from "service delivery issues, requiring technical inputs to reach the best 'evidence-based' decisions… (*by which*) the state is relieved of its burden of having to answer to its constitutional obligations for progressive realization of socio-economic rights" to viewing health as every citizen's due, thus necessitating re-dressing existing injustices and power imbalances (London, 2008; p. 71)(italics inserted). Universality, equity and comprehensiveness are three key components of a rights perspective to health policy. Universality implies the right is for all without exception. Equity gives recognition to present unwarranted differences among social classes, genders and ethnic groups. Comprehensiveness begins to address the determinants of health (Filho, 2008).

8.7.1   Housing Security

In a UN-HABITAT publication, 2006, justifiable elements of the right to adequate housing were identified as

> protection against arbitrary, unreasonable, punitive or unlawful forced evictions and/or demolitions; security of tenure; non-discrimination and equality of access in housing; tenant's rights; the right to equal protection and benefits of the law; equality of access to land, basic civil services, building materials and amenities; equitable access to credit, subsidies and financing on reasonable terms for disadvantaged groups; the right to special measures to ensure adequate housing for the households with special needs of lacking necessary resources; the right to the provision of appropriate emergency housing to the poorest sections of society; the right to participate in all aspects of the housing sphere; and the right to a clean environment and safe and secure habitable housing.

Homelessness and housing insecurity includes those sleeping outdoors, in shelters, couch surfing, paying more than 30% of one's income on housing, and being at risk of losing one's home.

If we go back to our hierarchy of needs, it being at the top of the pyramid of hierarchy of needs, um, if we're going to become a just society, there has to be a little more emphasis on secure housing and methods that can be done to cooperative housing. Um, currently we pressure a lot of the free market system to provide housing. I'm not convinced that's going to be enough. Um, I think there is a whole lot of potential in the cooperative housing movement. That doesn't seem to get off the ground, the free market system unto itself. And there, you know, the early '90s, there was a lot of emphasis and some funding into a co-op housing aspect. And there can be various forms to that. Short answer, housing is a basic right. Um, attention to the conditions that can create secure housing is a basic right. (health professional)

Within North End Halifax, there are few subsidized housing facilities.

And besides being a drop in centre, the 2nd level of the building has actually 19 housing units, it was a response to a need of people who were actually dying in run down exploitative housing and conditions and we felt that the best way to respond to that was to offer competition or offer something else to people besides that type of housing so we did a lot of lobbying to the three levels of government, the Mental Health Division, the Department of Health, the municipality, the province, the feds, ourselves, our health centre all came together to work on this initiative so it really reflects a collaborative approach in a grass root community response to issues and significant impact peoples' health. If you don't have a place to lay your head that's safe and secure, then you're in trouble. And this represents not only that but also, as I mentioned earlier, a gathering point or a community, as well for the people who are embraced in the community because of addiction and mental health related issues. (health professional)

But, we got too many social planners that, you know, don't keep their job for more than 2-1/2 years and everybody's got a different idea. 'Cause back, you know, when, when the original regeneration of Uniacke Square was done, there were so many possibilities and went to so many great community meetings of the people that lived there and the people that were their neighbours and all, you know, and the library was run differently and so, they had the opportunity of sponsoring women that came from other housing projects in North America and talked about, you know, what mistakes they'd made and how to, how to do it to make it, you know, better, you know, so that the, could be home ownership plans and things, and then, you know, the city gets amalgamated, and, all those, you know, those people are retired too. (community member)

Housing opportunities in the North End are becoming increasingly unavailable to many former residents of the area and to newcomers with limited finances.

296

It was the low income area, the whole area here, from Cogswell to North, from Agricola to Barrington St. In the 60's/70's, public housing came here first and then there was a lot of cooperatives built in this area. Along North St, Brunswick St, Barrington St., Co-ops were built and providing good housing for, and the people that lived there managed it themselves. Up on Creighton St off of Uniacke, Creighton, Maynard, Gerrish, that area, there was opportunity. If you lived in Uniacke Square, you had the opportunity to leave as you got a job and your income started to improve, you could leave Uniacke Square, go and rent a flat and from renting a flat you could afford to buy a home. Today, that is no longer the case. The rents are, like topping rents. So now people find themselves in Uniacke Square and really, unless they get a significant good job, that's where they're going to live. The co-operatives in this area, are dwindling and disappearing, because the first generation co-op folks, when they left, because their income improved, new folks going into those co-ops was not interested in managing the co-op. They just wanted to rent. And so what's happened is a lot of those co-ops have gone to private management companies now or they have come completely bought. So that housing stock that allowed a person an opportunity to move from public housing, to one day to home ownership, is completely wiped off. (community member)

Limiting affordable housing restricts and changes the composition of the neighbourhood. In the case of North End Halifax, it severely limits the opportunities for many who have found, within the community, a degree of acceptance denied to them elsewhere. Food security is closely linked with housing security.

8.7.2 Food Security

Food security was the next most common concern expressed during the interviews. In spite of the richness of Canada as a whole, in 2001, 2.4% of the Canadian population received food from food banks (Riches, 2002). The percentage is likely higher within the North End Halifax community. Food security is meant to include physical, economic and cultural access to sufficient, safe, nutritious food to meet dietary needs and food preferences. Community contributions to ease the food security gaps include food banks, breakfast programs for children, meals for those with housing and financial insecurity, collective kitchens and community gardens. Food (in)security is a political problem and an issue of basic human rights, sustainable development, health equity and inclusion (Riches, 2002). Charitable organizations have stepped in, yet their efforts are often adjudicated as inadequate (Teron, Tarasuk, 1999; Raine et al, 2003; Tarasuk, Eakin, 2003). As described in the interview excerpt below, many of the donations received by

food banks are unlabelled, outdated, or damaged; the nutritional value is sub-standard and the amounts rarely meet the needs (Teron, Tarasuk, 1999). In Canada, about one in five children lives in poverty and, unlike in the United States where school programs for meal supports are legislated and federally supported, children's feeding programs are largely through voluntary efforts. Raine et al, 2003, have defined these programs as "poverty-mitigating services rendered by volunteers to distribute donated goods to self-identified needy recipients" (p. 156).

Then the vast majority of what you can get, which is a sure thing, is, of course, the canned food stuff because it has such a long shelf life. But, as we know, processed food like that, it's, you know, the sodium alone could kill you, let alone whatever else they use to process the food. So sometimes it's a treat to get it. Like if you end up with a can of ravioli, it's like, whoa, that's like such bad business I don't want anyone, it's so bad for you but it's such like a nasty good treat. And sometimes there will be staples, flour, sugar or something. But it's a, what you get will never hold you for three weeks, it's only an adjunct to what else you might buy or get from somewhere else. So, unfortunately, no. I would say you cannot get a healthy, be a, eat in a healthy manner by eating only what you get at the food bank. But as an adjunct, if I go to the food bank and get, you know, cans of tomato sauce or whatever, so I don't have to buy spaghetti sauce, then that money can get rolled into, so then I can go buy my brown rice or whatever. (community member)

And there are, most of the significant population at Turning Point of guys who are working. Not quite making enough to have a place, but they are working. So, I mean, starting their day off with a breakfast and getting out to work is, means the difference, it's the difference in hanging onto your job or running out of energy at 12 o'clock and not being hired the next day. (health professional)

Nutritional adequacy has profound impacts on health and ability to learn and work. Not acting to ensure that all community members have access to adequate nutrition implicates all of us in the continuation of poverty. True alleviation of such problems as food insecurity can be enabled through grounding activities within the community.

8.8   GROUNDING ACTIVITIES WITHIN THE COMMUNITY

Grounding activities within the community is one way of enabling people to have an empowering role and be a constructive part of *enriching the community to enrich us all*. Community members best know their community, know what is likely to work and what isn't. That knowledge can help to disperse some power discrepancies. Building on previous successes recognizes the prior work of community members and can ease the

way forward, <u>attending to early childhood development</u> ensures sustainability, and <u>cool connections with youth</u> can exploit the enthusiasms and talents of youth who have an investment in the future in the community.

The essence of both asset-based community development and of appreciative inquiry is discovering and building on strengths of the community, particularly those that originate within the community itself.

8.8.1 Building on Previous Successes

There are many examples of successes achieved with and by community members including the North End Community Health Centre, the Mobile Outreach Street Health program, Northwood Senior Care, the Mi'kmaq Friendship Centre, Dalhousie Legal Aid and the two described below.

> (T)*he Black Educators Association; this organization began 40 years ago. They were very instrumental; they formed as an interested group of Black educators who felt that there was need for a voice within the education system. So they were teachers who came together. But these were humble beginnings. Came from the Black Report. And that was to report the study done on the education system here in Nova Scotia and how it impacted on children of African descent. The Black report has spurred a lot of very positive developments in terms of education. The creation of Black community services division within the Department of Education, I believe the only one of its kind in Canada. Secondly, the Black educators were assigned with the responsibility of students support of course, within the schools though out Nova Scotia… But there were segregated schools for the Black population.* (community member)

> *The Black Business Initiative (BBI), located on Gottingen St. This is an arm of the BBI, it was their training centre, where they did a lot of training for people of African descent who were in business helping people develop business plans to get into business, but also supporting business people in terms of how to manage your finances, how to do up an application for further funding, a better business plan.* (community member)

Not only are community members most aware of what changes need to happen, they are also best qualified to design the means to accomplish them. Community member's knowledge and children and youth are the potential of the future.

8.8.2   Attending to Early Childhood Development

In keeping with the concept *enriching the community to enrich us all*, Barnett, Belfield, 2006, concluded if high quality, intervention intensive preschool programs were inclusive of all children, not just the poorest, that society as a whole would gain. Such preschools resulted in permanent gains in cognitive abilities, school progress and high school completion for the children enrolled. Education is an enabler of productive futures.

> (T)*he Cunard Street Children's Centre is an interesting childcare centre. It's a centre, I can't remember how many children, probably about 90 or so children are there. They're pretty much all from the neighbourhood…This daycare centre gives kids an early start in terms of preparing them for school with some of the things that they need to know, numbers and letters and stuff like that. They're in a neighbourhood, they have access to the Centennial Pool. They have access to the George Dixon Centre, activities that go on there. They're not that far from the Commons. It's a childcare centre that is really perfectly located, quite centrally located, to be able to take advantage of some of the programs in the neighbourhood.* (community member)

(photograph by author)

> *The North End Parents Resource Center, very close by and just on the same theme, um, um, one of the big positive aspects of the Resource Center has been the peer support that has come out of the programs that run out of there and how dependent the success of that is on peer support and peer acceptance. (*health professional)

Well designed early childhood development programs require thoughtful utilization of interventions that have been proven to affect change. Such planning necessitates collaboration among many experts- parents, child care workers, specialists in early childhood development for example; it demands adequate resourcing and well qualified educators. Early childhood is a time when children can be influenced to adopt a healthy lifestyle, gain socialization skills that will serve them throughout life. It is when they can

300

become most understanding of diversity. The emphasis on healthy development must be carried through to include youth.

8.8.3   Cool Connections with Youth

Community youth are an often untapped resource full of idealism; they rapidly develop into our future.

> *And Palooka's. Well, you know it's cliché but get kids off the street and learn self-defense and get, get into shape and, you know, take out your frustrations on a speed bag or something instead of hurting someone and stealing their money. So I just thought, you know, it's a brand new building. And it's, it's a great place to learn to box and train and get into shape and those are, regardless of the fact that it's a sweet science and it's a violent sport really. You know, it's for a good.* (community member)

(photograph by participant #3)

> *This is a community garden that some children have, are managing just at the, in the front of this little field on, on, down in Brunswick Street between Uniacke Square housing development and St. Patrick's-Alexandra School, between Ahearn Manor, which is a public housing high-rise. There's, there is a community garden with children around it and they have been quite successful. They've had a couple of community markets. When the tomatoes were growing profusely, they made salsa and sold it on the street. Yeah, and they've had a couple of days that they had, you know, markets, and they have the fresh vegetables for sale, right there on site. People were coming and um, buying, and they had it all done up in, um, little bags.* (community member)

Investment in children and in youth (who in turn are invaluable resources for their community) is one of the best investments for improved community health. This expenditure may assist in recapturing business and economic development for the area.

8.9   RECAPTURING BUSINESS AND ECONOMIC DEVELOPMENT

Recapturing business and economic development is an important foundation for *enriching the community to enrich us all*. Business and economic development provide avenues for emancipation from poverty and empowerment of community members. As outlined by Mathie and Cunningham, 2003, community economic development relies on the development and/ or improvement of economic systems and infrastructure, enhancement of capacity of individuals and enrichment of the capacities of groups to undertake community economic development. Economic development within the nuclear area of North End Halifax is necessary to provide employment possibilities and financing for improvements such as readily available core services- affordable grocery stores, general clothing stores and banks. Merely decades ago, Gottingen Street was a thriving business area, but this has changed.

> *Well, that, you know, like, key properties got bought like that, like the different blocks and, in fact, that, like the area that's all those new low rise town house kind of things, where the Alexandra School had been, which was city owned, was a community center and had a lot of not for profit organizations. The community Y was there, and everything. Well, there was city welfare office was there. Family SOS was there. There was like, ah, a daycare was there. There were all kinds of, Center for Art Tapes was there. Like there was all kinds of NGOs and, you know, and community based organizations, you know, mixed in relatively, you know, whatever, and rent was cheap…you know, there were some people who had been, like, community leaders – ministers, and, and people that went to the Y, and teachers, and whatever, that had been there for 18-21 years, and so it seemed like three generations, come and felt quite proud of, you know, who went on to university and who have done this and who has, whatever. And, then suddenly, all those people retired and moved on or whatever, and so that the continuity was gone.* (community member)

Vacant lot where grocery was located (photograph by participant #1)

302

There are no financial institutions; there are no grocery stores within this community, because of course, those things were run by huge corporations and because the profit margin wasn't high enough. It's not that they weren't making a profit, but the profit margin wasn't high enough to meet their standards. I'm not sure, I wouldn't say it was the community in which it was located…closed because of the advent of shopping centres. So your main streets became vacant buildings. So they didn't have the commercial banking and so what private or individual banking they had couldn't support that infrastructure and they moved out of the community. The same as the grocery stores…Today there are none. So the impact of that is that people with the least amount of money paid the most for their groceries, because they don't have cars. They may be able to walk to the grocery store, but coming home they have to take a taxi, so that adds to the cost of food. (community member)

However, there are some businesses that have relocated to the North End.

This was, this is part of Mi'kmaq Friendship Center when it was a construction site. I chose that specifically just because there were a lot of local guys involved in that construction. It seems to be the construction project that is going on and on, but, umm, I just see, they just seem to employ just a lot of guys around from the neighbourhood… Yeah, quite literally from two, three doors down…Direction 180, which is a methadone treatment clinic…Umm, I'm not sure, I don't know who is spearheading it. Um, I don't know if it's done by a company or whether the Friendship Center is doing the hiring. I don't, I've just seen people working out of it. (community member)

(photograph by author)

(This picture) *is the Palooka's gymnasium. I was really excited about that building being renovated and used for that purpose. Philanthropist, Mike MacDonald decided he wanted to give something back to the community and built this building, and his focus is youth, and he's engaged the business community and charitable organizations to support the project and make it work so it's somebody understanding the basic needs of people and willing to do something government wouldn't necessarily be expected to do. It's preventative health care really is what*

it is. He's training young kids to be disciplined at, to respect their bodies and to focus on being the best at what they can be. It's more about the discipline and mindset than it is boxing…I think it made everybody feel good about the community and somebody's interested in it. Because I have been here almost 30 yrs and it's the first time that somebody from the private sector has contributed in a significant way to this community. (community member)

(photograph by participant #4)

I took a picture of the Staples building because again, there's a lot of history here. Until five or six years ago that was a vacant lot for more than 20 yrs. It's an example of business coming into the community and setting up shop and being successful and hiring locals to work there. I've always had the opinion, I felt that there's been no economic development of any significance in this community and it needs to be and people would like to live where they work. People come out of the suburbs and in to the city to work all the time we should respect that people look for work where they live. There're people in this community who never leave it. (community member)

Unavailability of a living wage has encouraged some to become sex workers or engage in selling drugs.

Get us out of the fucking sex trade. It's dangerous, it destroys our lives, it destroys our children…It's very hard for children to be raised by single moms; their lives are not as good, things are much more difficult, women suffer terribly. (community member)

Addressing the economic development of North End Halifax requires city planning that looks to equitable and restitutional distribution of benefits for all citizens. Economic re-development can enable accessibility of healthy lifestyle resources.

8.10   RENDERING HEALTHY LIFESTYLE RESOURCES ACCESSIBLE

Rendering healthy lifestyle resources accessible is one way of equalizing socio-economic power differentials to enable access to health for all. A healthy community *enriches the community and enriches us all*.

Having a healthy lifestyle is complex even for individuals with income, housing, food and social security. It is infinitely more taxing for people with limited resources. The built environment can hinder or help.

> *This is a photograph of the playground that's outside of the Joe Howe School which is on Maynard Street between North and Charles. It's got this sort of Astroturf ground that's kind of soft but it's not, it's synthetic so kids can fall and they won't bonk their heads too hard. I like that they've got this plastic play stuff there. And I see kids out there, like pre-school kids out there, with their guardians playing almost every day. It's really great. And the kids are running around and squealing, you know, being children. And it is nice to see little children run around squealing as a reminder that most of us as adults don't run around or squeal at all, let alone half as much as we should. And these kids are out and that movement is part of their natural lives. And it's not something they have to schedule in between picking up the dry cleaning and de-worming the cat, or whatever else people do. So I like that reminder of kids in the playground.* (community member)

(photograph by participant #1)

> *As an avid cyclist, more people should be cycling for, again, good health, exercise, cut down emissions, decongest the roads, all those good things. I just think Halifax is an incredibly unfriendly environment for biking...I can't imagine commuting to work on a bike because drivers are just awful.* (community member)

305

(photograph by participant #1)

However, these community resources are not accessible to all because of financial, power, life-style and other constraints.

> *And he was like a million years old and he couldn't clean properly and the place just got more and more kind of mouldy feeling, dusty feeling, that the machines weren't really well maintained, that it could be an intimidating place to go if the boxers were there. And there was just no asking for anything. There was no asking why the place wasn't clean. There was no getting the music turned down. And in order to continue going there as a woman, an older woman, the fight was too much. I just, the music wasn't going to get changed to something less pounding. It wasn't going to get turned down. The place wasn't going to get cleaned better. Nobody was going to care. Nobody at the front desk cared. There was never anybody in the weight room to ask for help or advice or about how to use this machine or that machine. It was like it was a private club for certain people and I felt more and more uncomfortable there and I just stopped going.* (community member)

8.11   SUMMARY BASED ON CRITICAL SOCIAL THEORY LENS QUESTIONS

As with the use of the other lenses, analyzing the interviews with a critical social theory lens was taxing and feasible only at a relatively superficial intensity. Nonetheless it was powerful and thought provoking. The study participants were able to portray their everyday world in a way that permitted me to see glimpses below the surface of their words. An overview answer to each of the critical social lens questions is given below.

1. What are the social, economic, historical, political or cultural constraints/ oppressions/ ideologies implicit in the interview information?

Oppression, conscious and unconscious to both the oppressors and those oppressed, was woven throughout the interviews. Civilized oppression has been defined as injustices embedded in the unquestioned norms, assumptions, policies and reactions of everyday

306

life (Deutsch, 2006). Injustice can result from how "consumption, investment, skill, and social capital" (Deutsch, 2006; p. 11) are distributed. Consumption capital encompasses standard of living which in turn reflects food, income, housing, education, physical and health security. Mal-distribution of consumption capital, and its associated poor health, was clearly evident in the interviews. Inequities of investment capital (resources used to create more capital) were reflected in references to housing and real estate opportunities. The skills found in North End community members may not reflect the "elite" skills of university faculty or professionals - the skills revered by the privileged and those with political power - yet they are of inestimable value.

Social capital includes a person's network of family, friends, neighbours and others. Within North End Halifax, there are those with powerful social networks, others with strong social ties and yet others who are alone. Capital within the community may appear limited; nonetheless, skills (when viewed from a broad perspective) and social capital are potential community strengths on which to build to redress oppression. Procedural injustice was noted with respect to acquiring needed services, housing or shelter opportunities, and in dealings with the acute care and justice systems. Voice, representation and information are largely owned by the middle class.

Not only were there issues of cultural constraints or differences related to race, ethnicity and sexual orientation, for example, there were more insidious barriers created by the norms of the middle class, White, able-bodied, heterosexual population. These norms regulated others to be seen as different or difficult or undeserving. The history of North End Halifax changed from one of affluence with a relatively homogeneous population to one with few businesses and a mixed population with the greatest diversity of persons-some welcomed, others not, many disadvantaged with respect to conventional power, and often blamed for ills not of their creation.

The political ideology in the past has been largely one of capitalism and individualism; where the wealthy and large corporations had power with political parties to affect the distribution of goods and the formulation of policies that favoured themselves and the

status quo. The image-makers (the media) for the most part have portrayed negative reflections of the community, reflections that some community members have come to believe of themselves. In particular,

> the power to take the initiative in a relationship: in beginning or ending a relationship, and in insisting on its being modified, and in taking a number of communication initiatives like the power to begin or end a specific contact (like a conversation), to insist on being listened to and on being given answer to reasonable and pertinent questions. (Deutsch, 2006, p. 18; p. 43).

is not conceivable to most North End Halifax residents.

Yet some participants expressed optimism with the most recent change in local government.

> *I put this up because it's quite astonishing. I don't think I've ever voted for anyone but NDP in my life and it's very astonishing to people, including me, that the NDP has formed the government. And because the NDP has formed the government in Nova Scotia, I feel, for the first time, in terms of health services and community services I feel a little bit of hope...So that's why I included the government as part of my idea of what helps me to do as best as I can for my health care. I believe, rightly or wrongly, that the NDP are terrifically concerned about the cost of health care and things for people.* (community member)

(photograph by participant #1)

2. How do the conditions described perpetuate the present circumstances? What does it allow us to see? What does it overlook?

The most glaring component perpetuating the present circumstances is the superficial treatment of the symptoms and not the root causes of poverty, homelessness, food and housing insecurity, and involvement in the sex and drug trades. Activities by volunteer groups and NGOs tend to help camouflage gaps and needed changes. The interviews

uncovered many incidences of patching, and not mending, problems such as food insecurity. Initial efforts to change this have occurred in Spryfield.

> *Food banks - there's a group out here called "The Urban Farm Museum Society" and there's also the Breastfeeding Support Network. The Bosom Friends Project is what it's called now. And there have been connections between The Urban Farm and the Food Action Committee of the Ecology Action Centre...and the Bosom Friends is about trying to increase the rate of breastfeeding...And the Urban Farm is promoting urban agriculture and food production in the city and we produced a cookbook that's based on local foods in season. We have a poster, healthy heritage...Eating local foods in season fosters environmental health, strengthens our social fabric and enhances economic wellbeing.* (community member)

3. Whose interests have been/ are being served by the way things are?

In general, it is the interests of the White, middle class professionals, businesses, agencies, NGOs, governments and organizations whose interests are being served. Their incomes, careers, funding and prestige would likely be altered by a shift towards addressing the determinants of health (Raphael et al, 2008).

> Individualism, a powerful philosophy and practice in North America, limits the public space for social movement activism. By transforming public issues into private matters of lifestyle, self-empowerment, and assertiveness, individualism precludes organized efforts to spur social change. It fits perfectly with a declining welfare state and also influences responses to health inequities. From this perspective, each person is self-interested and possessed of a fixed, competitive human nature. Everyone has the choice for upward mobility through hard work-ignoring how we develop through the process of living in society. Individualism presumes that individuals exist in parallel with society instead of being formed by society. (Raphael, 2008; p. 226).

The governments have benefited by off-loading to others the responsibility of meeting more and more social needs.

> *(P)eople responded to the needs as I say in the late 70's (*for food banks*) and because nobody else was responding to the needs, I do not mean to say that these church groups and volunteers are not doing good, that's the last thing I want to be interpreted from here, but they're filling a void that government has abdicated.* (health professional)

Filho, 2008, suggested that when health is viewed as a basic right, and that the determinants of health are responsible for life and quality of life, then they become morally mandatory for all people. This requires changing the starting point of decisions from a balanced budget to addressing needs.

In a true rights approach, duties have no conditions; the limit to each person's right is located in respect for the right of the other. The imperative political action here is public education, so that citizens can understand that the guarantee of "my" rights lies in the guarantee of the rights of each and every person…In this perspective of rights for all, the duty of the state is to act as guarantor of rights with responsibility for all of society. The citizenry engages in an active construction of society's responsibility to guarantee the right of all, building a reality that is actually possible. (Filho, 2008; p. 97-98).

4. Whose voice is dominating? Whose voice unheard?

Within the interviews, the study participant's voices were heard. But they spoke of the privileged voices of the wealthy, health professionals, businesses and organizations. Within the community, the voices of persons living with disabilities and new immigrants are muted. There is increasing advocacy for persons who are experiencing housing insecurity and some for persons living with poverty. There is less evidence that first voices have had an effect on the decisions and directions of community development as illustrated by one study participant's view.

I'd have, I'd have all the, all the housing in appropriate use with, with the businesses that people that live there could work in. And, I mean, there's possibilities, and its possibilities. But, you know, the thing is, you know, like the movies, if people that you know, have the good fortune to be able to snap up a property when it's there and whatever aren't entirely enthused with the folks that already live there and think that, you know, and there's, many GD, you know, goodie, goodie social services. You know, this is just one big welfare street, you know, and got rid of, you know, all those, you know, agents, helping, helping, helping, helping agencies, you know, get rid of the helping agencies, you know. (community member)

5. What are the theories-in-action (assumptions, values, beliefs) underlying the information?

Study participants clearly expressed their own value as humans and as knowledgeable community members. Within the community, many times they perceived their own invisibility; they felt disrespected as others or different or undeserving; they expressed beliefs of other cultures, particularly around connectivity and relationships and wholeness of persons; and unfortunately, some felt a degree of futility for changes that would meet their needs rather than those of the dominant populations. Yet, their pessimism was somewhat balanced by the optimism of others.

Metropolitan Regional Housing Authority…We provide affordable housing for low income to medium income people here in the city. People on Social Assistance, people with low income and provide what I consider to be good housing. We maintain our properties…I grew up in Uniacke Square. And I came in from the city of Africville…I was a tenant of Metropolitan Regional Housing up until 1976 when I got married and left Uniacke Square, so it's funny how the circle goes around. We feel that we do a pretty good job in terms of providing safe and affordable housing for people that are the most vulnerable in our community. And we also provide housing for seniors. Gordon B Eisner Manor and Sunrise Manor are two senior's buildings that we have here in the area. (community member)

6. What power differentials are being expressed in the information?

Unambiguous power differentials were noted between haves and have nots; between those traditionally educated and those not; between health professionals and patients; between givers and receivers; between governments and citizens; between White middle class individuals and others.

Legal aid services have changed quite a bit since the inception. The inception of Dal Legal Aid was to service low income people, people on welfare, dealing with all legal matters pertaining to that particular demographic…I think right now, Dal Legal Aid will only take on clients that are on Social Assistance I believe and I don't think they do any criminal. It's all civil matters they deal with, they don't deal with criminal matters. But none the less they provide a very valuable service in the community where they find themselves because a lot of tenancy issues that people have and they will take care of that. I still see a need for a legal aid service that deals with criminal matters, because they are the most serious matters and if you don't money to get yourself a good lawyer, I mean I know the courts will find a lawyer for you but it's still not the same. (community member)

The major points I gleaned were:

- The acknowledgment of privilege is not enough; structural changes must happen for example through policy (Vaught, Castagno, 2008)
- The rights-based approach can reframe how we as citizens see our responsibilities
- Society is accountable for normalizing seeking illness care through an emergency department but not for seeking basic shelter and food
- The Medicare-defined system has many overt and covert discriminating structures embedded in it.

The way forward, I believe, will include:

- Cooperative learning (Paluck, Green, 2009)

- Emphasis on quality of life of community members

- Education and engagement of people as citizens with ensuing shared rights and responsibilities

- To accomplish this, finding ways to disrupt routines and normalized behaviours; to enable unfettered communication.

CHAPTER 9 SYSTEMS THEORY LENS

> Individuals make choices, but society assigns consequences. Within systems of inequality, the consequences are grossly unequal (Dugger, 1998).

Through using a systems lens to examine interview data, *striving for a community-wide system for health* was identified as a basic social process for the achievement of health for North End Halifax community members. The absence of a true integrated, seamless healthcare (illness care) system provides the opportunity to envision a system for health, a system that embraces approaches to address the social determinants of health as well as the spectrum of health interventions from health promotion/ disease prevention to palliative care and bereavement follow-up. Five components of *visioning a community-wide system for health* evolved from the data - **shifting thinking** requires fundamental changes in how access to health and health care is conceptualized, **becoming community citizens** emphasizes the responsibilities we all have to enable health for community members, **planning together** becomes the way to achieve the community vision, **creating the environment for health** uses the new understanding of health care to design a supportive environment, and **weaving pathways** creates a tapestry directing integration and seamlessness. These core variables encompass all levels of eco-systems: microsystem (family), mesosystem (for example - friends, supports, food banks), exosystem (for example - institutional structures - costs for food, housing; resources for coping), macrosystem (for example- ideological values and beliefs of the culture, larger social and economic forces)(Mammen et al, 2009).

Figure 6　　　Systems Theory Lens Concept Map
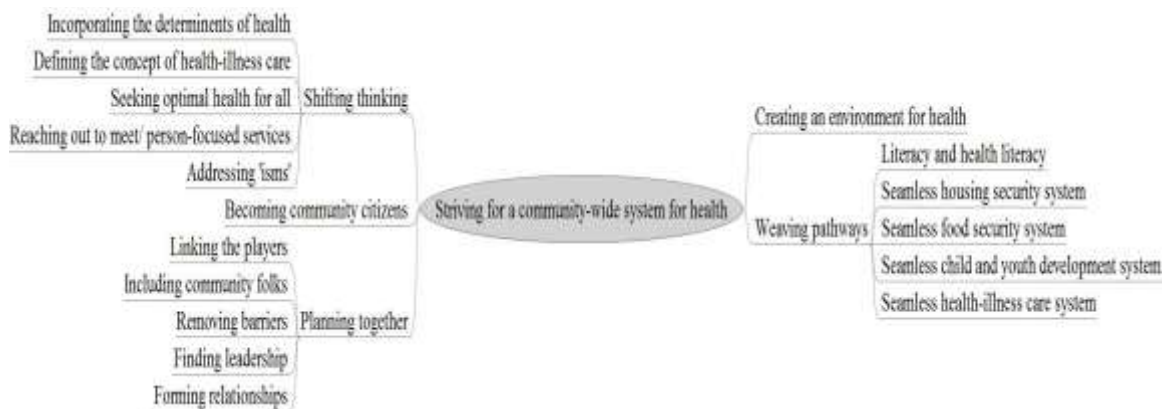
9.1 Striving for a Community-Wide System for Health

North End Halifax as a community has an opportunity to lead in *striving for a community-wide system for health*. The North End Community Health Clinic has already achieved national and international recognition (McGibbon, 2009) for its innovative approaches to serving a patient population largely ignored by the mainstream health systems. Whereas the North End Community Health Clinic and many other individuals, agencies and organizations have made significant differences in the lives of community members, these efforts have been largely independent without integration, alignment, cohesiveness and common understanding of issues and goals. Attainment of a *community-wide system for health* requires a paradigmatic shift in thinking of what a health system is comprised and how such a system is achieved.

9.2 Shifting Thinking

Shifting thinking grew as a substantive code from the interlinking concepts of incorporating the determinants of health (essential for making a difference in the health of North Enders), defining the concept of health care/ illness care (increasing the inclusiveness of efforts supporting health into a system for health), seeking optimal health for all (affirming that health is being sought for all community members), reaching out to meet (thus learning and understanding the needs from the perspectives of community members) and addressing "isms" (to clear a pathway for mutual understandings). **Shifting thinking**, in turn, is vital for *striving for a community-wide system for health*.

In his thesis, Spears, 2007, described a theory of bridging paradigms. The process of shifting thinking paradigms (one's usual set of beliefs, behaviours and actions) begins with a catalyst, conditioning of individual/ group to change (change readiness), and commitment. Potential catalysts are the more insidious repetition of Africville through the displacement of low income people from their community through increased gentrification, or poor community health statistics, or building on the increased interest in the area as a place to live and work.

> *So what's happened is that people who moved out to the suburbs all of a sudden started coming back in and purchasing the properties, renovating them and the assessments on the properties have gone way, way high. As you can see now, all the*

314

condominium developments here, there's one on the corner of Rockland, there's the one on the Brunswick St, brick house property there, that once was a school yard, that was Alexander school. You had the space down on the corner of Barrington and Cornwallis. You have Glube's Townhouses being built, there were the old Glube's store used to be. The terrace condominiums, where the old casino theatre used to be. All of those developments are going on and the cost of purchasing is out of the means of the historical people that lived in this community. So the people who lived here a long, long time are being squeezed in a very small area. Who knows what the future is going to bring, because they don't make more earnings. And land is becoming very expensive. (community member)

Other elements of shifting thinking are touched on in the following sections. The stages of bridging paradigms include jumping in (connecting with others, finding information), buying in (seeing oneself within the new paradigm) and owning it (achieving comfort and competence in new paradigm). Bridging requires purpose, investment and mentoring or supports. This framework is helpful to understand the immensity and complexity of changing the view of a health system - for individuals, communities, governments and others. However, study participants noted instances of significant changes in paradigms of thinking. The following is an example of shifting attitudes to acceptance.

(photograph by participant #5)

Barry House (shelter for women) *had a fire about a year ago, a year and a half ago and had to get all of the women out and then had to find a place to set up shelter again. And they did that on Wellington Street in the South End. It was very interesting to move there because they had a really, they had to go knocking on the doors and explain to the neighbours they were going to be living here and that this is what this place was. And you know, for the most part they did the transition really, really well. And they, they, there were some instances where, you know, the neighbours threatened to, somewhat, whatever, but the other thing that it did... they*

315

did some gardening, Barry, the folks at Barry House did some gardening, and, and it brought some of the other neighbours kind of out in a, in a social way, that talked to some of the women. And so, you know, who knows how that shifted people. Perhaps it did. (community member)

And of adapting to change.

Northwood also have always had kind of an interesting, they've always been very grounded in the community. And so they were one of the first. I mean, we have all of these assisted living seniors complexes being built now where Northwood pretty much right from the outset, they built a nursing home first but because…there was a gentleman who, I think, was involved with building Northwood, getting it built, whose wife was in Northwood and he was having a difficult time coming to visit her every day as he himself started to age and the idea was formed, well, if we had a unit of apartments where people could live independently, beside Northwood, they could maintain contact with their partners. And they were leaders in the field in doing this. They had a daycare centre across the road for their workers and it's not there, unfortunately, it closed. But they used to bring some of the older people over every week, went over. There was a regular time to come over and have kids and the elderly people do activities. (community member)

Part of our paradigm shift to a system for access to health must include incorporating the determinants of health.

9.2.1   Incorporating the Determinants of Health

Study participants intuitively understood the impact of the social determinants of health as defined in Chapter 6. As discussed in more detail in the analysis using no particular lens, building on present community efforts to address the determinants of health is crucial to improve the health of North End Halifax community members. A neighbouring community has begun to do this with their plan, a plan that systematically includes six elements based on the social determinants of health.

*Well, (*our plan*) was based on appreciative inquiry and we identified a lot of assets …we did surveys and talked to residents and found out a whole bunch of things that they really value about their neighbourhood…And the five strategies that we use are population health promotion strategies.* (community member)

Poverty and ill health are examples of the vicious cycles or reinforcing systems related to the determinants of health. Poverty leads to poor health which makes obtaining an adequate income through employment difficult which in turn predisposes to poverty.

Both equity and human rights principles require that health institutions systematically consider how the design or implementation of policies and programmes may directly or indirectly affect social marginalization, disadvantage, vulnerability or discrimination…Explicit adoption of equity and human rights approaches can ensure systematic attention to social disadvantage, vulnerability and discrimination in health policies and programmes. (Braveman, Gruskin, 2003; p. 540).

In order to break these cycles, one step is to redefine the concept of health care and illness care.

9.2.2   Defining the Concept of Health Care, Illness Care

Health care has been visualized as intersecting circles of the social determinants of health, individual identity and geography together defining access (McGibbon, 2009). When study participants spoke of health (illness) care, they spoke of the disconnectedness they often experienced in their health-illness-recovery journey. As people travelling through the health-illness maze, they did not separate their illness care needs from their daily health support needs (home care, outreach and the effects of the determinants of health). They did not distinguish between the bio-medical/ curative and psycho-social, supportive-health spectrum of care.

> *No one has ever said to me "for fuck sake, X, take your meds", no one. I just go and report that I've been another blob again or that I'm 100 percent compliant on these medications and not so compliant on those and unable to get a handle on my eating habits, which, if I could interject, I've read many, many books about eating and problems of eating and I've been to numerous therapists and I can't understand why system-wide, including the diabetic folks in the Bethune Building, never can deal with, have nothing in place to deal with the emotional aspects of overeating. Because you're not going to help me by telling me, yet again, that a carrot is better for me than a Mars bars. Like X, have you heard, here's the good word, Praise the Lord, a carrot is better for you than a Mars bar. Well, fuck, like everybody else, I grew up with Canada's food guide in the pyramid or the rainbow or whatever, different incarnations of being and it has nothing to do with that.* (community member)

The framework of population health was closer to study participants' concept of a health system.

> Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach those objectives, it looks at and acts upon the broad range of factors and

conditions that have a strong influence on our health…The population health approach recognizes that health is a capacity or resource rather than a state, a definition which corresponds more to the notion of being able to pursue one's goals, to acquire skills and education, and to grow. (Jensen, Kisley, 2005; p. 9)

The reality is that the parameters and design of our acute health care system (illness care) was and is largely defined by those in the system.

I think that, you know, that as health care providers, we get, we have a, a kind of standard of which we feel that people should, how people should interact, you know in certain, in, in other settings. If your doctor is 45 minutes late for their appointment with you, ah, we should understand that or you should maybe have brought something that you can read or you should be entertaining yourself somehow, right? But, you know if you get impatient, or if you huff and you sigh and you say "Where the fuck is the doctor?" to the receptionist, all of a sudden you are difficult. (health professional)

There is increasing recognition by both health professionals and clients that health and illness care are made up of partnerships.

I also believe that because I have this team of people working for me, you know, these doctors, and my nurse and whoever I end up seeing, that I need to be, I need to play as active a role as I can and my job is to be as compliant with my meds as much as I can and to try and lose 5 percent of my weight so that my blood pressure can go down far enough so that - I'm on a cocktail of anti-hypertensives - maybe I can get off one of those medications or have them lowered. Maybe I can become less of a burden to the health care system. I mean, there's all kinds of reasons for me, maybe I'd live longer, I forgot to put that one in. There's all kinds of reasons for me to be a more active participant with my team. (community member)

The everyday health related experiences of study participants highlighted the importance of developing a seamless continuum of health and illness care that also considers the impacts of all of the determinants of health.

And some of the stories that I hear include stories like of when one unit member, one resident would help the other because of need. It might be because of home services are not being provided adequately to the newly discharged client or the diabetic may not, may have a hyperglycaemic reaction, and they have neighbours who would be checking up on them. Or they have clients who were discharged from hospital in a wheel chair or amputation without appropriate home preparations for such a client. So our staff have gone in and seen the many complex issues that surround again a population who are living in the north end of Halifax who are among the poorest of the poor living in the poorest of health in this area of Halifax.

Interviewer – and if someone is discharged home from the hospital, would you know if they were your patient? Would you be notified in time that you could do something proactively?

Absolutely not. This is a huge, huge barrier to appropriate transition from hospital to the community. I would like to say that we were making some inroads here, but I don't think so. (health professional)

As in the "Third Way" framework of Hollander and Prince, 2002, Halifax North Enders see in their daily lives the need for a system for health rather than a pseudo healthcare (non)-system. A "Third Way" system links in education, housing, employment, income support services, justice, hospital/ community/ home care/ outreach services, recreation, transportation, prevention and health promotion to enable optimal health for all people.

9.2.3 Seeking Optimal Health for All

Seeking optimal health for all North End Halifax community members will require integration of the determinants of health into the present health care system and institutions/ services to address the health journey from wellness to death. Some health issues are more common in North End Halifax than in other neighbouring areas. An example is the lack of safe injection sites for drug users who are often also poor and / or homeless.

(photograph by participant #2)

Here we have a garbage can with pills sitting on the garbage can, yet to be put into little fry pans. There's a pill crusher and there's a vial where they squirt the water in. And there's the pill that's gonna go in there after sitting on garbage. So, when it

comes to health issues, that's a problem. Not giving a shit about where you place your rigs. (community member)

Inability to pay often results in less than optimal care and may cost the system more in the long run.

You know, eye exams aren't free anymore unless you're over a thousand or under two years, I'm exaggerating but, they'll be in another have, have not. The have nots will not have their eyes checked. The have nots with type II diabetes will have their vision fuck up on them and will not have it checked. The have nots cannot go to the dentist. (community member)

People living with poverty, homelessness and/ or addictions also suffer from feeling (or actually being) unwanted and disrespected by health care professionals (Stewart et al, 2005). Failure to adequately consider the life circumstances of North End Halifax residents makes transitioning of care even more disconcerting than for other individuals who have access to more resources.

We have collaborated with the community rehab team in that we have invited the OT (occupational therapy) *and PT* (physiotherapy) *in this area to sit on collaborate rounds, so that there is a better access to information of it's those that might have received referrals or involvement with OT or PT in the hospital. But not all clients certainly have gone through that source of health care. There's still a huge omission.* (health professional)

Approaches to care such as harm reduction for substance abuse instead of the disease model which uses a 12 step, or other intervention, to achieve abstinence are controversial and often not understood, thus not supported by those not familiar with persons living with addictions (Rothschild, 2010). Nor are the other intertwined health issues of this population well understood. A community-wide system for health requires consideration and embedding of the health needs from the perspectives of the various populations within the North End with each plan and action. It also requires approaches that are not intentionally or unintentionally oppositional to each other (i.e. harm reduction versus 12 step programs).

Mainline Needle Exchange is on Cornwallis Street. Um, the very obvious harm reduction stuff they are doing includes, um, needle exchange, ensuring that, um, drug users will only use clean needles. They also do needle sweeps. They're going around, ah, around Turning Point. They're checking around some areas in case there are any needles left. But their, most of their policy is, is an exchange of needles so that people who get needles, give needles back to get needles and that

tends to help things a whole lot. But they're also, they're another conduit. (health professional)

The challenges of caring for seniors are similar to other geographic areas but with the added concerns of poverty and other inequitable distributions of the determinants of health. Youth health is taxing for many reasons and the complexity is compounded in North End Halifax because of the proximity of drug dealing, the sex trade, poverty and crime (which are higher than in other areas of the city). People with mental illness are particularly poorly served. Although there is some supportive housing within North End Halifax for people living with mental illness, there is a population among those who are homeless who are not receiving adaptive functioning interventions that might improve the quality of their lives. People living with severe mental illness find it difficult to become integrated into any community and often suffer from "chronic residential mobility" (Kloos, Shah, 2009). Yet, the quality of neighbourhood support has a positive effect on the adaptive functioning and quality of life of people living with severe mental illness, often more of a positive effect than traditional mental health services (Kloos, Shah, 2009). Study participants expressed empathy for those community members living with mental illness.

> *Turning Point's a drop off area or drop off center I should say for the overrun at the Nova Scotia Hospital. At any given time a third of the people there are schizophrenic or schizophrenic/bipolar affected. You know, clinical depression. Drug addiction and schizophrenia, you know, it just goes on and on. We had, out of sixty-five people a year or so ago, thirty-two were schizophrenic. Well, that's not where they belong. There's people there that should in group homes, you know. They don't know what day of the week it is and you know, no real help has been offered them. There's an eighty-three year old man living there and now he's at the Vic or more, um, the Veterans Hospital. He's an inmate there 'til his Canada Pension funds run out, so they can throw him the hell out, you know what I mean? So, we don't have things in, in fact we don't have stuff. We don't have programs. We don't think about it because, you know, the Pollyanna thing. The rose coloured glasses.* (community member)

As noted by Zippay and Thompson, 2007, areas perceived to be impoverished, or have high crime rates, or otherwise undesirable, are more likely to have higher numbers of people living with mental illness in some sort of supportive housing, thus compounding the issues they face in a reinforcing cycle. In North End Halifax, there appears to be a mix of tolerance and support with limited resources. People living with mental illness or

321

substance abuse are in particular need of services that reach out to meet them in a person-focused way.

9.2.4   Reaching Out to Meet

Many North End Halifax community members have different everyday worlds than the average middle class, White, employed, heterosexual, healthy, traditional family man for whom most things are designed. From choosing one's agenda, obtaining food, making choices about recreational activities to purchasing needed goods, scheduling appointments, feeling comfort with the acute health care environment and reading the instructions on a medication bottle, these men are advantaged.

> *Even though some people who are living in their own rooms are certainly using the meals services, are depending on the meal services, people describe having been in a little bit more in control of their agenda, even though, even though, they are somewhat on the same schedule, if necessary there is a place to go and clear your mind until you go into that next line-up.* (health professional)

> *Yeah, and you know, like, really is it any different than, you know, your Uncle Joe, who drinks too much at every family get together. Like, you know, like we just, I think that we have made addiction, drug addiction, in particular intravenous drug and crack, you know, really into, we don't, we, we've forgotten about the person and we've focused solely on the behaviour that happens, when in fact, there's lots of times that, I don't know, we don't pay attention to anything related to the real person.* (health professional)

To unwind the spiral, health and illness services and opportunities must be equitably accessible for all. This means developing a system that is person-focused, not organizationally/ institutionally framed. It includes facing and correcting systemic "isms".

9.2.5   Addressing "isms"

Racism, sexism classism and other 'isms' are systemic, embedded and reinforcing; either consciously or unconsciously affecting our everyday behaviours and actions. Dugger, 1998, claims that separation into groups such as upper-class or African Nova Scotian is not the product of "spontaneous social order (invisible hand) or individual choice, but of collective action. Each system of inequality requires a different set of collective actions." (p. 288). These actions are systemically maintained through policies, procedures, norms

and behaviours; they become self justified, acceptable and consciously or unconsciously enforced and reinforced.

> Where the analysis of inequality starts makes a big difference. If you start before the imposition of inequality and then impose it, inequality is a diversion of resources and a taking. However, if you start after the imposition, the abstaining from redistribution looks as if you are abstaining from a taking; and if you started redistributing income to the underdogs, it would look as if you were reducing saving and investing. Here we have an *Alice in Wonderful* world where things are what they are because they *appear* to be that way. (Dugger, 1998; p. 289).

> The real solution to inequality is institutional reconstruction that eliminates systems of inequality, not marginal adjustment that smoothes off the rough edges of the systems of inequality. The real solution involves enlarging the participation of the previously stigmatized and excluded underdog groups. (Dugger, 1998; p. 290).

Aboriginal people and people living in poverty are examples of populations that systematically have been poorly served with respect to access to health.

(photographs by participant #5)

Um, these two I like the contrast of these also, in terms of, you know, health. I've a picture of, um, Brunswick Street Mission doors, you know, which is open on Sundays. And then, just down the street, or sorry, up the street from Brunswick Street Mission are these town houses again. With lots of open house signs on them for Sunday and ah, and, you know, my wonder around that is how many of the people who go into these open houses on Sundays, into these townhouses, will know about, will learn about what contributes to this wonderful open door, in this open house, down in on Brunswick Street. And what they will make, um, having only got a part of their community or neighbourhood. And what their contribution will be

there? So, ah, that's why I took those pictures. Those ones, want to be together as do these two. So, it some ways, like it's also that message of something kind of commercial versus something that's more spiritual. Right. It's, ah, this is certainly, um. You know, I think Brunswick Street Mission brings a sense of, um, ah, acceptance and openness that, um, that is a bit in contrast to kinda the open house, um, sign that's above, right. (community member)

What I guess I've noticed that's really important to think about, is the issue of community and community being. Um, the community that supports people who I work with, and the community that, um, and rejects, I guess, the community that I work with. So, and it's about, it's about stereotyping. It's about, um, what is community in the neighbourhood. (health professional)

Racism and heterosexism are still felt by community members, but this is improving.

Hopefully we'll get there. We are getting there, but I think generationally speaking, I know when I was growing up, racism wasn't discussed in my family. My parents didn't speak actively against it, but my daughter would be quite upset if it happened in the community where she was growing up that would be obviously, in terms of racism, she would be really upset about that. So anyway, just seeing that is positive for the community. (community member)

(photograph by participant #2)

Yeah, Mollyz, they were down to the south, now they moved up a street and I mean, it's a ghetto for gay guys. But, you know, it's, it's decent and, you know, the building is in good shape. That, that they're not afraid to, you know, to, they have no problems stating who they are and where they are, you know. There's never been incidents where any of the guys have got hurt or they, they've ever caused any problems, ah, when they were down by Palooka's, at the corner there, by the Salvation Army. I just looked at it as Gottingen Street is dealing with business. Maybe not the kind that you and I might frequent but yet, and this one is just, yeah, that's, that's a gathering place for the fellows and they've all, always been respectful there and so on. (community member)

Reducing the effects of "isms" would help to ease the way for all North Enders to engage and have a role in their community.

9.3   BECOMING COMMUNITY CITIZENS

Having members of the North End Halifax Community **become community citizens** is a way to ensure that root causes are sought from a variety of perspectives; that interconnectedness can be forged; and that simple rules are collectively developed. **Becoming community citizens** can facilitate the formation of a web of linkages among individuals, agencies and organizations with an impact on access to health.

> *(*A community vision*) is every man, woman and child knowing that they have a role to play in their community and agencies being more responsive to the needs and priorities of the people, not what they think residents need, and attracting resources to this area.* (community member)

As identified using other lenses, seeing ourselves as citizens, and accepting our privileges and the associated responsibilities and accountabilities (both those who are members of the community of North End Halifax and those who are not), is essential to facilitate change. Acts of constructive citizenship tend to generate positive feedback and increase citizenship behaviours and actions; likewise, unconstructive actions tend to generate negative citizenship.

> *I don't know if you saw on the news last night - CBC supper hour news – there was a story about a guy who has a daughter who is physically impaired so he built a deck around a swimming pool in the backyard so she could swim. And it has a wooden fence around it which had just gone up recently and I guess they came around yesterday to find spray painted on this fence "suck my dick motherfuckers." And this was like news at 6:00 on CBC. Because the man said we put all our money into the fence and we can't do anything, I don't know what to do, we can't do anything with the fence, and if I clean it up they're just going to come back and do it again, it'll be like a fresh canvas. Which I felt was exactly wrong because of this broken window theory. And I'm sure if somebody explained it to him he would have come around too.* (community member)

Aside from the aesthetics of broken windows, garbage and other signs of disrespect for the environment, studies have shown an association between these symbols and crime, disorder and drug dealing. These signs of neglect are taken as evidence of lack of citizen concern or monitoring by authorities. Policing of seemingly minor or nuisance crimes such as broken windows has lead to improvement in crime rates by breaking the cycle of disorder, fearful withdrawal by citizens, criminal population sense of low control and increase in criminal activity (Hinkle, Weisburd, 2008). Community policing as found in North End Halifax has been viewed as successful in decreasing area crime.

Police Office located next to Parent Resource Centre (photograph by participant #5)

The Halifax Police Department was key to it, any formative group to start talking about what can we do to make a difference. The police had had an office on Gottingen St called Charlie's, but it was only manned 8am-4pm. It just became a joke. So we talked about a police presence in the community, but one of the things the community said was that if you come into our community, you gotta come here for the long term, and you gotta be here 24 hours a day. So the police chief agreed to that and said yes we'll come in and we're committed to staying and we'll be opened 24 hours a day. All of the beat patrol police in this area, all have to go to that office to do up the reports. So that put a police presence in the community. (community member)

Active citizens are key to building healthy communities and communities with equitable access to health. Yet North End Halifax has a history of being studied without effects perceptible to most community members. This has engendered a dispirited feeling towards involvement. This was a sense that for me was always troubling as I struggled with how I could, at the end of my research, contribute something of help. Foster-Fishman et al, 2007, noted that community members could become involved at three levels: with community governance, design, decision-making and/ or planning; with design and implementation of projects or services; and in advocacy. A systemic approach to citizen engagement requires understanding and targeting of intervention goals. If the goal is to increase community member involvement, then examination of community capacity for change, including social ties (discussed under social capital) and leadership are important, as is community readiness for change. This includes a community belief that change is possible and willingness to undertake collective actions. In their study of community building initiatives, Foster-Fishman et al, 2007, found that perceived strength of neighbourhood leadership was one of the strongest predictors of whether community members were active. Perceptions about whether the neighbourhood was able to work

326

together and believed there was hope for change impacted on whether citizens were willing to undertake collective actions. From study participant interviews, it appeared there was a wide spectrum of beliefs about how well the community could work together and about whether change was possible. The engagement of North End Halifax community members requires a systemic approach to understand their viewpoints and to encourage citizen activities and collaborative planning.

9.4   PLANNING TOGETHER

How the community approaches **planning together** will be a critical determinant of the health system they build. Linking the players to achieve a seamless system, including community folk to ensure alignment with community needs, removing barriers to facilitate access, finding leadership that can successfully guide a complex adaptive system forward and forming relationships within and outside the community for both achieving a seamless system and expanding the resource pool evolved as components of **planning together**. Integrated **planning** is key to the creation of a *community-wide system of health.*

> *We need a plan of development in this community. People need a chance to work at the local McDonalds or whatever, there's something when you see people getting up and walking to work every morning and seeing what they're buying with their money and what they're accomplishing. I mean where do kids get their summer jobs? It's through their parents and their neighbours. They need that kind of engagement.* (community member)

From the study interviews, it was apparent that (in spite of or perhaps because of the many reviews, surveys and projects related to North End Halifax) there has not been a comprehensive, collaborative, systemic approach to planning based on community identified assets and dreams. One initial step might be simply linking the players in conversation.

9.4.1   Linking the players

During the late 1960's and early 1970's there were community organizers who went door-to-door contacting people, determining neighbourhood needs.

> *I think the stage that was different then, from now is, is that then, all of these different services that were being set up were things that people wanted and*

demanding and so there was an element of empowerment to the persons, there seems to be an element of "oh my god" all these agencies are here and were completely overwhelmed, it was a different quality and character, mind you the entire North American culture are of a different quality and character not just the North End of Halifax. (community member)

Present day circumstances may be more complex.

The other thing is that a lot of people are doing a lot of different things. Some of them are overlapping, some of them are conflicting and some of them don't, like one group doesn't know what the other group is doing and yet if you could kind of meld all those things together. But there's no natural linking within the community. That's true. And there's no sort of one leader, either. I mean, there are some names that crop up but there's no sort of one leader for the community. (community member)

Because the players are numerous and diverse, efforts to build a health system that encompasses the determinants of health and addresses needs over the lifespan and health spectrum requires crossing sector boundaries.

But who would take the lead on this. For one thing, housing in this government is outside of health care, so if they talked about Department of Primary Health, first they would have to include Department of Housing under the Department of Primary Health to help people appreciate the association between housing and health and poverty. And from there, both from the provincial level and the district level, to assume responsibilities, like you say, forming some sort of coalition or a directorate. (health professional)

These intersectoral boundaries are perpetuated by history, tradition, myths and culture. Working together requires more support for developing coalitions, collaborations and partnerships.

*(*We need*) to bump us up from networking and communicating to more partnerships and more collaboration across the community. And to, that whatever this wellness centre body is that works to build healthy public policy and creates supportive environments and do all that lovely work, has tentacles into the community but the people on that committee (*should*) include police and business people and service clubs and agencies and residents and the whole ball of wax.* (community member)

Policies, procedures and protocols can facilitate or hamper community linking. Community networking or web weaving should include connecting with all community folk.

9.4.2 Including Community Folk

The skills and knowledge of community folk are one of the richest assets of North End Halifax. Their contribution can knit the community together to mobilize and implement plans that see the way forward from a community-wide, complex adaptive systems view.

It's very value ridden, and ideologically driven, also. I think we need to have more discussions in the community to explain our values and why we believe what we believe because I think the more we do that the more we'll realize that everybody thinks very much similarly. There are differences in that quickly will get to a sense of responsibility – I think we're losing that in Canada. (community member)

(photograph by author)

There's a lot of invisible gardening that goes on in this community in the back yards. Many of the houses in this area, in this community, don't have front yards but they have these huge deep backyards. The front yards are right on the sidewalk and they have these little narrow alleyways between houses and you go out into the back yard into a complete oasis. And there are people who have lived here for a long time who have vegetable gardens and fruit, raspberry cane areas, and it's really quite amazing and it's wonderful. I laugh because we have a lot of young people living in our community now who are very much activist in the environmental movement and they're trying roof top gardening or container gardening and they kind of believe they've discovered gardening, urban gardening. Except you know, you can find older Black families in the North End of Halifax that have gardens in their back yards that have been there for probably 40 or 50 years on Creighton, Maynard, Gerrish, some of those streets. (community member)

But the community on the whole, unless they're being a part of it, kind of meeting on equal footing level and let's do something about the particular relationship. It's been a long time since we've done that. I think the community forced it in the late 80's around the a lot of the drug hits, people were being murdered on the street and

329

there were professional killings and the community said enough, enough, and we got community police and that was good and the library was very much involved in organizing those meetings and the community was tied together, they wanted something to have and we had a large, you know, everybody came and rallied around and really put the pressure on the municipality to bring the police into our community and change what was happening. A lot has happened. A lot of people argue that the money has been directed in the wrong way but most people would say it's done a good thing for us. I thought back, and it's really taken drug lords, giving them less ability to influence kids and the presence of the police has changed things in a positive way. (community member)

Planning in a community-wide, systemic way requires removing barriers.

9.4.3   Removing Barriers

The funding for non-profit organizations is tenuous at best and is further compromised by government systems forcing competition among groups, thus reinforcing a turf-ridden, scarcity mindset, siloed system.

There's no incentive to work collaboratively. There's never been a social client counsellor in this municipality we don't have members of executive directors of the various organizations meeting together on a regular basis to talk about what's one problem or area significance in this community that we can/could put a dent in. We'll all focus on it and make a small contribution. Why the hell aren't we doing that?? Part of the reason we are not doing it is because people are hiding their resources or they are competing to get money and if someone knows you are doing this, and they pick up an idea and run with it they'll take this from you and that from you. There're all kinds of reasons people don't collaborate. (community member)

Organizations sometimes deviate from their own goals in order to obtain funding to maintain their existence (Jensen, Kisely, 2005). As also expressed by study participants,

(m)any funding applications call for partnership without expressly recognizing the huge amount of work, resources, time, and energy that must go into building sustainable and meaningful partnerships. Developing partnerships across diverse sectors is seen as especially challenging. (Jensen, Kisely, 2005; p. 17).

In spite of lack of positive incentives, collaborative efforts do happen.

And we felt that the best way to respond to that was to offer competition or offer something else to people besides that type of housing so we did a lot of lobbying to the 3 levels of government, the mental health division, the Department of Health, the municipality, the province, the feds, ourselves, our health centre all came together to work on this initiative so it really reflects a collaborate approach in a grass root community response to issues and significant impact peoples' health. If

330

you don't have a place to lay your head that's safe and secure then you're in trouble. And this represents not only that but also as I mentioned earlier a gathering point or a community well for the people who are embraced in the community because of addiction and mental health related issues. (health professional)

(photograph by author)

The Cunard Street Centre was able to get this building because there was a push to push them out and I don't know what the plan was for the building but it was a city owned building, because when it stopped being a school it reverted back to the city. The city were really trying to get these folks out of this building for whatever the reason, I don't know what their plans were but there was a community push that went on to see that the children's centre stayed there and that the city sell that building to them for a dollar, to make sure that there would always be a presence there because the fear was that if they were moved out of there, they wouldn't find another home and all the spaces that the daycare subsidized so you would have lost all those subsidized daycare spaces. So the community rallied around the centre and were able to save that centre and keep it functioning even 'til today and they now own the building, so they were able to protect the integrity of their operations and by renting out the upstairs portion of it helps with the ongoing operational costs of the building. (community member)

Policies, languages of communication and information sharing can be barriers to or facilitators of change. Lack of a natural gathering place was a barrier identified by study participants. Some communities have approached smaller groups rather than attempting to have large inclusive meetings.

*And (*our organization*) wanted to make sure that we heard from all different kinds of voices, so rather than calling a big public meeting and hoping different kinds of people would come, we did small group meetings. So we heard from businesses; we went and talked to people who use food banks; we talked to parents in the school in*

331

a public housing neighbourhood; we went to environment groups...It's, you know, a variety of, we heard from church people. And so any one group was fairly homogeneous but we got diversity between the groups. (community member)

So even when people in one group think they have nothing to do with people in another group there are still, we still make sure there are conversations happening that may lead to different people being on the committee or maybe that committee will stay exactly the way it is but it will be hooked into the work of the other committees. So that as long as somebody knows what's going on over there, and what's going on in that other group, and what's going on in this third group, and people are talking to each other, then hopefully, we won't be duplicating, we will join forces, it's in relationships. It's all about relationships. And keeping those relationships healthy and alive and when we disagree, to air the disagreements and sort through it. (community member)

Effective leadership is one way of ameliorating barriers.

9.4.4   Finding Leadership

Whereas there are many individuals who have taken leadership in various initiatives, there is presently no overall leader/ leadership group to consolidate efforts and bring the many players together.

I think we need leadership both within the community and public sphere. It's a supportive and upbeat incentives through funding, to encourage people to work along with various agencies. We got a shelter system here! Not!! We've got Metro Turning Point, Salvation Army, Adsum House, Barry House – there're four of them and they don't work together. Yet each has a relationship to this community. Even the breakfast programs. Well there are various breakfast programs – Brunswick St United has been doing the breakfast, the churches have done it for youth, some faith based organizations have come to us, and those of us that are with the homeless, we have a meeting every couple of weeks called the Homeless Network, and that's what's needed. St Georges for example, wanted to do something, and I'd say hey look, there's no meal opportunity on a Saturday, so they'd the Saturday supper. So some of the faith groups will come to us. (community member)

However, governments still have accountability and responsibilities at all levels around quality of life, it's in the communities and municipality ought not negate that it has nothing to do with social housing, when it builds these damn condos, left, right and centre and pushes poor people out when it has a commitment to the people in the community regardless of their income level and find a way to show leadership and show people how to secure their housing. Bring the condo's on. Just, it didn't take seven years to build all those damn condos, there's more condo's than social housing. (community member)

332

The North Branch Library Women's Group. It was just this really important gathering place that was started by X and she started it I think in late to mid 70s and it still exists to this day. And I think women gather at the North Branch Library. Mrs. X, various elders of the community White and Black, would gather there and would participate in that group and were instrumental in various kinds of leadership roles in the community. (community member)

Leaders/ leadership for the future can be identified through increased and varied relationships within the community.

9.4.5   Forming Relationships

As with the approach in neighbouring communities, serendipity and a systemic approach to forming relationships are likely to be successful for community planning. Awareness of the interconnecting effects of respecting others, striving to understand another's worldview and building on the assets of North End Halifax will facilitate forming collaborative relationships to plan a future of optimal health for North End Halifax community members.

> *I think what needs to happen, to make something happen, is for a resource like a United Way, like a provincial government Department of Community Services, to actually have a new pocket of money, a new pocket of money that says this pocket of money is for this specific purpose to help you coordinate, to look at what's going on in the community and identify collectively the gaps, the best way to fill those gaps and who could do it, and that kind of stuff. And do it in a way that wouldn't threaten people, that wouldn't feel like people are going to be forced to amalgamate, somebody's going to be cut, somebody's going to be forced to shut down. People have been through so many versions of cuts, all of that kind of stuff. It's very threatening. And everybody is competing for the same dollar. So if you had an ability to do something totally different I think that could happen.* (community member)

9.5   CREATING THE ENVIRONMENT FOR HEALTH

Creating the environment for health provides a framework on which to build a community system of health that encompasses the acute, chronic and long-term illness sectors intertwined with the individuals, organizations and agencies related to the determinants of health. The environment has a reciprocating inter-relationship with health. The impact of environment and neighbourhood on health is the result of the interplay between characteristics of the environment and individual and group perceptions about those characteristics. Perceptions are influenced by shared norms and

values, traditions and cultures, interests and spiritual beliefs, and expected roles and division of labour (Macintyre et al, 2002; Wilson et al, 2009). Liveable neighbourhoods have been described as having "integrated mixed-use; neighbourhood based with integrated residential, retail, commercial and service industrial; inter-connected network; a flatter hierarchy of types *(of streets)*; traffic dispersed; neighbourhood independent retailers; *(and a planning objective to)* create community; create affordable housing; job containment." (Giles-Corti et al, 2007; p. 239)(italics inserted). Community-based efforts to change the social and physical environments, contrasted with efforts to change individuals, are more likely to result in health improvements (Sampson, 2003).

The environment has a significant impact on tobacco, alcohol and drug use; on diet and physical activity (Raphael, 2006). Often resorted to as a means of coping with material deprivation, stress or other challenges within their lives, the use of tobacco, alcohol and/ or drugs increase inequities in health. Greater disparity in incomes and distribution of resources (often paralleling social class) within communities exaggerates disparities in health. When examined over a population or individual's lifespan, the impacts of the determinants are cumulative (Raphael, 2006; Palloni, 2006).

Systemic urban planning is a vital part of achieving health for community members. In the abstract for his thesis, *The relationship between policy, planning and neighbourhood change: the case of the Gottingen Street neighbourhood, 1950-2000,* Melles, 2003, stated

> (d)espite theories that suggest decline is part of a neighbourhood's life cycle, this inquiry asserts that neighbourhood decline is not a natural process, but rather a condition influenced by policy, planning and investment decisions. It is ineffectual to suggest strategies for neighbourhood revitalization without analyzing and understanding the history of a neighbourhood. (p. xiii)

In his study, Melles, 2003, demonstrated sequential consequences beginning with the policy and program decisions of the 1950s-1960s, through the demographic changes of the 1960s-1970s that resulted in the commercial decline of the 1970-1980s. Of interest, he noted that there was no correlation with the amount of financial investment in the area and successful revitalization and suggested that it is not "the amount of the investment that is significant, rather it is how the investment occurs, and for what purpose." (p. xiii).

(W)hen the feds came down here and dropped a bucket of half a million dollars, no, more than that. There's money paving Gottingen St for crying out loud. The degree at which it's changing anything is really a good question. I remember people who know much more about the community than me, coming and saying do you know who got one of these fucking jobs? (community member)

(photograph by author)

As also noted by Melles, 2003, North End Halifax is nested within the larger Halifax Regional Municipality. Thus in planning for an environment to support achievement of health, there must be consideration of both the local neighbourhood and the larger surrounding areas; not only for the consequences a neighbourhood decision might have on the surrounding areas (and vice versa) but also for sharing of limited resources. Systemic planning for an environment for health includes walkability, active transportation, safety, aesthetics and places to go. The North End does have resources that can support a healthy life-style including the Centennial Pool, basketball courts, the Y, Palooka's, playgrounds, green space and horseshoe pits to name a few.

So that was one project that helped us look at what are the factors in the built environment that give people choices, that give people opportunities to make healthy choices. It doesn't mean they will make them but that at least you provide the opportunities. (community member)

And they (Palooka's) have actually a set of programs and staff and organizations or anyone in the community can come in take an exercise class at lunchtime or whatever so you know it was really nice to see that happen. (community member)

I think everybody has some kind of artistic ability within them and I just think it's very important interest...like, it's everything. And I think even in transcends disabilities, like, even if you can't see very well or hear very well, if you want to get into clay, like you can use your hands and mould something that way. It doesn't have to be like an easel or paint or whatever you traditionally think, it can be all kinds of different creative outlets. (community member)

Community environments, physical and social, have an effect on the health and quality of life of community members. In the model promulgated by Raphael et al, 2001,

quality of life is defined as the degree to which a person enjoys the important possibilities of his or her life in three areas. The area of *Being* reflects "who one is" and has physical, psychological, and spiritual components. *Belonging* is concerned with the fit between a person and his or her physical, social, and community environments. *Becoming* refers to the activities that a person carries out to achieve personal goals, hopes, or aspirations. Becoming involves practical or day-to-day activities, leisure pastimes, and those activities that help one to cope and grow. (p. 181)(italics as in original).

The quality of life of North End community members is hampered by such things as transportation challenges; seemingly inconsequential things not apparent unless one places oneself in the shoes of another; things that can have ripple effects such as greater food insecurity or social isolation.

Some of the buses still have steps, which makes it difficult if you've got a stroller and kids and so on. (community member)

Opportunities for improvement were noted by study participants including the following.

There are several vacant lots where potentially community gardens or parks could be created but apparently the owners are waiting for lucrative commercial offers. (community member)

(photograph by participant #3)

I can't imagine commuting to work on a bike because drivers are just awful. But having said all that, I think if there, the more cyclists there are, the more drivers do get used to us and do recognize that they're there. And, I mean, it's amazing in September when all the students come back how the streets just fill up. (community member)

Neighbourhood aesthetics have an effect on one's quality of life.

(photograph by author)

What's impressive now, when the owners sold, Victor (that owns the shoe shop), he bought the buildings and converted both buildings into night clubs and then when Ray Charles died, he had that mural put on the building, which is very nice, 'cause it captures another part of the community life of this community. It was a very music orientated, for Blacks, we used to have a club called the Gerrish Street Hall. It was up on, what is now called Buddy Day St, but the Gerrish St Hall housed the Black Masonic Club. It housed music; that was the place to be, Gerrish St Hall. That was the heart of the city in terms of music. Later on in the late 60's it got an upgrade it was Club Unusual, because it was getting more modern, the 60's stuff right, musicians, whenever they were in this city, no matter who they were, went to Gerrish St Hall. That's where the real music was played. (community member)

(photograph by participant #3)

(O)nce you leave a pile of debris in your backyard then your neighbour feels, "Well fuck it, I'll just leave a pile of debris in my backyard, I guess that's the thing they do around here. I guess no one is going to think badly of me if I just leave my crap in my backyard, or accessible to children walking down the street, or whatever, because it looks like that's what's done around here." And so in this neighbourhood, in our neighbourhood, my neighbourhood, there is definitely, that is part of what's going on, there's, you know, gentrification going on and people who obviously have a lot of pride in their dwellings but there is also this other side of the coin and that's, and that's visual and physical eyesores. Anybody can go in and get hurt in this stuff and it just looks fucking ugly. That's why I took that picture. (community member)

Spirituality and faith were mentioned as important aspects of the lives of North End community members. Urban planning is multifaceted and, if comprehensive, requires systemic thinking and a multi-levelled, multi-disciplinary approach to target ecology, community, governments, social environments, physical surroundings, policy, individuals, organizations and services (Sallis et al, 2006). Such an approach to planning recognizes that the efforts of an individual to improve her or his health are highly dependent on the foundation of the determinants of health she or he has available on which to build. Equally important, as stressed by Sallis et al, 2006, "most of the active living research so far has involved middle class, mostly white adults living in urban and suburban settings." (p. 316). Thesis study participants suggested that such planning should encompass housing, green spaces, transportation/ mobility, safety, recreation/ activities, infrastructure, local businesses and employment opportunities. The ecologic framework of Sallis et al, 2006, consisted of four active living domains: recreation, transport, occupation and household; domains referred to in interviews.

Study participants felt that more infrastructure was needed to support community development.

I know we need another community centre, I think we need some stores, I think we need grocery stores, I don't think we need artsy fartsy stores, I think we need real life stores, but the problem is the stores don't exist anywhere in the cities anymore, they don't just not exist in the North End, they don't exist anywhere right. I can't believe that to get a friggin box of nails – I'm just kidding, but to buy underwear, I have to go to Bayers Lake Industrial Park to Zellers to get some underwear. It's like, do you have to have a car to go to get underwear, do you know what I mean, there's no, so the economic infrastructure the poor communities, I mean, middle class people we like to have stores too, we like to have economic infrastructure

around us, but we don't require it to have a good lifestyle. 'Cause we can get to the shit we want to get and we have sufficient agency to mobilize by friendship rather than community and it's not a problem for us. (community member)

But I think to create organic communities there needs to be economy of scale, and I don't think that's going to happen anymore, it's like I remember someone telling me one time that the way when parks are built, the designers put these paths in, but progressive parks let people walk and then they put the paths in. That's how I think social policy needs to happen. So the North Branch Library didn't become a community centre, because it decided to be a community centre and a library, but the people walking in the path created a community centre out of it and you should be very careful to sell consciously. If the branch decided to stop being a library, it would also stop being a community centre. So it's this very delicate line by letting what has occurred become the trajectory that is validated in many different ways. (community member)

For organic community development, a concept in keeping with complex adaptive system development, interwoven connections and pathways are invaluable.

9.6   WEAVING PATHWAYS

The weaving pathways to realize a *community-wide system of health* are, in turn, interwoven from <u>literacy and health literacy</u> (a requisite to enable everyone to contribute), and <u>seamless housing, food, child and youth development and health maintenance and illness care systems</u>. These seamless systems, when fully created, will be invisibly joined to support health for all community members over their life journeys.

As can be gleaned from the analyses of study participant interviews, access to health and illness care is similar to a patchwork quilt with some pieces in place, some yet to be made and all waiting to be stitched together. Functional literacy is an important interlacing component for the development of an accessible, seamless health and illness care system.

9.6.1   <u>Literacy and Health Literacy</u>

Literacy skills are challenging for many Canadians. Rootman and Ronson, 2005, defined three major components of literacy: general literacy (reading ability, ability to use numbers, listening and speaking ability, comprehension, negotiation skills and critical thinking judgment); health literacy (ability to obtain, understand and communicate health information; ability to assess that health information); and other literacy (scientific,

cultural, computer, media, etc). Abilities within these literacies are shaped, in part, by the determinants of health and, in turn, health literacy has an impact on achieving health. Health literacy has three defined components: basic or functional (sufficient literacy skills to be able to function in everyday situations), communicative or interactive (cognitive and social skills to actively participate in daily activities and obtain meaningful information from different sources and communication vehicles and to apply that information) and critical literacy (advanced critical thinking skills, ability to critically analyze information and use it to gain control over health). Advancing health literacy includes both improving individual's skills and developing more accessible information sources in easily understandable and user-friendly formats.

> I think that literacy is a community development process. And I think that as a community development process, it will result in empowerment. In empowering people to make educated decisions about their lives and to do that in the context of being able to assess in the context other people's lives. (Rootman, Ronson, 2005; p. S71).

Study participants recognized the importance of information to maintaining health.

(photograph by participant #1)

The library is a huge part of my health care. Because when I want to self-diagnose as being high-functioning autistic or, you know, that I have Aspbergers or whatever, or that I have a tumour, or whatever I think my current problem may be, the library is, Google is certainly a tremendous thing to be able to access these days but I'm so, I'm old enough that more of my life is spent at the library than on Google…So health care books, if they're on the shelf at the library I can take them home for free. If they're not on the shelf at this branch of the library, I can put in a hold for a book that's anywhere in the Halifax Regional Library system and it will be brought to the North End Library for me. The Halifax Regional Library doesn't own it. I can put in a suggestion for purchase, which I have many times, and most of them, they buy them. Or I can put in a request for an inter-library loan. And I've had books come from the States, from Vancouver, from wherever. (community member)

Refocusing literacy efforts from individuals within a community to communities of individuals facilitates a more comprehensive and systemic approach. Such a system should recognize and support the spectrum of starting skills, life stages and life-long learning. Such a system would require weaving connections among schools, libraries, media, technology, early childhood development, senior's organizations and translators for example. An excellent example is the Black Educators Association.

> *The Black Educators as an association was founded by Black teachers, a small group of Black teachers who sort of had this idea that education is the great equalizer and we have to promote education more and we need to get the system to respond in a more systematic way to the marginalization of Black learners. So a group of Black teachers formed the Black Learners Association and they have been successful in having the Black Learner Advisory Committee established a report, the Black Report, a number of recommendations that covered everything from having more Black teachers in our education system to putting content in the curriculum that affirms the identity of African Nova Scotians in the life of the province and doesn't depict people from this particular community in negative and stereotypical ways, and all of this kind of stuff. It's been a massive undertaking to kind of change that system and they've done it with very few resources. These folks, their budgets have been pretty miniscule. They have offices across the province. Their head office is here in the North End but they operate in each of, I think, 30 some communities in Nova Scotia. They have outreach workers on the ground into all of the schools, the elementary schools, the junior and high schools. And they are trying very hard to make this a system-wide change, work for system-wide change, across the province to result in improvements in the educational obtainment of young African Nova Scotians.* (community member)

(photograph by author)

Just as there is the need for a systemic approach to health literacy, study participants pointed out the need for seamless systems of housing security, food security, child and

youth development, illness care and health care; these systems themselves should be interlinked with each other.

9.6.2 Seamless Housing Security System

Housing security was an issue for all study participants. Participants talked about lack of a systematic approach to housing security and homelessness; about "dabbling in and out of it" (community member).

> *I believe we should be putting moderate income families in the projects with a rent incentive. But what they do now is if you live in the projects and you get a job, your rent goes up, your rent goes up and your opportunity for welfare decreased. I believe we should use that as a determinate if you work and if you're on welfare and you work enough to bring yourself up to the low income cut off, then you shouldn't lose any of your welfare money. That should be supplemented a low income. So it's almost like a guaranteed wage. And your rent shouldn't go up, if you are a person of a moderate income and you want to live on a housing project in order to save money, investing in yourself or your children, why do we nickel and dime poor people.* (community member)

> *And in some ways it is pitting people against each other. If there aren't enough beds? Like, whereas maybe if there were enough beds you'd get at least that bit of protecting each other. Like I know there is a lot of protection, of collaboration in looking after each other, that happens, then to have a final piece, make you competitive because you're afraid you're not going to get your one more thing that will bring you off 'til tomorrow?* (community member)

> *If you have a secure income you have health. Property is a large determinant of someone's health.* (community member)

> *You need social housing for everybody, that's where they should be developing all the clusters here and there and putting people in there, along the streets where the majority of houses are private or people are mixed incomes and that sort of thing. And that the large density projects would be a mixture. So there needs to be incentives, so if you're in a position or if you have a moderate income and want to save for retirement or want to send your kids to university or whatever you want to do, buy a cottage or whatever, buy your own house later on.* (community member)

There is little concerted effort apparent to address the root causes of housing insecurity (Canada-wide, province-wide, municipal-wide or in neighbourhoods). Although there is some understanding of the root causes (such as poverty, mental illness, addictions and domestic violence; all of these have even deeper root causes), most efforts, themselves

disjointed, are directed at ameliorating the symptoms and not treating the disease. As noted by Frankish et al, 2005,

> (t)he complexity of the issue of homelessness requires the involvement of a whole range of stakeholders, including all levels of government, service providers, health professionals, biomedical/social science researchers, community groups and homeless people themselves. Both horizontal integration (across various sectors such as health, law, housing, social services) and vertical integration (across federal, provincial, territorial, and local governments, and within communities) are needed. Second, diversity of values, beliefs and perspectives on homelessness must be acknowledged, and public discourse is needed on the causes of homelessness in Canada and the appropriate response to them. (p. s27).

Study participants observed there is reason for optimism with respect to housing security if recent developments can be built on (such as those of the Creighton and Gerrish Group Development). Housing security is tightly linked to economic security, employment security and food security, all of which would benefit from a systemic approach.

9.6.3   Seamless Food Security System

The disjointed approach to achieving food security is a prime example where a systems approach would better meet the needs of North End Halifax. Although there is collaboration amongst the NGOs who run community kitchens, from the perspective of those who participated in the study interviews, this collaboration is mainly to determine whether and at which places to have meals available in the neighbourhood. One church group may look after the evening meal on Thursday and another on Monday, etc. There is no apparent overall strategy to comprehensively address food security for community members- not to address the acute needs of people or to ameliorate the root causes for food insecurity. Food banks, community gardens, grocery stores and soup kitchens form parts of a potential food security alleviation system. They do not work to prevent food insecurity.

> *In fact they only have these meals at one place, so breakfast at one place, lunch at one place and dinner at one place. So this supper is provided out of Hope Cottage, provided again by different churches who donated the food for various meals and this is all divided and organized by all denominations who partake in the delivery of suppers. So there's upward of 100 to 150 people that receive an evening meal, manned primarily by volunteers, the food is basic, not necessarily healthy, in the sense that it is high carbohydrate, fat wouldn't be considered, so your basic goulash or a pasta meal, your spaghetti. And it's not to say they are not doing a*

great job. They are doing a great job with what they have. But the point I would like make, is that in isolation of a government overview and certainly would not meet health outcomes by any stretch of the imagination, if government was doing an evaluation of it. (health professional)

Others spoke of misplaced priorities that seem to place an emphasis on a less critical component of the needed system.

So he raised about seventy-seven thousand dollars but, you know. They fixed up the kitchen but they didn't fix up the food…Why would you want a brand new kitchen to cook macaroni?...What, the priority is reversed. Improve the food quality. You know, it's difficult for the guys to get the right grammage of protein a day and, you know lots of calcium and just, you know. Would it hurt them to budget for real milk? You know, buy a bag of plastic spoons and say "Here this is your spoon", you know and the, the hygiene is. I mean, I, I, outwardly looks fine but, you know you go to that coffee table and, and look at the coffee stained sugar globs and this old spoon and often someone will lick the spoon and it. It's, it, you know what, it's just a tragedy and I just stopped going over. I just said, no, no, no, no. no. I get sick too often as it is without, you know, tempting fate by eating in a place where, you know, the hygiene in certain areas is poor at best. (community member)

Well, I'm not a huge fan of food banks, in the sense of there's no learning, there's no. People are desperately in need, I know that, but it sort of doesn't, there don't seem to be very many programs associated with suggesting how people might either cook with some of this. I know in the Feed Nova Scotia, I volunteered with them for a while. Anyway, I have lots of issues around food banks, let's put it that way. But they are an unfortunate necessity and this is one that's right in the community and certainly the furniture bank is a very good idea, both from the environmental side as well as, if you need something, it's there. (community member)

However, Parker Street Food Bank does attempt to enable people to work towards a changed and better future.

And they also fill gaps in what the formal social service system will provide. They help people a lot with heat bills, oil in the wintertime, power bills in the wintertime, those kinds of things. And they also, it's interesting, they started a very basic skills development for computer skills for people who, you know, you would never in a million years imagine would have access to a computer, the internet and what have you. And people go there and they feel very comfortable to be able to work with the folks at Parker Street and they're pretty amazing in what they do. (community member)

One of the most devastating consequences of food insecurity are the long-term effects on childhood (and thus adulthood) development. The basics of food and housing security are foundational for a seamless child and youth development system.

344

9.6.4 <u>Seamless Child and Youth Development System</u>

North End Halifax does have resources for early childhood and youth development such as daycare, pre-schools, parent supports, Youthnet as well as playgrounds and ARK, a drop in centre for youth.

> *The playground? A green place. A place where children can be safe and play and do things kids are supposed to do. I think there are some nice playgrounds around the city. I do think there's some lovely playgrounds and in the North End too. Yeah, it's just a pleasant place to be. I don't know about this particular playground but when my girls were growing up, we used to go to the playground with them and it's just wonderful to go sit there after supper, leave your dishes and go talk to other parents. You get as much out of it as your kids do. It's almost like, a meeting? Yeah. And cheaper than the mall. It really looks well maintained. It's new. I think HRM does a good job of maintaining playgrounds. I would almost think like if you were a lonely person and you just went and sat in a playground, you wouldn't feel so lonely, you'd sit there and watch the kids and hear them laugh and it can't help make you feel better and feel more involved and attached. There's lots of activity too.* (community member)

> *Um, this is a picture of ARK. ARK is a drop-in center for youth. They provide good healthy food. They provide, ah, a lot of ah, psychic support. And again, same approach, is that relationship building– free to be me. That's right. Ah, they have a music room. They have a pottery studio. They have a couple of guitars hanging on the wall. They've got some art supplies. Yeah, the importance of self expression.* (health professional)

(photograph by participant #6)

Early childhood education and care has been documented to be a significant short-term and long-term determinant of health (Friendly, 2009). Canada has a theoretical (unrealized) concept for comprehensive early childhood education and care (ECEC) that embraces "early learning, lifelong learning, school readiness (or 'readiness to learn'),

child development, parents' employability, women's equality, balancing work and family, anti-poverty, alleviating at-risk status, and social integration.". There is

> overwhelming evidence that the positive effects of ECEC programs occur only if they are high quality and that, indeed, poor-quality programs may have a negative effect, especially for children from low-income families. Thus it is the *quality* of ECEC programs that is critical in determining how developmentally effective they are, not merely whether children participate in them. (Friendly, 2009; p. 130).

High quality programs have well-educated staff, place children in groups of manageable size, provide "challenging, non-didactic, play-based, creative, enjoyable activities" (p. 130) and have "consistent adult and peer groups in well-designed physical environments." (p. 130). Such programs have long lasting positive effects. Friendly stresses such opportunities are particularly important for children with disabilities.

Another group of children likely to benefit greatly from ECEC are those from families who are experiencing poverty, substance abuse, single parenthood or violence. Their lives are further complicated by the fragmentation of support services. Children and families seeking support often find that the services they require are not interconnected thus necessitating negotiations with a variety of agencies each with their own process and information requests, procedures and processes. These agencies can include clinics, mental health, hospitals, social services and educational. Their services may overlap, duplicate or conflict (Morrow et al, 2010). This is but one example of the lack of seamlessness for health maintenance and illness care. Relative to other OECD countries, Canada performs poorly with respect to ECEC and North End Halifax struggles to support early childhood development for their community children and youth.

9.6.5   Seamless Health Maintenance and Illness Care System

The complexities of the populations of North End Halifax and the illness issues they face provide an impetus for rethinking the health maintenance and illness care system. Study participants indicated that, minimally, the components as illustrated in **Figure 12** should be considered and incorporated. A study participant described a portion of a seamless

health system through the North End Community Health Clinic where all the partners in her care could follow her progress through access to an electronic health record, where the local pharmacist was in close contact with her and her partners in her care; where her care was integrated, convenient and comprehensive. Within Nova Scotia there are other initiatives that can begin to form a seamless system: the Chronic Disease Model and the Model of Care project. These are very disease/ bio-medically focused. However, there is a building literature on developing integrated systems that span the wellness - illness spectrum (see for example, Kazak et al, 2010).

Through envisioning a model and framework for a community-wide system for health, work can begin to achieve the vision, piece-by-piece, by being aware of how each element supplements, interacts with and balances elements being worked on by others. The lack of a truly seamless system is a problem not only for people living in North End Halifax, but for all Nova Scotians and, indeed, all Canadians. While there are certainly elements that can be improved by and within the North End Halifax community itself, a seamless wellness-illness system requires involvement of many individuals, groups, communities, organizations, agencies, businesses and governments. Yet, even small accomplishable steps will lead to improvement in the health of North End Halifax residents when centered in the context of a wider wellness-illness system.

9.7   SUMMARY BASED ON SYSTEMS THEORY LENS QUESTIONS

1.   What are potential system issues raised in these interviews?

The system issue raised most frequently by study participants was the need for a health system (wellness-illness system) to include attention to the determinants of health. It is also evident they perceived systemic disadvantage for subpopulations within the community; and that those systemic inequalities lead to further inequalities and inequities (Baylis et al, 2008). Participants also noted the systematic exclusion (including social exclusion) of groups (intentionally or unintentionally) from health resources. They highlighted poor understanding, by those presently having the most influence on health resources, of the daily dilemmas many community members face. They noted that inter-sectorality of solutions creates systemic barriers to addressing root causes of poor

community health (Hankivsky, Christoffersen, 2008). The most stridently voiced system issue was the abdication by governments of their role and responsibilities particularly related to the social determinants of health.

> *A non-profit agency meeting the health needs the government's not meeting of our homeless population, transient, mentally ill. I'm very adamant to say that the government is shirking its duties of providing services not only health but housing and I refer to housing as a health need. And it should not be separated, but it is in Nova Scotia very much so. And as a result, we see many complications of one's health care related to the lack housing, the lack of affordable and decent and appropriate housing.* (health professional)

2. What are potential system inconsistencies/ incongruencies/ incompatibilities raised in these interviews?

Study participants identified lack of incentives, and actual disincentives, to working collaboratively to create a system for access to health. There were varying levels of optimism about community leadership, community cohesion and ability or willingness to adopt a new worldview and collaborate. The major systemic incongruency or incompatibility is that between the hospital-based and community-based approaches to health. Participants mentioned the inconsistencies in hopes and aspirations for the community's future and whose voice would be heard loudest in determining that future. The community has several systemic "isms" to overcome. These "isms" are expressed consciously and unconsciously; intentionally and unintentionally and are buried deep within the routine practices and activities of the community.

> *So we talked about a police presence in the community, but one of the things the community said was that if you into our community, you gotta come here for the long term, and you gotta be here 24 hrs a day. So the police chief agreed to that and said yes we'll come in and we're committed to staying and we'll be opened 24 hrs a day. All of the beat patrol police in this area, all have to go to that office to do up the reports. So that put a police presence in the community. I gave them a unit to put their office in. Then what we did was install cameras outside the police office. Those cameras scanned up and down Uniacke St and in that area. The other thing we did was turbo lighting in Uniacke Square. Matter of fact, the lighting was shot out. Because the lighting was all on poles, and they actually shot them out with guns. So I said you know what, these guys with their guns, they know all the people that live in these buildings, they're not going shoot, so I went and put the lights on the building and I haven't lost a light since. Because I knew these guys aren't going to shoot at the house, they're families and cousins and people they know, but they will shoot at a light standard.* (community member)

3. What system relationships are affected in the information shared?

To adequately create an accessible system for health and illness care, there were innumerable needed relationships and connections identified. These included education, housing, employment, income support services, justice, hospital/ community/ homecare/ outreach services, recreation, transportation, environmental, and prevention/ health promotion organizations/ groups/ agencies as well as all levels of government. It requires multi-level, multi-disciplinary approaches; it includes changes to policies, by-laws, legislation; it means a paradigm shift in thinking about access to health. It requires a shift to a philosophy of inter-being (interconnectedness, interdependence and interrelatedness) to address the human components of systems (Kristy, 2006).

> *First we have to elect a government that has this appreciation or could be talked into having this appreciation…The Department of Primary Health really should be shouldering this responsibility. And even to see that the Department of Health, community services and Department of Health Promotion and Prevention have all separate ministers (*no longer*) and therefore portfolios, therefore turfs, therefore silos, so how can we break down those silos to ensure that policies are addressed across the board. That policies aren't just approved just inside each department, if they affect ....I don't know, it's a big question and big issue. It will continue as long as the departments are separated.* (health professional)

4. What system interdependencies could potentiate or negate this situation?

All of the system relationships identified in question #3 can either potentiate or negate achieving equitable access to health for North End Halifax community members. The complexities associated with achievement are magnified by the diversity of values, beliefs and attitudes of people within and outside the community. The challenges of creating positive relationships and inter-relationships among diverse community members to enable improved health outcomes were apparent from the interviews. Yet in systems, particularly complex adaptive systems, small changes can leverage large results.

> *I think the strength in this community is all of the little groups. And that comes out of an historical context, you know, that goes back - in fact, if you look at the Dutch church and St. Georges and the founding of those churches, like the people who founded St. Georges also founded the Dutch church. The Dutch church was there first and then they outgrew that space and they went on to build St. Georges and there was a group that stayed behind because they didn't want a new church, they wanted their old one. And so that fragmentation, I think, has a history in the community. But all of these little organizations give a lot of different people an*

opportunity to be really active where if you had one organization you'd have a small group that would be active and you'd lose that kind of dynamism - there's no such word - but you'd lose that dynamic, I think.(community member)

Participants identified several potential areas of leverage to *strive towards a community-wide system of health*. As suggested by McDaniel, 1997 (and in keeping with asset-based community development; Mathie, Cunningham, 2003), benefit can be accrued by the traditional hierarchy giving up control and shifting planning to the community; creating new organizations unfettered (relatively) by the past; enhancing the quality of connections; increasing mutual understanding of the lifeworlds of others; providing opportunities for co-learning and decreasing competition.

5. Are there delayed consequences of this situation?

At the moment, the balance between positive reinforcing cycles (towards increasing poor health) and negative reinforcing cycles (towards increasing optimal health) are in favour of decreasing access to health. This is likely to lead to increased demand for expensive curative interventions, whereas greater emphasis on ameliorating the etiologies of poor health is predicted to be ultimately less costly (Raphael, 2006).

If you're in receipt of social assistance right now, you're on something called Quick Card for dental care. And to go to the dentist the rules have spelled out you must be in pain, it must be an emergency for you to go to the dentist. They don't pay for checkups. They don't pay for fillings. They only pay for emergency work and at that, the amount given by Quick Card does not cover what my dentist, who's this plain ordinary guy on Robie Street, very nice guy, doesn't even cover what he charges.(community member)

6. Are root causes considered in this situation?

One pervasive and troubling root cause identified is the propensity of the worldview of the White middle-class to dominate and systemically, invidiously, insidiously determine outcomes; at the level of society to the level of individuals. Study participants were acutely aware that roots causes were rarely considered, particularly those related to poverty and its consequences.

On a national level, our conservative government, in contrast to a social democratic government, has weakened our social support infrastructure to the detriment of more equitable health achieved in other countries such as Sweden.

> *As you know Canada isn't a poor country. However, we rate eighth in how we treat people. Denmark, in Scandinavia, Holland, in, that, that wouldn't be put up, you know. We are really new school here. We are the new world and we're very immature about* (social supports). (community member)

7. Is (are) there (a) simple rule(s) that is (are) applicable?

Plsek and Wilson, 2001, suggested there can be simple rules for healthcare organisations. Some of their simple rules are applicable to North End Halifax and access to health: "care is based on continuous healing relationships", "decision-making is evidence-based", "care is customised according to patients' needs and values", "knowledge is shared and information flows freely" and "the patient is the source of control" (p. 748). As implied by study participants, other simple rules might be 'treat all people with respect', 'take the time to reflect on my life and ask to understand', 'meet me where I am', 'consider my context and all of the impacts on my health as we together develop a plan' and 'sew together all the pieces so I can follow the path'.

The major points I gleaned were:

- The potential of replacing the concept of helping with that of inter-being
- The widely recognized need for seamlessness and transparency within the illness care system must be expanded to a seamless and transparent system for access to health (explicitly embedding the determinants of health)
- Positive surroundings breed positive surroundings
- Structures (such as policies) should be changed first, then people will follow
- Strength of the neighbourhood leadership is crucial

The way forward, I believe, will include:

- Organic development of leadership from within the community
- A community linker to jumpstart a new way of viewing *striving for a community-wide system for health*

- Initial external resources to allow the area's population to develop its way to plan together as an inclusive community

- Integration beginning locally in areas over which the community has control with boundary-spanning expansion as successes are achieved.

CHAPTER 10　　　COMPARISONS OF LENSES

My purpose in exploring the use of the three lenses (feminist theory, critical social theory and systems theory) was to see if forcing oneself to look at things in a different way might help to expand one's thinking about, and thus understanding of, questions being researched. All of these theories were unfamiliar to me and therefore this examination is based on an elementary level of understanding. My belief is that a deeper understanding could only be expected to provide an even more revealing picture.

10.1　COMFORT LEVEL WITH LENSES

As stated above, I was inexperienced and had no previous background in academic study that would have prepared me with a fundamental foundation on which to build further understanding of feminist, critical social or systems theory. I, therefore, have likely committed unknowing and unintentional transgressions in my application of these theories. Yet I feel that the discipline of focusing the analyses through the lenses as I understood them served me well in expanding my views.

I had anticipated that I would find the systems lens the most comfortable but I confess to becoming entangled in cycles, systems thinking and systems theory (with a bit of complex adaptive theory thrown in!). Unexpectedly to me, I was most comfortable with the feminist lens as I understood it. The questions used to focus the analysis for each lens I created to reflect, as best I could, basic elements of each lens. Some turned out to be more-user friendly than others and this is certainly an area for improvement if this approach is to prove useful for others. One suggestion is the lens(es) could be meaningfully developed from the agency or organization's values.

10.2　THE VALUE OF THE THREE LENSES

The experience of using the three lenses for analysis of the policies and the interviews differed. For the policy analyses, it was easy to see how the application of the lenses broadened thinking about and could change the policy content. It is, perhaps, difficult for some to become enthused about policy writing; it can be regarded more as a duty rather than an organization defining exercise. It is often seen to be more expedient to approach

the task of policy development using the lens with which one is most familiar. This, for the majority of the Board, is likely the lens of White, middle class business men and women. Coaching was likely received from health professionals with a largely traditional viewpoint of health centres (hospitals) as well as some degree of self-interest. The resulting policies are as could be expected if developed from such viewpoints. For the first policy analysed, I used a different lens to examine each section of the policy; thus the analysis within each section was quite detailed and allowed me greater room for exploration. For the analyses of the second policy, I first did an overview with an awareness of the three lenses in mind. I then applied the lens questions in sequence (feminist, critical social and system) to the entire policy. Both of these approaches to the policy analyses wrought significant changes in how the policy might have evolved. Both approaches had value as by happenstance, one lens may be more suited to the particular subject matter. The second approach - applying the three lenses questions to a written policy can serve to determine if a policy would benefit from revision or as a check on the particular aspects of a newly written policy. With the development of a new policy, a more in-depth, ongoing analysis incorporating the particular lens theory could proactively broaden dialogue and considerations related to the policy. Applying the lenses sequentially to each policy section can be time consuming, but may result in time-savings in the long term. Organizations and policy-makers could develop lens questions that more accurately reflect their values and mandate.

The experience gained in using the lenses for examination of the two policies was helpful for their application to the grounded theory analyses of the study participant interviews. With the interview analyses, I used the questions as a tool to focus my thoughts as the codes and themes emerged from the data (constant comparison). For me the lenses provided a type of *boundary object* that facilitated conveying theory-based monologue (or dialogue between me and the unknown reader) and reasoning with respect to the policy and interview analyses.

10.3   POLICY ANALYSES AND THE THREE LENSES

The objectives of the <u>first component of this thesis research</u> were:

    1.   to examine two broadly applicable administrative policies through the lenses of feminist theory, critical social theory and systems theory; and

    2.   to determine how the lenses affected the analysis of the policies

Chapters 4 and 5 provide the results of the examination of the two policies.

As discussed above, for the analysis of the Board Policy (*General Governance Commitment*), the use of the theory lenses considerably altered the tone, interpretation and content of the policy. Even though the three lenses were not all applied to each section of the policy, the tenor of change with each lens was apparent, each having a distinct emphasis. The feminist lens stressed aspects of care and ethics; the critical social theory highlighted ideologies and power; and the systems theory lens reinforced the importance of root causes and feedback loops.

In the analysis of the second policy (*Conflicts of Interest Policy*), where the three lenses were applied to the whole policy, similarities and differences can be detected through perusal of the lens questions and comments.

10.3.1 <u>Common Elements</u>

Both the feminist lens and the critical social theory lens recognized the impact of power differentials in conflict of interests; both acknowledged the norm and standards as being those of White middle-class (male); both noted the impact of politics and the emphasis on autonomy. All three lenses called attention to absence of consideration for diverseness. The critical social theory lens and the systems theory lens both clarified aspects of the policy that were systemic and/ or served to perpetuate the present circumstances.

10.3.2 <u>Differences</u>

The feminist lens brought the importance of relationships to the forefront for both identifying conflicts of interest and for addressing conflicts of interest. The emphasis with the feminist lens was less on autonomy and more on connectedness. The failure to

address many of the daily conflicts of interest experienced by frontline staff (the majority of whom are women) was clear when using the feminist lens. The critical social theory lens illuminated how little consideration there is within the policy for others than the dominant populations (which in this instance also included the privileging of health professionals over patients and families); how many were unseen and unheard. The systems theory lens emphasized root causes, feedback loops and outside influences.

10.3.3 Inferences and Learnings from Using the Lenses

The use of the lenses generated wicked (as in complex adaptive systems) or tough questions: for example, using the feminist lens to examine the Board Governance Commitment Policy (What are the costs or benefits, and for whom? What responsibility does the Health Centre bear within the healthcare system? Does the Health Centre have responsibilities for restitution; for redressing inequities?). Again, using the feminist lens, it was easy to see that policy, based on dominant population norms, can both conceal and perpetuate discriminations and inequities.

Although there was overlap between the feminist theory and critical social theory lenses, both provided slightly different perspectives. One of the lenses might suit a particular organization better than another. There was little overlap between these two lenses and the systems theory lens. Significant gaps in analysis of the policy would have occurred if at least the systems lens and one of the feminist theory lens or the critical social theory lens were not used. Overall, the use of the three lenses appeared to be helpful in the development of deeply thought out or critical analysis of policy.

10.4 INTERVIEW ANALYSES AND THE FOUR APPROACHES

(the three lenses and no particular lens)

The objectives of the second component of the research were:

1. through the medium of photography and grounded theory analyses of study participant interviews, to better understand the access to health for North End Halifax community members; and

2. to determine if the use of the three lenses as a component of the grounded theory analyses would provide a greater depth of understanding of issues related to access to health for North End Halifax community members.

Questions addressed through the study:

a. Can the medium of photography help to elucidate community assets for building better health?

b. Can the viewpoints of community members be leveraged to illustrate a new pathway for community health that can be communicated to policy and decision makers?

c. Can viewing the data obtained from the photo-elicitation/ interviews through the trifocal lenses of feminist, critical social and systems theory change and/ or broaden the understanding obtained without the use of such lenses?

The discussion that follows attempts to show how the four approaches expanded my thinking about the interviews.

I was extremely fortunate and challenged by the richness of the interview conversations. It was the richness of those interviews that made it very difficult to determine a manageable number of codes, particularly as the exercise was repeated four times for each interview; once using the traditional approach and then with each of the lenses. Each interview was analysed sequentially with no lens, the feminist theory lens, the critical social theory lens and the systems theory lens. However, these analyses were separated over time and by other interview analyses to decrease continuance of thoughts from analysis through one lens to the next. I have outlined here the common elements, differences and combined effectiveness of the four approaches.

10.4.1 Common Elements

There was no real duplication of major themes that emerged from the interview data using the four approaches; that is none of the theme groupings were precisely overlapping. Whereas some of the components of themes were similar, the overall viewpoint differed. For example, the concept of *shifting paradigms* was immersed in the

themes of **shifting political emphasis** (critical social theory lens), **shifting the paradigm of helping** (feminist theory lens), **reconceptualising health care** (feminist theory lens) and **shifting thinking** (systems lens). Shifting paradigms was implicit in almost all of the themes and associated codes.

Attention to the *determinants of health* was common to all approaches, although under differing themes. Indeed, attention to the determinants of health was threaded throughout the themes and codes. With using no particular lens, the determinants of health were a key component of **seeking a foundation of security for all** and individual determinants of health were highlighted in **promulgating housing as a key to health** and in <u>calling for food security</u>. Using a feminist lens, the determinants of health were a major component of **reconceptualising health care** and individual determinants were stressed in **ensuring food security** and <u>making homes available</u>. For the critical social theory lens, the determinants of health appeared under <u>towards the determinants of health</u>, and individual determinants are found under <u>housing security</u>, <u>food security</u>, <u>attending to early childhood</u> and <u>towards alleviating poverty</u>. Under the systems theory lens, reference was found in <u>incorporating the determinants of health</u> and <u>developing a seamless health-illness care system</u>.

The concept of *addressing racism and classism* was a factor using all four approaches, albeit expressed in different ways. With varying degrees of emphasis, all four ways of analysis noted the benefits of asset-based community development, the value of citizens and citizenship, the abrogation of responsibility by governments and building an environment supportive of health.

Building on community assets was a theme that emerged when using no particular lens (<u>creating a new future on community strengths</u>) and a code with the feminist theory lens (<u>building on community assets</u>), a code (<u>building on previous successes</u>) with the critical social theory lens, and in the discussion of **weaving pathways** using the systems theory lens.

The presence of inequities and the imperative to examine more deeply root causes was scattered throughout the discussion using the four approaches. Gardens, gardening and the aesthetics of the community as well as an underlying respect for the community were interlaced in the conversation coding no matter the lens used. And limited access to health and to illness care, albeit rarely explicitly mentioned, was implicit in the interviews and identified with all four approaches.

Becoming *citizens* and engaging in *citizenship* was a component in each of the approaches, as were gentrification and mixed housing. All approaches stressed housing, food, education and employment security, albeit not always in themes or code headings. All highlighted the predominance of White, middle class influence on norms and standards; all noted the abdication of responsibility by governments and the importance of basic rights.

10.4.2 Differences

The differences in analysis results with each lens were largely in the degree to which they emphasized specific elements. When using *no particular lens* for the analyses of the interviews, I was struck by how many divisions and separations we as society have created. I was humbled by the many ways, as a member of a dominant population, we have irresponsibly distanced ourselves from others; how we have wittingly and unwittingly acted to eventually lead to the health inequities that are clearly illustrated within the populations of North End Halifax. I perceived housing as a metaphor for separations of populations. I felt that knowing and understanding more about another could bridge differences and permit seeking common goals. *Othering* was my predominant perception while reading the interviews; othering with the hope of future *togethering*. Two components not coded using the other lenses were using boundary objects and image making. The other difference I noticed between the analysis without a specific lens and with the three theory lenses was in the guidance the lenses provided.

The *feminist lens*, for me, accentuated the concept of caring and relationships; of families and nurturing in a way the other lenses did not. I saw more clearly the benefits of health approaches of other cultures and of a community worldview rather than an individual, autonomous one. The need to problematize the White, middle class male influence on the daily life of all of us more easily emerged from the data when viewed through a feminist theory lens. Similarly, the need to shift how helping is perceived, and enacted, became obvious. And interwoven throughout the analysis were the particular challenges of women and how women are valued.

With the *critical social theory lens*, power and disparity in power were the predominant foci. The lens highlighted the community disparities and the need for inclusive thinking and planning. The view through a critical social theory lens crystallized the thought, for me, that the way forward to better access to health for North Enders entailed reframing for the dominant populations that the quest was one that would benefit us all. "(F)rom each according to his *(sic)* ability, to each according to his *(sic)* needs." (Filho, 2008; p. 95).

The *systems theory lens* inevitably stressed systems and the need to examine root causes. It emphasized the systemic and pervasive effects of inequalities and inequities. It underscored the many inter-relationships and mutual dependencies we have as members of communities. It brought attention not only to the disconnectedness of the illness-care system, a significant enough concern, but also the total lack of consideration of addressing the interdependencies with other sectors affecting the determinants of health.

The differences among the four approaches were largely in emphasis and the nuances of the thinking and discussion generated. For some aspects, the four approaches were complementary and potentially nested one within another as illustrated in the following diagram.

360

Figure 7   Food Security
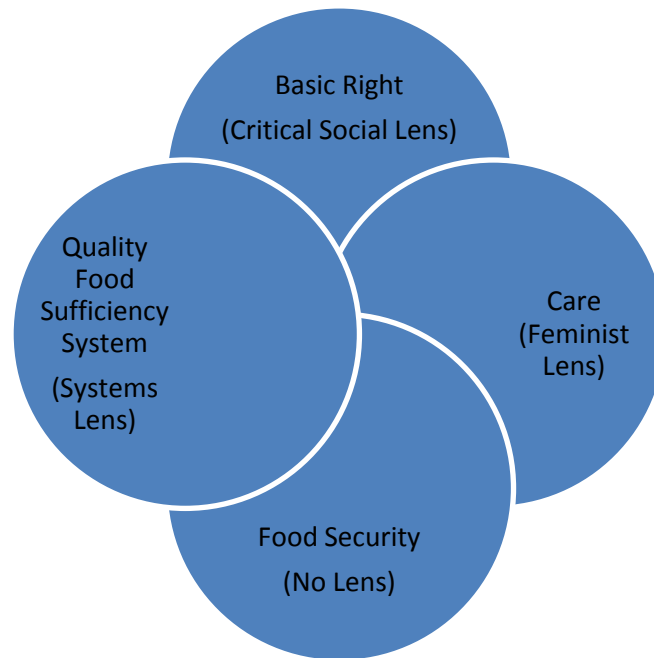
Likely due to the grounded theory methodology itself, there were no glaring gaps between approaches; again, there were definite differences in emphasis. I detected few conflicts generated by the use of the three lenses; rather they differed in degrees of emphasis on particular components. There were potential conflicts between care and justice, care and helping. Yet as suggested in the analyses, these potential conflicts can be resolved by balancing the ethic of care with an ethic of justice, and beneficial helping achieved with a social justice approach rather than a charitable approach.

As I developed the questions for each lens, their purpose was only to determine if the use of a particular lens would provide an added degree of discipline to aid in the analysis of data using grounded theory methodology. For me, it helped to see things I might not otherwise have seen. Because the study interviews themselves naturally induced thoughts of feminism, social justice and systems, the impact of the lenses may be less than for the policy analyses where these concepts are more unnatural.

10.5   GROUNDED THEORY AND THE USE OF THE THREE LENSES

For my grounded theory methodology, I attempted to follow the classic approach of Glaser, 1978, as clarified by Glaser and Holton, 2004 (see Chapter 5). Glaser stressed

approaching data analyses without preconceived ideas and minimalist literature review prior to the theory generation that emerges from the data. As noted in Chapter 5, one criticism of grounded theory is the difficulty of examining social interactions or other factors that impact on power relations. The use of the three lenses enabled examination from a feminist, critical social and systems viewpoint. The lenses as used did not force data into categories, rather they raised questions about the data. Glaser (1978, 2004) suggested the following set of questions for successful open coding.

> *"What is this data a study of?"*
> *"What category does this incident indicate?"*
> *"What is actually happening in the data?"*
> *"What is the main concern being faced by the participants?"*
> *"What accounts for the continual resolving of this concern?"*

For this thesis analyses, these questions were supplemented with the questions related to each of the theory lenses; thus the approach seemed to be in keeping, and not in conflict, with the methodology as designated by Glaser. In **Table 6**, I have presented a representative sample of coding of the same interview segment using no particular lens, feminist theory lens, critical social theory lens and systems theory lens. I choose this particular interview segment because I enjoyed the story told within it.

Table 7   Comparison of Coding

No specific lens	Code	Concept
I have a great St. Georges story. I really love St. Georges church. It's a beautiful church…I got a call from a young man who was about to enter the priesthood from the Anglican church. He had been involved with Youthnet, which is their after school program for kids and I have been a supporter of that program for a long time. So, he called me and he asked me if I would consider coming to a church service they did four or five days before Christmas. They do a candlelight service – Advent service – with readings and beautiful music. And he asked me if I would come and do a reading and I said yes, I would. And he told me they were going to invite two other non-parishioners to do a reading. So we had rehearsal for this and I met the other two people and one of the other two people was a 13 year old African Nova Scotian boy in their after school program. And he was doing a reading and the night of the service we were all there together at the front of the church and we did our readings and it was beautiful. The lights were low and there were lots of candles and the choir moved around. There was a harpist. It was very beautiful. Anyway, at one point during the service the little guy leaned over and he said to me, "man, is this ever weird." So I said to him, "what's weird?" And he said, "no one's clapping for the choir." And so I said to him, "this is an Anglican church and it's not quite the same, they don't necessarily clap for the choir." And he said, "well I think they should clap for the choir." So Reverend Thorne who was the priest there at the time sent me an email afterwards thanking me for coming and he said if you have suggestions let me know. So I wrote him back and I said I really enjoyed it and thank you for asking me but next year I think there should be clapping for the choir.	Beauty in neighbourhood Positive outcome of Youthnet Belief in program Citizenship Diversity Joy Communication Differences Customs Beliefs Connecting	Community strengths Community strengths Community strengths Seeing North Enders as citizens Exposing divisions Community strengths Communicating to understand Exposing divisions Removing separations

363

Feminist theory lens	Code	Concept
I have a great St. Georges story. I really love St. Georges church. It's a beautiful church…I got a call from a young man who was about to enter the priesthood from the Anglican church. He had been involved with Youthnet, which is their after school program for kids and I have been a supporter of that program for a long time. So, he called me and he asked me if I would consider coming to a church service they did four or five days before Christmas. They do a candlelight service – Advent service – with readings and beautiful music. And he asked me if I would come and do a reading and I said yes, I would. And he told me they were going to invite two other non-parishioners to do a reading. So we had rehearsal for this and I met the other two people and one of the other two people was a 13 year old African Nova Scotian boy in their after school program. And he was doing a reading and the night of the service we were all there together at the front of the church and we did our readings and it was beautiful. The lights were low and there were lots of candles and the choir moved around. There was a harpist. It was very beautiful. Anyway, at one point during the service the little guy leaned over and he said to me, "man, is this ever weird." So I said to him, "what's weird?" And he said, "no one's clapping for the choir." And so I said to him, "this is an Anglican church and it's not quite the same, they don't necessarily clap for the choir." And he said, "well I think they should clap for the choir." So Reverend Thorne who was the priest there at the time sent me an email afterwards thanking me for coming and he said if you have suggestions let me know. So I wrote him back and I said I really enjoyed it and thank you for asking me but next year I think there should be clapping for the choir.	Nurturance through beauty Youth support Reaching out Identified as different (ethnicity) Youth to adult linking Understanding another Valuing perspective of youth	Building on community assets Investing in childhood development Accepting others as peers Addressing inequities Forming relationships Understanding the everyday world Valuing the intrinsic worth of all

Critical social theory	Code	Concept
I have a great St. Georges story. I really love St. Georges church. It's a beautiful church…I got a call from a young man who was about to enter the priesthood from the Anglican church. He had been involved with Youthnet, which is their after school program for kids and I have been a supporter of that program for a long time. So, he called me and he asked me if I would consider coming to a church service they did four or five days before Christmas. They do a candlelight service – Advent service – with readings and beautiful music. And he asked me if I would come and do a reading and I said yes, I would. And he told me they were going to invite two other non-parishioners to do a reading. So we had rehearsal for this and I met the other two people and one of the other two people was a 13 year old African Nova Scotian boy in their after school program. And he was doing a reading and the night of the service we were all there together at the front of the church and we did our readings and it was beautiful. The lights were low and there were lots of candles and the choir moved around. There was a harpist. It was very beautiful. Anyway, at one point during the service the little guy leaned over and he said to me, "man, is this ever weird." So I said to him, "what's weird?" And he said, "no one's clapping for the choir." And so I said to him, "this is an Anglican church and it's not quite the same, they don't necessarily clap for the choir." And he said, "well I think they should clap for the choir." So Reverend Thorne who was the priest there at the time sent me an email afterwards thanking me for coming and he said if you have suggestions let me know. So I wrote him back and I said I really enjoyed it and thank you for asking me but next year I think there should be clapping for the choir.	Community support Christianity Ecumenical bridging within Christianity Different (Anglos not identified by race) Celebration WASP norms Other norms Equalizing of power differentials	Grounding activities in the community Walking the talk of diversity & inclusion Mitigating power differentials

Systems theory lens	Code	Concept
I have a great St. Georges story. I really love St. Georges church. It's a beautiful church…I got a call from a young man who was about to enter the priesthood from the Anglican church. He had been involved with Youthnet, which is their after school program for kids and I have been a supporter of that program for a long time. So, he called me and he asked me if I would consider coming to a church service they did four or five days before Christmas. They do a candlelight service – Advent service – with readings and beautiful music. And he asked me if I would come and do a reading and I said yes, I would. And he told me they were going to invite two other non-parishioners to do a reading. So we had rehearsal for this and I met the other two people and one of the other two people was a 13 year old African Nova Scotian boy in their after school program. And he was doing a reading and the night of the service we were all there together at the front of the church and we did our readings and it was beautiful. The lights were low and there were lots of candles and the choir moved around. There was a harpist. It was very beautiful. Anyway, at one point during the service the little guy leaned over and he said to me, "man, is this ever weird." So I said to him, "what's weird?" And he said, "no one's clapping for the choir." And so I said to him, "this is an Anglican church and it's not quite the same, they don't necessarily clap for the choir." And he said, "well I think they should clap for the choir." So Reverend Thorne who was the priest there at the time sent me an email afterwards thanking me for coming and he said if you have suggestions let me know. So I wrote him back and I said I really enjoyed it and thank you for asking me but next year I think there should be clapping for the choir.	Appreciation Systemic physical, spiritual beauty Community focus Celebration Child/ youth supports Ecumenical Connections through beauty/ spirituality Systemic norms Acknowledging others Building on opportunities	Becoming community citizens Seamless child and youth development system Reaching out to meet Removing barriers Shifting thinking Addressing 'isms' Removing barriers Planning together

Both Glaser and Strauss have presented coding category guides. Glaser, 1978, listed eighteen theoretical coding families of which the most commonly used is the six "Cs" (causes, contingencies, contexts, covariances, consequences and conditions).

In order to use them, they must emerge and patience and trust in the constant comparative coding process will allow this. Eighteen coding families is not the limit. Studying them will spawn others. The analyst should study them to increase his *(sic)* sensitivity toward their emergence. Glaser, 1992; p. 46)

Neither the lenses nor their associated questions were specifically used as coding families (nor were any of Glaser's eighteen coding families).

In my review of pertinent literature for writing this thesis report, I found an article by Kushner and Morrow, 2003. These authors discussed a critical feminist grounded theory methodology, an approach that combined feminist and critical theories (proving there is little new under the sun). They stated that theoretical triangulation of grounded theory, feminist theory and critical theory would encourage internal dialogue within the research approach to bring out the best and compensate for limitations of each perspective. They proposed

> a constant grounding process at the level of data gathering and analysis, coupled with internal check (constant comparisons in the terminology of grounded theory) on theoretical arguments based on back and forth movement between questions posed within both feminist and critical theories. (p. 38).

Through email correspondence with one of the authors (Kushner, 2010), it is apparent that their approach was less structured and more based on their own natural way of thinking. I believe that the concept of using specific lenses that focus on the values and beliefs and/ or concerns of the research question does not transgress the grounded theory methodology of Glaser. Rather, I believe the lenses can be an enhancement to the methodology. To avoid criticism of the use of the lenses limiting or constraining emergence of concepts from the data, the initial analysis could use the traditional methodology (no conscious lens).

With respect to the validity of the four basic social processes/ concepts that resulted from the grounded theory analyses, Glaser, 1978, specified that theories developed through grounded theory should have fit, relevance, workability and modifiability. I believe the concept maps help to anchor the concepts and basic social processes developed from the analyses. By weaving back and forth through the interview data, the codes and categories,

and the basic social processes, I found that they were congruent, thus satisfying the criterion of *fit*. I feel the basic social processes that emerged have *relevance* to achieving access to health for members of the North End Halifax community; that they have resonance, and are reflective of the community-past and present and potentially future. Their *workability* can only be assessed in the future if the concepts are adopted by the community. For community development to be truly effective, I think concepts should be developed more directly by community members. I perceive that the concepts are eminently suited to *modifiability*.

CHAPTER 11   CONCLUSIONS

It was both reassuring and disappointing for me to find that much of the information gleaned from the interview data could be substantiated by others in published literature…reassuring as a means to validate the results and disappointing as many of the findings were already known. I was amazed by the many similar threads that ran through the policy and interview analyses; the published literature readings reinforced these threads; all were intricately interlaced, rarely conflicting and often strengthening and integrating the concepts that emerged.

11.1   CONNECTING THE CONCEPT MAPS

The first point of integration I explored was the potential to connect all four of the concept maps from the interview analyses (using no particular lens, feminist theory lens, critical social theory lens and systems lens). I had been struggling with finding single words to capture the most important aspect of each basic social process that resulted from the four approaches. My initial construct from *ethic of care* was *family*; for *from othering to togethering* was *relationships*; for *enriching the community to enrich us all* was *extending connections*; and for *striving for a community-wide system of health* was *moving to the goal*. However, I was uneasy as it didn't quite encapsulate the concepts and definitely didn't lead to something short and snappy as an overall basic social process. After re-reading the article by Mathie and Cunningham, 2003, it became apparent that the overarching basic social process for which I was seeking the words to express could be best articulated as *from bonding to bridging to linking to mobilizing to achieve equitable access to health*.

> Woolcott and Narayan differentiate between *bonding* and *bridging* social capital. In this categorization, bonding social capital enables people to 'get by'; bridging social capital enables people to 'get ahead'…Bonding social capital is evident in the close-knit relations of friends and families who can be depended on for basic survival in times of stress…Bridging social capital provides leverage in relationships beyond the confines of one's own affinity group, or even beyond the local community. (Mathie, Cunningham, 2003; p. 479)

Further reading on social capital uncovered the third component of *linking* (Szreter, Woolcock, 2004) and, finally, the last component of *mobilizing* (Seifer, Sgambellurt, 2008).

Figure 8   Overall Concept Map

The four basic social processes from the analyses using no specific lens, the feminist theory lens, the critical social theory lens and the systems theory lens complemented and expanded depth of thinking and the strength of the resulting theory. Combining the four conceptual maps adds an additional layer of thinking which can be applied to seeking pathways towards health.

From othering to togethering is one way to facilitate moving from bonding (which usually occurs within groups of like people) to bridging and linking relationships together as a new group with common interests and community focus. MacNaughton and Davis, 2001, suggested that in teaching young Anglo-Australian children about indigenous Australians, avoiding grouping or homogenizing people into a collective them, decreasing the use of binary categories, and circumventing positioning people as different from the dominant population helped to see individuals and the potential for different groupings based on other (togethering) characteristics. Shifting *from othering to togethering* can provide a collective momentum to mobilize community action.

Adopting an ethic of care with its emphasis on healthy relationship building is another way of enabling progression from bonding to mobilizing. Through embracing the determinants of health as boundaries for a health *care* system, an ethic of care as described in this thesis (with the incorporation of social justice) and the interview

analyses highlighting the requirement to problematize the dominant population can serve as guides for the journey to community mobilization.

Enriching the community to enrich us all can serve as a powerful reframing to engage those who are well off (in terms of finances, health, spirituality, skills, knowledge etc) to utilize those advantages to augment bridging and linking. With rights, privileges and advantage come responsibilities that are largely unacknowledged and untapped. The evidence of mutual benefit of improvements for all can provide impetus to exert power to the gain of the whole community. As a concrete example, moving services closer to the people affected can make it more feasible for other community services to become available: community occupational therapy resources can be built on to enable other home care services. It includes gaining the understanding that the norms and standards of the dominant population should not be the norms and standards that automatically (unthinkingly) dictate the norms and standards used to build the community future and improve community access to health.

Striving for a community-wide system for health can help to delineate equitable access to health and the linkages required to achieve a system for health that ensures equitable access to health. It underlines the need for a systemic approach; an approach based on simple rules that are meaningful for all community members. It reinforces the mandate for interconnectedness of all individuals and all efforts aligned to mobilize for community action. It stresses planning together.

Two contextual undercurrents of the discovered basic social process *from bonding to bridging to linking to mobilizing to achieve equitable access to health* are the obligation to ameliorate the inequitable effects created by the determinants of health and the potential for health policy to contribute to that amelioration. The significance (positive or negative) of the determinants of health on individual or population health is affected by public policy (Raphael, 2006). However to date, much of that public policy is directed towards individual focused public health strategies. As stated by Bambra et al, 2005, "both the masking of the political nature of health, and the forms of the social structures

371

and processes that create, maintain and undermine health, are determined by the individuals and groups that wield the greatest political power.". As outlined by Frankish et al, 2007, the development of policy to affect change in poverty or the built environment, for example, will require both vertical and horizontal cross-sectoral collaboration. This effort will be inevitably ethical and moral dilemmas.

The ethics of and accountability for population health or health of communities is woven throughout the basic social processes identified. Community health shares similarities with and differences from public health. Public health functions have been defined as "health protection, health surveillance, disease and injury prevention, population health assessment and health promotion." (Kenny et al, 2006). Community or population health is concerned with all aspects of health from health promotion through to disease management to terminal care as viewed from a community rather than individual stance. Ethical decision-making to achieve equitable access to health for the North End Halifax community would seem to potentially share principles with public health ethics and with health policy ethics. Both privilege the health of groups over individuals; policies are one means through which community change can be accomplished. Kenny and Giacomini, 2005, suggested the development of a framework for health policy ethics distinct from that of bioethics and research ethics. In their discussion, they mention the *ethic of care* as "rooted in concepts of duty and responsibility for others", a duty "expanding from personal and intimate issues to public and political issues" (p. 253), as has been interpreted in this thesis. They raise the issue of normative ethics and question on whose judgments they should be built. With respect to the substantive ethical aspects (criteria for decision-making and action) of health policy, they noted that policy "is intrinsically collective and social." (p. 254). Substantive ethics traditionally have been divided into distributive justice and social justice, both of which are concerns for North End Halifax.

In addition, they mention the inevitable presence of conflicts of interest. As can be surmised from the Health Centre Conflict of Interest policy analysis (Chapter 4), the lens through which the policies are viewed would create significant differences in how these conflicts of interest are addressed. With respect to procedural ethics, they stated the focus

is usually on "principles such as *fairness, inclusion, participation and transparency*" (p. 256; italics as in original), all pertinent for improving access to health. Baylis et al, 2008, proposed a framework based on a relational account of public health ethics, a framework that appears to be quite relevant to improving access to health for communities. Components of this framework include relational autonomy (an individual's autonomy is considered within a relational milieu or social environmental context and accounts for differential effects of decisions), social justice (with "particular attention…paid to identifying and unravelling complex webs of privilege and disadvantage" [p. 8]), and relational solidarity, particularly important to garner the collective strengths of the community (based on "a shared interest in survival, safety and security" without a divide between us and them [p. 10]). As identified in *Enriching the community to enrich us all*, all individuals are socially and community-based, thus inextricably interlinked. Reframing *mobilizing to equitable access to health for all* as a community responsibility is compatible with their proposed ethical framework.

A third contextual element is the potentially available social capital within and related to North End Halifax. Social capital (implicated in bonding and bridging) has become an important concept within Canadian (and other) governmental systems. The Policy Research Institute of Canada has developed a social capital framework as a starting point for the development of indicators and the measurement of social capital (Franke, 2005). This framework does not completely capture more recent thinking about social capital but does indicate the interest of the federal government. There is considerable debate about whether social capital can be conceived as capital in the same way as physical, human or economic/ financial capital. However, for the purposes of this thesis, the concept of social capital as a resource or building block for community development and community access to health is helpful. It has parallels with cultural, knowledge and information capital. The definition of social capital is not yet standardized, however most concepts of social capital agree that social relationships (individual people or groups/ communities) enable access to resources (Derose, 2009).

However, social capital may have negative aspects such as strong bonding ties leading to exclusion, unreasonable claims among those with tightly linked relationships, requirements to conform to group norms and other pressures that prevent individuals from benefiting from bridging or linking relationships. Strong bonding ties can potentiate othering (Derose, 2009). Yet bonding ties (usually within families and close friends) can provide needed support. Bridging ties (horizontal ties, usually weaker and among peers or peer groups) and linking ties (vertical ties, between individuals or groups at differing hierarchical positions)(Ferlander, 2007) are required to accomplish the goal of equitable access to health. These ties are more likely to foster togethering. Within the context of North End Halifax, it is important to point out that there are valuable and necessary resources embedded in all members and groups of the community; resources that are vital to achieving the quest of access to health. Much of the literature to date has been focused on a White, middle class concept of resources.

Figure 9 Integrated Conceptual Map - Thesis Theory Related to Access to Health
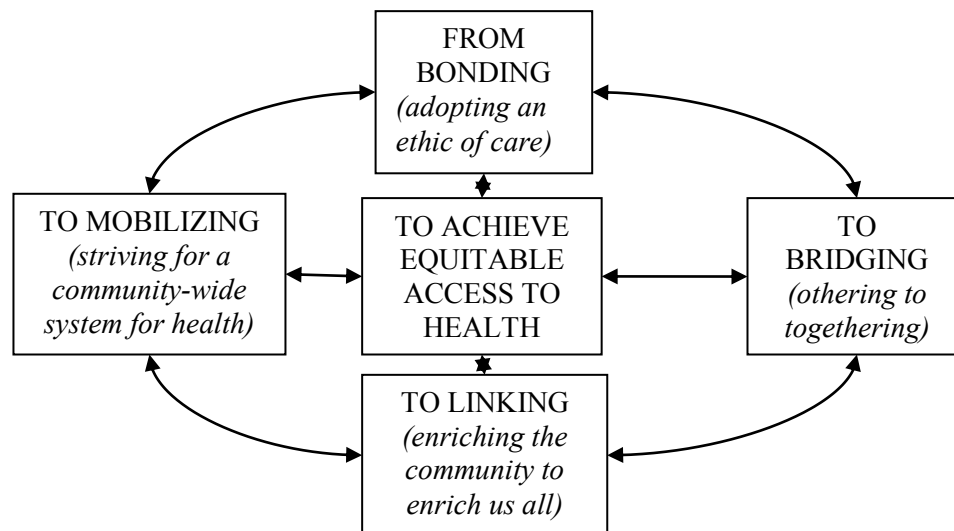
Within the theory illustrated in **Figure 9**, the basic social processes derived from the four grounded theory approaches form a foundation and the underpinning for the overarching theory FROM BONDING TO BRIDGING TO LINKING TO MOBILIZING TO ACHIEVE EQUITABLE ACCESS TO HEALTH. The four foundational basic social processes are not equivalent to the illustrated component of the overarching basic social

process with which they are paired, but rather an indicator of influences that can provide guidance for implementation. This framework, along with specific lenses tailored to the values of the North End Halifax community can be used to develop policy *to achieve equitable access to health*.

11.2 Pathways to the Future

There were many concepts scattered throughout this thesis write-up. I explored below how they can be tied in with the information obtained through the community members' interviews. These concepts are examined in alphabetical order.

11.2.1 Access

Accessibility has been identified as having two components - socio-organizational (for example, gender of the health provider, specialization) and geographical (for example, time and physical distance). Barriers to access include financial, physical, attitudinal, values/beliefs, cultural, transportation, geographical, and availability - all mentioned by study participants as challenges faced. Starfield, 2001, developed the model for access to health care as illustrated below. Although genetic and biologic characteristics were not identified by study participants, the remaining elements of the model are compatible with their thoughts. It could serve as a framework for future planning. This model also stresses the importance of policy, an importance that is discussed further below.
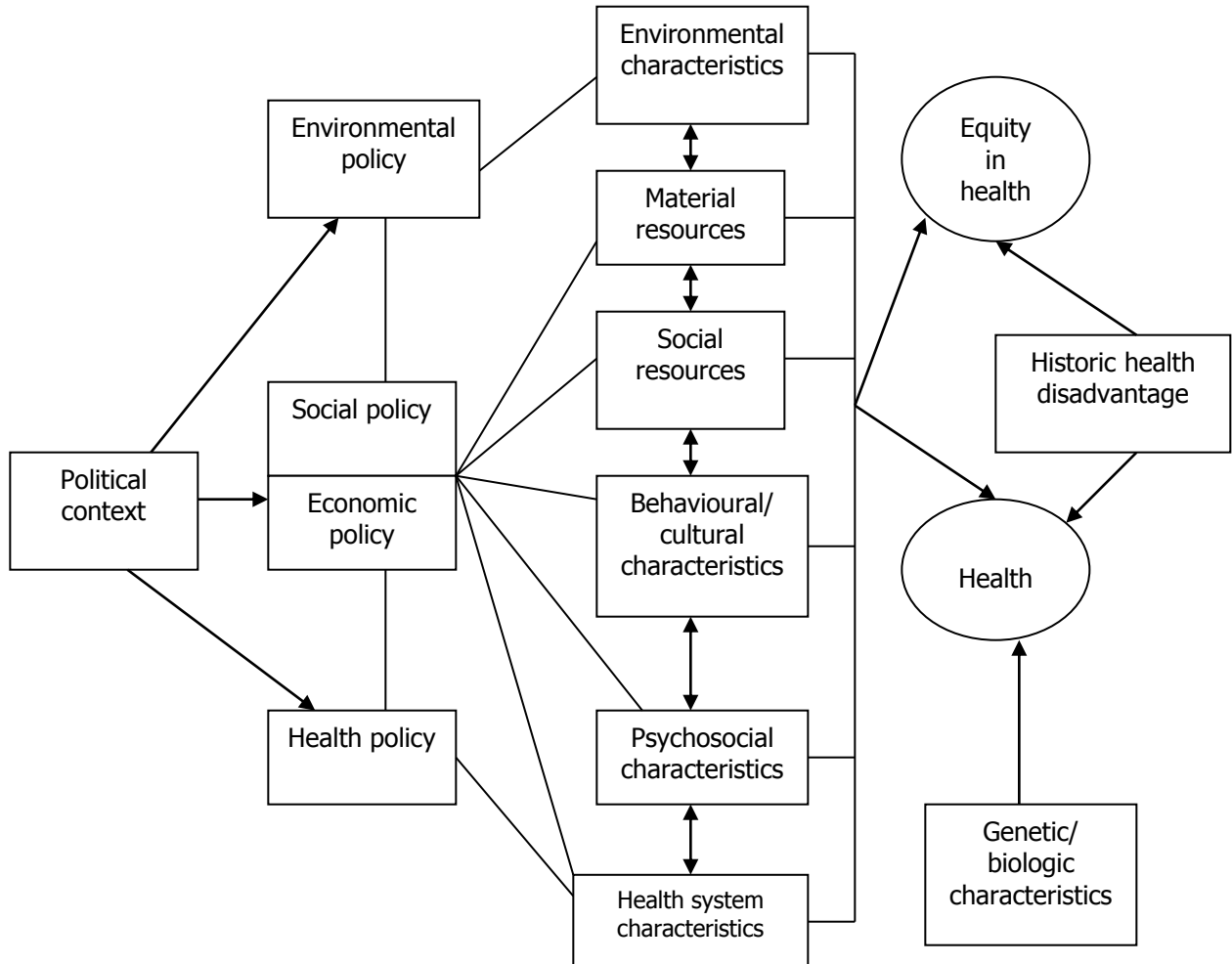

(photograph by author)

Many study participants identified the community garden as an important example of increasing access to health.

Figure 10   Access to Health

11.2.2 <u>Accountability</u>

Governmental accountability was an issue for study participants. Analyses of the interviews pointed out the need for all of us to increase our accountability as citizens and for the dominant population(s), specifically, to reconsider their balance of privilege and accountability. Although study participants placed blame on governments, accountability differs significantly from blame. Emanuel and Emanuel, 1996, delineate three models of accountability in health care - professional, economic and political. They proposed that the spectrum of physician (and other health professional) accountability encompasses

accountabilities to patients, governments, payers, employers, hospitals, professional associations and courts. I suggest that professional, economic and political accountability need to be supplemented with citizen accountability. Kenny, 2006, noted that for appropriate accountability, relationships must be established, mutually determined responsibilities and authorities, answerability for performance and applicable sanctions. Within the context of access to health for North End Halifax community members, these principles can provide a useful guide for equitable accountability by all players.

One thing that inspired me to continue on with this thesis work was a CBC radio interview with Mr. Irving Carvery, a man known for his optimistic outlook, where he lamented that much of the media reporting on North End Halifax concentrated on the negative whereas he felt there were many positives about the area that should be emphasized and could be built on. That viewpoint fits well with two concepts mentioned earlier: appreciative inquiry and asset-based community development.

11.2.3 Appreciative Inquiry

Appreciative inquiry is closely linked to asset-based community development. Appreciative inquiry is based on eight principles (Preskill, Boyle, 2008). These principles fit comfortably with the three theory lenses used for analyses. They include reality is socially constructed, inquiry and change can occur concurrently, stories are powerful, positive intentions breed positive intentions, positive relationships facilitate positive effects, acting for the whole brings the best out in people, to make change we must be the change we wish to see, and people perform best with freedom to choose how and when they contribute. Appreciative inquiry builds on the philosophy that what is paid attention to is what will grow; paying attention to the positive leads to more positive outcomes. This approach seems beneficial for North End Halifax community development.

11.2.4 Asset-based Community Development

Asset-based community development (ABCD) is an approach developed by Kretzmann and McKnight, 1993, to counter the conventional needs-based approach, an approach that denigrates community members by accentuating their deficiencies. Community members

come to assimilate the belief in their incapabilities and look to others, usually outsiders for help and solutions. Through the use of an ABCD framework, belief in the community and its members, and their varied capabilities and intimate knowledge of the community, is used to plan a better future. However, this is not an easy route to follow for there are many individuals and organizations that benefit from the way things are now and from planning approaches that pay only token attention to community members. As Mathie and Cunningham, 2003, have summarized (p. 477):

> ABCD can be understood as *an approach*, as a *set of methods* for community mobilisation, and as a *strategy* for community-based development. As an approach to community-based development, ABCD rests on the principle that a recognition of strengths and assets is more likely to inspire positive action for change in a community than is an exclusive focus on the needs and problems. At its core are associations of community members, both formal and informal. As engines of community action, and as a source of power and leaderships, those associations are considered assets of the community...accompanying this approach is a set of methods that have been used to mobilise community members around a common vision or plan. While there is no blueprint, these methods could typically include:
> - collecting stories of community successes and analysing the reasons for success;
> - mapping of community assets;
> - forming a core steering group;
> - building relationships among local assets for mutually beneficial problem solving within the community;
> - convening a representative planning group;
> - leveraging activities, resources, and investments from outside the community.
>
> Finally, ABCD is a strategy for sustainable community-driven development.

A significant component of asset-based community development is an asset map and asset mapping is particularly valuable for North End Halifax as it "celebrates differences rather than homogeneity" (Canadian Rural Partnership Asset Mapping: a handbook; p. 5; www.rural.gc.ca). A neighbourhood asset map defines primary building blocks (cultural organizations, individual businesses, religious organizations, citizens organizations, home-based enterprise, gifts of labelled people, individual capacities, associations of businesses and personal income); secondary building blocks (assets within the community but largely controlled by outsiders; higher education institutions, hospitals/ clinics, public schools, libraries, fire departments, parks, police, vacant buildings and land, social service agencies, energy/waste resources) and potential building blocks

(resources outside the neighbourhood and controlled by others; public information, capital improvement expenditures, welfare expenditures); all of which were identified by study participants.

North End Halifax, as can be gleaned from the conversations sprinkled throughout this thesis, has many assets on which to build. As noted by Mathie and Cunningham, 2003, there are challenges to undertaking ABCD. These include ensuring it is a community-driven process, enabling inclusive participation, finding and fostering local leadership, seeking a conducive environment and adjusting to the flow of developments. Although these challenges were also noted by study participants, they gave illustrations of successfully overcoming barriers. For example, within an illness care framework, the North End Community Health Clinic has been exemplary in their efforts to reach out to under-served populations, meeting them where they are comfortable; striving to enhance seamless interdisciplinary care; and forming relationships and partnerships that foster collaboration, enhancement of the resource pool and enabling understanding of diverse health needs.

11.2.5 <u>Boundary Objects</u>

Although not referred to as boundary objects, participants mentioned people and activities that functioned as boundary objects such as the North End Community Health Clinic and community gardens. Community gardens are a wonderful example where communication is enhanced through working together to grow produce and flowers; learning together about horticulture, entrepreneurship and healthy eating; exhibiting citizenship through community contributions; and celebrating success! As illustrated by the thesis interviews, photographs are an excellent boundary object. Policy designed by and for the community could serve as future boundary objects as could community linkers and boundary spanners.

11.2.6 <u>Change</u>

There were several models of change introduced throughout the thesis. Health care, access to health and the North End Halifax community can easily be conceived as

complex adaptive systems. McDaniel, 1997, proposed 12 leverage points for change strategy (see p. 41) within complex adaptive systems. Those which seem particularly applicable for change efforts to improve access to health for North Enders include giving up control (by the socio-economically privileged), creating new organizations with new forms, enhancing the quality of connections, teaching people what other people are doing, thinking about organizational design as an ongoing process, facilitating goal discovery by community members, decreasing emphasis on competition and increasing emphasis on cooperation, working smarter (systemically), and making provision for the emergence of visions and values.

To achieve true access to health for members of the North End Halifax community, second-order change (a paradigm shift in viewpoints) is required. Foster-Fishman et al, 2007, offer a systemic second-order change model (see p. 42). An initial step is to define the boundaries of the change required. To improve access to health for North End Halifax community members, the boundaries are complex and include the people living within a certain geographically defined area and should comprise a health system that is seamless and inclusive of the means to address the determinants of health. However, these boundaries must be defined by community members and stakeholders. Thus the boundaries include all levels of government, citizens, services, organizations and businesses to name but a few. The problem statement could be "how will we work together to develop an accessible health system to optimize the health of North End Halifax members?".

Some of the health system associated norms (attitudes, values and beliefs) have been identified through community member interviews, as have potential system resources. Instead of accepting all of the present policies and regulations, there is the opportunity to propose changes that would facilitate developing a health system; changes that would be cognizant of the norms of varied populations involved. Equitable, inclusive, transparent sharing of power and decision-making has been identified as important by study participants. The Foster-Fishman et al, 2007 model also stresses looking for root causes in system norms (particularly relevant for North End Halifax), system resources (which

potentially need to be re-directed towards population health rather than illness care), and system operations such as the need for community leadership. The health system interdependencies would be complex and embrace many usually segregated people, organizations, services and governmental departments. Further study would need to be done to understand the dampening and potentiating effects of these interdependencies, system regulation and feedback loops, and potential interaction delays. Further study is also required to identify effective levers for change.

Whereas the Foster-Fishman et al, 2007, model is largely focused on planning change, Kotter, 2007, developed an eight-step model for implementing change- create urgency, form a powerful coalition, create a vision for change, communicate the vision, remove obstacles, create short-term wins, build on the change and anchor the changes in (community) culture. Again, this approach appears to correspond with views of study participants.

Conceptualizing the system for access to health for members of the North End Halifax community as a complex adaptive system provides a useful framework.

11.2.7 <u>Complex adaptive systems</u> (see p. 39)

> A complex adaptive system (CAS) is a collection of individual agents that have the freedom to act in ways that are not always predictable and whose actions are interconnected such that one agent's actions changes the context for other agents (Plesk, 2000; p. 312-313).

A question for North End Halifax is 'will seeing a community-wide health system as a complex adaptive system help move from *bonding to bridging to linking to mobilizing*?'. Plesk's, 2000, key elements in designing a complex adaptive system suggest yes. These elements are:

- using biologic metaphors: for study participants, gardening was a metaphor and organic planning (building on the pathways created naturally by use of everyday folk)

- creating conditions for natural evolution: study participants spoke of the need for balance, for example, of gentrification, mixed housing and affordable housing.

Some of these changes have already evolved and cautious continued introduction, building on natural happenstances, seem to be acceptable to the community.

-providing simple rules and minimum specifications: this seems to me to be key so that the many community contributions can meld together to form the system desired by the community.

-setting forth a good enough vision: with innumerable players, obtaining agreement on a detailed vision would be challenging. The development of a vision in which each member can visualize her- or him-self would seem to be an appropriate approach.

-procuring a space for natural creativity to emerge from local actions within the system: this seems from study participant interviews to be a comfortable fit for the community.

An important aspect of systems is the negative entropy or tendency to involute. This suggests it is vital when working towards an improved community health system for North End Halifax that bridging and linking occur with others outside the community boundaries. Another characteristic of systems that fits well for North End Halifax is that systems are capable of equifinality (that is different ways to achieve the same ends) thus permitting people and groups to contribute in ways that are comfortable for them. Soft systems methodology suggests that the processes for improvement should be given away to the people in the situation (something for which community members are asking). It also implies that improvement actions should be based on finding accommodations or versions of the situation whereby those with conflicting interests can live with the solutions. Study participants spoke of self-organization and emergence, concepts that fit with complex adaptive systems. Both systems theory and complex adaptive systems theory stress the need to upset the equilibrium in order to make progress and/ or change. Complex adaptive systems benefit from decision-making at the level closest to those impacted, from chunking or building on manageable portions to create a coherent whole when these chunks are guided by simple rules. Chunks that are working within North End Halifax are, for example, the North End Community Health Clinic and the Black Business Initiative. Understanding more about why and how they are successful will help

other chunks to be constructed to build a healthy whole. These philosophies also fit with asset-based community development as a way to redress inequities in health.

11.2.8 Inequities in Health

The etiology of health care disparities is multi-factorial. As summarized by Fiscella, 2003, etiologies include patient/ user factors (practicalities such as job, child-minding, transportation; feelings such as distrust, fear, preference differences; language differences); physician factors (bias, racial discordance, training); health plan (health care components covered, location of services) and community/ societal factors (segregation, availability of safety net providers). Others have highlighted the contribution of neighborhood characteristics, age and attitudes towards health risk (Kirby et al, 2006). Almond, 2002, reviewed literature on inequities of health and culled these antecedents needed to move towards equity:

- ✓ recognition of prior conflict between competing needs;
- ✓ intolerance of avoidable inequalities in health;
- ✓ respect for the principle that everyone has a right to health;
- ✓ needs assessment criteria and framework;
- ✓ commitment to egalitarian principles;
- ✓ policies ensure that those who can benefit the most, receive services;
- ✓ staff training needs identified and met.

Although study participants did not mention staff training needs except obliquely when referring to treating others with respect, the remainder of the antecedents were identified. Almond, 2002, also enumerated the hoped for consequences or indicators of equity, but cautions there is no specific evidence in their support:

- ✓ empirical data would indicate that all receive a high standard of services, and that the services have been utilized by those who stand to benefit the most.
- ✓ narrower health differentials would develop between advantaged and disadvantaged people as all have access to services.
- ✓ epidemiological data would demonstrate that morbidity and mortality are lower amongst the disadvantaged (or the gap in the inequalities escalator is closing).
- ✓ health service staff and clients would be satisfied that all groups receive the same high standards of services.

These indicators may be helpful for evaluating any changes undertaken with respect to access to health.

11.2.9 <u>Leadership</u>

Both asset-based community development and complex adaptive system theory advise that the best leadership is achieved by placing control and power with those in the community who have the particular knowledge, skill and interest required for the task at hand. The pathway to the future must involve community leaders and leadership. Although there are many within the community that have taken leadership for various aspects of community improvement (and directly or indirectly, improvements in community health), study participants did not identify an obvious leader or leadership group. To accomplish the goal of community-wide health, leadership must focus on alignment of vision, goals, plans and tasks. As discussed under the analysis of the Board *General Governance Commitment* policy, leadership within a complex adaptive system (such as that needed for improved access to health) has three roles- administrative, adaptive and enabling (Uhl-Bien et al, 2007). Leadership within North End Halifax can be found in positions of organizational bureaucracy and throughout the community; there leaders who can create connective, dynamic, distributed interactions and relationships (Uhl-Bien et al, 2007). In this sense, leadership is not focused on an individual or individuals, but rather the collective, who through communally created goals, move as an amoeba towards a chemoattractant guided by simple rules. Leaders emerge adaptively as the need requires. Increased interconnectedness, interdependencies, exchange of ideas and information, collaborative solutions and beneficial tensions or challenges can be fostered through enabling leadership. Leadership can remove barriers to collaboration, interconnectedness and exchange of resources; it can discourage non-useful adaptations (those which do not further the mission and follow core values).

11.2.10 <u>Potential of Policy</u>

Each of the study participants advocated, directly or indirectly, for changed or new policies. As policies have the potential to determine how resources are distributed, they can be crafted to address the determinants of health.

The World Health Organization, 2000, conceived a national health policy framework that could be adapted for North End Halifax:

- policy should identify objectives and address major policy issues such as equitable distribution of resources;
- policy should designate the respective roles of the public and private sectors in financing and provision;
- there should be identified policy instruments and organizational arrangements in both the public and private sectors to meet system objectives;
- policy should set the agenda for capacity building and community development;
- policy should provide guidance for prioritizing expenditure, thus linking analysis of problems to decisions about resource allocation
- policy should facilitate overall fairness of the health system.

Study participants were particularly vocal with respect to governments (federal, provincial, municipal) and their failure to develop and implement policies to facilitate a more equitable and fair environment supportive of health for all. This failure is really our collective failure as citizens. As suggested by Townsend, 1994, governments could expand the scope of health policy to embrace the determinants of health; they could enable inter-sectoral collaboration and inter-departmental financing. Fairness is a criterion suggested by Daniels et al, 2000, for assessing policies. With respect to policies developed to address access to health for North End Halifax community members, fairness would incorporate the concepts of equitable outcomes in health, access to resources, efficiency and effectiveness in resource management and allocation, accountability and appropriate autonomy. Policy assessment must heed the values of those impacted (Norheim, 2002). Appropriate values for public or population policies include the common good, solidarity, accountability and social justice (Giacomini et al, 2008); values well suited to North End Halifax as conveyed by study participants. Such ethical approaches will facilitate the balance between autonomy/ individualism and community perspectives.

For North End Halifax, a community-wide systemic approach is critical (Lovato, et al, 2007; Lloyd et al, 2008). Equally important would be the incorporation of community-developed substantive ethics (for example reciprocity, sustainability, concern for the vulnerable, stewardship and balance of power) and procedural ethics (for example, inclusion, fairness, transparency, participation)(Kenny, Giacomini, 2005). One challenge for the development of policy related to access to health for North End

community members is the difficulty of democratic policy crafting. As illustrated by the Health Centre Board *General Governance Commitment* policy and the *Conflict of Interest* policy, in-depth scrutiny of policy, either during development or revision, is resource intense (to develop applicable background material) and complex. However, the use of multiple methods of engaging community members, balanced with rigorous research, could permit the development of policy that is community founded, values-based, and evidence-informed.

Community involvement in the formulation of policy will vary with the target of the policy (local/ community versus federal) as well as other characteristics of the policy. Health Canada's public involvement continuum spans receipt of information to providing information, to being part of dialogue, to engagement in the decision-making process to being a decision-maker and partner (Public Health Agency of Canada, 2007). In the development and implementation of policy designed to improve community health, community members must be active participants and partners wherever the opportunity arises.

The National Institute for Mental Health values-based capabilities (working in partnership, respecting diversity, practicing ethically, challenging inequities, promoting recovery, identifying people's strengths and needs, providing user-centered care, making a difference, promoting safety and positive risk taking, and personal development and learning)(Williams, Fulford, 2007) seem well suited for adaptation to North End Halifax related policies. The following framework, adapted from Williams and Fulford, 2007, provides guidance for such an approach (**Figure 11**).

Figure 11   Values-based and Evidence-based Policy
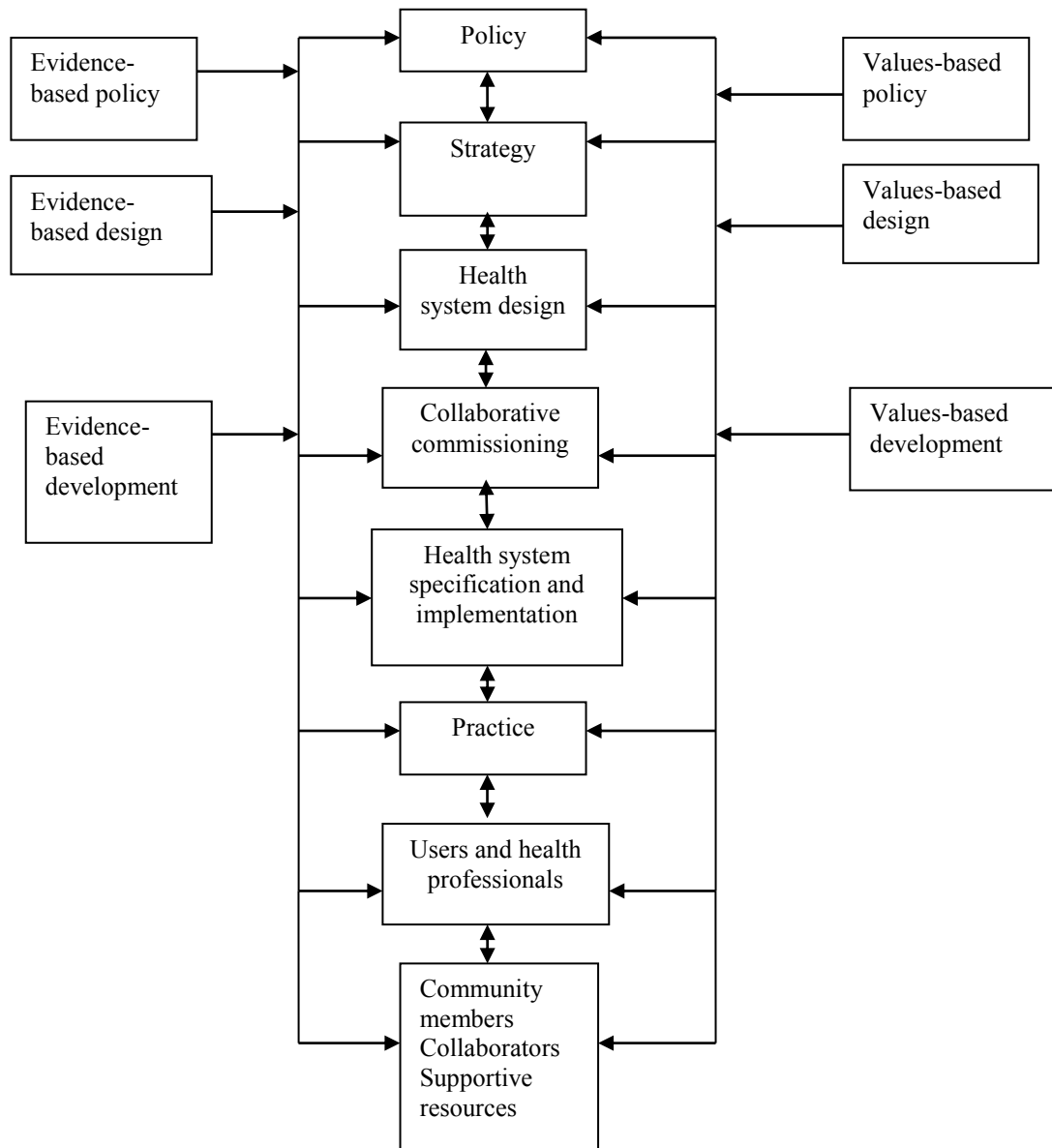
Within a community-wide approach to policy development, there must be alignment of policy, incentives, community control, participation and accountability with community capacity.

Daniels et al, 2000, developed benchmarks for assessing policies. The benchmarks were founded on the concept of fairness and equal opportunity theory.

> Fairness is a many-sided concept, broader than the concept of equity. Fairness includes equity in health outcomes, in access to all forms of care and in financing. Fairness also includes efficiency in management and allocation, since when

resources are constrained their inefficient use means that some needs will not be met that could have been. For the public to have influence over health care, fairness must also include accountability. Finally, fairness also includes appropriate forms of patient and provider autonomy. (Daniels et al, 2000, p. 740).

Fairness could also be conceived to include responsiveness of the health system (or organization) to the legitimate expectations of the populations served, where legitimate connotes needed, beneficial services (Murray, Frenk, 2000). Suggested benchmarks address intersectoral public health (for example, literacy as it relates to health), financial barriers to equitable access, non-financial barriers to access, comprehensiveness of benefits and tiering (no categorical exclusions), equitable financing, efficacy/ efficiency/ quality of health care, administrative efficiency, democratic accountability and empowerment (including fair grievance procedures) and patient and provider autonomy. Fairness and justice can be distributive, procedural, interpersonal or informational (Piccolo et al, 2008).

> In an increasingly technological healthcare environment, concerns about cost dictate that health services researchers take the cost of care into account. Costs expressed in dollar amounts further contribute to the quantification of healthcare concerns and the privileging of quantitative factors in healthcare decision-making. Where in these equations does one find the fundamental respect for human dignity that underpins (healthcare's) societal mission? One is reminded of Wilde's (1909) definition of the cynic as one who "knows the price of everything and the value of nothing.". (Cody, 2003; p 294).

To achieve equitable access to health, the definition of costs must be expanded to include all costs - personal, social, environmental.

11.3 EVALUATION AND KNOWLEDGE TRANSFER

A component of the knowledge transfer related to this research will be the presentation of North End Halifax photographs (taken by the researcher and the study participants) in a public forum. There will be a Café Scientifique forum for community participation. In addition, the Board Policy analyses will be shared with the IWK Board members and an adapted framework will be presented for incorporation into their policy development.

11.4 SUMMARY

Examination of the *Board Governance Commitment* policy through a feminist lens illuminated the middle-class biases of the policy, the emphasis on autonomy rather than community, the way that some voices were shut out and its failure to acknowledge inequities. Examination through a critical social theory lens showed that the policy did little to encourage facilitation of access to health for marginalized or under-served populations, that the power of the Health Centre was pre-eminent with little emphasis on sharing. With the systems theory lens, the lack of Board guidance in the clarification and shaping of overarching Health Centre values as well as the need for a new, nimble concept of leadership (such as adaptive leadership) became apparent. Although strategic planning may be seen as inhibiting to complex adaptive system functioning, there is no mention of planning within the policy. It was abundantly clear with the systems theory lens that self-organizing elements forming networks are much more likely to accomplish positive change that the independent parts cannot (Glouberman et al, 2003). The systems theory lens highlights the need for the Health Centre to situate itself within the larger health system.

For the *Conflict of Interest* policy, the overview identified the approach as focused on legalities and discipline rather than the less objective, nuanced aspects of conflicts of interest. Lack of consideration for the many day-to-day conflicts of interest experienced by front-line staff (the majority are women) was recognized through the feminist lens. The critical social theory lens emphasized the largely inherited, unearned privileges of the dominant population, the relatively narrowly defined conflicts encompassed within the policy, and the lack of incorporated values, ethics and principles. The systems lens highlighted the many interconnections and interdependencies that affect conflicts of interest.

With respect to increased understanding of the access to health for North Enders, the predominant themes were the impacts of the determinants of health (particularly food, housing, employment and education security), the wish for integration and not assimilation of the diverse populations of North End Halifax, the persistence of

discrimination, the requirement for active citizens and the present community capacities; the pervasive influence of White middle-class norms, standards, behaviours and attitudes on our daily lives was noted; and the oft unrecognized disadvantage this engenders for significant segments of our population. The grounded theory analysis without a particular lens strongly pointed out our human tendency for separateness, individuality and autonomy. The feminist lens stressed the need to reframe help and helping to better meet the needs of those requiring support, the necessity for officials to step back and allow community members prominence in leadership, the benefit of problematizing the world of the White middle-class, the requirement for relationship building and the need for greater accountability, particularly by governments. The critical social theory lens facilitated the recognition that reframing the quest, as one where the whole community and population profit from the benefit accrued to individuals and groups within that population, would likely increase acceptance and commitment to improvement. Through the systems theory lens, it was patently obvious that a systemic approach to access to health was required, including attention to root causes and the development of cohesive leadership to guide the endeavour.

As gleaned from study participants, they envision access to a health system that incorporates addressing the determinants of health, one that is respectful of all persons, that is seamless and that extends from health to death (see **Figure 12** below).

11.5   LIMITATIONS AND AREAS FOR FURTHER RESEARCH

This research was theory generating rather than theory testing and thus just provides a starting point for further research. An obvious next step would be determining the effectiveness of using lenses tailored to the values of the specific organization or project.

11.6   LESSONS LEARNED

1. I came to realize more poignantly the absolute pervasiveness of the norms and standards as defined by the dominant population; defined with the expectation that everyone would embrace these norms and standards (and their contained rules) as the way to be and thus the way in which one is adjudicated.

Brown and Smith, 1989, emphasized that

> (m)en have firmly established themselves as the norm with women counterpoint to them…Women …are the *opposite* or *second* sex in relation to men, service users exist in relation to a supposed norm and are described in terms that emphasise their deviation from it. Thus they are *dis*abled as opposed to able, *in*sane as opposed to sane, *sub*normal as opposed to normal. (p. 106)(italics as in original).

> The dominant social group will allow labels to be changed or sanitised (e.g., 'subnormal' to 'having learning difficulties') and may even concede real improvements in material conditions…However, their power to move the boundaries around themselves, to move the goal posts at will (even if they appear more lenient) merely highlights the basis of control. 'Rights' which are given can be taken away. (p. 110).

2. Balance between opposing perspectives is essential: for example, concerns of individuals and communities; bonding, bridging and linking; norms of the dominant population and of non-dominant populations; responsibilities of individuals and communities; health care and illness care; burden to change of those privileged and those not; leadership and guidance from within the community and outside.

3. Beginning with the aim of a thriving community rather than focusing at the level of a health system is important, for at the level of a thriving community, the determinants of health are naturally included and the potential for appropriate linkages amongst the needed players is likely greater. Alliances, partnerships and collaboratives might be more prone to form, rather than just connections.

4. Adopting an expansive view of knowledge might help to level the playing field.

5. Imagining the community from, for example, the perspectives of someone who is homeless, someone living in poverty, someone living with disabilities could help to envision a community with equitable access to health.

11.7   CONCLUSIONS

1. The trifocal lenses amplified the view of the policies, enabling, to me, a more considered and broader formulation of the policies. The lenses can benefit policy development to more broadly encompass views other than those of the White, middle class male.

2. The trifocal lenses enabled deeper insight regarding the interviewees and the interview analyses.

3. Specifically-developed, theory-based lenses are a useful addition to grounded theory.

4. The use of photo-elicitation was an effective tool to gain richness in community member interviews.

5. From the input of study participants, a comprehensive view of the desired access to health for North End Halifax community members could be pictured (**Figure 12**).

11.8 GOING FORWARD

With respect to achieving equitable access to health for members of the North End Halifax community, I believe Filho, 2008, provides valuable guidance.

> There are risks to discussing equity from a perspective of targeting, where actions are targeted to the poorest of the poor while ignoring the social factors that cause poverty and exclusion. A view that approaches equity through social policies that seem to discriminate positively, in fact, risks merely consolidating the dominant society divisions, normalizing inequities and a chronic disrespect for rights. To adopt the equity approach, we must systematically question whether proposed policies and actions create a principle of justice; we must also examine how our initiatives consolidate universal and comprehensive responses. (p. 95).

The use of specifically tailored lenses would assist with this approach. I believe we need to adopt a neighbourhood context of well-being and collective efficacy "to signify an emphasis on shared beliefs in a neighbourhood's conjoint capability for action to achieve an intended effect, and hence an active sense of engagement on the part of the residents." (Sampson, 2003; p. 558). I believe the intricate balance required to change the present access to health for North Enders will necessitate a fundamental transformation in how those with privilege and resources view their responsibilities and accountabilities to share with those lacking them; indeed a fundamental adjustment in how we view resources to see them where we previously haven't.

11.9 CONTRIBUTIONS OF THE THESIS RESEARCH TO NEW KNOWLEDGE

This thesis research contributed new knowledge regarding the usefulness of a structured approach to policy analysis and to data analyses within a grounded theory methodology. Future research could modify the particular lenses and the questions.

In addition, analysis of North End Halifax community member interviews highlighted the need to dig deeply and address root causes for poor health as THE major endeavour. The emphasis in other recent surveys and recommendations related to North End (and other segments of) Halifax is still largely on changing individuals in poor health to conform with White middle class ideas of health and responsibilities for health, rather than emphasizing the paradigm shift required by socioeconomically advantaged individuals and communities to accept the responsibilities and accountabilities that accompany their privileges.
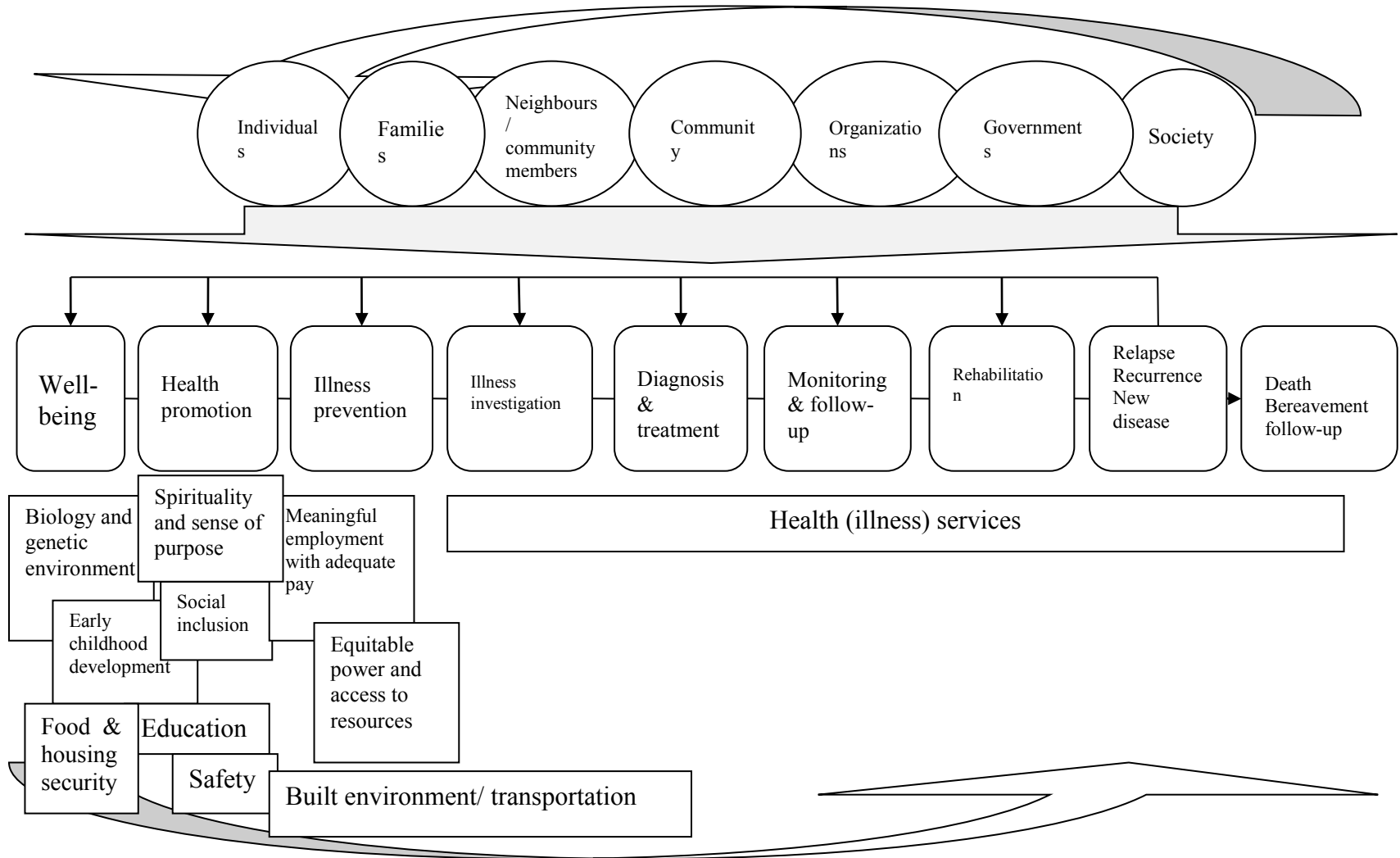
Figure 12 Health System

REFERENCES

Abelson J, Guavin F-P. 2004. *Engaging citizens: one route to health care accountability*. Canadian Policy Research Networks.

Adams T. 2009. The changing nature of professional regulation in Canada, 1867-1961. Soc Sci History 33:217-243.

Adelson N. 2005. The embodiment of inequity. Can J Public Health 96: Suppl 2:s45-61.

Adloff F. 2006. Beyond interests and norms: toward a theory of gift-giving and reciprocity in modern societies. Constell 13:407-427.

Agger B. 2006. *Critical Social Theories: an introduction*. 2nd edition. Paradigm Publishers, London.

Akabayashi A, Slingsby BT, Takimoto Y. 2005. Conflict of interest: a Japanese perspective. Cam Quart Health Eth 14:277-280.

Akman DE, Toner BB, Stuckless N, Ali A, Emmott SD, Downie FP. 2001. Feminist issues in research methodology: the development of a cognitive scale. Fem & Psych 11:209-227.

Allen D. 2009. From boundary concept to boundary object: the practice and politics of care pathway development. Soc Sci & Med 69:354-361.

Allen D, Benner P, Diekelmann NL. 1986. Three paradigms for nursing research: methodological implications. In *Nursing Research Methodology*. Edited by Chin P. Aspen; Rockville, MD.

Almond P. 2002. An analysis of the concept of equity and its application to health visiting. J Adv Nurs 37:598-606.

Alvesson M, Deetz S. 2000. *Doing critical management research*. Sage Publications, London.

Alvesson M, Skoldberg K. 2000. *Reflexive methodology*. Sage, London.

American College of Physicians. 2004. Position Paper. Racial and ethnic disparities in health care. Ann Int Med 141:226-232.

Anderson E. 2001. "Feminist Epistemology and Philosophy of Science." *Stanford Encyclopedia of Philosophy*, Edward N. Zalta (ed.). (accessed November, 2009).

Andrulis DP. 1998. Access to care is the centerpiece in the elimination of socioeconomic disparities in health. Ann Intern Med 129:412-416.

APA Policy & Planning Board. 2007. Who cares about APA policy and does it have an impact? Amer Psychol 62:491-503.

Asch A. 1998. Distracted by disability. Cam Quart Health Ethics 7:77-87.

Bambra C, Fox D, Scott-Samuel A. 2005. Towards a politics of health. Health Prom Internat 20:187-193.

Banks M. 2001. *Visual methods in social research*. Sage Publications, London.

Barnett WS, Belfield CR. 2006. Early childhood development and social mobility. Future Child 16:73-98.

Barreto RM. 2007. Community planning to end homelessness: a cross-case analysis in a changing policy environment. Unpublished dissertation.

Battalora JM. 1999. Toward a critical white racial ethics: constructions of whiteness in antimiscegenation law. Unpublished dissertation.

Baylis F, Kenny NP, Sherwin S. 2008. A relational account of public health ethics. Public Health Ethics 1:1-14.

Bearfield DA. 2009. What is patronage? A critical examination. Pub Admin Rev 69:64-76.

Beekun RI, Hamdy R, Westerman JW, HassahElnaby HR. 2008. An exploration of ethical decision-making processes in the United States and Egypt. J Bus Ethics 82:587-605.

Begun JW, Zimmerman B, Dooley K. 2003. Health care organizations as complex adaptive systems. In *Advances in Health Care Organization Theory*. Jossey-Bass, San Francisco.

Beiser M. 2005. The health of immigrants and refugees in Canada. Can J Public Health 96: Suppl 2:s30-44.

Bennett C. 2003. Patients in a globalized world: keeping hospitals in perspective. Health*papers* 4:50-56.

Benton W, Loppie S. 2001. Navigating the cancer care system: African Nova Scotians' experience. http://www.cancercare.ns.ca/sitecc/media/cancercare/AfricanNSExperienceReport(1).pdf. (accessed September, 2009).

Besier JL. 2004. Organizational behaviour in a complex system- a pilot study: the impact of a change model on health care practice improvement. Unpublished dissertation.

Bhutta ZA, Darmstadt GL, Hasan BS, Haws RA. 2005. Community-based interventions for improving perinatal and neonatal health outcomes in developing countries: a review of the evidence. Pediatr 115:519-617.

Biller-Andorno N, Lie RK, Meulen RT. 2002. Evidence-based medicine as an instrument for rational health policy. Health Care Analysis 10:261-275.

Blacksher E. 1998. Desperately seeking difference. Cambridge Quart Healthcare Ethics 7:11-16.

Block P. 2008. *Community*. Berret-Koehler Publishers, San Francisco.

Bopp M, Bopp J. 2006. *Recreating the world*. Four Worlds Press, Calgary.

Borden L, Serido J. From program participant to engaged citizen: a developmental journey. J Commun Psychol 37:423-438.

Bowers B. 2006. Executives transitioning from a silo to a systems-based approach in a complex healthcare organization: implications for continuous leadership development. Unpublished dissertation.

Bradshaw-Camball P, Murray VV. 1991. Illusions and other games: a trifocal view of organizational politics. Organiz Sci 2:379-398.

Braveman P. 2003. Monitoring equity in health and healthcare: a conceptual framework. J Health Popul Nutr 21:181-192.

Braveman P, Gruskin S. 2003. Poverty, equity, human rights and health. Bull WHO 81:539-545.

Braveman P, Marchi K, Egerter S et al. 2010. Poverty, near poverty, and hardship around the time of pregnancy. Matern Child Health J 14:20-35.

Braithwaite A. 2002. The personal, the political, third-wave and postfeminisms. Feminist Theory 3:335-344.

Brems E. 1997. Enemies or allies? Feminism and cultural relativism as dissident voices in human rights discourse. Human Rights Quart 19:136-164.

Breton E, Richard L, Gagnon F. 2007. The role of health education in the policy change process: lessons from tobacco control. Critical Public Health 17:351-364.

Brody H. 2005. Patient ethics and evidence-based medicine- the good healthcare citizen. Cam Quart Health Ethics 14:141-146.

Brown H, Smith H. 1989. Whose 'ordinary life' is it anyway? Disability, Handicap & Society 4:105-119.

Brown ME. 2002. Leading with values: the moderating influence of trust on values acceptance by employees. Dissertation, Pennsylvania State University.

Browne A. 1995. The meaning of respect: a First Nations perspective. Can J Nurs Research 27:95-109.

Buchkowsky SS, Jewesson PJ. 2004. Industry sponsorship and authorship of clinical trials over 20 years. Ann Pharmacother 38:579-585.

Cabrera DA. 2006. Systems thinking. Unpublished dissertation.

Cain DM, Loewstein G, Moore DA. 2005. The dirt on coming clean: perverse effects of disclosing conflicts of interest. J Legal Stud 34:1-25.

Calhoun C. 1995. The Frankfurt School: its history, theories and political significance. Contemp Sociol 24:703-705.

Callahan D. 2002. Ends and means: the goals of health care. In *Ethical dimensions of health policy.* Edited by Danis M, Clancy C, Churchill LR. Oxford University Press.

Calnan M, Rowe R. 2008. Trust, accountability and choice. Health, Risk & Society 10:201-206.

Cameron KS, Quinn RE. 2006. *Diagnosing and changing organizational culture.* Jossey-Bass, San Francisco.

Camilleri M, Gamble GL, Kopecky SL, Wood MB, Hockema ML. 2005. Principles and process in the development of the Mayo Clinic's individual and institutional conflict of interest policy. Mayo Clin Proc 80:1340-1346.

Campbell FAK. 2008. Exploring internalized ableism using critical race theory. Disabil & Soc 23:151-162.

Campbell JC, Bunting S. 1991. Voices and paradigms: perspectives on critical and feminist theory in nursing. Adv Nurs Sci 13:1-15.

Campbell R, Wasco SM. 2000. Feminist approaches to social science: epistemological and methodological tenets. Amer J Community Psych 28:773-791.

Canadian Public Health Association. 1996. Action statement for health promotion in Canada. Ottawa, CPHA.

Canadian Public Health Association. 2005. A framework for collaboration on health policy. A tool for voluntary organizations working in health, Health Canada and the Public Health Agency of Canada.
http://www.projectvoice.ca/English/Tools/FrameworkforCollaboration.pdf.
(accessed September, 2009).

Carlisle S. 2001. Inequalities in health: contested explanations, shifting discourses and ambiguous policies. Crit Pub Health 11:267-281.

Carr A. 2000. Critical theory and the management of change in organizations. J Organiz Change Manage 13:208-220.

Carroll TN. 2002. Interdependencies in organizational design: searching for the 'edge of chaos'. Unpublished dissertation.

Castleden H, Garvin T, Huu-ay-aht First Nation. 2008. Modifying photovoice for community-based participatory Indigenous research. Soc Sci Med 66:1393-1405.

Chafetz JS. 1997. Feminist theory and sociology: underutilized contributions for mainstream theory. Ann Rev Soc 23:97-120.

Charles N, Harris C. 2007. Continuity and change in work-life balance choices. Brit J Sociol 58:277-295.

Checkland P. 2000. Soft systems methodology: a thirty year retrospective. Sys Res Behav Sci 17:S11-58.

Chervenak FA, McCullough LB. 2004. An ethical framework for identifying, preventing and managing conflicts confronting leaders of academic health centres. Acad Med 79:1056-1061.

Chervenak FA, McCullough LB. 2007. The identification, management and prevention of conflict with faculty and fellows: a practical ethical guide for department chairs and division chiefs. Amer J Obs Gynec 197:e1-5.

Chilton M, Rose D. 2009. A rights-based approach to food insecurity in the United States. Amer J Pub Health 99:1203-1211.

Chilvers R, MacDonald G, Hayes A. 2009. Supported housing for people with severe mental disorders. Cochrane Library 1:1-12.

Chino M, DeBruyn L. 2006. Building true capacity: indigenous models for indigenous communities. Amer J Pub Health 96:596-599.

Chopra M, Munro S, Lavis JN, Vist G, Bennett S. 2008. Effects of policy options for human resources: an analysis of systemic reviews. Lancet 371:668-674.

Christens BD, Hanlin CE, Speer PW. 2007. Getting the social organism thinking: strategy for systems change. Amer J Community Pyschol 39:229-238.

Christensen M, Hewitt-Taylor J. 2006. Empowerment in nursing: paternalism or maternalism? Brit J Nurs 15:695-699.

CHSRF/FCRSS. 2006. Weighing up the evidence.
 http://www.chsrf.ca/other_documents/pdf/weighing_up_the_evidence_e.pdf.   (accessed September, 2009).

Chunharas S. 2006. An interactive integrative approach to translating knowledge and building a 'learning organization' in health services management. Bull WHO 84:652-657.

CIHR. 2004. CIHR procedure for addressing allegations of non-compliance with research policies. Canada. http://www.cihr.ca/e/29362.html. (accessed November, 2009).

Clapton J. 2008. 'Care': moral concept or merely an organisational suffix. J Intellect Dis Res 52:573-580.

Coburn D. 2000. Income inequality, social cohesion and the health status of populations: the role of neo-liberalism. Soc Sci Med 51:135-146.

Cockburn T. 2005. Children and the feminist ethic of care. Childhood 12:71-89.

Code L. 1991. *What can she know? Feminist theory and the construction of knowledge*. Cornell University Press, Ithaca.

Cody WK. 2003. Paternalism in nursing and healthcare: central issues and their relation to theory. Nurs Sci Quart 16:288-296.

Coffield F, Edward S, Finlay I, Hodgson A, Spours K, Steer R, Gregson M. 2007. How policy impacts on practice and how practice does not impact on policy. Brit Educ Res J 33:723-741.

Cohen EC. 2008. Implementing a paradigm shift: housing first but not housing alone. Unpublished dissertation.

Cohen JJ, Siegel EK. 2005. Academic Medical Centers and medical research: the challenges ahead. J Amer Med Assoc 294:1367-1372.

College of Registered Nurses of Nova Scotia. 2002. *Professional boundaries and expectations for nurse-client relationships*.

Collins LH. 1998. Illustrating feminist theory. Psychol Women Quart 22:97-112.

Community Counts. 2007. http://www.gov.ns.ca/finance/communitycounts/default.asp. (accessed September, 2009).

Cosgrove L. 2003. Feminism, postmodernism, and psychological research. Hypatia 18:85-112.

Creswell JW. 1998. *Qualitative inquiry and research design: choosing among five traditions*. Sage Publications, Thousand Oaks.

Creswell JW. 2003. *Research design: qualitative, quantitative and mixed methods approaches*. 2nd edition. Sage Publications, Thousand Oaks.

Cruess RL, Cruess SR. 2008. Expectations and obligations- professionalism and medicine's contract with society. Perspect Biol Med 51:579-598.

Dak J. 2002. Understanding the anatomical structure of a conflict of interest. J Health Care Comp (Sept-Oct):4-8.

Daniels N. 2001. Justice, health, and healthcare. Amer J Bioethics 1:1-16.

Daniels N, Bryant J, Castano RA, Dantes OG, Khan KS, Pannarunothai S. 2000. Benchmarks of fairness for health care reform: a policy tool for developing countries. Bull WHO 78:740-750.

D'art D, Turner T. 2003. Independent collective representation: providing effectiveness, fairness, and democracy in the employment relationship. Employ Respons Rights J 15:169-181.

Davidoff F, DeAngelis CD, Drazen JM et al. 2001. Sponsorship, authorship and accountability. N Eng J Med 345:825-826.

Davis JH, Schoorman FD, Donaldson L. 1997. Towards a stewardship theory of management. Acad Manage Rev 22:20-47.

Davitt JK, Choi S. 2008. The impact of policy on nursing and allied health services: lessons from the Medicare Home Health Benefit. Res Ger Nurs 1:4-13.

Decelles KA. 2007. Locked up: exploring the complex nature of conflicting values systems and their effects on work attitudes. Unpublished dissertation.

Derose KP, Varda DM. 2009. Social capital and health care access. Med Care Res Rev 66:272-306.

Deutsch M. 2006. A framework for thinking about oppression and its change. Soc Justice Research 19:7-41

Dickenson D, Vineis P. 2002. Evidence-based medicine and quality of care. Health Care Anal 10:243-259.

Dietz MG. 2003. Current controversies in feminist theory. Ann Rev Polit Sci 6:399-431.

Dillon RS. 2009. Respect. Stanford encyclopedia of philosophy. http://plato.standford.edu.entries/respect. (accessed February, 2010).

Dobrow MJ, Goel V, Upshur REG. 2003. Evidence-based health policy: context and utilisation. Soc Sci Med 58:207-217.

Dolan SL, Garcia S, Auerbach A. 2003. Understanding and managing chaos in organizations. Int J Manage 20:23-35.

Dowdall GW, Golden J. 1989. Photographs as data: an analysis of images from a mental hospital. Qual Sociol 12:183-213.

Downie J. 2009. Glass houses: the power of money in bioethics research. Int J Fem Approach Bioethics 2:97-115.

Dugger WM. 1998. Against inequality. J Econ Issues 32:287-303.

Duke J. 2009. Mixed income housing policy and public housing residents' 'right to the city'. Crit Soc Policy 29:100-120.

Edlund JE, Sagarin BJ, Johnson BS. 2007. Reciprocity and the belief in a just world. Personal Individual Diff 43:589-596.

Emanuel EJ, Emanuel LL. 1996. What is accountability in health care? Ann Intern Med 124:229-239.

Emmison M, Smith P. 2000. *Researching the visual. Images, objects, contexts and interactions in social and cultural inquiry*. Sage Publications, London.

Engberg-Pedersen T. 2008. Gift-giving and friendship. Harvard Theol Rev 101:15-44.

Engster D. 2005. Rethinking care theory: the practice of caring and the obligation to care. Hypatia 20:50-74.

Entwistle VA, Watt IS. 2006. Patient involvement in treatment decision-making: the case for a broader conceptual framework. Patient Educ Counsel 63:268-278.

Epstein RA. 2007. Conflicts of interest in health care: who guards the guardians? Perspect Biol Med 50:72-88.

Erickson PA. 2004. *Historic North End Halifax*. Numbus Publishing, Halifax.

Erlen JA, McDaniel C. 1994. Conflict of interest: its relationships to integrity in the academic setting. J Prof Nurs 10:91-96.

Ermath E. 2000. What counts as feminist theory? Feminist Theory 1:113-118.

Etowa JB. 2005. Surviving on the margin of a profession: experiences of Black nurses. Unpublished dissertation.

Fafard P. 2008. Evidence and healthy public policy: insights from health and political sciences. National Collaborating Centre for Health Public Policy.

Fairclough N. 2001. *Language and power*. Second edition. Longman, London.

Fang WL, Ellwein MC. 1990. Photography and ethics in evaluation. Eval Rev 14:100-107.

Fee M, Russell L. 2007. 'Whiteness' and 'Aboriginality' in Canada and Australia. Fem Theory 8:187-208.

Fenby BL. 1991. Feminist theory, critical theory and management's romance with the technical. Affilia 6:20-37.

Fendler L, Tuckey SF. 2006. Whose literacy? Discursive constructions of life and objectivity. Educ Phil Theory 38:589-606.

Ferlander S. 2007. The importance of different forms of social capital for health. Acta Sociol 50:115-128.

Ferris LE, Singer PA, Naylor CD. 2004. Better governance in academic health science centres: moving beyond the Oliveri/ Apotex affair in Toronto. J Med Ethics 30:25-29.

Field MJ, Lohr KN, editors. 1992. *Guidelines for clinical practice: from development to use*. Institute of Medicine. National Academy Press, Washington, DC.

Filho AND. 2008. A human rights approach to quality of life and health: applications to public health programming. Health Human Rights 10:93-101.

Fiscella K. 2003. *Assessing health care quality for minority and other disparity populations*. Agency for Healthcare Research and Quality, publication # 03-0047-EF.

Fisher JA. 2006. Co-ordinating 'ethical' clinical trials: the role of research coordinators in the contract research industry. Sociol Health Ill 28:678-694.

Flannery MC. 2001. Quilting: a feminist metaphor for scientific inquiry. Qualitative Inquiry 7:628-645.

Fogel J, Friedman HH. 2007. Conflict of interest and the Talmud. J Bus Eth 78:237-246.

Ford CL, Airhihenbuwa CO. 2010. Critical race theory, race equity and public health: towards antiracism praxis. Amer J Pub Health 100:30-35.

Foster-Fishman PG, Cantillon D, Pierce SJ, Van Egeren LA. 2007. Building an active citizenry: the role of neighborhood problems, readiness, and capacity for change. Am J Community Psychol 39:91-106.

Franke S. 2005. *Measurement of social capital: reference document for public policy research, development, and evaluation*. Ottawa: Policy Research Initiative. Canada Research Index.

Frankish CJ, Casebeer A, Moulton GE et al. 2007. Addressing the non-medical determinants of health. Can J Public Health 98:41-47.

Frankish CJ, Hwang SW, Quantz D. 2005. Homelessness and health in Canada. Can J Public Health 96: Suppl 2:S23-29.

Freedman R, Lewis DA, Michels R et al. 2006. Editorial. Conflict of interest, round 2. Am J Psych 163:1481-1483.

Friendly M. 2009. Early childhood education and care as a social determinant of health. In *Social Determinants of Health*, 2nd edition. Edited by Raphael D. Canadian Scholars' Press Inc, Toronto.

Freudenberg N. 2005. Public health advocacy to change corporate practices: implications for health education, practice and research. Health Educ Behav 32:298-319.

Fulford KWM, Colombo A. 2004. Professional judgement, critical realism, real people, and, yes, two wrongs can make a right! Philosophy Psychiatry Psychology 11:165-173.

Gamble VN, Stone D. 2006. US policy on health inequities: the interplay of politics and research. J Health Politics, Policy, Law 31:93-126.

Gerber A, Lauterbach KW. 2005. Evidence-based medicine: why do opponents and proponents use the same arguments? Health Care Analysis 13:59-71.

Giacomini M, Baylis F, Robert J. 2007. Banking on it: public policy and the ethics of stem cell research and development. Soc Sci & Med 65:1490-1500.

Gibson E, Baylis F, Lewis S. 2002. Dances with the pharmaceutical industry. Can Med Assoc J 166:448-450.

Gibson JL, Sibbald R, Connolly E, Singer P. 2008. Organizational ethics. in *The Cambridge Textbook of Bioethics,* Cambridge University Press, UK.

Gibson-Graham, JK. 1994. `Stuffed if I know!': Reflections on post-modern feminist social research. Gender, Place & Culture 1: 205-224.

Giles-Corti B, Knuiman M, Pikora TJ, van Neil K, Timperio A, Bull FCL, Shilton T, Bulsara M. 2007. Can the impact on health of a government policy designed to create more liveable neighbourhoods be evaluated? An overview of the RESIDential Environment Project. NSW Public Health Bulletin 18: 238-242.

Gioia DA, Donnellon A, Sims HP. 1989. Communication and cognition in appraisal: a tale of two paradigms. Organiz Stud 10:503-530.

Gladwell M. 2000. *The tipping point.* Little, Brown and Company. New York.

Glaser BG. 1978. *Theoretical sensitivity. Advances in the methodology of grounded theory*. Sociology Press, Mill Valley, USA.

Glaser BG. 1992. *Basics of grounded theory analysis. Emergence vs forcing*. Sociology Press, Mill Valley.

Glaser BG. 2001. *The Grounded Theory Perspective: conceptualization contrasted with description*. Sociology Press, Mill Valley, USA.

Glaser BG, Holton J. 2004. Remodeling grounded theory. The Grounded Theory Review 4:1-24.

Glaser BG, Strauss AL. 1967. *The discovery of grounded theory.* Sociology Press, Mill Valley, USA.

Glouberman S, Campsie P, Gemar M, Miller G. 2003. *A toolbox for improving health in cities: a discussion paper*. The Caldeon Institute of Social Policy, Ottawa.

Gold JL, Laxer MS, Rochon PA. 2004. Monitoring contracts with industry: why research ethics boards must be involved. Health Law Review 11:13-16.

Goldenberg MJ. 2007. The problem of exclusion in feminist theory and politics: a metaphysical investigation into constructing a category of 'woman'. J Gender Stud 16:139-153.

Gomez ML, White E. 2010. Seeing one another as "other". Teach Teach Educ 26:1015-1022.

Goodell GE. 1985. Paternalism, patronage and potlatch: the dynamics of giving and being given to. Current Anthropol 26:247-266.

Goodlin WE, Dunn CS. 2010. Three patterns of domestic violence in households: single victimization, repeat victimization, and co-curring victimization. J Fam Viol 25:107-122.

Graber DR, Kilpatrick AO. 2008. Establishing values-based leadership and value systems in healthcare organizations. J Health Human Serv Admin 31:179-197.

Graham H. 2004. Social determinants and their unequal distribution: clarifying policy understandings. Milbank Quart 82:101-124.

Graham ID, Harrison MB, Brouwers M, Davies BL, Dunn S. 2002. Facilitating the use of evidence in practice: evaluating and adapting clinical practice guidelines for local use in health care organizations. J Obs Gynec Neo Nurs 31:599-611.

Grant S, Humphries M. 2006. Critical evaluation of appreciative inquiry. Action Res 4:401-418

Grasswick HE, Webb MO. 2002. Feminist epistemology as social epistemology. Soc Epistem 16:185-196.

Groves KEM, Sketris I, Tett SE. 2003. Prescription drug samples- does this marketing strategy counteract policies for quality use of medicines? Clin Pharm Therapeut 28:259-271.

Guyatt G, Akl EA, Hirsh J et al. 2010. The vexing problem of guidelines and conflict of interest: a potential solution. Ann Int Med 152:738-741.

Hadfield GK. 1995. The dilemma of choice: a feminist perspective on the *limits of freedom of contract*. Osgoode Hall Law J 33:338-351.

Haines SG. 1998. *Systems thinking & learning. The manager's pocket guide*. HRD Press, Amherst.

Haines IE, Olver IN. 2008. Are self-regulation and declaration of conflict of interest still the benchmark for relationships between physicians and industry? Med J Austral 189:263-266.

Hammersley M. 1992. On feminist methodology. Sociology 26:187-206.

Hankivsky O. 2004. *Social policy and the ethics of care*. UBC Press, Vancouver.

Hannabuss S. 2001. A wider view of knowledge. Libr Manage 22:357-363.

Harber B, Ball T. 2003. From the blame game to accountability in health care. Policy Options Nov:49-54.

Hardin G. 1968. Tragedy of the commons. http://dieoff.org/page95.htmhttp://dieoff.org/page95.htm. (accessed December, 2009).

Harding R, Hamilton P. 2009. Working girls: abuse or choice in street-level sex work? A study of homeless women in Nottingham. Brit J Soc Work 39:1118-1137.

Harding S. 2004. A socially relevant philosophy of science? Resources from a standpoint theory's controversiality. Hypatia 19:25-47.

Harper D. 2002. Talking about pictures: a case for photo elicitation. Visual Studies 17:13-26.

Harris N. 2007. Radical activism and accidental philanthropy: the impact of first wave feminist activism on the later construction of child care policies in Australia and the United States of America. Women's Studies International Forum 31: 42-52.

Hartstock N. 1998. Marxist feminist dialectics for the 21st century. Science & Society 62:400-413.

Hawkesworth ME. 1989. Knowers, knowing, known: feminist theory and claims of truth. Signs 14:533-557.

Hawkesworth M. 1999. Analyzing backlash: feminist standpoint theory as analytical tool. Women's Studies Inter Forum 22:135-155.

Hayward K, Colman R. 2003. *The tides of change: Addressing inequity and chronic disease in Atlantic Canada- a discussion paper*. www.pph-atlantic.ca. (accessed September, 2007).

Hedgecoe AM. 2004. Critical bioethics: beyond the social science critique of applied ethics. Bioethics 18:120-143.

Hekman. 1990. Comment on Hawkesworth's "Knowers, knowing, known: feminist theory and claims of truth". Signs 15:417-419.

Hemmings C. 2005. Telling feminist stories. Feminist Theory 6:115-139.

Hern HE, Koenig BA, Moore LJ, Marshall PA. 1998. The difference that culture can make in end-of-life decision making. Cam Quart Health Ethics 7:27-40.

Heslep RD. 2006. *Ten basic questions about education*. The Edwin Mellen Press, Lewiston.

Hill B. 2006. Reconciling Locke's definition of knowledge with knowing reality. South J Philos 44:91-105.

Hines S. 2007. Transgendering care: practices of care within transgender communities. Crit Soc Pol 27:462-486.

Hinkle JC, Weisburd D. 2008. The irony of broken windows policing: a micro-place study of the relationship between disorder, focused police crackdowns and fear of crime. J Crim Just 36:503-512.

Hoffman L, Coffey B. 2008. Dignity and indignation; how people experiencing homelessness view services and providers. Soc Sci J 45:207-222.

Hofrichter R. 2003. *Health and social justice: politics, ideology, and inequity in the distribution of disease*. Jossey-Bass, San Francisco.

Holbrook A, Bourke S, Fairbairn H, Lovat T. 2007. Examiner comments on the literature review in PhD theses. Stud High Educ 32:337-356.

Hollander MJ, Prince MJ. 2002. *Analysis of interfaces along the continuum of care*. Health Canada.

Homer JF, Drummond MF, French MT. 2008. Economic evaluation of adolescent addiction programs: methodologic challenges and recommendations. J Adol Health 43:529-539.

Hongvivatana T. 1984. *SEARO. Technical publication no. 4: Evaluating primary health care in health care South-East Asia*. New Delhi: World Health Organization Regional Office for South-East Asia.

Howell-Jones GE. 2005. Counselling First Nations: experiences of how Aboriginal clients develop, experience, and maintain successful healing relationships with non-Aboriginal counsellors in mainstream mental health settings, a narrative study. Unpublished dissertation.

Hudson MI, Russell K. 2009. The treaty of Waitangi and research ethics in Aotearoa. Bioeth Inq 6:61-68.

Humphries KH, van Doorlaer E. 2000. Income-related health inequality in Canada. Soc Sci Med 50:663-67.

Hundleby C. 2002. The open end: social naturalism, feminist values and the integrity of epistemology. Soc Epistem 16:251-265.

Hurst SA, Mouran A. 2008. A question of method. The ethics of managing conflicts of interest. Eur Mole Biol Org 9:119-123.

Hussain A, Smith R. 2001. Declaring financial competing interests: survey of five general medical journals. Brit Med J 323:263-264.

Jackson R. 2003. The impact of the built environment on health: an emerging field. Am J Public Health 93:1382-1384.

Jackson BE, Pederson A, Boscoe M. 2006. Gender-based analysis and wait times: new questions, new knowledge. (in Postl B. 2006. *The Final Report of the Federal Advisor on Wait Times*). www.cewh-cesf.ca/healthreform/index.html. (accessed October, 2009).

Jegede S. 2009. African ethics, health care research and community and individual participation. J Asian African Studies 44:239-253.

Jensen L, Kisely S. 2005. Public health in Atlantic Canada: a discussion paper. Public Health Agency of Canada. www.atlantic.phac.gc.ca. (accessed November, 2009).

Joint Commission for Accreditation of Health Care Organizations. 2004. *Comprehensive accreditation manual for hospitals: the official handbook*. Joint Commission, Oakbrook Terrace, Illinois.

Kassirer JP. 2001. Financial conflict of interest: an unresolved ethical frontier. Amer J Law & Med 27:149-162.

Kast FE, Rosenzweig JE. 1972. General systems theory: application for organization and management. Acad Manage J 15:447-465.

Katz D, Caplan AL, Merz JF. 2003. All gifts large and small. Towards an understanding of the ethics of pharmaceutical industry gift-giving. Amer J Bioethics 3:39-46.

Kazak A, Hoagwood K, Weisz JR et al. 2010. A meta-systems approach to evidence-based practice for children and adolescents. Amer Psychol 65:85-97.

Keddy B, Sims SL, Stern PN. 1996. Grounded theory as feminist research methodology. J Advan Nurs 23:448-453.

Kelly MP, Bonnefoy J. 2007. *The social determinants of health: developing an evidence base for political action*. National Institute for Health and Clinical Excellence, UK.

Kendall S, Tannen D. 2003. Discourse and gender. Chapter 28 in Schiffrin D, Tannen D, Hamilton HE, eds. 2003. *The handbook of discourse analysis*. Blackwell Publishing Ltd, Oxford.

Kenny NP. 2002. *What good is health care?* CHA Press, Ottawa.

Kenny NP. 2004. *What's fair? Ethical decision-making in an aging society*. The Change Foundation.

Kenny N. 2006a. Some ethical reflections on accountability. Healthcare Papers 7:65-71.

Kenny N. 2006b. Uncharted territory: Hippocratic ethics and health systems. Can Assoc Med J 174:1385.

Kenny N, Giacomini M. 2005. Wanted: a new ethics field for health policy analysis. Health Care Analysis 13:247-260.

Kenny NP, Melnychuk RM, Asada Y. 2006. The promise of public health: ethical reflections. Can J Public Health 97:402-404.

Kenny N, Joffres C. 2008. An ethical analysis of international health priority-setting. Health Care Anal 16:145-160.

Kenny NP, Sherwin SB, Baylis FF. 2010. Re-visioning public health ethics: a relational perspective. Can J Pub Health 101:9-11.

Khan AA, Bhadardwaj SM. 1994. Access to health care. A conceptual framework and its relevance to health care planning. Eval Health Prof 17:60-76.

Khisty CJ. 2006. A fresh look at the systems approach and an agenda for action: peeking through the lens of Churchman's aphorisms. Syst Prac Act Res 19:3-25.

Khushf G. 1998. The scope of organizational ethics. HEC Forum 10:127-135.

Kidd SA. 2007. Youth homelessness and social stigma. J Youth Adoles 36:291-299.

Kiely-Froude C, Abdul-Karim S. 2009. Providing culturally conscious mental health treatment of African American Muslim women living with spousal abuse. J Muslim Mental Health 4:175-186.

Killion CM. 2001. Understanding cultural aspects of health through photography. Nurs Outlook 49:50-54.

Kincheloe JL, McLaren P. 2005. Rethinking critical theory and qualitative research, in *The Sage Handbook of Qualitative Research*. 3rd edition. Editors- NK Denzin, YS Lincoln. Sage Publications, Thousand Oaks.

King S, Peterson L. 2006. Leadership perspectives on complexity in systems change. www.starfield.ca. (accessed September, 2009).

Kirby JB, Taliaferro G, Zuvekas SH. 2006. Explaining racial and ethnic disparities in health care. Med Care 44:64-72.

Kirova A, Emme M. 2008. Fotonovela as a research tool in image-based participatory research with immigrant children. Int J Qual Meth 7:35-57.

Kitson, no date. Innovation in an evidence based culture. Powerpoint presentation www.ahfmr.ab.ca/download.../2e22001f0b2acf17abd885a337b733d5. (accessed November, 2010).

Kloos B, Zimmerman SO, Scrimenti K, Crusto C. 2002. Landlords as partners for promoting success in supported housing: "it takes more than a lease and a key". Psych Rehab J 25:235-244.

Kloos B, Shah S. 2009. A social ecological approach to investigation relationships between housing and adaptive functioning for person with serious mental illness. Am J Community Psychol 44:316-326.

Kotter JP. 2007. Leading change. Why transformation efforts fail. Harvard Bus Rev 85:96-103.

Kressin NR, Glickman ME, Peterson ED et al. 2007. Functional status outcomes among white and African-American cardiac patients in an equal access system. Am Heart J 153:418-425.

Kretzmann J, McKnight J. 1993. *Building communities from the inside out: a path toward finding and mobilizing a community's assets*. Chicago, Il: ACTA Publications.

Krieger N. 2005. Defining and investigating social disparities in cancer: critical issues. Cancer Causes Control 16:5-14.

Kushner KE, Morrow R. 2003. Grounded theory, feminist theory, critical theory: toward theoretical triangulation. Advan Nurs Sci 26:30-43.

Labacqz K. 1998. Difficult difference. Cam Quart Health Ethics 7:17-26.

Langille D. 2009. Follow the money; how business and politics define our health. In *Social determinants of health.* Second edition. Edited Raphael D. Canadian Scholars' Press Inc, Toronto.

Lather P. 1991. *Getting smart: feminist research and pedagogy within the Postmodern*. Routledge, New York.

Lemmens T. 2004. Confronting the conflict of interest crisis in medical research. Monash Bioeth Rev 23:19-40.

Lemmens T, Singer PA. 1998. Bioethics for clinicians: 17. Conflict of interest in research, education and patient care. Can Med Assoc J 159:960-965.

Levin BW, Schiller NG. 1998. Social class and medical decision-making: a neglected topic in bioethics. Cam Quart Health Ethics 7:41-56.

Levinsky NG. 2002. Nonfinancial conflicts of interest in research. New Eng J Med 347:759-761.

Lewis MW, Grimes AJ. 1999. Metatriangulation: building theory from multiple paradigms. Acad Manage Review 24:672-690.

Liddiard R, Ritvo R. 1986. Self-care and health policy: a conflict of interests. In *Self-care and health in old age: health behaviour implications for policy and practice*. Edited by Dean K. Croom Helm, London.

Liedtka JM. 1996. Feminist morality and competitive reality: a role for an ethic of care? Bus Ethics Quart 6:179-200.

Lillie-Blanton M, Parsons PE, Gayle H, Dievier A. 1996. Racial differences in health: not just black and white, but shades of grey. Annu Rev Pub Health 17:411-448.

Lind RA. 2005. Evaluating research misconduct policies at major research universities: a pilot study. Account Res 12:241-262.

Lipford JW, Yandle B. 2009. The determinants of purposeful volunteerism. J Socio-Econ 38:72-79.

Lipton S, Boyd EA, Bero LA. 2004. Conflicts of interest in academic research: policies, processes and attitudes. Account Res 11:83-102.

Lloyd JE, Wise MJ, Weeramanthri T. 2008. Changing shape: workforce and the implementation of Aboriginal health policy. Austral Health Rev 32:174-185.

Lomas J, Culyer T, McCutcheon C, McAuley L, Law S. 2005. Conceptualizing and combining evidence for health system guidance. http://www.chsrf.ca/other_documents/pdf/evidence_e.pdf. (accessed November, 2009).

London L. 2008. What is a human rights-based approach to health and does it matter? Health Human Rights 10:65-80.

Lovato CY, Sabiston CM, Hadd V, Nykiforuk CIJ, Campbell HS. 2007. The impact of school smoking policies and student perceptions of enforcement on school smoking prevalence and location of smoking. Health Educ Res 22:782-893.

Lurie N. 2002. What the federal government can do about the nonmedical determinants of health. Health Affairs 21:94-106.

MacDonald M. 2001. Finding a critical perspective. Chapter 7. In *Using Grounded Theory in Nursing*. Eds. Schreiber RS, Stern PN. Springer Publishing Company.

MacDonald NE, Halperin B, Chaple EB, et al. 2006. Infectious disease management: lessons for Cuba. Can J Infect Dis Med Microbiol 17:217-220.

MacGregor S. 2004. From care to citizenship. Ethics & Environ 9:56-84.

Machold S, Ahmed PK, Farquhar SS. 2007. Corporate governance and ethics: a feminist perspective. J Bus Ethics 81:665-678.

Macintyre S. 2003. Evidence based policy making. Brit Med J 326:5-6.

Macintyre S, Ellaway A, Cummins S. 2002. Place effects on health: how can we conceptualise, operationalise and measure them? Soc Sci Med 55:125-139.

Mackenbach JP. Howden-Chapman P. 2003. New perspectives on socioeconomic inequalities in health. Perspect Biol Med 46:428-444.

Mackie JE, Taylor AD, Finegold DL et al. 2006. Lessons on ethical decision making from the bioscience industry. PLoS Med 3: e129 [0605-0610]. www.plosmedicine.org. (accessed October, 2009).

MacNaughton G, Davis K. 2001. Beyond 'othering': rethinking approaches to teaching young Anglo-Australian children about indigenous Australians. Contemp Issues Early Childh 2:83-94.

Magilvy JK, Congdon JG, Nelson JP, Craig C. 1992. Visions of rural aging: use of photographic method in gerontological research. Gerontol 32:253-257.

Mammen S, Bauer JW, Richards L. 2009. Understanding persistent food insecurity: a paradox of place and circumstance. Soc Indic Res 92:151-168.

Manias E, Street A. 2000. Possibilities for critical social theory and Foucault's work: a toolbox approach. Nurs Inquiry 7:50-60.

Marmur D. 2002. Ethical reflections on social inclusion. Working paper series. www.laidlawfdn.org. (accessed October, 2009).

Mastroianni AC, Kahn JP. 1999. Encouraging accountability in research: a pilot assessment of training efforts. Account Res 7:85-100.

Mathie A, Cunningham G. 2003. From clients to citizens: asset-based community development as a strategy for community-driven development. Devel Pract 13: 474-486.

Matson-Koffman DM, Brownstein JN, Neiner JA, Greaney ML. 2005. A site-specific literature review of policy and environmental interventions that promote physical activity and nutrition for cardiovascular health: what works? Am J Health Promot 19:167-193.

Mayeda G. 2005. Re-imaging feminist theory: transgender identity, feminism and the law. Can J Women Law 17:423-472.

Maynard M. 1995. Beyond the 'Big Three': the development of feminist theory into the 1990s. Women's History Rev 4:259-280.

Maynard M. 2002. Studying age, 'race' and gender: translating a research proposal into a project. Int J Soc Res Method 5:31-40.

McDaniel RR. 1997. Strategic leadership: a view from quantum and chaos theories. Health Care Management Review 22:21-37.

McGibbon E. 2009. Health and health care: a human rights perspective. In *Social Determinants of Health,* 2nd edition. Edited by Raphael D. Canadian Scholars' Press Inc, Toronto.

McIntyre A. 2003. Through the eyes of women: photovoice and participatory research as tools for reimagining place. Gender, Place & Culture 10:47-66.

McIntyre-Mills J. 2010. Participatory design for democracy and wellbeing: narrowing the gap between service outcomes and perceived needs. Syst Pract Action Res 23:21-45.

McKnight J, Kretzmann J. 1996. *Mapping community capacity*. Institute for Policy Research, Northwestern University.

Meagher G, Parton N. 2004. Modernising social work and the ethics of care. Social Work & Society 2:10-27.

Mechanic D. 1996. Changing medical organization and the erosion of trust. Milbank Quart 74:171-189.

Meier BM, Fox AM. 2008. Development as health: employing the collective right to development to achieve the goals of the individual right to health. Human Rights Quart 30:259-355.

Melles BB. 2003. The relationships between policy, planning and neighbourhood change: the case of Gottingen Street neighbourhood, 1950-200. Unpublished dissertation.

Mello MM, Clarridge BR, Studdert DM. 2005. Academic medical centers' standards for clinical-trial agreements with industry. N Eng J Med 352:2202-2210.

Menkel-Meadow C. 1991. Justice and gender. Signs 16:603-606.

Meyer B, Sugiyama K. 2007. The concept of knowledge in KM: a dimensional model. J Know Manage 11:17-35.

Meyers C. 2007. Clinical ethics consulting and conflict of interest: structurally intertwined. Hastings Center Report 37:32-40.

Miller AB. 2000. Rethinking homelessness: dignity as a core issue in the lives of homeless people. Unpublished dissertation.

Miller R. 2005. Creating boundary objects to aid knowledge transfer. KM Review 8:12-15.

Miller WL, Crabtree BF. 2005. Clinical research. In *The Sage Handbook of Qualitative Research*. 3rd edition. Edited by Denzin NK, Lincoln YS. Sage Publications, Thousand Oaks.

Mills A, Spencer EM. 2005. Values based decision making: a tool for achieving the goals of healthcare. HEC Forum 17:18-32.

Mills PJ. 1994. Feminist critical theory - unruly practices. Sci Soc 58:211-214.

Minkler M (editor). 2008. *Community organizing and community building for health*. Rutgers University Press, New Jersey.

Mischen PA, Jackson SK. 2008. Connecting the dots: applying complexity theory, knowledge management and social network analysis to policy implementation. Pub Admin Quart 31:314-338.

Mitchell A, Shillington R. 2002. Poverty, inequality and social inclusion. http://www.laidlawfdn.org/sites/default/files/laidlaw_publications/working_papers_social_inclusion/wpsosi_2002_december_poverty-inequality.pdf. (accessed March, 2010).

Moffitt P, Vollman AR. 2004. Photovoice: picturing the health of aboriginal women in a remote northern community. Can J Nurs Research 36:189-201.

Moher D, Schultz KF, Altman D et al. 2001. The CONSORT statement revised recommendations for improving the quality of reports of parallel-group randomized trials. J Amer Med Assoc 285:1987-1991.

Montgomery JD. 2007. The structure of norms and relations in patronage systems. Social Networks 29:565-584.

Moody RC, Horton-Deutsch S, Pesut DJ. 2007. Appreciative inquiry for leading in complex systems: supporting the transformation of academic nursing culture. J Nurs Educ 46:319-324.

Moore G, Croxford B, Adams M, Refaee M, Cox T, Sharples S. 2008. The photo-survey research method: capturing life in the city. Visual Studies 23:50-62.

Moore SM, Charvat J. 2007. Promoting health behaviour change using appreciative inquiry: moving from deficit models to affirmation models of care. Family Community Health: Suppl 1; 30:s64-s74.

Mooy JM, Gunning-Schepers LJ. 2001. Computer-assisted health impact assessment for intersectoral health policy. Health Policy 57:169-177.

Morrow CE, Mansoor E, Hanson KL, et al. 2010. The Starting early Smart Integrated Services Model: improving access to behavioral health services in the pediatric health care setting for at-risk families with young children. J Child Fam Stud 19:42-56.

Murray CJL, Frenk J. 2000. A framework for assessing the performance of health systems. Bull WHO 78:717-731.

Myser C. 2003. Differences from somewhere: the normativity of whiteness in bioethics in the United States. Amer J Bioethics 3:1-11.

Navarro V, Shi L. 2001. The political context of social inequalities and health. Soc Sci Med 52:481-491.

Neema S. 2005. *The impact of health policies and health sector reform on the readiness of health systems to respond to women's health needs, with special focus on reproductive health, reproductive rights and HIV/AIS*. Self printed by United Nations (EGM/WPD-EE/2005/EP.11).

Nicotera N. 2007. Measuring neighborhood: a conundrum for human services researchers and practitioners. Am J Community Psychol 40:26-51.

Nitzberg J. 2005. The meshing of youth development and community building. New Direct Youth Develop 106:7-16.

Norheim OF. 2002. The role of evidence in health policy making: a normative perspective. Health Care Analysis 10:309-317.

Nowell BL, Berkowitz SL, Deacon Z, Foster-Fishman P. 2006. Revealing the cues within community places: stories of identity, history, and possibility. Am J Community Psychol 37:29-46.

Nsiah-Jefferson L. 2006. Evidence-based quality enhancement and treatment inequities: the influence of overall institutional success and other hospital characteristics on adherence to ACC/AHA guidelines for NSTE-ACS by race and gender- a critical race theory perspective. Unpublished dissertation.

Nunnery-Winkler G, Meyer-Nikele M, Wohlrab D. 2007. Gender differences in moral motivation. Merrill-Palmer Quart 53:26-52.

Ohmer ML, Meadowcroft P, Freed K, Lewis E. 2009. Community gardening and community development: individual, social and community benefits of a community conservation program. J Commun Pract 17:377-399.

Olesen V. 2005. Early millennial feminist qualitative research: challenges and contours. In *The Sage Handbook of Qualitative Research*, 3rd edition. Denzin NK, Lincoln YS, editors. Sage Publications, Thousand Oaks.

Oliffe JL, Bottorff JL, Kelly M, Halpin M. 2008. Analyzing participant produced photographs from an ethnographic study of fatherhood and smoking. Res Nurs & Health 31:529-539.

Oliffe J, Thorne S, Hislop TG, Armstrong E-A. 2007. "Truth telling" and cultural assumptions in an era of informed consent. Fam Community Health 30:5-15.

Ostlin P, George A, Sen G. 2003. *Gender, health and equity: the intersections.* In *Health and Social Justice*, edited by Hofrichter R. Jossey-Bass, San Francisco.

Oswick C, Robertson M. 2009. Boundary objects reconsidered: from bridges and anchors to barricades and mazes. J Change Manage 9:179-193.

O'Toole T, Conde-Martel A, Gibbon JL et al. 2007. Where do people go when they first become homeless? A survey of homeless adults in the USA. Health Social Care Community 5: 446–453.

Oullette-Kuntz H, Garcin N, Lewis MES, et al. 2005. Addressing health disparities through promoting equity for individuals with intellectual disabilities. Can J Public Health 96: Suppl 2:s8-22.

Pachai B, Bishop H. 2006. *Historic Black Nova Scotia*. Nimbus Publishing Limited, Halifax.

Palloni A. 2006. Reproducing inequalities: luck, wallets, and the enduring effects of childhood health. Demography 43:587-615.

Paluck EL, Green DP. 2009. Prejudice reduction: what works? A review and assessment of research and practice. Annu Rev Psychol 60: 399-367.

Papanikolaou GN, Baltogianni MS, Contopoulos-Ioannidis et al. 2001. Reporting of conflicts of interest in guidelines of preventive and therapeutic interventions. BMC Med Res Method 1:3-7.

Pascale RT. 1999. Surfing the edge of chaos. Sloan Manage Rev 40:83-94.

Pederson A, Raphael D. 2006. Gender, race and health inequalities. In *Staying Alive*; edited by Raphael D, Bryant T, Rioux M. Canadian Scholars' Press, Toronto.

Pescosolido BA, Martin JK, Lang A, Olafsdottir S. 2008. Rethinking theoretical approaches to stigma: a framework integrating normative influences on stigma (FINIS). Soc Sci Med 67:431-440.

Peter E, Spalding K, Kenny N, Conrad P, McKeever P, Macfarlane A. 2007. Neither seen nor heard: children and homecare policy in Canada. Soc Sci Med 64:1624-1635.

Petticrew M, Whitehead M, Macintyre SJ, Graham H, Egan M. 2004. Evidence for public health policy on inequalities: 1. The reality according to policymakers. J Epidemiol Community Health 58:811-816.

Piccolo RF, Bardes M, Mayer DM, Judge TA. 2008. Does high-quality leader-member exchange accentuate the effects of organizational justice? Eur J Work Org Psychol 17: 273-298.

Picton RM. 2009. "A capital experience". National urban renewal, neoliberalism, and urban governance on LeBreton Flats in Ottawa, Ontario, Canada. Unpublished dissertation.

Phillips DC. 1972. The methodological basis of systems theory. Acad Manage J 15:469-477.

Pink S. 2001. *Visual ethnography*. Sage Publications, London.

Plesk P. 2000. Appendix B. Redesigning health care with insights from the science of complex adaptive systems. In *Crossing the Quality Chasm: a new health system for the 21st century*. The National Academy of Science, Washington, DC.

Plsek PE, Wilson T. 2001. Complexity, leadership, and management in healthcare organizations. Brit Med J 323:746-749.

Plotnick RD, Garfinkel I, McLanahan SS, Ku I. 2006. The impact of child support enforcement policy on non-marital childbearing. J Polic Anal Manage 26:79-98.

Pointer DD, Orlikoff JE. 1999. *Board work*. Jossey-Bass, San Francisco.

Poon M K-L. 2006. The discourse of oppression in contemporary gay Asian diasporal literature: liberation or limitation? Sex Cult 10:29-58.

Potter N. 2001. Feminism. Philosophy Psychiatry Psychology 8: 61-71.

Preskill H, Boyle S. 2008. Multidisciplinary model of evaluation capacity building. J Eval 29:443-459.

Psaty BM, Rennie D. 2006. Clinical trial investigators and the prescribing patterns, another dimension to the relationship between physician investigators and the pharmaceutical industry. J Amer Med Assoc 295:2787-2790.

Public Health Agency of Canada. Atlantic Region, vulnerable populations. 2007. www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Tides_of_change/4_e.html. (accessed January, 2010).

Purcell R. 2009. Images for change: community development, community arts and photography. Commun Develop J 44:111-122.

Qian W, Razzaque MA, Keng KA. 2007. Chinese cultural values and gift-giving behaviour. J Consum Mark 24:214-228.

Quantz D. 2001. Public participation in health policy: a case study of the Region 4 Aboriginal Community Health Council. Unpublished dissertation.

Racher FE, Vollman AR. 2002. Exploring the dimensions of access to health services: implications for nursing research and practice. Res Theory Nurs Pract 16:77-90.

Raine K, McIntyre L, Dayle JB. 2003. The failure of charitable school- and community-based nutrition programmes to feed hungry children. Crit Pub Health 13:155-169.

Raphael D. 2002. Addressing health inequalities on Canada. Internat J Health Care Qual Assur 15:i-viii.

Raphael D. 2006. Social determinants of health: present status, unanswered questions, and future directions. Int J Health Serv 36:651-676.

Raphael D. 2007. *Poverty and policy in Canada*. Canadian Scholars' Press Inc, Toronto.

Raphael D. 2009. *Social determinants of health*. 2nd edition. Canadian Scholar's Press Inc, Toronto.

Raphael D, Curry-Stevens A, Bryant T. 2008. Barriers to addressing the social determinants of health: insights from the Canadian experience. Health Policy 88:222-235.

Raphael D, Renwick R, Brown I et al. 2001. Making the links between community structure and individual well-being: community quality of life in Riverdale, Toronto, Canada. Health & Place 7:179-196.

Rau HE. 1998. A complex adaptive systems methodology for organizational assessment. Unpublished dissertation.

Reason P. 1999. Integrating action and reflection through co-operative inquiry. Manage Learn 30:207-226.

Reeves AJ. 2008. Honouring womanhood: understanding the conceptualization and social construction of young adult First Nation women's sexuality in Atlantic Canada. Unpublished dissertation.

Reitz-Pustejovsky M. 2003. Critical analysis of social politics and public policy addressing homelessness: an ethic of justice informing the practice of care. Unpublished dissertation.

Regine B, Lewin R. 2000. Leading at the edge: how leaders influence complex systems. Emergence 2:5-23.

Rennie D. 2004. Trial registration: a great idea switches from ignored to irresistible. J Amer Med Assoc 292:1359-1360.

Restoule BMM. 1999. Healing in Ojibwa First Nation communities: investigating the relationship among acculturation, health and identity. Unpublished dissertation.

Richards TN, Garland TS, Bumphus VW, Thompson R. 2010. Personal and political? Exploring the feminization of the American homeless population. J Poverty 14:97-115.

Riches G. 2002. Food banks and food security: welfare reform, human rights and social policy. Lessons from Canada? Soc Pol Admin 36:648-663.

Rioux M. 2006. The right to health. In *Staying Alive*, Editors: Raphael D, Bryant T, Rioux M. Canadian Scholars' Press Inc, Toronto.

Roder J. 2008. The Kikinaw Housing Project, Winnipeg Manitoba: green low-income housing, tenant-centred management, and resident well-being. Unpublished dissertation.

Rogers D. 2004. Before "care": Marietta Kies, Lucia Ames Mead, and feminist political theory. Hypatia 19:105-117.

Rootman I, Ronson B. 2005. Literacy and health research in Canada. Can J Public Health 96:Suppl 2:s62-77.

Ross DP. 2003. *Policy approaches to address the impact of poverty on health- a scan of policy literature*. Canadian Institution for Health Information.

Rosser WW, Kasperski J. 1999. Organizing primary care for an integrated system. Health*papers* 1:5-21.

Rothschild D. 2010. Partners in treatment: relational psychoanalysis and harm reduction therapy. J Clin Psychol 66:136-149.

Rounds K, Ormsby TC. 2005. Health policy for children and youth. http://www.sagepub.com/upm-data/5977_Chapter_5_Jenson_Fraser__I_Proof_3.pdf. (accessed January, 2010).

Roy D. 2004. Feminist theory in science: working toward a practical transformation. Hypatia 19:255-280.

Ruger JP. 2007. Health, health care, and incompletely theorized agreements: a normative theory of health policy decision making. J Health Politics, Policy and Law 32:51-87.

Rushton CH, Reina ML, Reina DS. 2007. Building trustworthy relationships with critically ill patients and families. Advan Crit Care 18:19-30.

Rutten A. 1995. The implementation of health promotion: a new structural perspective. Soc Sci Med 41:1627-1637.

Ryan GW, Stern SA, Hilton L et al. 2009. When, where, why and with whom homeless women engage in risky sexual behaviours: a framework for understanding complex and varied decision-making processes. Sex Roles 61:563-553.

Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. 1996. Evidence-based medicine. Brit Med J 312:71-72.

Sallis JE, Cervero RB, Ascher W, Henderson KA, Kraft MK, Kerr J. 2006. An ecological approach to creating active living communities. Ann Rev Public Health 27:297-322.

Saltman RB, Ferroussier-Davis O. 2000. The concept of stewardship in health policy. Bull WHO 78:732-739.

Sampson RJ. 2003. The neighborhood context of well-being. Perspect Biol Med 46:s53-64.

Sampson-Cordle AV. 2001. Exploring the relationships between a small rural school in Northeast Georgia and its community: an image-based study using participant-produced photographs. Unpublished dissertation.

Sands RG, Nuccio K. 1992. Postmodern feminist theory and social work. Social Work 37:489-494.

Schafer A. 2004. Biomedical conflicts of interest: a defence of the sequestration thesis-learning from the cases of Nancy Oliveri and David Healy. J Med Ethics 30:8-24.

Schultze U, Stabell C. 2004. Knowing what you don't know? Discourses and contradiction in knowledge management research. J Manage Studies 41:449-573.

Scott-Findlay S, Pollock C. 2004. Evidence, research, knowledge: a call for conceptual clarity. Evidence-Based Nurs 1:92-97.

Sedlak WC. 2008. Getting to know your neighbour: the efficacy of social networks in mixed-income housing. Unpublished dissertation.

Seifer SD, Sgambellurt A. 2008. Mobilizing partnerships for social change. Progress Community Health Partnerships: Research, Education, Action 2:81-82.

Sherwin S. 2004. BRCA testing: ethics lessons for the new genetics. Clin Invest Med 27:19-22.

Sherwin S. 2008. Whither bioethics? How feminism can help to reorient bioethics. Int J Feminist Approaches Bioethics 1:7-27.

Shlay AB, Rossi PH. 1992. Social science research and contemporary studies of homelessness. Ann Rev Sociol 18:129-160.

Siegel DL. 1997. The legacy of the personal: generating theory in feminism's third wave. Hypatia 12:46-75.

Sielbeck-Bowen KA, Brisolara S, Seigart D et al. 2002. Exploring feminist evaluation: the ground from which we rise. New Directions Eval 96:3-8.

Silvers A. 1995. Reconciling equality to difference: caring (f)or people with disabilities. Hyptia 10:30-55.

Silversin J, Kornacki MJ. 2000. Creating a physician compact that drives group success. Med Group Manage J 47:54-58.

Smith DE. 1990. *Texts, facts, and femininity*. Routledge, London.

Smith DE. 1997. Comment on Hekman's "Truth and method: feminist standpoint theory" revisited. Signs 22:392-398.

Smylie J, Fell D, Ohlsson A. 2009. A review of Aboriginal infant mortality rates in Canada: striking and persistent Aboriginal/ non-Aboriginal inequities. Can J Pub Health 101:143-148.

Sorin L. 2006. Perspectives on the use of indigenous healing practices: an indigenous research project. An unpublished dissertation.

Sollitto S, Hoffman S, Mehlman M, Lederman RJ et al. 2003. Intrinsic conflicts of interest in clinical research: a need for disclosure. Kennedy Instit Ethics J 13: 83-91.

Souliere D. 2004. Community engagement and the medicine wheel. Opportunities Waterloo Region. ISBN 0-9734467-2-2.

Spears SW. 2007. Bridging paradigms: a grounded theory study of individuals shifting ways of thinking. Unpublished dissertation.

Spitzer DL. 2005. Engendering health disparities. Can J Public Health 96: Suppl 2:s78-96.

Star SL, Griesemer JR. 1989. Institutional ecology, 'translations' and boundary objects: amateurs and professionals in Berkley's Museum of Vertebrate Zoology, 1907-39. Soc Stud Sci 19:387-420.

Starfield B. 2001. Basic concepts in population health and health care. J Epidemiol Community Health 55:452-454.

Steinman MA, Bero LA, Chren MM, Landefled CS. 2006. Narrative review: the promotion of Gabapentin: an analysis of internal industry documents. Ann Int Med 145:284-293.

Stevens PE, Hall JM. 1992. Applying critical theories to nursing in communities. Public Health Nurs 9:2-9.

Stewart M, Reutter L, Makwarimba E et al. 2005. Determinants of health-service use by low-income people. Can J Nurs Research 37:104-131.

Stokols D. 1996. Translating social ecological theory into guidelines for community health promotion. Amer J Health Prom 10:282-298.

Storberg-Walker J. 2007. Bowing from others: appropriating social capital theories for "doing HRD". Advan Develop Human Resour 9:312-340.

Stoudt BG. 2009. The role of language & discourse in the investigation of privilege: using participatory action research to discuss theory, develop methodology, & interrupt power. Urban Rev 41:7-28.

Strauss A, Corbin J. 1998. *Basics of qualitative research*. 2nd edition. Sage Publications, Thousand Oaks.

Stuber J, Meyer U, Link B. 2008. Stigma, prejudice, discrimination and health. Soc Sci Med 67:351-357.

Syme V, Mussell B. 2001. Aboriginal mental health: 'what works best?' http://www.carmha.ca/publications/aboriginal-mental-health-what-works-best. (accessed March, 2010).

Szreter S, Woolcock M. 2004. Health by association? Social capital, social theory, and the political economy on public health. Int J Epi 33:650-667.

Tarasuk V, Eakin JM. 2003. Charitable food assistance as symbolic gesture: an ethnographic study of food banks in Ontario. Soc Sci Med 56:1505-1515.

Teron AC, Tarasuk VS. 1999. Charitable food assistance: what are food bank users receiving? Can J Pub Health 90:382-384.

Terry SF, Burke W. 2003. Banning pens and pads misses the main point. Amer J Bioethics 3:63-65.

Thompson DF. 1993. Understanding financial conflicts of interest. N Eng J Med 329:573-576.

Thompson J, Baird P, Downie J. 2001. The Oliveri Report: the complete text of the report of the independent inquiry commissioned by the Canadian Association of University Teachers, Toronto: Lorimer. http://www.dal.ca/committeeofinquiry[25.7.05]. (accessed June, 2010).

Thorne S, Kirkham SR, MacDonald-Emes J. 1997. Interpretive description: a noncategorical qualitative alternate for developing nursing knowledge. Res Nurs Health 20:169-177.

Thurston WE, MacKean G, Vollman A et al. 2005. Public participation in regional health policy: a theoretical framework. Health Policy 73: 237-252.

Tonelli MR. 2007. Conflict of interest in clinical practice. Chest 132:664-670.

Torjman S, Leviten-Reid E. 2003. *The social role of local government*. Caledon Institute of Social Policy. ISBN 1-55382-049-5.

Torr R. 2007. What's wrong with *aspiring* to find out what has really happened in academic feminism's recent past? Feminist Theory 8:59-67.

Townsend E. 1994. Enabling empowerment or managing medical cases? Occupational therapy's mental health work. Unpublished dissertation.

Treadwell HM, Northridge ME. 2007. Oral health is the measure of a just society. J Health Care Poor Underserved 18:12-20.

Tsui J, Windsor C. 2001. Some cross-cultural evidence on ethical reasoning. J Bus Ethics 31:143-150.

Uhl-Bien M, Marion R, McKelvey B. 2007. Complexity leadership theory: shifting leadership from the industrial age to the knowledge era. Leadership Quart 18:298-318.

UN-HABITAT. 2006. Enabling shelter strategies: review of experience from two decades of implementation. www.unhabitat.org/programmes/housingpolicy/publications.asp. (accessed February, 2010).

Valera P, Gallin J, Schuk D, Davis N. 2009. "Trying to eat healthy": a photovoice study about women's access to healthy food in New York City. Affilia 24:300-314.

Varcoe C. 2006. Doing participatory action research in a racist world. West J Nurs Res 28:525-540.

Vaught SE, Castagno AE. 2008. "I don't think I'm a racist": critical race theory, teacher attitudes, and structural racism. Race Ethnicity Educ 11:95-113.

von Bertalanffy L. 1972. The history and status of general systems theory. Acad Manage J; Dec:407-426.

Wadsworth Y. 2008. Is it safe to talk about systems again yet? Self organ-ising processes for complex living systems and the dynamics of human inquiry. Syst Pract Act Res 21:153-170.

Walby S. 2000. In search of feminist theory. Feminist Theory 1:236-238.

Waldman JD. 2007. Thinking systems need systems thinking. Syst Res 24:271-284.

Wang C. 1999. Photovoice: a participatory action research strategy applied to women's health. J Women's Health 8:185-192.

Wang C, Burris MA. 1997. Photovoice: concept, methodology, and use for participatory needs assessment. Health Educ Behav 24:369-387.

Wang CC, Redwood-Jones YA. 2001. Photovoice ethics: perspectives from Flint photovoice. Health Educ & Behav 28:560-572.

Warren S. 2005. Photography and voice in critical qualitative management research. Account, Audit Account J 18:861-882.

Wasserman JA, Clair JM, Wilson KL. 2009. Problematics of grounded theory: innovations for developing an increasingly rigorous qualitative method. Qual Res 9:355-381.

Watkins JM, Mohr BJ. 2001. *Appreciative inquiry*. Jossey-Bass, San Francisco.

Watson G. 2005. Socrates' mistake. Amer Scholar 74:78-87.

Webster's College Dictionary. 1991. Random House. New York.

Wentzel SL, Green HD, Tucker JS, et al. 2009. The social context of homeless women's alcohol and drug use. Drug Alcohol Depend 105:16-23.

Westheimer J, Kahne J. 2004. What kind of citizen? The politics of educating for democracy. Amer Educ Res J 41:237-269.

White DD, Wutich A, Larson KL et al. 2010. Credibility, salience and legitimacy of boundary objects: water managers' assessment of a simulation model in an immersive decision theatre. Sci Public Policy 37:219-232.

Whitehead M, Petticrew M, Graham H, Macintyre SJ, Bambra C, Egan M. 2004. Evidence for public health policy on inequalities: 2. Assembling the evidence jigsaw. J Epidemiol Community Health 58:817-821.

Whitener LM. 2000. Using Hongvivatana's model to evaluate health care access: a field study of adolescent women's access to reproductive health care services in rural Missouri counties. Unpublished dissertation.

Wicks D. 2004. The institution of tenure: freedom or discipline? Manage Decis 42:619-627.

Wicks R, Trevena LJ, Quine S. 2006. Experiences of food insecurity among urban soup kitchen consumers: insights for improving nutrition and well-being. J Amer Diet Assoc 106:921-924.

Williams D (editor). 2007. *Black Women Who Made a Difference in Nova Scotia*. Halcraft Printers, Novs Scotia.

Williams R, Fulford KWM. 2007. Evidence-based and values-based policy, management and practice in child and adolescent mental health services. Clin Child Psychol Psychiat 12:223-242.

Wilson J, Musick M. 1999. The effects of volunteering on the volunteer. Law Contemp Probl 62:141-168.

Wilson K, Eyles J, Elliott S, Keller-Olaman S. 2009. Health in Hamilton neighbourhoods: exploring the determinants of health at the local level. Health & Place 15:374-382.

Wilson K, McCrea-Logie J, Lazar H. 2004. Understanding the impact of intergovernmental relations on public health: lessons from reform initiatives in the Blood System and Health Surveillance. Can Public Policy 30:177-194.

Winter B. 2000. Who counts (or doesn't count) what as feminist theory? Feminist Theory 1:105-111.

Witherbee N. 2008. Homeless prevention: back in community hands. Unpublished dissertation.

Woolf SH, Johnson RE, Fryer GE, Rust G, Satcher D. 2004. The health impact of resolving racial disparities: an analysis of US mortality data. Am J Public Health 94:2078-2081.

World Health Report. 2000. *Health systems: improving performance*. Printed by the World Health Organization.

Wuest J. 1994. A feminist approach to concept analysis. West J Nurs Res 16:577-586.

Wuest J, Merritt-Gray M. 2001. Feminist grounded theory revisited: practical issues and new understandings. Chapter 8. In *Using Grounded Theory in Nursing*. Eds. Schreiber RS, Stern PN. Springer Publishing Company.

Young J. 2010. Migration, ethnicity and privilege: an exploration of representation and accountability. Sys Pract Action Res 23:101-113.

Zimmerman B, Lindberg C, Plesk P. 2001. *Edgeware: insights from complexity science for health care leaders.* VHA Inc, Texas.

Zins C. 2007. Conceptual approaches for defining data, information, and knowledge. J Amer Soc Info Sci Tech58:479-493.

Zippay A, Thompson A. 2007. Psychiatric housing: locational patterns and choice. Amer J Orthopsych 77:392-401.

Zufferey C. 2009. Making gender visible: social work responses to homelessness. J Women Soc Work 24:382-393.