EVALUATION OF COMMUNITY EMPOWERMENT IN A COMMUNITY-BASED HEALTH PROMOTION PARTNERSHIP

by

Jennifer L. Scarr

B.N., The University of Manitoba, 1990

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING in THE FACULTY OF GRADUATE STUDIES

The School of Nursing

We accept this thesis as conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

October, 2000

© Jennifer L. Scarr, 2000
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of School of Nursing

The University of British Columbia
Vancouver, Canada

Date Oct 6, 2000
A qualitative evaluation of community empowerment in a community-based health promotion project, Hand-In-Hand, was completed. Hand-In-Hand offers a free weekly drop-in service where families are able to access information and services pertaining to their health and developmental issues. The project was developed by a steering committee comprised of health care providers and community members to address two main concerns expressed by community women: difficulty accessing health information and services, and a perceived lack of respect from the health care system.

Four community women, members of the Hand-In-Hand steering committee, were interviewed for the study. The data from the interviews was analyzed using the qualitative research methods of inductive content analysis and constant comparative analysis. The findings indicated that six phases were instrumental in the process of community empowerment: initial involvement, building relationships, demonstrating commitment, building partnerships, achieving individual empowerment, and increasing community capacity. Outcomes related to each of the phases were identified. The process of community empowerment was iterative rather than linear. The participants moved freely between the phases as they proceeded to the final phase of community empowerment.

The process and outcomes of community empowerment have implications for nursing research, practice, education, and administration, along with health policy. The lessons learned from this study should contribute to a better understanding of the process of community empowerment, education of community health practitioners, and support of community initiatives by health care administrators and leaders.
Community

Somewhere there are people
  to whom we can speak with passion
  without having the words catch in our throats.
Somewhere a circle of hands will open to receive us,
  eyes will light up as we enter, voices will celebrate with us
  whenever we come into our own power.
Community means strength that joins our strength
  to do the work that needs to be done.
  Arms to hold us when we falter.
  A circle of healing. A circle of friends.
  Someplace where we can be free.

(Baldwin, 1998)
# TABLE OF CONTENTS

ABSTRACT .............................................. ii

LIST OF FIGURES ..................................... vi

ACKNOWLEDGMENTS ................................... vii

CHAPTER ONE: INTRODUCTION ...................... 1
    Background of the Problem ...................... 1
    Problem Statement ................................ 1
    Significance of the Study ...................... 2
    Purpose .......................................... 3
    Research Question ................................ 3
    Definition of Terms .............................. 3
    Summary ........................................ 4

CHAPTER TWO: LITERATURE REVIEW .............. 5
    Empowerment in Health Promotion .............. 5
    Empowerment within Community-Based Partnerships 7
    A Definition of Empowerment .................. 10
    The Evaluation of Empowerment ................ 12
    Summary ........................................ 14

CHAPTER THREE: RESEARCH METHODS .......... 15
    Research Design .................................. 15
    Study Participants ................................ 15
    Process of Information Sharing and Recruitment 16
    Data Collection .................................. 16
    Data Analysis and Interpretation .............. 17
    Rigor in Qualitative Research .................. 19
        Reliability .................................... 19
        Validity ...................................... 20
    Ethical Considerations .......................... 20
    Assumptions ..................................... 21
    Summary ........................................ 22

CHAPTER FOUR: PRESENTATION OF FINDINGS ... 23
    Background of the Hand-In-Hand Project ........ 23
    Overview of the Research Project .............. 24
    Initial Involvement ................................ 28
    Relationship Building ............................ 29
    Demonstrating Commitment ...................... 33
    Partnership Building ............................ 35
LIST OF FIGURES

Figure 1: Process of Community Empowerment 26
ACKNOWLEDGMENTS

To my husband, David, for his ongoing support and encouragement, it has not gone unnoticed. To my daughter, Erin, for her understanding that can be seen in her two year old smiles. To the members of my thesis committee, I would like to recognize their expertise and assistance in the completion of the thesis. And lastly, to the four community women who allowed me to listen to their stories: I would like to express my deepest gratitude.

Thank you, all.
CHAPTER ONE
INTRODUCTION

Background of the Problem

The rhetoric surrounding empowerment has grown significantly during this current age of community health awareness. Empowerment has become a well-discussed and trendy buzzword but it has not been suitably quantified or measured (Lord & McKillop Farlow, 1990; Rissel, 1994). A common use of terms and language would make communication about empowerment easier and assist in the establishment of a clear definition so that the evaluation can proceed (Rissel). In addition, The Canadian Public Health Association, in the Action Statement for Health Promotion in Canada (1996), asserted that the development of evaluation methods for community-based health promotion work is needed in order for health professionals to increase the efficiency of the health care system. The increased emphasis on community development initiatives has shifted the focus from the individual to the community when addressing issues of empowerment. With more and more health care providers encouraging community members to get involved in the planning and implementation of health services, it becomes imperative that community empowerment is defined and evaluated.

Problem Statement

The study evaluated a community-based health promotion partnership, specifically the Hand-In-Hand project; a free weekly drop-in, where families were invited to access information and services pertaining to their health and developmental issues. The stated purpose of Hand-In-Hand was that, through a collaborative partnership between service providers and community members, a community-based health
promotion service would be developed to address the difficulty of accessing health information and services and the perceived lack of respect from the health care system. Through a weekly drop-in health service, families with children were able to access community health nurses, counselors, and a pediatrician in a respectful and comfortable environment. A steering committee, comprised of community members, service providers, and health care providers, met regularly to discuss issues and plan solutions associated with the project. In addition, families who had used the service were encouraged to become involved in planning, providing, monitoring, and evaluating the program. In this way families and service providers worked together to address the program’s stated goals and build relationships among program participants.

Although the service has been operating for almost two years, the aspect of empowerment, and more specifically community empowerment, has not been critically analyzed or evaluated. In this research project, Hand-In-Hand was evaluated by examining community empowerment in a community-based health promotion partnership.

Significance of the Study

Through the evaluation of a community-based health service, health care providers gain knowledge about community empowerment. Determining a common definition of empowerment will facilitate the process of evaluating community development initiatives. Examining the process of community empowerment provides opportunities to engage community members in building community capacity. The information collected in this study could be used to train effective community developers and to increase support for community-based health promotion initiatives.
Purpose

The purpose of this study was to evaluate community empowerment in a community-based health promotion partnership, Hand-In-Hand.

Research Question

Do community members who are part of the community-based health promotion partnership (Hand-In-Hand) experience community empowerment?

Subsidiary questions arising from the overall research question included:

1. What is the nature of the relationship of community members with Hand-In-Hand health care providers?
2. What is the nature of the relationship of community members with other health care providers?
3. Is there evidence of increased involvement in the community by community members?
4. Is there evidence of increased involvement by community members with other community issues?

Definition of Terms

Hand-In-Hand: a free weekly drop-in, where all families are invited to access information and services pertaining to their own health and developmental issues.

Community Empowerment: an increased level of individual (personal and psychological) empowerment with a socio-political action component in which members have actively participated, and the achievement of some redistribution of resources or decision making favorable to the community or group in question (Rissel, 1994).

Steering Committee Members: a group of partners in the project, including health care
providers, service providers, and community members.

Community Members: women of different ethnic cultures whom live or frequent the Grandview-Woodlands area. These women are representatives of various community groups that were involved in focus group discussions to determine the community's specific health concerns.

Health Care Providers: community health nurses, counselors, and a pediatrician.

Summary

The research undertaken in this study focuses on the evaluation of community empowerment within a community-based health promotion partnership, Hand-In-Hand. With an increased emphasis on community development initiatives focusing on the community rather than the individual, it becomes imperative that community empowerment is defined and evaluated. Through the evaluation of a community-based health promotion partnership health care providers are better able to identify and explain community empowerment and function as effective community developers.

The next chapter includes a review of relevant literature, followed by an explanation of the research methodology, and presentation of the findings. After the findings are discussed, conclusions will be drawn, and implications for nursing and health policy will be summarized.
CHAPTER TWO

Literature Review

Canadians take pride in the universal health care system that they have enjoyed for many years. Although the universal nature of the health care system is beneficial to many, it tends to undermine the identity of minority groups (Fuller, 1997). With a health care system that treats all people the same, ethnic minority clients' beliefs, actions, and experiences are often disregarded (Fuller). The challenges that immigrants face range from securing affordable housing, learning a new language, upgrading qualifications for career opportunities, and coping with family tension (Matuk, 1996). To make the Canadian health care system truly "universal," all groups in Canadian society, including ethnic minority and immigrant populations, must be invited to participate in the development of health care services so that culturally specific health needs can be determined. By evaluating community empowerment in a community-based health promotion partnership that specifically addresses immigrant groups, health care providers would be better equipped to facilitate the participation of all populations. In order to provide the context for the evaluation, the literature regarding empowerment within health promotion and community-based partnerships will be reviewed and analyzed. From the information provided by the literature review, a definition of community empowerment will be developed. The community empowerment definition will assist in the evaluation of a community-based health promotion partnership, Hand-In-Hand.

Empowerment in Health Promotion

Throughout the health promotion literature, the central focus has been on how health professionals can encourage people to take control over their own health. The idea
of "control" can be directly linked to the concept of empowerment. For example, the World Health Organization (WHO), Health and Welfare Canada, and the Canadian Public Health Association (CPHA) (1986) in the Ottawa Charter for Health Promotion defined health promotion as the process of enabling people to increase control over, and improve their health. Furthermore, Reutter and Ford (1997) stated that enhancing client competence through the strategy of validating, and then building on client strengths, is foundational to health promotion. The building of strengths continues throughout the helping process and develops the client's capacity for autonomy and responsibility (Zerwekh, 1992). More recently, the Canadian Public Health Association's (1996) statement of health promotion principles; i.e., respecting the individual's self-worth, intelligence and capacity of choice, also points to the importance of enhancing the client's capacity to take control over their health.

Although health promotion is about individuals taking control of their health, people must be "empowered" in order for them to accomplish the task of regulating their health behaviors (Raeburn, 1992; Reutter & Ford, 1997; Zerwekh, 1992). Through empowerment, the people whose health and well-being are of concern set their own goals and priorities, make their own decisions, and determine their own destinies (Raeburn). By these guidelines empowerment is a process whereby people move from being dependent and powerless to feeling a sense of control and participatory competence (Lord & McKillop Farlow, 1990). Rissel (1994) has labeled this phenomenon as “psychological empowerment, whereby individuals have a feeling of greater control over their own lives following active membership in groups or organizations” (p.45). It is individuals, not health professionals, who determine when they have control over their lives and whether
they are empowered. If the power of defining health belongs to those experiencing it then health professionals must surrender the need to control and become effective resources for community health development (Labonte, 1989). Consequently, it is the individual who has ownership over his/her health behaviors, and determines when empowerment has been achieved. Furthermore, empowerment is something that does not occur purely from within, nor can it be done for others; rather, it describes our intentional efforts to create more equitable relationships with one another in order to facilitate empowerment (Registered Nurses Association of British Columbia (RNABC), 1992).

**Empowerment within Community-based Partnerships**

For empowerment to fit within the community-based health promotion perspective, an increase in community capacity must be demonstrated. Health promotion activities that support and strengthen community groups help to create healthy living conditions and healthy lifestyle within these groups (CPHA, 1996). In that context, the vital components required to build community capacity include the development of partnerships and the facilitation of participation (Kang, 1995; Kickbusch, 1984). The initial steps to increasing community capacity include health promotion initiatives that transfer power from health professionals to community members. McKnight (1995) stated that community capacity requires a shared responsibility of people with many talents. As each community member's capacities are recognized, the collective power of the group is represented (McKnight). Initiatives proposed to strengthen community capacity rely on the formation of partnerships and community participation in order to implement successful change.

Through partnerships with health professionals, the community works to define its
problems, to set priorities for action, and to design solutions, in which community members assume active leadership roles (Courtney, Ballard, Fauver, Gariota, & Holland, 1996). This concept of health partnerships offers new approaches for linking health providers and communities to create a health care system that is responsive to local needs (Pender, 1996). Additionally, partnerships offer a means of communication and collaboration that can assist the community in obtaining the power to identify and achieve solutions that they would not be able to do on their own (Pender). The concept of partnership requires a transformation of the professional role from chief actor to partner while at the same time, the client role changes from passive recipient to partner (Courtney et al.). In the pursuit of a healthier, more capable community this reformulated community-health professional partnership is crucial (Courtney et al.). It is only by considering both professional knowledge and community expertise that the community will be able to define its own health and well-being and act more effectively on its own behalf (Courtney et al.; Hughes, 1995; Stewart, 1995). Therefore, authentic partnerships that are formed between health professionals and community members have the potential to build community capacity and to enhance community empowerment.

Whereas partnerships between community members and health professionals help to build community capacity, it is the sense of being valued, together with the initial act of participation, that leads the person to gradually assume more responsibility within the group or organization (Lord & McKillop Farlow, 1990). In Lord and McKillop Farlow’s study, the authors discovered that as people gained in self-confidence, they sought out more avenues for participation; involvement in community activity enhances self-confidence and sense of personal control. With an increased sense of personal control,
community members hold the power to define their own health needs and develop appropriate health promotion initiatives. Strategies used by health care professionals, such as, encouraging community members to invest time in the planning of health initiatives that will benefit residents, help to promote public participation, and are a major aspect of community empowerment (Kang, 1995; Stachenko, 1994). Moreover, because it is important to encourage community participation, mechanisms that engage people in dialogues about community development processes need to be determined in an effort to enable them to participate and to experience personal growth (Lord & McKillop Farlow, 1990). Partnership and participation are both essential to the building of community capacity.

If the first step towards empowerment is to return to the community the power of definition, then an initiative can only be classified as health promotion if it involves the process of enabling and empowering individuals or communities (Labonte, 1987; Rootman & Goodstadt, 1996). Before the community defines its health needs, it must first determine who will be included in the community. McKnight (1997) ascertained that a universally accepted definition of community is lacking. Therefore, it is patronizing to believe that health professionals are able to determine community membership; it is important that the community members themselves are given the opportunity to define their community. From a sense of personal control and competence, and the establishment of a working relationship between community members and health professionals, participants become conscious of their own capacities and rights and are able to describe and define their community (Lord & McKillop Farlow, 1990).

Inasmuch as increased community capacity is essential to the empowerment of
communities; the element of ownership must also be addressed in an effort to fully understand empowerment in the community-based health promotion perspective. It has been demonstrated that without health professionals giving up ownership of the health program, the community does not really embrace the program and the initiative fails to address the community's actual health needs (Demers & White, 1997). When designing health programs, health professionals need to recognize that for a power transfer to occur and equality to be established, the program participants must be the ones to identify the problems and plan the solutions (Lord & McKillop Farlow, 1990). Community-based services are built on collaboration and partnerships between community members and health care providers (Flynn, 1997). It has been argued that the community's contribution to health needs assessments and public policy activities creates ownership in determining public health programs (Kang, 1995). With effective community collaboration and building on community assets, creative strategies and approaches to solving community problems can be developed (Flynn). Consequently, health professionals can no longer act unilaterally in their attempt to solve problems for people; community members must be involved in developing their own solutions (Courtney et al., 1996).

A Definition of Empowerment

Through the analysis and synthesis of the health promotion literature, it has been determined that “community empowerment” is the definition that best assists in the evaluation of community-based health promotion partnerships. Rissel (1994) described community empowerment as a “raised level of psychological empowerment among its members, with a socio-political action component in which members have actively participated, and the achievement of some redistribution of resources or decision making
favorable to the community or group in question" (p.45). In addition to community participation, this definition includes the aspects of individual/psychological empowerment along with community empowerment. The relationship between individual/psychological and community empowerment is symbiotic, with the components of the former essential to the success of the latter. In order to satisfy the elements of community empowerment, there must be evidence of psychological empowerment of individuals.

At the same time as participation in and influence over a group or organization is an important stage of both individual and community empowerment, participation in collective action is also fundamental to the successful redistribution of resources (Kang, 1995). In addition to individual empowerment, a group or organization must be able to demonstrate a positive change in the socio-political environment of their community (Rissel, 1994). The mutuality of contribution in terms of individual and community empowerment is necessary for alleviating problems and assisting in the measurement of successful change (Kang). Communities that are empowered through organization and active participation develop leaders with leadership skills and are able to attack an array of conditions that compromise their health and well being (Pender, 1996). Collective action and consciousness-raising through the development of a more caring and politically competent community become the first step in addressing the social and environmental determinants of health (Shiel & Hawe, 1996).

Although the community health movement was initiated in part to counter the trends of individualism and authoritarianism (by reducing inequity and fostering empowerment of people so that they can take control of their own health destinies), the
approaches to practically all health promotion projects are, in fact, expert-driven (Guldan, 1996). Expert-driven projects presuppose that individuals can take control of their lives by following expert guidelines. It is known that communities become marginalized and invisible in the project conceptualizations, planning, and implementation, when external agencies impose their conditions (Guldan). Groups without power, or who report feeling powerless, experience a decreased level of health status (Rissel, 1994). Alternatively, community empowerment offers possibilities for demonstrating direct physical health improvements through the effects of structural changes achieved through collective political action (Rissel).

The Evaluation of Empowerment

The evaluation of empowerment in community-based health promotion partnerships is relevant in these times of decreasing healthcare dollars and increasing demands on the healthcare system. With little current research to explain the process whereby people move from being dependent and powerless to feeling a sense of control and participatory competence, it becomes important to demonstrate the extent to which any new program actually succeeds in empowering a community and the impact that community control has on collective health (Lord & McKillop Farlow, 1990; Shiel & Hawe, 1996). Rissel (1994) has proposed that longitudinal studies are needed that not only look at end-points, but also at the process and elements necessary for achieving community empowerment. With a better method of capturing and measuring empowerment in studies, researchers will be closer in determining whether there is a relationship between empowerment and health measures (Rissel).

To evaluate community empowerment it is important that, along with evidence of
outcome, there is an indication of process. The process that is best suited for the task of evaluation is community development, which has all of the basic elements inherent to community empowerment. Through health professional and community partnerships, the participants in community development are able to change or redistribute resources that affect their health and well being by determining, acting on, and evaluating a plan of action. For example, Hand-In-Hand was developed through a collaborative partnership between various service providers and community members to address the issues of accessibility and respectability of health information and health care services. By demonstrating a successful community development process, community members are closer to satisfying the elements essential for community empowerment. The first step in evaluating community empowerment in community-based health promotion partnerships, therefore, is to determine whether there is evidence of community development (Rissel, 1994).

By using the community development process, health professionals are able to extend professional timelines in order to move communities towards the outcome of empowerment. For example, by spending large amounts of time securing the necessary resources, health professionals are able to assist both advantaged and disadvantaged communities in the completion of a community development project. Community development is successful when the community members set the agenda and decide on which issues and goals to address, while the health care professional facilitates the process.

Ideally, the outcome of the community empowerment process is to increase individual empowerment among community members and actually enhance their control
over resources (Rissel, 1994). Individual empowerment notwithstanding, a measure of community empowerment or competence cannot simply be obtained by summing up empowered individuals (Shiel & Hawe, 1996). Breslow and Tai-Seale (1996) discovered that the transition to community empowerment occurred only when local people became more deeply involved in issues that affected their communities. Therefore, an increase in the control over resources, a positive change in the socio-political environment, and an increase in the reported level of individual empowerment are the appropriate outcomes for evaluating empowerment in a health promotion program (Rissel).

Summary

There is ample literature focusing on the concept of empowerment, yet there is limited literature about its evaluation. More specifically, the literature on the evaluation of community empowerment is clearly lacking. It was determined that the concept of empowerment is located within both health promotion and community-based partnership literature. A definition of community empowerment was developed in order to facilitate the evaluation of a community-based health promotion partnership. In addition, outcomes were identified to decide whether community empowerment was achieved.
CHAPTER THREE

RESEARCH METHODS

A qualitative descriptive design was used to identify concepts that could be linked to outcomes associated with community empowerment. Inductive content analysis was the method of choice. A description is provided of the study participants, recruitment procedures, and the ethical considerations associated with the study. The processes of data collection, analysis, and interpretation are presented. The issue of rigor in qualitative research is discussed as it related to the processes used in this study.

Research Design

In order to gain a better understanding of community members’ experiences in a community-based health promotion partnership, qualitative methods were used for data collection and analysis. The experiential information was necessary in order to determine the success of community empowerment through the Hand-In-Hand project. The participants were asked to describe their current and previous experiences with the project. The method that appeared most appropriate for this retrospective study was inductive content analysis. Inductive content analysis is the systematic and objective reduction or simplification of recorded language to a set of categories that represent the presence, intensity, or nature of selected characteristics (Waltz, Strickland, & Lenz, 1991). In addition to inductive content analysis, the researcher also utilized the techniques of constant comparative analysis, which assisted in the description of the experience and an evaluation of whether the outcomes had been achieved.

Study Participants

A sample of convenience, comprised of the Hand-In-Hand steering committee
members who were also community members, was used. By limiting the sample to community members, the researcher was able to focus on their experiences with the Hand-In-Hand project and to evaluate their perception of community empowerment.

Criteria for inclusion included:

1. Past or present member of the Hand-In-Hand steering committee
2. A community member.
3. English speaking.

Process of Information Sharing and Recruitment

The researcher discussed the research proposal with the steering committee including community members during a regularly scheduled meeting. After the steering committee reviewed and approved the study, the community members of the steering committee (hereafter referred to as community members) were given an Information Letter (Appendix A). Community members who were interested in participating in the study were invited to contact the researcher at their convenience. Once participants volunteered, the researcher further clarified the study and its procedure in person or by phone. At this time, the researcher and participant scheduled an interview at a mutually convenient place and time. Each participant was asked to sign a consent form (Appendix B). Sample size for this study was determined by saturation (i.e. additional information did not provide further insight into the discovered categories) of the data.

Data Collection

Interviews were conducted using a semi-structured interview guide (Appendix C). Predetermined open-ended trigger questions were used during the initial stages of the interview to develop a rapport with the participant (Appendix C). These general questions
allowed the participant to freely discuss her experiences at Hand-In-Hand. In addition, specific open-ended questions were used to elicit experiential information pertaining to the nature of the partnership and community capacity, so that evaluation of community empowerment could be undertaken. The questions were revised by the researcher and community members to clarify concepts and to elicit data in more depth. The data were collected during a face-to-face interview lasting approximately one hour. Interviews were audio tape-recorded and transcribed verbatim. Data were collected until saturation had been reached. Saturation determined sample size.

Data Analysis and Interpretation

For the purposes of this study, inductive content analysis was used which includes: defining the universe of content to be examined, identifying the concepts to be measured, selecting the unit of analysis, developing the sampling plan, and determining a way of categorizing the content (Krippendorff, 1980). The interviews were also analyzed using continuous comparative analysis (Glaser & Strauss, 1967; Maxwell & Maxwell, 1980):

1. Analytic units were created: Interviews were tape-recorded and transcribed verbatim.

2. Concepts to be assessed were identified: The interview questions were designed to ascertain changes in relationships with health care providers, evidence of increased community involvement, and indication of engagement with other community issues. These questions were designed to elicit descriptive categories that would provide insight about the participants’ individual empowerment and their sense of community empowerment.
3. Units of analysis to be employed were selected: The phrases and sentences from
the participants' interviews served as the units of analysis.

4. Sampling plan was developed: For this study the sampling plan involved
examining the entire universe of content.

5. Content was categorized: The researcher categorized the content by inducing
emergent categories and concepts that addressed outcomes associated with individual and
community empowerment.

6. Interviews were analyzed: The researcher analyzed the interviews using
(a) The process of continuous comparative analysis began with analyzing each
interview immediately following the interview. The researcher read each interview twice
to get an overall picture of the participant's experience. During the third and fourth
readings the interview was broken down into words or phrases. Preliminary coding began
with the researcher determining words or phrases with common themes or meanings.
Common themes or categories were grouped together, with notations regarding the
common themes or categories written in the margins.
(b) Once two or three interviews had been coded as per above, the researcher
compared and contrasted the interviews with all of the previous ones. The researcher
coded a word or phrase for a category and compared it with previous words or phrases in
the same and different categories (Glaser & Strauss, p.106). By comparing, contrasting,
and questioning each interview with the preceding interviews the researcher was able to
uncover similarities and differences or patterns in the data and to further develop
categories (Maxwell & Maxwell, 1980). Along with the margin notes, the researcher
wrote memos to document the ongoing emergence of similar themes or to record conflicts in her thinking. Memoing was used to keep the researcher's analysis fresh and to develop categories in the most logical manner (Glaser & Strauss). The discovered patterns provided the researcher with tentative conceptual categories and concepts (Maxwell & Maxwell).

(c) After completing steps (a) and (b) the researcher went back to the transcribed interviews and further refined the categories and concepts. Again, memos were written to document the process of modifying categories and concepts. Constant comparative methods continued to be used throughout the analysis. As categories and concepts developed they were refined in later interviews. Comparisons were made among and between the generated concepts and the theoretical concepts from the existing literature. The comparisons, which aided in the development of each concept's characteristics, were a constant and on-going process that continually generated new properties (Maxwell & Maxwell, 1980).

(d) Each interview was read for a sense of the experience, similar concepts were grouped into a more general category, labeled categories were compared and contrasted with ones discovered in previous interviews. The process of assigning labels to categories was accomplished through a review of the relevant literature and re-reading each interview. Out of this arose the concepts that represented the phases and outcomes in the process of community empowerment.

Rigor in Qualitative Research

Reliability

To address the reliability of the study, the researcher documented the data analysis
through an audit trail. In an audit trail, the researcher provides a clear delineation of the units to be categorized and the rules for assigning them to categories so that the reader is able to understand how codes, concepts, and categories were discovered (Waltz et al., 1991). In addition, the researcher had the thesis committee members independently review and categorize the data; using similar procedures to those outlined by Maxwell and Maxwell (1980). The results suggested that the interpretation was reliable or could be reproduced. By addressing the issue of reliability another researcher would be able to replicate the study, thus assuring that the analytical results represent something real (Krippendorff, 1980).

Validity

Validation was accomplished through a second interview with two of the study participants. Each participant read a summary of the analysis and offered feedback to the researcher about whether the analysis captured their understanding of the experience. Specifically, the participants were asked if the phases and content reflected their experience with the Hand-In-Hand project. The information obtained in all of the discussions was used to clarify, expand, and verify the information from the initial interviews. Consultations with thesis committee members about the similarity between concepts and processes and interview data assisted in the confidence about the validity of the findings.

Ethical Considerations

To protect the rights of the participants in this study, several procedures were undertaken before the study could proceed. Prior to contacting participants, the proposal was reviewed by the University of British Columbia Behavioral Sciences Screening
Committee and the Vancouver/Richmond Health Board (Appendix D). In addition, a letter of support was obtained from The Vancouver Aboriginal Friendship Centre Society (Appendix E).

The purpose of the study was explained verbally to the participants by the researcher and community members were given a written Information Letter (Appendix A). Participants were asked to sign a consent form (Appendix B). A signed copy of the consent form was given to each participant. The written consent stated that the participants could withdraw from the study at any time without penalty. The consent form also informed participants that they could refuse to answer questions or request erasure of any audio-tape or portion of an audio-tape at any time during the study. Confidentiality was maintained by coding the participants' names so that identities were known only to the researcher. Access to the data, audio-tapes, transcriptions, and memos were limited to the researcher and members of the thesis committee. Audio-tapes, transcripts, and research memos were stored in a locked cabinet at the researcher's residence. All material pertaining to the research (audio-tapes, transcripts, and memos) will be kept in a locked environment for one year after completion of the research study. After this time period has expired all audio-tapes will be erased and transcripts and memos will be destroyed. Published and unpublished materials do not include names of persons or institutions or any other identifying information.

Assumptions

It was assumed that the participants in the study would answer the research questions with honesty and insight. Furthermore, by guaranteeing the participants anonymity, the researcher re-assured the participants that their participation in the study
would not affect the care they received from Hand-In-Hand service providers.

The researcher was also a Hand-In-Hand service provider and was aware of the potential for her biases to affect the analysis and coercion in terms of participants feeling pressured to participate in the study. Issues regarding bias were addressed through reflective journaling, openness to participants' feedback, and postanalysis discussions. Coercion was addressed through encouraging potential participants to contact the researcher after receiving the information letter rather than having the researcher initiate contact.

**Summary**

In summary, qualitative methods were used for data collection and analysis. It was determined that inductive content analysis was the most appropriate method for the study. A total of four women, who were community members of the Hand-In-Hand steering committee, were interviewed. Through open-ended questions the participants were able to describe their past and present experiences with the Hand-In-Hand project. The process of inductive content analysis assisted the participants in verbalizing how their experience with Hand-In-Hand had affected their perceptions of individual and community empowerment. Continuous comparative analysis was used to develop the categories followed by community members verifying and validating the emerging process, categories, and outcomes.
CHAPTER FOUR
PRESENTATION OF FINDINGS

Background of the Hand-In-Hand Project

Two community health nurses from the Vancouver/Richmond Health Board (Community Health Area 2), and a faculty member, with community health experience, from the University of British Columbia School of Nursing, initiated the community-based health promotion project. Community health nurses were questioning the traditional service delivery to families with young children, particularly those that were considered socially isolated. The nurses were of the opinion that the community health services that were offered to these families were not meeting their needs. Research expertise and support was obtained from the University of British Columbia School of Nursing faculty member who was not only familiar with the community health services, but was also interested in generating research regarding the health issues of families in the community.

Initially, the two nurses and the faculty member met with facilitators of existing multiethnic women's groups (Polish, Vietnamese, Latin American, Aboriginal, and Anglo-Canadian) to discuss the issue of appropriateness of community health service delivery and determine whether this topic would be of interest to their group members. After this discussion, it was decided that more general questions about the women's experiences with the Canadian health care services would be addressed in focus group sessions. Once informed consent had been obtained, the focus group discussions took place in women's groups, which were meeting regularly for many reasons: parenting support, anger management, and social networking. The women from the established
groups were invited to discuss their experiences with the Canadian health care system. After the women told their stories and the stories were compared and contrasted to other focus group discussions, the community health nurses and the faculty member analyzed the focus group conversations and determined common themes. These themes were verified when they returned to the original groups to confer about the commonalities among the groups. All of the focus group participants were invited to engage in further dialogue with the nurses in a project, with the hope of effecting some sort of change within the health care system. The changes requested by the participants were to make health information more accessible and health services culturally sensitive and more respectful. Through this process a small group of women representing various groups became part of the steering committee for the Hand-In-Hand project. The steering committee decided that the name Hand-In-Hand best described how health care providers and community members were trying to work together to make positive changes to the health care system.

Overview of the Research Project

Four community women from the Hand-In-Hand steering committee responded to an invitation from the researcher (one of the community health nurses originally involved in the Hand-In-Hand project) to participate in a study (Appendix A). The participants were asked to describe their experience in the Hand-In-Hand project, a community-based health promotion partnership. The women were interviewed for approximately one hour. All of the study participant's had immigrated to Canada; English was their second language. The women had children of various ages and the women worked outside of the home or attended school.
Inductive content analysis was used to analyze the data with categories developed using the principles of continuous comparative analysis. Labels for categories were assigned that fit with existing literature and reflected the content of the interviews. Validation was accomplished through re-interviewing two of the study participants and through conferences about the data analysis and the findings with thesis committee members. Each participant read a summary of the analysis and offered feedback to the researcher. The discussions were used to clarify, expand, and verify information obtained from the initial interviews and to validate the categories that were determined through the analysis. Through constant comparative analysis six distinct phases emerged from the data: initial involvement, relationship building, demonstrating commitment, partnership building, achieving individual empowerment, and increasing community capacity (see Figure 1).

Through the process of data analysis, it became evident that there were certain parameters that comprised each phase. The phase of "initial involvement," was delineated by the women becoming motivated and indicating reasons why they were interested in becoming involved in the project. In "relationship building," open honest discussion was an important factor to advance the participants into a mutual exchange of ideas and active participation. This reciprocal relationship, where all parties were listening and being listened to, was the first step towards establishing trust. Through "demonstrating commitment," participants gave their time and energy, participated in the planning and supplied feedback. In this way, they were not only demonstrating commitment to
Figure 1: The Process of Community Empowerment

Initial Involvement

Relationship Building

Outcome: Trusting Relationships

Partnership Building

Outcome: Commitment to Project's Goals and Outcomes

Achieving Individual Empowerment

Outcome: Increased Self-esteem, Self-confidence, and Knowledge

Increasing Community Capacity

Outcome: Increased Awareness of Community Needs

Community Empowerment

Demonstrating Commitment

Outcome: Equal Partnership

If the participants become involved in another community development initiative the process and outcomes have the
process and outcomes, they were also committed to their own learning and growth. In "partnership building," the relationship between health care providers and community members evolved and roles began to change. Partnership building was demonstrated through mutual goal setting, ongoing negotiation, and contributions from all committee members. The concept of equality was developed when the Hand-In-Hand steering committee members shared power in a non-judgmental and non-controlling manner. The next phase was "achieving individual empowerment," in which participants were able to act more effectively on their own behalf because of increased knowledge, self-esteem, and confidence. In the final phase "increasing community capacity," participants demonstrated that they were questioning, exploring, and contemplating other community issues. This was largely due to the fact that they had become knowledgeable about resources available to them and were able to utilize this knowledge to advocate for other community members.

As the participants were working their way through the process towards "community empowerment," there were various outcomes that occurred along the way (see Figure 1). The outcomes included relationships with other group members, partnerships with health care providers, and feeling empowered as an individual. During analysis and review of the data it became evident that the process of building community empowerment was not linear; rather it appeared to be iterative, with process and outcomes working together and building on each other.

To further the understanding of the processes involved in achieving community empowerment in a community-based health promotion partnership; each phase will be discussed in depth. Hereafter, the women or community members will be referred to as
participants and the nurses involved in the project will be referred to as health care providers. Also, where proper names appear, pseudonyms are used.

Initial Involvement

Throughout the interviews it became clear that the participants had to be motivated before they became involved. Whether the motivation was to assist or help people, get to know women from different cultures, to socialize, or to have fun, all the participants were interested in taking the discussions further to see where they would lead. One participant stated that she “...thought maybe it would give me some chances to meet other women from other groups.” A participant who was new to Vancouver was “...interested in doing something, going and learning and listening.... I didn’t know anybody, I was just looking for something like that, getting to know people.” Another participant stated that she “...always wanted to help people and I thought maybe my opinion would count and I think it would be fun.... I didn’t count on it going this far, it was a nice surprise.”

An additional attraction to the project for the participants was the invitation to have an open dialogue with health care providers. This was the first time that some of the participants were able to tell their stories about their experiences with the Canadian health care system and they were motivated to share their experiences: "We were touched that somebody cared to ask us about our experiences." Another participant claimed that the safe environment allowed her to “...complain legally, telling the truth.”

Although most of the participants indicated that they were interested in taking part in the discussions, there were differences in how much each of them participated. Some chose to do more observing and less discussing, while others were quite comfortable in sharing
their experiences. Whether the participants were observers or discussants, they
determined from their initial involvement that the project was worth pursuing; all
participants became members of the Hand-In-Hand steering committee. One participant
commented: “At first I wanted to... hear and see, I don’t know if I wanted to get
involved.” The experience was different for another participant: “I was a new immigrant,
I remember my English was very bad, I couldn’t communicate very well at this time and I
was so depressed and frustrated, and so when I came to the first meeting you was very
good, I feel very good because it was very participatory.” There appeared to be some
acknowledgement that the participants had something important to say and that others
wanted to listen.

In addition, all the participants stated that there was an abundance of learning that
happened in the initial stages which helped further their involvement and build
relationships with the other steering committee members, including the healthcare
providers. One participant suggested that her involvement “…would be a way to really
get to know the way the medical services work here.” While another felt the group was
“...a good practicing environment especially if you speak another language.” Whether the
motivation was education or socialization for the participants, they felt valued and
decided that the project was worth their time and energy and started the process of
building relationships and alliances.

Relationship Building

As the process continued, a relationship was starting to form between the
participants and the health care providers. This is the first indication of outcomes arising
from the phases of the overall process. The process of initial involvement led to
relationship building, which helped to develop the outcome of a relationship between health care providers and community members (refer to Figure 1). The participants stated that it was through the comfortable atmosphere and open discussion that occurred in the steering committee meetings that community members and health care providers were able to work towards the initial steps of a trusting relationship. One participant commented that “…all the women involved in the discussion groups, they felt right at home….and that many women who are very shy because of their inability to speak English well, felt welcome.” The participants acknowledged that the relationships formed in the Hand-In-Hand project felt comfortable, welcoming, open, respectful, and honest.

Most of the participants stated that the health care providers involved in the project assisted in the clarification of ideas. One participant stated that the health care providers did not “put words” in their mouths, “…they helped us find the words….to clarify what we wanted to say.” Another participant voiced ways that the health care providers demonstrated a respectful relationship: "You hear us, you don’t put your ideas, you receive our ideas, you are listening….you are honest….you help to develop the ideas of the people, you heard and also you help to plan and develop what the people want to say, it was a very respectful relationship.” A third participant reflected on the fact that the relationship was “good” from the beginning because “…we really all were eager to do something.”

As the relationship building continued, the participants began to share information regarding how the alliances being formed with Hand-In-Hand steering committee members were different from any other relationships they had with health care providers. The relationships formed in the Hand-In-Hand project appeared to have a “give and take”
aspect. This reciprocal relationship between the participants and the health care providers was possible because there was a mutual exchange of ideas and all parties were actively taking part in the discussions. One participant believed that this happened because “...the knowledge that nurses had and the willingness to share the knowledge with us, because we were interested.” She went on to state that “...this was a much different relationship....more trust has been formed.”

The atmosphere that emerged from the steering committee meetings was similar to that of a support group. One of the participants stated that the Hand-In-Hand steering committee meetings were “...very participative....we laughed....we talk about our lives....we support each other.” For another “...all the processes of sharing....amazing for me.” While a third participant determined that by being able to “...talk more freely....helped me to address issues more.”

It was discovered during the data collection and analysis that the group functioned mainly as an English speaking committee. This was a concern for one participant because the project had originally been developed to assist multicultural communities. She described her concerns for non-English speaking participants as: "You want to say something, you don’t, you can’t because although you may think about it and have the words in your language you still can’t express it as you would like to express it." One of the participants discussed the frustration of not being able to understand English and how this was detrimental to another woman. The latter woman stopped coming to Hand-In-Hand steering committee meetings because she only understood part of what was being discussed. This individual felt frustrated and decided not to continue because she believed that she was holding up the group process. Even though there was an effort made to have
translators available to interpret, there was not enough time allotted in the meeting for this to occur successfully. The following quote highlights the study participant's concerns:

I remember “Jane” for example and she telling me about her frustration of coming and being challenged about understanding half and the other half not and maybe feeling uncomfortable that she was making me translate for her, break the meeting....you prefer to make yourself invisible....she felt embarrassed to be stopping me to have me translate her. It didn’t make me feel good actually....I felt like it should happen, it is important to have her because she is very involved with other community women, within the community that I don’t have access to.

By not making the concerted effort to keep this woman involved with the Hand-In-Hand project, relationships were not built with all interested community members and consequently the project was not able to address all the community needs.

It was determined that lack of English and lack of ability to translate served as a barrier to developing trusting relationships. Through validation with the study participants it was found that even though most of the participants on the Hand-In-Hand steering committee did not speak English as their first language, they had a basic understanding of English. The participants were able to communicate their ideas and understand most of what was discussed at the meetings. One of the participants commented: “I never feel any discrimination, because I didn’t speak very well English.”

An outcome of the participants’ involvement with Hand-In-Hand was the improvement in their English speaking and reading skills as the project progressed. By the end of this phase participants were able to demonstrate a trusting relationship with the health care
providers and other steering committee members. The relationships formed in this phase were foundational to the next phase; demonstrating commitment.

Demonstrating Commitment

All the participants had something to say about commitment, whether it was commitment to the process and outcomes of the project, or commitment to their own individual learning and growth. Commitment was an important aspect of their experience with the Hand-In-Hand project. To the participants commitment meant more than just attending meetings. The participants stated that steering committee members must also actively participate in project planning by giving input and feedback over the long term. All of the participants stated that commitment was important because it kept the process going with a continuous flow of ideas. One participant stated that “...the only way you can create change for some people is through long term commitment and persistence.”

Clear guidelines with regard to commitment were important for another participant, “...if you want to be involved you just have to devote some of your time, it’s not just drop in.” She felt that if people started they “...have to go on....at least for a while,” otherwise “...it goes around in circles.”

The data demonstrated that the outcome of commitment to the project happened at different levels for various participants. There were some people who dropped in from time to time and gave their input but never really spent an extended period of time discussing, planning, or evaluating how the project was progressing. Those people tended to slow down the discussion and it became circular rather than proceeding to the next stage of development. For example, one participant found that “...many people who were involved from the beginning they didn’t continue, they just came once and then they
decided not to come and after two or three meetings, they came again.” She concluded that “...the discussion wasn’t a continuous one,” and the group was “...just coming to the same topic again and again and it slow us down a bit.”

Another level of commitment was demonstrated when the participants came to most of the meetings and actively participated in the planning, implementation, and evaluation of the project. These participants established a commitment to the process and outcomes of the project. Because commitment to the project took both time and energy, all community members were not able to manage it. One participant stated that “…you guys limited with volunteer people....very busy because they're being parents, working and being a mom, you know me being a mom and barely making it, all this sort of stuff so it’s really difficult....you got to try to accommodate the most you can and be committed.” Another participant commented that “…I received a beautiful letter of you guys saying thank you and how helpful it was, it was so good somebody recognized your thoughts, your opinion and what you say, it was very nice for the reason that I was thinking oh no, I was so tired I can’t do anything but I want to continue because I feel that it’s a neat project and you put all the energy there and I want to continue doing that too.” Receiving recognition for the participant’s commitment to the project helped to bolster their energy in the midst of busy and demanding lives.

One participant discussed the length of the project and how much time and energy this amount of commitment took. She determined that the project must be seen as significant and important to people in order for them to continue meeting and planning. This participant gave an example of how people might demonstrate this type of commitment: “…for people if they come into a meeting and they may be willing to say we
don’t eat, we’ll eat something at home and we can meet without refreshment, if they are really getting what they want, if they really getting results they are going to be willing to do that but if not they won’t.” Getting results, for the participants, involved seeing some benefit from the enormous amount of time, energy, and thought that went into the project.

Some of the participants stated that commitment needed to be demonstrated both by the volunteers and the people getting paid. If evidence of commitment is lacking from either group then there was not real commitment and meetings would happen for the sake of meeting rather than planning for change. The process of building the Hand-In-Hand project was lengthy, “three years,” and as one participant commented: “...it’s a lot of time and it's long term, it's very long term and most funding and most projects don’t work long term more than one year or two years and then they want results unfortunately.” She went on to state that “…you need those things to work otherwise people get tired and then at the end it just turns into a “oh well” let’s keep meeting but you lost the little significance and they forgot what the real commitment was about.” Demonstrating commitment was a significant concept for this participant: “…if you really believe that that is the way it should work, ...you believe in process and you believe how process should be, ...you gotta be committed to that...”. As the participants worked through the phase of demonstrating commitment they began taking on more responsibilities to the project’s success.

**Partnership Building**

Once relationships were formed and commitment was demonstrated, the participants proceeded into the phase of building partnerships. Building partnerships appeared to them to be more than active participation from all the members of the
steering committee in planning, implementing, and evaluating the project. From the data it was concluded that this concept required role changes for the health care providers and the community members. They each had to make significant contributions to the process of developing a community-based health promotion partnership. There is evidence that the health care providers and the community members began to work together as equals to achieve the objectives. One participant claimed that the partnership was a "...different experience from anything else." Another participant saw the health care providers and the community members working at the "...same level."

The participants stated that mutual goal setting and ongoing negotiations about goals in a context of equality, were all important to the outcome of partnership and ownership of the project. They determined that the demonstration of power sharing was only beneficial to the development of true partnership if it was non-judgmental and non-controlling. One participant commented: "I learnt from you and you learnt from us...help to develop the ideas of the people." The health care providers assisted by encouraging the community members to develop their own solutions to the issue of access to health information and more respectful health services. For example, one participant determined that "...both sides contribute something" and then "...something starts to cook."

Partnerships and ownership occur when all contributions help to achieve the goals of the project.

This type of partnership with health care providers was a new phenomenon in the lives of most participants. It helped to dispel many of their fears of speaking out about their discomfort with the health care system. One participant stated that her previous experience with health care providers was limited to "...questions and answer, not a
discussion;” she continued, “...nobody cared too much to hear my opinion about things.” She described the health care system as an “...Iron Curtain....some kind of wall between health care providers....like teacher and the student....don’t cross the boundary” and through her experience with Hand-In-Hand she discovered that “...there are doors some where.” Another participant stated that her experience with Hand-In-Hand helped her to see health care providers “...more like real people....something becomes less a myth....becomes reality....pretty neat....helped me feel more comfortable with nurses.”

The data suggested that the formation of partnerships also had challenges. Some of the participants stated that the nature of the partnership and the trust and caring that was developed between the health care providers and the community members proved to be somewhat detrimental to the project. At times there appeared to be an imbalance in the sharing of responsibilities and contributions to the project among the steering committee members, which interfered with the groups’ progression towards the projects’ goals. One participant suggested that “...you guys [health care providers] too much involved....most people were taking, not giving....[you were] too nice to stop them.” With the health care providers “taking care of things” the participants became dependent and the goals of partnership were undermined. Another participant commented that there was “...too much trust in the committee ....program started to focus on the running, functioning, mundane things ....forgot about how it really started and why....the process got lost.” As the participants worked through the process of partnership building they were able to achieve the outcome of forming an equitable partnership with the health care providers and the other participants, with all parties responsible for the goals of the project. Equal ownership enabled the participants to move forward toward achieving individual
Achieving Individual Empowerment

The equal partnership the participants had with the health care providers began to influence them in other aspects of their lives. One participant described how the work she did with the health care providers in the Hand-In-Hand project helped in her relationship with other health care providers: “I don’t treat them as people with ready answers....I can ask more questions.” It was clear that after her involvement with the Hand-In-Hand project she became more confident with her knowledge of her rights and she had an increased comfort with health care providers. Other participants made various comments about changes in their self-confidence and self-esteem: “I have rights to say that I know a lot....I can say what I don’t like....I speak up.” Another participant suggested that her experience with Hand-In-Hand “…helped me get my strength....more confident to ask for service....our knowledge is important.” A third participant believed that through her involvement she “…felt comfortable to suggest something....I am definitely more willing to speak up.” Being willing to speak up suggested that the participants felt that they had some power in their relationships with health care providers and that they could be assertive about their knowledge and needs.

The data also clearly indicated that involvement of the participants with the project helped them gain a better understanding of the Canadian health care system and educated them about their rights to health care services. Additionally, an unanticipated outcome was the development of communication skills so that the participants were able to act more effectively on their own behalf. One participant was now able to “...deal with health care providers differently....pretty straight forward....I tend to direct.” While
another stated that "...you got to tell them what you want....what you need....what your opinions are ....that's the only way you can make changes happen."

One participant used the skills she acquired to direct an issue she experienced in her work environment. She was having a difficult time with her immediate supervisor. She went through the proper conflict resolution steps to contend with this issue, first talking to the person she had the problem with and then when this was not dealt with as she believed it should have been, she went to the committee who directs the supervisor. In the end she decided to quit the job because she felt the issue was not managed appropriately. She stated that her supervisor "...was more maintaining this professional thing....limiting the community women's role....patronizing stuff....I decided that I will not put up with that....I don't and I won't." She continued, "...you better be frank with people" which was "...another thing that the relationship that being in the group" did for her. The participant expressed her power by having the confidence to leave her job in order to find other work where she would be valued.

Another unanticipated outcome that emerged from the data was the positive way the participants worked with the health care providers in the Hand-In-Hand project had an impact on them personally. One participant commented that she "...really didn't think that I could bring anything to contribute....this experience has helped me to get over some of that." One of the participants questioned whether this increased level of self-esteem and self-confidence was because all the women involved in the project had certain personalities or characteristics that aided in this development. She queried whether the project itself helped to develop this or whether all the women initially had the potential. This participant believed that she "...always had the feeling and intuition of doing it
...[Hand-In-Hand] helped to develop the potential....circumstances come along
...potential develops....keeps growing....other opportunities....keeps going." With the
increased self-esteem, confidence, knowledge, and skills the participants had achieved in
the phase of individual empowerment they were prepared to look outside themselves to
the larger community. The outcomes associated with achieving individual empowerment
contributed to the participants’ ability to assert themselves in order to increase
community capacity.

Increasing Community Capacity

Increasing Community Capacity

By developing self-esteem, self-confidence, and abilities the participants used
their experience with the Hand-In-Hand project to assist others with their lives. The
experience of one participant “...helps me in my job....I have meetings with the Health
Board....nurses.” Another participant stated that it “...made me feel like it’s okay....feel
more comfortable about talking to other women about the nurses....you should really be
open to these women [nurses]....they just regular people....they will help you....I tried to
pass that on to people....they are real, touch them.”

The participants have been able to move from their individual empowerment to
contemplate addressing other issues in their communities. For example, one participant
stated that she is “...not afraid to get involved.” While another “...never consider myself
capable of doing certain things....I’m getting involved.” Another participant is now
“...more willing to become involved....wouldn’t have any problems being involved in
other steering committees.” One participant commented that her experience with the
Hand-In-Hand project has helped her “...learn from mistakes....approach similar problems
differently....learn from it....make process more beneficial to everyone.” It can be
determined that the outcomes of increased awareness of community needs and efforts to address them were attained as each participant worked through the process of increasing community capacity.

After analyzing and re-analyzing the data, it was discovered that although there was evidence of increased community capacity, confirmation of community empowerment was lacking. Even though all the participants stated that they are currently questioning, exploring, and contemplating other community issues, they have not yet been able to positively change the socio-political environments in which they function. The participants were knowledgeable about resources available to them and to other community members and they have learned skills that are imperative to the community development process. However, they have not been able to demonstrate an increased control over resources, which is a critical element in community empowerment (Rissel, 1994). At this point, the participants are located in the phase of increasing community capacity. The outcomes suggest only the potential to develop community empowerment because of the lack of effort to control community resources and creating a change in the socio-political environment. As a result, it cannot be concluded that community empowerment was an outcome of Hand-In-Hand. There was documentation of individual empowerment and community capacity building but evidence of community empowerment was not attained. Perhaps more time is required for the outcomes to further the process into the realm of community empowerment.

Summary

Through the utilization of qualitative research methods, inductive content analysis and continuous comparative analysis, it was discovered that the process of community
empowerment involves six phases; initial involvement, relationship building, demonstrating commitment, partnership building, achieving individual empowerment, and increasing community capacity. By working through each of these phases various outcomes such as trusting relationships with steering committee members, commitment to the process and goals of project, equitable partnerships, increased self-esteem and self-confidence, and advocating for community’s needs appeared along the way. It was determined that the process of community empowerment builds outcomes and these outcomes work together with processes in order that the participants can advance to the next phase. From the findings, it was determined that the participants are still in the phase of increasing community capacity and are currently working towards community empowerment.
CHAPTER FIVE

DISCUSSION OF FINDINGS

Evaluation of Hand-In-Hand, a community-based health promotion initiative, revealed that six phases were identified in the process of participants working toward community empowerment. The phases that emerged from the data included: initial involvement, building relationships, demonstrating commitment, building partnerships, achieving individual empowerment, and increasing community capacity. In addition to the phases, outcomes related to the phases were identified (refer to Figure 1).

It was determined that the process of community empowerment proceeded in an iterative manner rather than linear. In describing the process in this way the author is able to demonstrate the potential for participants to move back and forth between the phases. The participants were able to revisit previous phases in order to achieve a higher level of outcome associated with the phase.

Each phase will be discussed, along with the actual and unanticipated outcomes that emerged from the data. The phases and outcomes will be presented to further develop an understanding of the iterative nature of the process of community empowerment. Recent literature will be cited to validate and interpret the study findings. Finally, reasons will be offered as to why community members have yet to attain the phase of community empowerment.

Initial Involvement

The participants had to be motivated before they became involved in the Hand-In-Hand project. Initial involvement meant a variety of things to the participants; i.e., socialization, education, or support. The common reason for the participants' continuation
in the project was the desire to make health information more accessible and the
Canadian health care system more sensitive to cultural and gender differences. Although
Matuk (1996) found that immigrant women did not report any difficulties in accessing
health care, cultural insensitivity was identified, in another study, as a barrier to health
care for many immigrant women (MacKinnon, 2000). The participants, all of whom were
immigrant women, believed that they would make health care in Vancouver easier to
access and more respectful of people’s various cultural practices and personal knowledge.

Lord and McKillop Farlow (1990) noted that the empowerment process usually
begins with one or more motivational triggers, such as a crisis, frustration, or outrage.
When people become emotional about an issue they are more willing to do something
about it. In the Hand-In-Hand project the women became motivated to get involved
through telling stories of their distressing experiences with the health care system. After
the women vocalized their experiences, the group was energized into action by focusing
on their emotions of outrage and disgust. Eng, Salmon, and Mullan (1992) determined
that first person passionate involvement is required of all parties in the process of
community empowerment. It is through such involvement that people feel more in
control and their stress level is reduced, freeing them to make decisions that will have a
healthy impact on their lives (Lord & McKillop Farlow). Rather than only listening, the
women decided to use their energy to identify mechanisms to make aspects of the
Canadian health care system more accessible and respectful. This type of participation is
a healthy alternative to suspicion, passivity, or resignation (Rains & Wiles Ray, 1995).

Once the women were motivated, the next challenge for health care providers was
to establish an atmosphere that appeared attractive to community members in a setting
that was conducive to formal planning and discussions. Breslow and Tai-Seale (1996) found that informal community meetings or 'fiestas' where a discussion of health concerns was mixed with food and music were sometimes attended by hundreds of people. The Hand-In-Hand steering committee meetings always began with dinner and informal discussion. Childcare was provided and transportation costs were reimbursed to community members. In this way, the Hand-In-Hand steering committee meetings provided a comfortable, relaxed atmosphere where the women could discuss their concerns and issues without the added stress of arranging childcare or dinner.

It was in this relaxed, informal environment that the community members and the health care providers began to share common experiences and concerns, a first step in the development of relationships. With health care providers acting more like peers than distant care providers and becoming active community members, they are able to demonstrate an investment in the success of the community (Eng et al., 1992). In becoming part of the community culture, health care providers addressed the barrier of lack of active community involvement, and were able to engage the community members (Eng et al.).

The shared emotional connection that developed between the community members and the health care providers in Hand-In-Hand was also important to the further development of the group. McMillan and Chavis (1986) determined that it is not necessary for group members to have participated in community history in order to share it, but they must identify with it. The connections that are formed between group members at the beginning can either assist or hinder future group processes and facilitate or inhibit the strength of the community (McMillan & Chavis). The development of a
strong bond between the women and the health care providers occurred during the discussions that took place in the Hand-in-Hand steering committee meetings. In the relaxed atmosphere of the steering committee meetings, community members, as well as health care providers, were able to share their ideas, beliefs, and opinions. When individual values are shared among community members the community is able to organize and prioritize its need-fulfillment activities (McMillan & Chavis).

Lord and McKillop Farlow (1990) emphasized the necessity for people who feel powerless to connect with someone who will listen. Health care providers instituted an inviting atmosphere through actively listening and openly accepting the opinions of the participants. Open discussions, wherein another person's point of view was accepted, allowed the health care providers to address another barrier to community participation: establishing trust. The message that community initiatives would not only be flexible but would also be responsive to the community's changing needs and conditions, was accepted by the community members. Goodman (1998) supports the importance of flexibility and responsiveness of health care providers to community initiatives. Breslow and Tai-Seale (1996) indicate that if the goals and objectives of the project arise from community members then the assistance of health professionals is well received.

The safe environment that was offered at the initial discussion groups was a new phenomenon for most of the participants. Due to previous experiences in their own countries, this was the first time that some of the participants were able to voice their opinions without fear of repercussions. Kieffer (1984) described this phase as "era of entry;" participation is exploratory, unknowing, and unsure, and individuals are discovering their political muscles and potential for external impact. The act of
participating feeds the empowerment process (Lord & McKillop Farlow, 1990).

If citizen participation contributes to the empowerment process, then health care providers should adopt a collaborative approach because complex community health initiatives cannot be implemented by only one person (Goodman, 1998). Community participation is an active process in which the community identifies its needs and works in partnership with health professionals to meet its needs for improved health (Sawyer, 1995). Community members are in the best position to identify untapped resources and priorities. Through the active involvement of community members, appropriateness of services will be improved and underused or misuse of resources will be reduced (Rains & Wiles Ray, 1995). Health care providers and community members in Hand-In-Hand were committed to the goals of the project and that working together would be beneficial to all. Once this was determined both parties were able to further the process towards relationship building.

Relationship Building

With the continuation of open and honest discussions, the Hand-In-Hand steering committee members were able to move forward and establish trust with each other. The trusting relationship began with the mutual exchange of ideas and active participation of all the steering committee members in the planning phase of the project and continued to develop in the implementation and evaluation phases. As the project progressed and decisions had to be made, communication became more reciprocal. All steering committee members listened and considered each other's ideas and opinions. A collaborative relationship requires trust and respect for one another, and for the work and perspectives that both the health care providers and community members contribute, all
important aspects of the empowerment process (Clarke & Mass, 1998; Speer & Hughey, 1995). The collaborative nature of the relationships in Hand-In-Hand contributed to the project moving forward and addressed the issues of accessibility and respect first described by the focus groups. Clarke and Mass concluded that this evolving relationship maximizes the contributions of each individual and recognizes the complementary roles.

The participative nature of the Hand-In-Hand steering committee contributed to empowerment because, according to Lord and McKillop Farlow (1990), it increased social contact, reduced isolation, and enabled participants to take part in meaningful activities.

Relationship building is a major undertaking in the process of community empowerment because community members' previous experiences with health care providers and group process may not have been positive. In an effort to enhance client competence, health care providers must share not only professional knowledge but also build on the client's experiential knowledge (Reutter & Ford, 1997). Individual steering committee members were able to gradually assume more responsibility within the Hand-In-Hand steering committee because everyone valued the participants' experiential knowledge and participated in the group.

An issue identified in the findings was that relationships were not formed with all community members who were interested in becoming involved in the Hand-In-Hand project. Translators were used to assist non-English speaking community members to take part in the discussions. Unfortunately these attempts were not successful because community members who did not speak or understand English soon stopped coming to steering committee meetings. Lord and McKillop Farlow (1990) found that in order for
all participants to experience personal growth, health care providers need to find mechanisms that engage people in extended dialogue. The use of translators presented challenges to all parties and was not effective for a variety of reasons: the group’s inexperience with translators, the interpreter’s inexperience with group process, the accuracy of the translation, and the community members frustration with the amount of time it took to have their ideas translated.

The participants who were able to communicate in English brought their own cultural experiences to the discussions and used their stories to further the project and group processes. In the Hand-In-Hand project, a basic understanding or an interest in learning the English language was a necessity for the continuation of the group process and the ongoing work of the project. As noted earlier, an unexpected outcome was the dramatic improvement of the participants' English speaking and writing skills as the project progressed.

Another unanticipated outcome was that the relationships that were formed between health care providers and community members benefited not only the community, but also the larger health care system. The positive relationships enhanced the community members’ ability to address other community issues. Participants described circumstances where they had the opportunity to educate and support other community members as they interacted with the Canadian health care system. McMillan and Chavis (1996) determined that a greater bond is formed with community members when the experience is positive. If the experience is a negative one, then not only will it be detrimental to the people involved in the relationship but also to the community at large.
The invitation to participate should not suggest “tokenism” or a “one-shot-deal” (Lord & McKillop Farlow, 1990). Nominal participation results when people perceive that their participation is coerced or imposed on them by health professionals (Sawyer, 1995). McMillan and Chavis found that strong communities are those that invite members to share in important events and interact in positive ways to resolve community issues. In addition, steering committees offer opportunities to honor members, to invest in the community, and to experience a spiritual bond among members (McMillan & Chavis). Furthermore, Bracht, Kingsbury, and Rissel (1999) determined that a positive environment fosters cooperation and sets the stage for the development of community ownership. Participation must be resourced with power, knowledge, and skills; otherwise it will be tokenism and there is no assurance that the community’s actual needs or goals will be met (Sawyer).

In the Hand-In-Hand project community members felt that each person’s viewpoint was perceived as valuable and worthwhile. Lord and McKillop Farlow (1990) found that health care providers are able to develop collaborative relationships with community members by unquestioningly accepting their contributions and believing in their capabilities. Rains and Wiles Ray (1995) determined that the information acquired through these types of collaborative relationships reduced the inequities that surrounded the power of knowledge, elevated the common knowledge of a community, and empowered people to think and value their collective understanding. Acknowledgment of the participant’s experiential knowledge is foundational and complementary to the health care providers’ professional knowledge because it provides the conditions for ensuring that professional knowledge is meaningful and relevant (Reutter & Ford, 1997). If people
believe that they are making a contribution, there is a direct positive effect on their level of self-confidence, which then spreads into all aspects of their lives (Lord & McKillop Farlow). Health care professionals who want to be facilitators of personal empowerment must intuitively understand this notion of valuing the individual (Lord & McKillop Farlow).

Health care providers and community members need to be aware that relationship building is a long-term process; many one-on-one interactions must occur over time so that trust is developed, expectations become clear, and interpersonal challenges are confronted (Speer & Hughey, 1995). Mahon, McFarlane, and Golden (1991) determined that community assessment and establishment of trust between the health care providers and community members was the lengthiest phase of their program. Comments by steering committee members from Hand-In-Hand indicated that this time was well spent because the established trusting and collaborative relationships made the subsequent phases towards community empowerment easier to achieve.

The support group atmosphere that was formed between the community members and the health care providers was an outcome that was not anticipated at the beginning of the Hand-In-Hand project. To the surprise of many of the participants, the relationships formed in the Hand-In-Hand project benefited them in other aspects of their lives outside of the steering committee meetings. For example, one participant used the group’s support and encouragement to apply for a job working in the health care field. She was successful in the job interview and now works full-time advocating for seniors. This participant was able to demonstrate the complexity of the process of community empowerment; the skills and knowledge that was developed through her participation in
the Hand-In-Hand project spilled over into her professional life. Another participant decided to apply for post secondary education, while another began working on her Co-op board.

Demonstrating Commitment

Once the participants in the Hand-In-Hand project had established trusting relationships among themselves and the health care providers they started to become more committed to the project. This was confirmed by the increasing amount of time and energy that the participants gave to the project. The project has taken over four years to develop and is presently still evolving to meet the always changing needs of the community. Most of the community members that started the process four years ago continue to attend meetings, participate in the planning, and provide feedback. This incredible journey has not been without its challenges, but all steering committee members are currently committed to the continuation of Hand-In-Hand and to increasing their involvement in order to maintain the service.

In addition to demonstrating a commitment to the processes and outcomes of the Hand-In-Hand project, the participants were also committed to learning about community-based health promotion partnerships. Each participant was able to identify different knowledge that was acquired during her experience with Hand-In-Hand. The participants gained knowledge about the Canadian health care system, learned about group process, and developed their English communication skills. Goodman (1998) suggests that effective interpersonal communication, team building, group process, negotiation, teaching skills, political acumen, and the ability to gain cooperation and trust are all required skills of the community engagement process. These skills were relevant
not only to health care providers, who were the facilitators of the group, but also were important to community participants who were the group members. The knowledge and skills acquired by the participants enabled the group to move further along in the process of community empowerment because they could demonstrate their commitment to the project in tangible ways.

It was evident that each participant's life situation affected and influenced her ability to attend meetings and take part in the planning discussions. Some of the participants came to meetings infrequently because of family commitments. This did not deter them from providing the steering committee with suggestions and feedback, and when they were able to attend a steering committee meeting they actively participated in the discussions. Although individual participants had various levels of commitment, all of them stated that ongoing and significant commitment must be demonstrated if the Hand-In-Hand project is to effect change.

The steering committee consisted of volunteers (community members) and paid staff (health care providers). The issue of paid versus unpaid steering committee members could have had a significant impact to the Hand-In-Hand project's outcomes. The participants in the study stated that as volunteers they felt strongly about the project and the issues being addressed. They were able to demonstrate their devotion to the program goals and outcomes by providing a significant amount of unpaid time and energy. The strong emotional connections that the participants felt towards each other and other steering committee members allowed them to rely on one another, to challenge ideas and behaviors among them, and to pursue the common goals of the Hand-In-Hand project. In addition, the participants noted that the health care providers demonstrated an equal
amount of commitment to the project, attending evening steering committee meetings, facilitating group discussions, and providing resources for food and childcare. Whether the committee members were paid or unpaid, all of the participants demonstrated a strong commitment to the Hand-In-Hand project. The participants demonstrated their commitment by assuming responsibility for the ongoing process and outcomes of the project. Inasmuch as Hand-In-Hand benefited from the commitment of the volunteers, Sawyer (1995) cautioned that those who volunteer might be the least representative of the community because they may represent only a small segment of the community.

**Partnership Building**

As the participants and health care providers moved through the phases of relationship building and demonstrating commitment, the bonds that were being formed became stronger and stronger. In the case of Hand-In-Hand the partnership building moved participants from taking responsibility for the project to engaging in full partnerships. Courtney et al. (1996) suggest that evolution of relationship into partnership requires a transformation of the professional role from chief actor to partner, and the client role from passive recipient to partner. The health care providers' role of "expert" shifted to "coach" in the Hand-In-Hand project, with the participants becoming the "expert." Goodman (1998) concluded that when involving community members in the development and implementation stages of an initiative, the evaluator acts as a coach, collaborator, and builder of capacity. The role changes in Hand-In-Hand involved a shift in perspective for both the health care providers and the community members. The participants moved from taking responsibility to actively shaping the process and outcomes and suggesting alternative approaches. Poulton (1999) describes this change as
a shift away from the medical, paternalistic model of health to a humanistic model that valued individuals for the contribution they made and enabled individuals, families, and communities to shape their own destiny. Although the role change took time, patience, and considerable trial and error, the alteration in both the health care providers and community members' context became important to the continuation of the project. Courtney et al., (1996) and Lord and McKillop Farlow (1990) observed that the role changes that health care providers and community members undergo facilitate an increased level of trust and equality. The health care providers and the participants were able to share power as equal partners.

The power sharing that developed between the health care providers and the participants occurred in a non-judgmental and non-controlling manner. The health care providers were not protective of their “turf”. A number of authors suggest that, before power sharing and mutual respect among partners can be developed, professional protectionism needs to be addressed to ensure equal participation in discussions and decision-making (Poulton, 1999; Voyle & Simmons, 1999). For health care providers, partnership requires giving up unilateral control, sharing power, and learning to develop a new type of relationship with community members and for participants, it involves assuming more responsibility for taking actions, creating solutions, and results (Courtney et al., 1996). A healthy, competent community is not a gift given by health care professionals but an accomplishment of a broad base of community members and others who are involved in the ongoing processes of empowerment (Rains & Wiles Ray, 1995). In Hand-In-Hand it was evident that sharing power, giving up control, and developing partnerships was a new way of functioning for not just health care providers but also for
participants and this unfamiliar territory became more familiar as the process continued.

As indicated in the presentation of the findings, it was important for all group members to increase their responsibilities in the operation and functioning of the group. Courtney et al. (1996) ascertained that as community members assume a more active leadership role, they became involved and invested in developing their own solutions. In the case of Hand-In-Hand the health care providers seemed to facilitate mutual goal setting, ongoing negotiation, and contributions from community members. According to Speer and Hughey (1995), these actions assist in the development of power for the community. In addition, Rains and Wiles Ray (1995) found that when the community relied on local wisdom to develop a plan, decide on solutions, and determine a method of evaluation, participants developed their leadership potential. Health care providers must abandon the notion that they are the sole interpreters of community health because this attitude confers unearned privilege upon professional interpretation and strips the community of its ability to interpret and actualize its own needs (Schroeder, 1994). The success of the Hand-In-Hand partnership was dependent on the shared purpose, shared power, and shared control of all steering committee members. A successful partnership encourages ownership of local problems in a way that gives voice and strength to local solutions (Rains & Wiles Ray; Voyle & Simmons, 1999).

If partnerships mandate relationships that are based on mutual respect, expertise, knowledge, and authority, then care must be taken that community health projects continue to reflect community-chosen goals rather than those of health professionals (Breslow & Tai-Seale, 1996; Courtney et al., 1996; Schroeder, 1994). True power sharing between health service users and health care providers is invariably a vision rather than a
reality in a system that remains professionally dominated (Poulton, 1999). In the Hand-In-Hand project, the participants stated that because of the re-alignment of the roles of health care providers and community members, they were able to develop a mutual plan that addressed the community’s health issues. Schroeder has determined that this type of partnership is based on advocacy, which invites engagement with people in non-hierarchical ways and addresses them as equals. It is only through partnerships that communities can realize the power of their own contributions to improving their health and well-being (Courtney et al.). The community-health professional partnerships that were developed in the Hand-In-Hand project formed one critical path towards achieving a healthier, more capable community.

Although the partnerships that were developed between health care providers and community members were exciting, participants also expressed some concerns. The steering committee members remained the same for a number of years and without additional ideas and energy they felt that this proved to be somewhat detrimental to the Hand-In-Hand project. Without new community members to assist and guide the project, Hand-In-Hand continued to offer a drop-in service that only met the needs of a small portion of the larger community. The participants were concerned about the small numbers accessing the service but had difficulty envisioning other modes of service provision. Speer and Hughey (1995) state that when individuals stay in one role for a substantial period, their perspective on community functioning and organizational development can become calcified. This often leads to their assuming a gatekeeper role, which can discourage participation, thus limiting the extent to which the organization is capable of renewing itself (Speer & Hughey).
Another negative aspect associated with Hand-In-Hand was the lack of clear group guidelines. Sawyer (1995) proposed that one of the first steps in community participation should be a dialogue between community members and health professionals about the level of participation that the community values and what the role of the health professional will be for that community. The participants stated that if the group had been better prepared with clear rules and guidelines early in the process, then they would have been able to proceed further in addressing the issues of access to health information and respectability of the health care system.

If reinforcement is a motivator, then it is obvious that for any group to maintain a positive sense of togetherness, the individual-group association must be rewarding for the members (McMillan & Chavis, 1986). In the Hand-In-Hand project, participants were rewarded with a strong emotional connection between steering committee members and acknowledgement of their contributions as equal partners in the project. The participants felt as much ownership of Hand-In-Hand as the health care providers and simply resisted any effort to disband the project. Through new partnership approaches, capability and empowerment are enhanced so that individuals and the community may act more effectively on their own behalf (Courtney et al., 1996).

Achieving Individual Empowerment

The participants became empowered through the development of strong alliances and equal partnerships with each other and the health care providers. Outcomes of the process of acquiring knowledge during the various Hand-In-Hand steering committee meetings were that the participants had a better understanding of the Canadian health care system and were able to act more effectively on their own behalf. According to Reutter
and Ford (1997) client competence is enhanced by professionals sharing knowledge that is relevant to the client’s experiences. Reutter and Ford discovered that nurses were able to build on clients’ experiential knowledge by acknowledging, giving positive feedback, being there, and gently persuading. It was validating and empowering for the Hand-In-Hand participants to know their ideas and opinions were valuable and were being sought. Moreover, they were empowered by seeing their suggestions incorporated into the project and influencing the outcomes. Courtney et al., (1996) found that it is particularly empowering for community members when professionals are the ones who are listening.

By building on the participants’ experiential knowledge, health care providers are able to effectively enhance the participants' competence for health, including participants' outcomes of increased self-esteem and self-confidence (Reutter & Ford). In this way empowerment is not a commodity acquired but is a transforming process constructed through action (Kieffer, 1984).

The participants described their increased self-esteem, self-confidence, and abilities as a result of partnering in Hand-In-Hand. Consequently, they were able to question, inquire, and ask more of the health care providers with whom they came into contact. In a sense they translated their equitable power relations with the health care providers at Hand-In-Hand to other situations. Lord and McKillop Farlow (1990) discovered that individuals who achieved the greatest degree of control in their lives were those who refused to accept their situation, and instead kept questioning and searching for options. Courtney et al. (1996) caution that the professional is most effective when using a process that allows community members to discover and exercise their own power at their own pace. Once this element of individual empowerment is complete, the process
leads to the ultimate goal, which is to enhance the participant’s capacity to act more effectively on his/her own behalf (Courtney et al.).

If empowerment is both process and outcome, then it can be argued that as the process evolved, many participants found that their growing consciousness of their own capacities and rights helped them to develop a sense of personal control and competence. This increased personal control and several authors (Jones & Meleis, 1993; Lord & McKillop Farlow, 1990) voice competence in relation to awareness of a person’s capacities and rights. In an effort to facilitate empowerment, the health care providers began to help the participants develop a critical awareness of their situation. Jones and Meleis (1993) suggest that increased awareness enable participants to master their environment and achieve self-determination. Courtney et al. (1996) found that once participants were able to act more effectively on their own behalf their capacity was enhanced so that they were able to prevent future problems or address the problems more effectively. In this way, empowerment is the ultimate form of participation as it signifies the development of the power of individuals, groups and communities (Poulton, 1999). With increased self-esteem and self-confidence, and awareness of capacities and rights, the participants were able to guide health care services at the community level, ultimately achieving the outcome of individual empowerment.

With an atmosphere of respect and acceptance, the Hand-In-Hand project gave the participants the opportunity to try out aspects of their own individual empowering behaviors. As indicated in the presentation of findings, this might not have been possible in the participants' countries of origin because of fear of persecution. Reutter and Ford (1997) determined that competence involved feeling capable of engaging in behaviors
that promote health and having the knowledge, skills, and resources to carry out the behaviors. In addition, MacKinnon (2000) found that immigrant women often suffered from low status and prestige in Canada, which along with language difficulties, affected their access to the Canadian health care system.

One of the issues raised by a participant in the study was whether the potential for individual empowerment was already part of participant character or personality. The participant questioned whether the project's safe environment helped to free this part of the participant's personality and as a result she was able to demonstrate empowering behaviors. While it is possible to identify certain general factors that contribute to personal empowerment, the specifics vary from one person to another (Lord & McKillop Farlow, 1990). The empowerment process is highly individualized and related to timing and to the interaction of external resources and internal motivations (Lord & McKillop Farlow).

As the data in this study suggests, empowerment is both an internal and external process. The participants in Hand-In-Hand described changes in their internal characteristics as well as their external behaviors. They were able to be more assertive with health care professionals and in other aspects of their lives. Empowerment can encompass the participant's rights, strengths, and abilities, which implies competence or the development of potential (Jones & Meleis, 1993). Lord and McKillop Farlow (1990) learned that while external resources are essential to personal empowerment, it is the interaction of the person with these resources that maximizes personal control and impact. Empowerment is transactional in that it involves interaction and relationships with others and incorporates environmental as well as individual change through sharing
of resources and collaboration (Gibson, 1991). The findings from this study support the transactional nature of empowerment described in the literature. It was through interpersonal interactions with the steering committee members that skills and knowledge were gained by the participants and translated into their environment.

As the participants in the Hand-In-Hand project worked through the process of individual empowerment they began to address community issues beyond the mandate of the project. The first step in this process was increasing community capacity. Lord and McKillop Farlow (1990) found that as people gained self-confidence, they would seek more avenues for participation and their involvement in community activity would enhance their self-confidence and sense of personal control. Lord and McKillop Farlow identified the key to growth in community member’s personal empowerment was involvement in community life.

Increasing Community Capacity

As the participants began to advocate for themselves they discovered that they were also able to assist other community members. They utilized their new knowledge about the Canadian health care system to help other community members negotiate the system. According to Rains and Wiles Ray (1995) and Shiel and Hawe (1996), when a community has a collective appreciation for health and an expanded constituency for health, they are able to move with self-reliance toward improved health, leaving the community more empowered. All the participants in the study appeared to be thinking and contemplating other community issues. From the participants’ extension to larger community issues, it can be concluded that they are currently located in the phase of increasing community capacity. Sense of community or the feeling that comes from
belonging, caring, and taking part in community life has been considered a prerequisite or precondition variable for effective collective action to promote health (Shiel & Hawe).

Empowerment includes both capacity and equity, referring to a group's knowledge, skills, networks, and opportunities to participate in decision making and getting one's fair share of resources (Shiel & Hawe, 1996). The implication is that multiple levels of intervention are necessary for optimal improvement of community competence and health, and that building empowered communities is a long-term and complex process (Eng et al., 1992; Speer & Hughey, 1995). The findings of the study indicated that the lengthy process of community empowerment had both successes and pitfalls along the way. The accomplishment of increasing community capacity required support from additional service provider agencies. With the assistance of these agencies the participants were able to increase their awareness of community needs and make an effort to address them.

A critical base for primary community health care exists when control over health solutions belongs to both health professionals and the community, thus enhancing community competence (Eng et al., 1992). The emphasis on increased community capacity and involvement, demands new roles for professionals as partners and facilitators of health (Courtney et al., 1996). A key element in organizing the power of community competence is changing the distribution of resources within a community (Speer & Hughey, 1995). If the health of individuals reflects and results from the health of the communities in which they live, then the extent to which communities and their members have the ability to manage and care for their own health is an important dimension of this relationship (Eng et al.). By becoming aware of the resources required
to address community initiatives the Hand-In-Hand participants have been able to
advocate for themselves and for other community members. They have been successful in
getting various community groups to put resources into Hand-In-Hand. For example,
space for the drop-in was provided by the Aboriginal Friendship Centre, the
Vancouver/Richmond Health Board covered food and childcare costs, and MOSAIC
assisted in accessing translators.

Community Empowerment

As indicated in the findings, the author concluded that the participants have not
moved into the phase of community empowerment. The participants were not able to
state ways that community resources had been re-allocated and a socio-political action
component had been addressed. Rissel (1994) suggests that these are both critical
elements to community empowerment. To satisfy both of these conditions the
participants would need to demonstrate the movement of health care resources to address
community driven initiatives and actively participate in the development of community
health policies. Whether or not the participants will be able to move into the phase of
community empowerment remains to be seen, but there are a variety of reasons why the
group has not been able to accomplish these conditions. The researcher believes that the
end phase of the community empowerment process can be achieved by providing the
participants more time for training and skill development. Bracht et al.,(1999) found that
effective citizen and volunteer involvement includes appropriate information and
guidance; in the process of learning new skills, citizen ownership is enhanced, which is a
critical step in community empowerment. Through education regarding the principles of
community development, community members have a better understanding, interest, and
commitment in sustaining program efforts in the community (Bracht et al.). With this new understanding and knowledge, the daunting task of changing an established health care system becomes more attainable.

The fact still remains that health care professionals fear loss of control by turning over intervention work to community members (Bracht et al., 1999). A key implication for empowerment theory in the community is that there must be a clear connection between empowerment sources and the development or exercise of social power (Speer & Hughey, 1995). The findings of the study indicate that community groups and organizations will never achieve community empowerment unless they are able to exercise their social power in order to redistribute resources.

As indicated in the findings and suggested by the literature, community capacity must be well established before the phase of community empowerment is achieved. The Hand-In-Hand group continues to work at becoming empowered as a community. Evidence of community empowerment will be a redistribution of community health care resources and involvement in establishment, implementation, and evaluation of healthy public policy. Once this has been accomplished the community members on Hand-In-Hand steering committee will be able to define themselves as an empowered community.

The iterative nature of the process of community empowerment implies that the next time participants become involved in other community initiatives it will be easier to move through the phases. Potentially participants will be able to satisfy the elements of each phase more quickly then previously experienced because of prior knowledge and familiarity with the phases. Although, the movement through the phases is also dependent on various other factors such as individual experience, dynamics of the group, and
resources available to the group.

Summary

Through revisiting the study’s findings and closely examining the relevant literature it can be determined that as the participants work through the process of community empowerment there are both actual and unanticipated outcomes. The outcomes in each of the phases assist in furthering the process of community empowerment. This gives credibility to the conclusion that the process of community empowerment is iterative and not linear. The iterative nature of the process gives rise to the fact that the participants are able to work between phases and all the elements in one phase do not need to be satisfied before the participant can move onto the next phase.

It was also determined that the participants are currently functioning in the phase of increasing community capacity and are working towards community empowerment. The participants must address the issues of reallocation of resources and socio-political actions before they are able complete the process to community empowerment. With their increased knowledge about group process and community development, the participants are better equipped to take on other community initiatives. The participants may be able to work through the phases of community empowerment more quickly, making it easier to address future community endeavors.
CHAPTER SIX
SUMMARY, LIMITATIONS, CONCLUSIONS, AND
IMPLICATIONS FOR NURSING AND HEALTHY PUBLIC POLICY

Summary of the Study

A qualitative study was undertaken to evaluate community empowerment in a community-based health promotion partnership. The four women interviewed were asked to describe their experiences with the Hand-In-Hand project, the relationships that were formed with the health care providers, and how this relationship differed from previous relationships with other health care providers. The data were obtained through a one hour interview using open-ended questions and were transcribed verbatim. Inductive content analysis and continuous comparative analysis were utilized in the study (Maxwell & Maxwell, 1980; Waltz et al., 1991). The methods allowed the researcher to develop categories directly related to the participants' personal experiences. The study findings were validated through a second interview with two of the participants and by inviting comments on a summary of the findings. Additionally, validation was obtained during postanalysis discussions with thesis committee members and some data analysis by the committee.

Six phases in the process of community empowerment emerged from the analysis; initial involvement, relationship building, demonstrating commitment, partnership building, achieving individual empowerment, and increasing community capacity. The participants determined that each phase had some elements that needed to be satisfied before they could move onto the next phase. As the participants moved through each phase outcomes emerged during the process. It can be concluded that each phase enables
participants to achieve the process outcomes and that the outcomes help to further the process of community empowerment. The iterative nature of the process of community empowerment allows the participants to move back and forth between the phases as necessary. It is speculated that when the participants become involved in another community initiative similar to the Hand-In-Hand project, the process and outcomes will potentially be repeated.

Participants who are familiar with the process of community empowerment may benefit from their previous experiences and may move through the phases of another community initiative at a faster pace than previously experienced in the Hand-In-Hand project. Lord and McKillop Farlow (1990) concluded that when someone is successful in a situation, they gain more control, and then it is not quite so difficult the next time.

Limitations of the Study

The conclusions drawn in this study are limited due to the small sample size. The researcher was able to interview four out of eight possible participants. Although the findings are significant to the study participants and the health care providers involved in the Hand-In-Hand project, the findings should not be generalized to other populations. By using a sample of convenience, a limited perspective was obtained.

Another limitation in this study was the researcher's previous involvement with the project. As one of the health care providers who initiated the discussions with community members and provided service, the data obtained through the interviews may be biased. Although the participants readily told their stories to the researcher, there was the ever present danger of the researcher being too close to the study topic. With the researcher unable to “keep her distance” there becomes a concern that the data analysis is
impeded due to the researcher’s familiarity with the project (Morse & Field, 1995). The researcher and the participant may not elaborate on certain parts of the story because there is an understanding of awareness between them. This can prove to be detrimental to the outcomes of the study as clarification about various issues might have assisted in data analysis. To decrease the potential for researcher bias, techniques, such as, reflective journaling and thesis committee postanalysis discussions were used throughout the study.

Conversely, the researcher's involvement with the Hand-In-Hand project was also seen as a benefit to the study. Sword (1999) states that the researcher's familiarity with the subject and sensitivity to participants deepens the understanding and enhances the creation of meaning. The trusting relationship that had been previously established between the researcher and the participants allowed the interview to flow with some ease.

Finally, the chosen research method also limited the findings of the study. The retrospective nature of the study places considerable importance on the participants being able to accurately recall events and feelings that may have occurred up to four years ago. Although the method allowed the researcher to subjectively interpret the data, it was also limited to the interpretation of the individual researcher and the thesis committee. Bearing this in mind the researcher exercised caution when judgment was required in the analysis of the data and recognized that this judgment was contextual and limited (Waltz et al., 1991).

In addition to journaling and postanalysis discussion, the participants validated the study’s findings. All of these techniques not only minimized researcher bias but also assisted in addressing the potential limitations of the study.
Conclusions

Through data analysis, review of the literature, and postanalysis discussions with participants and thesis committee members several conclusions were reached:

1. There are six phases inherent to the process of community empowerment: initial involvement, relationship building, demonstrating commitment, partnership building, achieving individual empowerment, and increasing community capacity.

2. The participants went through the phases of community empowerment in an iterative pattern, with each phase building on the next and all the phases contributing to community empowerment.

3. While the process of community empowerment is unfolding the participants are able to move back and forth between the phases.

4. Participants in the Hand-In-Hand project are currently located in the phase of increased community capacity and are proceeding to the phase of community empowerment.

5. The skills and knowledge that the participants gained in the Hand-In-Hand experience may enable them to work through the process of community empowerment at a greater speed in future community initiatives.

6. As the participants worked through the six phases, there were not only anticipated outcomes but also several unanticipated outcomes, that assisted them in moving towards the final phase of community empowerment.

7. Participants in the Hand-In-Hand project need to reallocate community health resources and address socio-political aspects to complete the process of community empowerment (Rissel, 1994).
8. There is a shift of control from health care providers to community members in the process of community empowerment.

9. It is important that new members continue to be invited to participate in steering committee discussions for the Hand-In-Hand project to continue to meet the needs of the community.

Implications for Nursing

Research

The results of the study indicate that it is crucial for both nurses and community members to gain experience in research and program evaluation methods. Moreover, funding bodies must recognize this work by sponsoring projects that evaluate empowerment at both the individual and community level. Given the enormous amount of effort that practitioners usually devote to the development and delivery of community health initiatives, it simply is prudent that evaluation be used to inform program refinements and other improvements with the goal of optimizing effectiveness (Goodman, 1998). If program stakeholders perceive evaluation as an integral part of the program, then community understanding, stakeholder commitment, and utilization of results will be enhanced (Goodman).

The qualitative methods utilized in the study enabled the researcher to clearly understand the participants experience in the Hand-In-Hand project. Whether nursing researchers use qualitative or quantitative methods, scientific rigor is an important consideration before any study proceeds. Allison and Rootman (1996) caution that if scientific rigor is sacrificed, then health promotion research may become so unstructured as to make a mockery of systematic inquiry. The challenge for researchers is to mount
and conduct scientifically rigorous studies in important areas of community health that do not immediately lend themselves to investigation using traditional designs and methods (Allison & Rootman).

In this study scientific rigor was addressed by exploring how community empowerment in a community-based health promotion project, Hand-In-Hand, was experienced by the participants. Allison and Rootman (1996) and Lord and McKillop Farlow (1990) found that research pertaining to empowerment should be conducted by exploring how the phenomenon is experienced by community members, with the researcher acting as a tool or resource for the community. With the researcher devoting additional time and patience, negotiating with community partners, then community participation will not necessarily lead to a loss of rigor (Allison & Rootman). In the Hand-In-Hand project the health care providers negotiated the research agenda with the community members. Allison and Rootman found that taking the time to negotiate a research agenda with all parties resulted in a greater likelihood that there will be a closer match between the interests of researchers and those of the research practitioners.

Although the findings from the study have provided insight into nursing research regarding the evaluation of empowerment, further investigation is required. Research needs to be undertaken to determine the length of time it takes community members to move into the phase of community empowerment. Conclusions need to be drawn about whether the community members will move through the process of community empowerment with increased speed the next time they are involved in another community initiative.
As indicated in the findings, community health nurses who are interested in working with the community need to see the community from a different perspective. Nurses must realize that community members have a valuable contribution to make and nurses should regularly question the community about health care services. The community becomes part of and involved in the evaluation of their own community health care programs (Mahon et al., 1991). As the participants moved through the phases they became increasingly empowered through their involvement in the evaluation process. Community awareness, involvement, commitment, and ownership are essential program elements, therefore, the health care professional must encourage people to draw upon their own experiences and to seek the solutions which they hold within themselves (Lord & McKillop Farlow, 1990; Mahon et al.).

The findings suggest that in order to develop partnerships with community members, a role change or a shift in perspective is required of health care providers. Health care providers need to adopt the role of facilitator of empowerment rather than teacher of health. The results are confirmed by Lord and McKillop Farlow (1990) when they determined that health care providers should see health promotion as assisting people and not changing illness-producing behaviors. If nurses ascribe to an empowerment model, they will adopt the role of facilitator and resource person, recognizing that self-awareness, self-growth, and reallocation of resources, are the tools of empowerment, not the services provided (Gibson, 1991). In addition to the role change health care providers have a responsibility to use their professional power to advocate for the benefit of the community. Sawyer (1995) determined that nurses who utilize their
power in order to advocate for the community have completed the role change. The expert community health nurse knows how to provide informational, emotional, and evaluation support (Reutter & Ford, 1997).

Community capacities not deficiencies should be the focus of health care providers who are concerned with the empowerment process. Lord and McKillop Farlow (1990) found that health care providers should acknowledge, through changes in their professional practices, that people themselves are the most important resources for community change. The findings indicate that health care providers should not assume they are the experts regarding community issues. Nurses must build on assumptions of community's strengths and capabilities, not needs and inabilities, thus enabling community members to act more effectively on their own behalf (Kieffer, 1984; McKnight, 1997). In this study the phase of partnership building required the health care provider to be there and to work with the community on particular actions. Courtney et al, (1996) suggested that an equal partnership between health care providers and community members assists in the confidence that facilitating empowerment will improve health. When nursing interventions empower groups to develop their health potential, the nursing profession contributes significantly to achieving health for all (Jones & Meleis, 1993).

The findings suggest that health care providers should be willing to give up some of the control they have over community health services if they are truly interested in becoming involved in health promoting community initiatives. Sawyer (1995) found that community involvement often threatened professionals because it required the sharing of professional sources of power: knowledge and skills. It is important for community health nurses to recognize that they benefit from a system that keeps people powerless and
dependent upon their services, and that it may be difficult to let go of this control. More often, it is the passive compliance of others that is most frequently sought by health care professionals because the meaning of partnership is not fully understood or accepted by them (Sawyer). In the study the health care providers identified the community as being the client but as Sawyer suggests nurses frequently provide care within a health care system that does not support the full participation of the community.

This study's finding of a gap between language and the reality of participation is confirmed by Lord and McKillop Farlow (1990). For example, the use of translators in a community project is only beneficial if the entire group is supportive. Every effort must be made to ensure that the person who is translating and the person who is receiving the translations feel comfortable and part of the group dynamics. Speer and Hughey (1995) state that activities that emphasize building organizations, cultivating relationships among members, and engaging in action-reflection dialectic emerge as critical empowerment principles. Community members must see their participation in community initiatives as both important and relevant. The efforts of health care providers in the Hand-In-Hand project to get community members involved is reflective of empowerment principles.

As indicated in the findings, community health nurses who are genuinely interested in addressing community needs must see themselves as coaches rather than as teachers. Additionally, health care providers should take an active role in working with the community to redistribute or reallocate community health resources. Using an empowerment model, the nurse is not only a resource person but a resource mobilizer, facilitating access to both personal and environmental resources that foster a sense of control and self-efficacy and support health (Gibson, 1991). Nurses often attempt to alter
the individual client's attitudes toward health, rather than address the broad range of determinants of health (Sawyer, 1995). Health care professionals need to expand their scope of practice shifting from behavioral health determinants, to health determinants defined in psychological, social, environmental, and political terms (RNABC, 1992). As stated in the Ottawa Charter for Health Promotion (WHO et al., 1986), important health goals are the capacity to define, analyze, and act upon problems in one's life and living conditions. With health professionals shifting their perspective they will be in a better position to appreciate the tremendous contribution that the determinants of health have on a community. Once this is accomplished, the health professionals will be able to give up their dominant position in health care and become advocates for the community in order to procure needed resources to improve health status for their clients (Jones & Meleis, 1993; Sawyer, 1995).

Flynn, Ray, and Selmanoff (1987) have asserted that nurses are ideally suited to social action, and this commitment has been demonstrated throughout the history of community health nursing. Perhaps the most important function of this form of health advocacy is that it legitimizes the concerns and efforts of community groups that might otherwise be dismissed as "fringe" by media or senior government officials (Labonte, 1987). Health professionals need to use their capacities, skills, contacts, and resources and make them available to strengthen the power of communities (Labonte, 1999; McKnight, 1997). Unfortunately, as the findings suggest, nurses often do not see themselves as being activists. Political advocacy skills must be developed and used on behalf of communities and in partnership with them (Sawyer, 1995).
Education

Nursing education does a disservice to nurses by not providing a more substantial community health component in current nursing curricula. Community health nurses must be prepared to think globally and act locally (Flynn et al., 1987). The findings in the study indicate that community health nursing programs need to undergo a paradigm shift and assist students in gaining skills in community advocacy, facilitation, and partnership, rather than an emphasis on being a prescriber of solutions. Currently, nursing education prepares students to assume leadership roles in a variety of settings, which has great potential to damage the process of creating community competence and empowerment (Eng et al., 1992). The fact remains that the knowledge and skills acquired by most nursing students offers little to prepare them to function effectively in empowering communities (Eng et al.).

It is important that educators assist nursing students to learn what the scope of community health nursing is; coach not teacher; resource person not expert. Nursing educators and community health nurses would benefit from ongoing inservices on community health nursing and its changing environment. In addition, mentoring of nursing educators by practicing community health nurses who are experienced in the use of empowerment strategies would enhance nursing curricula. Equally important is the basic understanding that communities are living organisms and that no one health care professional can master all strategies or even participate directly in all of them (Eng et al., 1992). Nursing students need to be given meaningful experiences as true partners rather than prescriptors of care (Courtney et al., 1996). Unfortunately, the assumption that individuals understand their own needs better than professionals is not one that is
generally shared by health service providers (Lord & McKillop Farlow, 1990). One of the central lessons to be learned is that health care providers should not seek to do for others what they must do for themselves; providers must strive to collaborate with community members in developing the emotional and practical resources the community requires (Kieffer, 1984).

Administration and Leadership

If nursing research, practice, and education shift their perspective on how nurses work with the community, then it is prudent for nursing administrators and leaders to do the same. Administrators need to encourage nurses to take on community development projects with a health partnership focus. The study's findings suggest that support of community-based health promotion projects can be demonstrated by ensuring that practicing nurses have the resources needed to assist in the success of a project, rather than limiting resources so the project is doomed from the beginning. Commitment to community projects is illustrated through the allocation of budgetary moneys.

It has long been stated that the social, economic, environmental, and political determinants of health should guide community health practices, yet nurses continue to practice under the medical model providing services that the community may or may not want or need (RNABC, 1992). It is reasonable to expect administrators to spend significant moneys on evaluating community programs to determine if community health services are really meeting the needs of the community.

Although direct investment in health and social welfare to support community health promotion projects is needed, funding for community health promotion is usually insecure (Guldan, 1996). Casebeer, Scott, and Hannah (2000) found that new structures
and processes required for sustained change in health care delivery are often elusive and run counter to existing professional turfs and traditional funding priorities. Nursing administrators and leaders can take a political stance and support community-based health promotion projects by reallocating resources and evaluating such projects. Although this would be ideal, Sawyer (1995) found that it rarely occurs since planners usually only give lip service to evaluation.

One way this issue may be addressed is for administrators and health care providers to develop a permission statement; a contract between administrators and health care providers describing the extent of resources that will be allocated to the community (Labonte, 1987). The permission statement allows health care staff to work actively with community groups in developing broader-based approaches to socio-environmental health problems (Labonte). Permission statements both empower and protect agency or department staff whose help may be sought by groups involved in community defined endeavors (Labonte). By investing in joint practice initiatives, health authorities can create capacity to share learning and progress with other health care jurisdictions concerned with moving towards community-based models of care (Casebeer et al., 2000).

In addition to permission statements, nursing administrators and leaders must also accept alternative ways of evaluating community programs. Community development projects, which attempt to reduce inequalities in health and empower the public, do not produce easily quantifiable outcomes in a short length of time (Guldan, 1996). Labonte (1999) found that evaluations that express change in numbers can be useful, but are often inappropriately suited to capturing the social-justice and empowerment that underpins community development. In the case of accountability in community development work,
Labonte believes that simply noting the changes among people, and engaging them in their own evaluation of that change, is often sufficient.

Perhaps the most dramatic finding in the study was the need for health authorities to change their perspective and trust the experiential knowledge of local people. Health systems attempting to create more community-oriented approaches need to develop goals and objectives that are locally appropriate and attainable (Casebeer et al., 2000). This knowledge may not always be scientifically verifiable, but it constitutes an initial understanding around which groups and institutions might discuss and analyze how they can cooperate in creating healthier people and healthier living conditions (Labonte).

As implied in the findings, barriers and constraints to community participation are fundamentally related to issues of resources, power, and control; a conclusion supported by Sawyer (1995). Increasing resources is not, however, the all-encompassing answer for being and becoming healthy (Jones & Meleis, 1993). If individuals are not active participants in creating and using these resources, gaps between the resources and the individual's health will continue to grow (Jones & Meleis). This new way of thinking will require a shift in the ideology of many health-promotion employers, from one of content (dissemination of health knowledge to reduce individual risk factors) to one of context (changing social relations of power to reduce economically structured risk conditions, Labonte, 1999), a shift that many nursing administrators may not be ready to take.

Healthy Public Policy

For community-based health promotion to become a mainstream mode of dealing with public health, a major reorientation of attitudes in government and medical circles
will have to occur (Guldan, 1996). Governments and health boards must be willing to get the community involved in determining their own health policies. If governing bodies are truly interested in “health for all” then it is imperative that they secure community involvement in the planning, implementation, evaluation of community health services, and establishment of health policies. The characteristics of healthy public policy should include both environmental and socioeconomic determinants of health: people's housing, supports, and the choices they make (Glass & Hicks, 1995). Popular education emphasizes active participation, breaks down "teacher-student" polarity, avoids manipulation by experts, and emphasizes the collective nature of learning (Labonte, 1987). Healthy public policy is a process requiring a commitment from government departments, agencies, organizations, interest groups, and the community (Glass & Hicks). Multisectoral collaboration and social change enable communities to achieve basic health.

Currently, the British Columbia health care system is made up of various health boards whose members are community volunteers. These community volunteers devote an enormous amount of time and energy to try to make the health care system fair and equitable in meeting the community’s needs. The magnitude of unpaid community labour that health boards are asking of community members is incalculable. It must be questioned if this is fair or ethical treatment of community volunteers. Should not health boards honor the community's expertise with some recognition, monetary, or other concrete benefits?

Demonstrating benefits of community health promotion programs to government decision-makers for policy and financial support requires quantitative evaluations
showing progress and positive outcomes (Guldan, 1996). Glass and Hicks (1995) determined that evaluation is an integral part of the policy process and planned evaluations should be carried out at specific intervals throughout healthy public policy development. The healthy public policy process must include both health care providers and community members as key components in the evaluation (Glass & Hicks). However, evaluation of community health promotion programs is problematic because of the programs long duration, lack of a planned feedback or monitoring system, and health outcomes that often elude quantitative measurement (Glass & Hicks; Guldan). Until these evaluation problems are overcome and clearer measures can be developed that are valid and measure qualitative outcomes, community health promotion programs will continue to face difficulty in demonstrating benefits (Guldan, 1996).

Summary

As Kieffer (1984) stated, empowerment is a long-term and continuing process of adult development. The findings revealed that the participants in this study gained significant social influence and although they were not able to reallocate resources or become politically active in the community at large they did become more effective in local decision making. While they indicated that they had not acquired community empowerment, they did advocate for themselves and other community members. The fundamental empowering transformation is the transition from sense of self as helpless victim to acceptance of self as assertive and an efficacious citizen (Kieffer).

The findings in the study suggest that nursing research, practice, education, administration, and leadership require a paradigm shift in their view of community. Community members should no longer be viewed as passive recipients of health care,
they are active players in the health care game. All levels of nursing must embrace the community’s experiential knowledge and invite community members to take part in the planning, implementing, and evaluating of community health programs. Future health care proponents are calling for all health professionals to engage in multidimensional, health promoting, collaborative coalitions and partnerships with the communities being served (Baldwin, 1995). Therefore, nursing researchers, practitioners, educators, administrators, and leaders should see community-based health promotion as not simply a technical endeavor or an administrative efficiency, but a deeply ethical and moral project (Labonte, 1999).
References


Appendix C

Interview Guide

Opening Questions:
Please describe your experience with the Hand-In-Hand project.
How did you become involved with the project?
What did you think you would get out of this involvement?

Specific Questions:
1. Nature of the relationship with Hand-In-Hand health care providers.
Describe the nature of your relationship with the health care providers at Hand-In-Hand.
Strengths? Difficulties?
Is this different from the relationship/experience you have had with health care providers in the past?

2. Nature of the relationship with other health care providers.
Has your experience with the health care providers of Hand-In-Hand changed/influenced your relationship with other health care providers? If so, how? In what way?

3. Evidence of increased involvement with community.
Has your involvement with Hand-In-Hand changed your thinking about your community? If so, how?
Has your experience with Hand-In-Hand changed your involvement with your community? If so, how?

4. Evidence of increased involvement with other community issues.
Has your experience with Hand-In-Hand led you to become involved in other community steering committees? If so, how?
How has your involvement with Hand-In-Hand helped you in becoming involved in identifying and addressing other community issues? If so, how?