**Ruling Relations in the Intake Assessment of a Pregnancy Outreach Program**

By

Vaida Siga

BSN, University of Victoria, 1981

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

MASTERS OF NURSING

In the Faculty of Human and Social Development

We accept this thesis as conforming to the required standard

[redacted]

Dr. M. Campbell, Supervisor
(Faculty of Human and Social Development)

[redacted]

Dr. M.E. Purkis, Departmental Member
(School of Nursing)

[redacted]

Dr. B. Wharf, Outside Member
(Faculty of Human and Social Development)

[redacted]

Dr. M. Callahan, External Examiner
(School of Social Work)

## TABLE OF CONTENTS

Supervisor: Dr. Marie Campbell

## Abstract

This thesis uses Institutional Ethnography to examine how intake assessment in a British Columbia Pregnancy Outreach Program organizes worker-client interaction. The Pregnancy Outreach Program targets service to "high risk prenatals". The study argues that the epidemiological based intake assessment process creates a barrier to participation of the very clients it seeks to serve and limits the extent to which staff can establish a relationship with the client. It argues that classifying the client as "at risk" owing to social disadvantage is experienced negatively by the client, and constitutes social difference between staff and client. At odds with the scientific model that population health brings into the program is a community development approach that has been included in its organization. It is expected that this would allow clients to feel more comfortable with the service, and thus, the program to be successful. Inclusion of a community development approach, however, sets out two distinct and conflicting work processes within the program. The formal work as organized by the intake assessment is textualized and provides accountability measures. Specific work practices based on community development ideology organize the informal work of the program. Though these support staff/client relationships and client participation, the latter are subordinated to the formal work process. The study argues that because formal work practices are part of the management technologies of the Ministry of Health, they are dominant and supercede informal work practices. This creates troubles both for client participation and for workers.

Examiners: [redacted]

Dr. M. Campbell, Supervisor (Faculty of Human and Social Development)

[redacted]

Dr. M. E. Purkis, Departmental Member (School of Nursing

[redacted]

Dr. B. Wharf, Outside Member (Faculty of Human and Social Development)

[redacted]

Dr. M. Callahan, External Examiner (School of Social Work)

## Acknowledgements

I would like to acknowledge Marie Campbell, my supervisor, whose guidance through this thesis process was invaluable. Her persistence when mine failed made completion of this thesis possible.

I would also like to thank Brian Wharf, Marilyn Callahan and Mary Ellen Purkis for their support.

I feel I have gained a great deal of knowledge through the courses provided by my thesis committee, and I would like to respectfully acknowledge their contribution to my learning.

I would also like to acknowledge those women who shared their insights and knowledge with me and thereby allowed me to better understand how their world is organized. Their strength, pride and resilience in the face of such devastating life circumstance never ceases to amaze me.

In particular, I would like to thank Rita Marshall, my work partner and sounding board, for sharing her wisdom and insight.

## Dedication

I would like to dedicate this thesis to my family, particularly my son's Cody and Cole, and husband Harvey Nauffts who were there for me through this experience, and mother Verna who inspires me to question the accepted.

## INTRODUCTION

Reproductive care in industrialized nations has changed dramatically over the past century. Control of reproductive care practices has shifted from women to men, from personal control to organizational control, and from lay care provider to professional care provider (Martin, 1992; O'Brien, 1989; Smith, 1984a; Oakley, 1976). Though production and economic progress have dominated how our western society is organized, society is dependent on reproduction (Shiva, 1996; Martin, 1992; Gil, 1990; O'Brien, 1989). Reproduction and reproductive care ultimately affect society as a whole.

It is vital for our society to consider the impact of changes in reproductive care. In order to ensure the provision of effective care that will help sustain reproduction into the future for "the common social good", it is important to examine reproductive care practices. We must ensure that reproductive care programs are designed carefully so the intended objectives are met and changing needs affecting reproduction, and thus the health of the population as a whole, are addressed.

Reproductive care practices in North America are changing and being adapted to fit within the existing health care delivery system, which itself is in flux. Recent trends in health care planning have been guided by principles of "population health". Cost effective programming is targeted toward health intervention in populations who are identified to be **epidemiologically at risk** (Frank, 1995, Labonte, 1995).

Where reproductive care is "targeted", it is particularly important to ensure the services are appropriate for the population being targeted. If targeted programs are to address the needs of a specific population the circumstance, issues and concerns of that population must be understood. Several authors have pointed out that organizational structures can limit the input and participation of clients, and therefore the ability of a service to be responsive to client need (Wharf, 1995; Ferguson, 1984a; Smith, 1975). McKenzie and Wharf point out "We have argued that gaps between policy and practice result in both bad policies and bad practice, and that a major contributing factor is the all too common corporate approach to management which tends to exclude the voices of women, Aboriginal people and other minorities including front-line staff and consumers." (1995, p. 84) Inclusion of the voice of the targeted population is

essential to organizing policy and practice that effectively address health issues to be targeted. Care must be taken to ensure that services do not exclude the very clients to whom they are targeted.

The Pregnancy Outreach Program in British Columbia is one such targeted program. It is designed to provide service to a population of women who have been identified epidemiologically to be "at risk" for a healthy birth outcome. This program was piloted British Columbia in 1988, when eight program sites were established. It has proven very effective in reaching women who were not accessing traditional medical care prenatally, and has now been expanded to 21 sites across British Columbia. A primary objective of the Pregnancy Outreach Program is to decrease the incidence of low birth weight infants. "Two thirds of infants who die in the first year of life are low birth weight infants,...low birth weight infants are 40 times more likely to die than infants of normal birth weight." (Martin & Armstrong, 1995).

In this research I explore the work practices of the Pregnancy Outreach Program at one program site. The Pregnancy Outreach Program was initially established at a time when health care was well funded, and there was growing awareness of the devastating affects of fetal alcohol syndrome. Despite considerable health care cutbacks, this program has continued to flourish. The success of the Program in making services accessible to a targeted population allow it to thrive as a "cost effective" population health program during these times of fiscal restraint. This research allows an examination of the successes and limitations of the work and organizational practices of one targeted prenatal program.

As a hospital nurse, community health nurse, and presently as coordinator of a Pregnancy Outreach Program, prenatal care has always been a mandated component of my practice. In all three kinds of nursing work I found that provision of care was based on a systematic approach of using an intake form to assess risk and then planning care and providing information or referral based on the intake assessment. This standardized process of intake assessment is a common professional/administrative feature of most health care.

In my work as a nurse I have often found that the standardized intake assessment is the most formal and potentially uncomfortable interaction throughout my contact with a prenatal client. I found that the assessment tool had to be used with care to avoid creating a barrier to interaction with some

clients, yet the intake assessment is central to how work in prenatal care is organized. The intake assessment is used to assess client risks, to plan care, and to document the care or "work" done. Because the intake assessment is a central feature of the work in Pregnancy Outreach Programs, and because I have found it troublesome to use in my own practice, my research began with examining the intake assessment process of the Pregnancy Outreach Program.

I begin this thesis with a discussion of practice incidents where I have found the standardized intake assessment process to be a problem. This identifies the problematic, a set of puzzles that I seek to understand. Based on this, I then identify my research objectives and research question. In Chapter One I refer to the literature which helped me formulate a conceptual framework to serve as a basis for my investigation. In Chapter Two the methodology I used for this study is discussed, and I outline my research methods and how I carried out my study. Chapter Three describes the Pregnancy Outreach Program, it's history, organization, and intake process. Staff and client experiences of the intake process are described in Chapter Four and client reflection on the discomfort felt during this process is discussed. I argue that the intake assessment is a documentary process that routinely eliminates the contextual circumstance of the client and organizes work around a "problem version" of the objectified client. In Chapter Five I argue that a formal and an informal work process exist. The formal work process is based on the intake assessment and serves the accountability needs of the organization. The informal work process serves the needs of the client and makes services acceptable to them. In Chapter Five I argue that administrative policy has set the stage for these two work processes to exist at the local work site. I make the argument that a "community based approach" exists within the otherwise medically/epidemiologically oriented organization of the Pregnancy Outreach Program of the Ministry of Health in British Columbia, and practical troubles occur in front line practice because these two very different and conflicting ideologies are cornerstones of the Program.

## Problematic

In nurse's training I was indoctrinated into the "right way" to provide labour and delivery care according to the medical model and institutional norms of my training hospital. My university based degree program provided valuable

instruction on the "right way" to provide prenatal services according to nursing theory and the existing community health programs of the Ministry of Health. My knowledge was firmly grounded in scientific fact and methodology. The nursing process formed the basis for my client assessment and care planning.

When I began to practice community health care I found both the Medical Services Branch of Health and Welfare Canada, and the BC Ministry of Health had standardized risk assessment forms and processes that formed the basis for prenatal care. Use of these tools and processes was relatively easy and fit with my grounding in the nursing process and with indoctrinated values which primarily recognized scientific knowledge.

As I used these tools and processes to provide prenatal care, however, I became acutely aware that the assessment tool itself could create a barrier to interaction. I soon realized that the standardized approach I had been taught was acceptable to some clients, but not to others. Though the assessment tool initially provided a good format to guide discussion about risk factors in pregnancy, it seemed the more risks I identified, the less interested clients were in participating in "the program".

By ticking off "problems" the interaction became focused on negative aspects of the pregnancy. Women identified by the assessment as 'high risk' were usually already very conscious of the issues in their lives that health care providers considered to be dangerous for their own health, and for that of their unborn baby. Most were poor, had experienced family violence, had difficulties in school, and lived in communities where substance abuse was a norm in socializing. Their circumstance often limited the control they felt they could exercise in their own lives. To point them out as "risks" seemed to be adding "insult to injury".

I began to view the risk assessment as necessary documentation that needed to be completed for organizational purposes. Over the years I learned new ways of doing the work that I had been taught was "right" so that it did not prevent interaction with a specific client or in a specific situation. Until recently I never questioned my quandary over what was "right" as contrasted to using an approach that worked in the circumstance. I assumed that my difficulty was somehow related to my own failing, or that of my client. I eventually found in my practice that if I was flexible and creative, I was, in most circumstances, able to meet the practice and documentation requirements of management, as well as

maintain a relationship with the client. This did not, however, allay my feeling that there was something fundamentally wrong with the process.

When I started work in a Pregnancy Outreach Program I believed the service would be similar to prenatal services I provided in my community health practice. I had some concerns that the program would be a duplication of service. As the outreach site became established, however, I soon realized it offered a very different type of service.

Frequent personal contact by trained lay counselors in a setting that is comfortable and accessible to the client provides a continuity of service and a bonding between staff and clients that was not present in prenatal care within the community health system. Some strategies developed by the Pregnancy Outreach Program seem to help decrease isolation of clients. Weekly drop-in sessions where a meal is shared provides an opportunity for clients to learn about community resources and topics of interest to them. It provides an opportunity to learn from other women, to share stories of prenatal and birthing experiences, and to form supportive relationships. I soon realized the Pregnancy Outreach Program provides a richer and more meaningful service for women than the community health system. The care is more personalized and responsive to individual clients. More importantly, it was developed specifically for the "high risk" clients who are using the service.

While I recognized the outreach programming was offering what I perceived to be an extremely valuable experience for these 'high risk' women, I was also acutely aware that there was no account kept of this most valuable piece of the 'work'. The only accounts we were creating of our work were numerical data, such as the number of clients seen, number of drop-in sessions held, and information we gathered on the risk assessment, or 'intake form'. The interaction, support and personalized care that represent a unique strength of the program are not recorded. To those who interpret the outcomes of the program, it would not be apparent that interpersonal support was provided, nor that outcomes were affected by anything other than health information about risk factors.

The intake assessment in the Pregnancy Outreach Program forms the basis for most of the program documentation and reporting. It is used to initially collect client data that is pertinent to the pregnancy, and to determine client "risk factors". This then forms the basis for planning care. Care, or the work done to

address the identified "risk", is documented along with client outcomes such as "changes" in risk factors and the birth outcome. The assessment process gathers information on specific aspects of the woman's lifestyle that are known to be risks in having a healthy birth outcome. These are identified as 'problems' to be addressed. Although social, economic, and even political circumstance play a large role in risk factors, the 'problems', such as eating poorly or smoking, are identified to be 'the woman's'. These identified 'problems' are targeted for intervention and a plan is developed to help the woman make lifestyle changes.

In my experience, identifying a problem for intervention meant "we" (the program staff) had to act on this to somehow decrease the risk to the baby. I found that the process took the situation out of context, identified the problem to be specifically that of the woman, and put responsibility for addressing the problem squarely on the woman. I could provide scientific based information on why and how she should address "the problem" and I could provide referrals, but in taking action she was alone, in the same circumstance, and with the same personal resources as before our interaction. Identifying problems to be targeted provided me with information upon which to formulate a plan for care, but did little to change the woman's circumstance.

It seems to me that the intake process focuses attention on negative aspects of the pregnancy, rather than building on the women's strengths. Risk assessment and the nursing process support the role of the health care provider as the expert, and scientific knowledge as a valuable resource to be provided. It does not empower the woman to change her own circumstance, and most often the risk factors are related to her social circumstance.

Built into Pregnancy Outreach Program practice is an opportunity for staff to build relationships with clients. Staff get to know the clients and their individual circumstance. I found that some staff tended to focus their care on personal interaction rather than being guided solely by the assessment and formal plan. Care would center on client issues or crises that arose, and would be personalized and responsive to client's changing circumstance. Though staff may add alternative work processes where necessary to personalize care, the assessment and nursing process still form the basis of all program documentation and organize the formal work of the program. It became clear to me that this additional work that I considered to be valuable was not captured by the standardized risk assessment and reporting format. Yet, conducting my work

solely as guided by the assessment was not only difficult, it often put my relationship with the client at risk.

For example, one risk assessment I completed for "T", clearly identified that "T" and her fetus were at risk because of substance abuse and poor nutrition. We built a strong relationship, and though we discussed nutrition and substance abuse on numerous occasions, it was not this 'technical information' that proved to be the most useful part of the interaction.

"T's" circumstances were extremely oppressive. She was a First Nation's woman, and her parents had both been largely raised in residential schools. Both parents abused alcohol, and alcohol abuse was the norm for socializing in her community. "T" spent much of her life in foster care or being moved between relatives. She was the victim of family violence and sexual abuse. She herself abused alcohol and was now in an unstable relationship with an abusive partner. This would be her fourth child. Two of her other children were in foster care and one had been adopted. Though extremely intelligent, social circumstances had limited her progress in school. "T" worked at seasonal employment and did not receive financial support from her common-law partner.

The risk assessment could not clarify how "T's" personal and cultural history impacted on her present circumstance. It could not indicate how disempowered she felt, and how this limited her ability to cope. Much of my care focused initially on trying to understand her circumstance, issues and concerns. I was then able to identify some of her strengths and support her own efforts to cope with the pregnancy and her circumstance. By the end of the pregnancy, "T's" approach toward her children, relationship and pregnancy had changed dramatically. She was acknowledging how her decisions were impacting her life and she began "taking charge".

The context of "T's" risks, however, was not captured by the intake assessment, and thus the valuable work done was not reflected in program documentation. Her risk assessment identified "inadequate nutrition, cigarette smoking, alcohol use, other drug use, refusal of/resistance to appropriate services, isolation, unstable relationship, financial problems and inadequate housing" to be "risk factors". The changes she made in her life were not captured by the documentation on the intake form. Though she had made dramatic changes in her life, alcohol use, smoking, relationship problems, financial problems, housing problems and inadequate nutrition still needed to be

addressed. Her risk assessment and chart identified that there was little change in these "identified risk factors". Changes that had occurred and were valuable to her own well being and thus to that of her infant were not clearly identifiable on her chart because they did not fall within the risk categories of the intake and charting process. The most valuable work done with "T" could not be captured within the context of decreased risk, and thus valuable work that was done was not acknowledged by the program documentation. In years following her delivery she was able to address most of these issues, largely due to changes that did occur throughout her pregnancy and with the support of program staff.

Another concern about the intake assessment process that was brought to my attention was how its use could fail to identify client needs, and therefore misdirect care. An intake was completed on a client who had attended a Pregnancy Outreach Program during her previous pregnancy. This client was familiar with the program and routines for documenting, so the assessment was easily completed in a direct interview format. The assessment identified surprisingly few risks. When I commented on her "low risk", I was informed by a lay counselor who was familiar with this client, "She's just telling you what you want to hear." Indeed, as I became more familiar with the client it was increasingly clearer that her initial assessment was seriously flawed.

The client had learned during her last pregnancy what risk factors she should address. She was able to discuss the "scientifically appropriate" information, which indicated she had a solid grasp of her risk factors. She was able to relate a dietary intake that included all the appropriate nutrients in all the appropriate amounts. Grasping the scientific knowledge, however, had not changed her circumstance. Her "risks" had not, in fact, been altered. Her income was still limited and she remained in an environment where alcohol and drugs were used excessively. Though she was able to identify orange juice as an important part of her diet she did, in fact, still rely on the cheaper drink crystals. Though she was able to identify that smoking was a problem and she had "cut down", she still relied heavily on smoking to relieve stress. Though there were still significant risks to her pregnancy, these failed to be identified by the initial assessment process.

In this instance, rather than focus care on the identified risks, or rather the lack of identified risks, we based care on information we gathered through personal interaction as we pieced together an understanding of her

circumstance. Our work became to support her in identifying her strengths and in building on these strengths to address her own issues. Again, in this instance valuable work was done, but none fit well within the standard intake process and documentation of the Pregnancy Outreach Program. This woman took the initiative to enroll in a parenting course, and to gather information on immunization. She and her common-law partner budgeted to purchase a car, thereby decreasing their isolation. In the final documentation, however, all that is recorded is that nutrition, smoking, financial problems and inadequate housing are still "risks".

Documentation in the Pregnancy Outreach Program is based on the intake assessment. I could see that the assessment process sometimes failed to identify what are obviously issues for the woman. In order to maintain a relationship with a woman it is important to understand her situation and discuss her concerns and issues. I found I sometimes had to add personalized work processes to the normal practice as guided by the intake assessment document in order to understand a client's concerns and to maintain a relationship with her.

How is it that in order to do what we know to be valuable work we feel like we are stepping outside of the "right way", or accepted way of doing that work? How is it that the client's issues, concerns and circumstance, and the work that I find to be most valuable, become invisible in the reporting and documentation? These are the puzzles that formed the basis of my inquiry. In my experience use of the intake assessment tool, a common feature of existing health care practice, was particularly problematic where clients are identified to be most “at risk”. The purpose of this inquiry, then, was to explore the puzzles that arose for me in my work at a Pregnancy Outreach Program site, beginning with the way the assessment seemed to organize the work and influence interactions.

The implications this study has for other services that use standardized risk assessment, particularly those targeted to "at risk" populations, should not be overlooked. Though one Pregnancy Outreach Program is the primary site for this investigation, risk assessment is in widespread use throughout human service practice.

## CHAPTER ONE - Conceptual Framework

### Standpoint

Maguire states "The power of a paradigm is that it shapes, in nearly unconscious and thus unquestioned ways, perceptions and practices within disciplines...A paradigm influences what we choose not to attend to; what we do not see." (1988, p. 11). This research was undertaken within the constructivist paradigm. The constructivist paradigm assumes that all knowledge is constructed. Unlike the positivist paradigm, which assumes rigorous research will produce valid, replicable, thus objectively true findings, the constructivist paradigm assumes that what is discovered is dependent upon the context in which that knowledge or insight is gained. Given another context, whether it be a different history, chronology, methodology, theoretical base, or simply a different complement of individuals involved in the research, the constructivist researcher acknowledges that findings could look very different.

Whereas in the positivist paradigm the researcher goes to great lengths to remain "objective", and not influence the research to remove bias, in constructivist research it is assumed that the research process and the standpoint of the researcher will make a difference to the context and thus to the conclusions of the study. In the constructivist paradigm there is an awareness that the research process itself will affect the research findings. In non-positivist research, then, it is important to the rigor of the study to include the "stance" of the researcher. In this way the influences of the researcher, research process and research question remain apparent.

In institutional ethnography, a process for social inquiry developed by Dorothy Smith, identifying the standpoint of the researcher becomes key to the rigor of the investigation. Rather than situating the inquiry of social interaction in theoretical and social discourse, the researcher begins the inquiry in the situated context of the interaction being studied. Smith refers to the situatedness of the researcher as the "standpoint" (Smith, 1992). The standpoint locates where the inquiry will begin. It defines the contextual reality of the researcher and the site of investigation. It makes clear the situatedness from which the research will be undertaken. As the researcher, I acknowledge that my standpoint has influenced my research interest, how I conceptualized the research problem, how I investigated the problem, and what conclusions I have drawn from my data.

Though in my past practice I found many aspects of the standardized approach to health care to be troublesome, I did not question how my work was organized. Course work, literature and lecturers on institutional ethnography, critical thought, feminism, policy, economics and discussions of globalization have dramatically influenced my world view over these past years. I found that as I learned to critically reflect on my past experiences, I became more interested in considering whose interests are served by standardized caring practices, and how those being "cared for" are impacted by this organization.

Institutional ethnography assumes that within all societies there are "ruling relations", or accepted means of organizing the society. These ruling relations, put in place through the legal, political, and economic systems, all help to "construct" how social interaction flows, or takes place. The ruling relations become accepted as the norm for interaction, and often the role of these ruling relations in constructing a specific interaction become invisible. Institutional ethnography provides a methodology for explicating the ruling relations that come together to construct a specific social interaction, and to examine elements of these ruling relations that may have unintended consequences. Smith (1992) calls the experiencer's account of a local situation in which ruling relations are invisible, yet dominant, the "problematic".

This research provided me with the opportunity to explore and critically reflect on practices that I found to be troublesome for clients. I begin by exploring the standardized intake assessment process that is used within the context of one prenatal health care program that is targeted to these "high risk" women. That is my problematic, or the site of real-life puzzles to be explored. Concepts gained from my past work experience and the theoretical constructs of feminist theory and institutional ethnography are used to inform this research and my research standpoint.

Institutional ethnography offers researchers a way of understanding the ruling relations that organize their informants lives, lives that are thus subordinated to ruling relations. Because my concern is the appropriateness and accessibility of prenatal services being provided to "high risk", or "marginalized" women, this research was undertaken from the standpoint of these women. For the purposes of this research I examined the intake assessment process of the one Pregnancy Outreach Program site from the standpoint of the client. My problematic tells me that client issues, concerns and circumstance are made

invisible in the intake assessment and documentation process of the Pregnancy Outreach Program.

**Theoretical Constructs That Inform My Standpoint**

Feminist theory assumes that women have a world view and experience that are unique from those of men. The theory provides a framework within which to explore, define, describe and explain women's circumstance (Chinn & Jacobs, 1987; Bunting & Campbell, 1991; Wetzel, 1986). If society is dependent on reproduction by women, and feminist theory represents the perspective of women, it makes sense for a feminist perspective to be used as a basis for investigating reproductive care. I use concepts from feminist theory to inform this research.

One premise of feminist and critical thought is that dominant social structures in western industrialized nations are based on relations of power and control, and that women have been excluded from these ruling relations (Campbell & Manicom, 1995; Smith, 1987). Many authors point out how destructive this marginalization has been for women (Armstrong & Armstrong, 1994; Martin, 1992; Gil, 1990; Smith, 1984a). "Too often health care, human resources, and educational systems are hierarchical and destructively controlling" (Wetzel, 1986, p. 167).

Feminist theory seeks to validate women's experience and give women voice in social relations by seeking social change. Action toward making women's experience more central within organized society, is inherent in the theory (Ferguson, 1994b; Bunting & Campbell, 1991; Chinn, 1991). Martin (1992), Smith (1984a), and Oakley (1976) all argue that, though reproduction is a female function in society, women in North America have limited voice in reproductive care practices. If society is to ensure the health of future generations, it is important for that women be supported in their reproductive functions (Armstrong & Armstrong, 1994; Martin, 1992; Gil, 1990). This suggests that in order for reproductive care to be effective, it must consider the perspective, circumstance, and concerns of the women it is meant to serve. Feminists and others are adamant that women must have voice in their reproductive care, and in the organization of that care.

Several authors discuss how reproductive practices in western industrialized nations have shifted from being the domain of women, with care

based on experiential knowledge, to being organized within the domain of men, with care based on scientific knowledge (Martin, 1992; Smith, 1984a; Oakley, 1976). Feminist theorists point out that the experiential, subjective knowledge traditionally relied on by women became subordinate to scientific/technical knowledge (Bunting & Campbell, 1991, Martin, 1992, Smith, 1987). Though science has produced valuable knowledge that ultimately improved health, it went beyond the realm of seeking and producing knowledge and began to organize, in unseen ways, how health was thought of and health care was practiced (Smith, 19884a). The difficulty lies not with science itself, but with the colonization of science and scientific approaches into our everyday world, into our interactions and relationships, without first considering the effects (Martin, 1992, Smith, 1984a).

In her article, The Renaissance of Women (1984a), Dorothy Smith asserts that with the establishment of capitalism, a new "order" within society was created. As new technologies formed the basis of new kinds of knowledge, old methods of gaining knowledge or wisdom through experience were no longer valued. Technical knowledge was increasingly textualized and built upon, and this became the dominant knowledge. A ruling apparatus based on systematic scientific development of technologies and knowledge emerged.

> "... women were progressively excluded as men established a monopoly, or at least final control, over the practice of medicine. In gynaecology and obstetrics, men actively drove women out of the field or subordinated their practice to systems of training and qualification over which the male physician had dominion" (Smith, 1984, pg. 59).

David Allen (1985) seems to concur with Smith in that he identifies that technical/scientific ways of knowing are dominant. Allen points out that empirical knowledge is used to rationally predict and therefore to control whatever is being studied, and the overuse of this dominant model has negative impacts. Allen states,

> "The medicalization ... of everyday life, where specialists whose authority is rooted in technical science attempt to define some human actions as pathologic and hence subject to their control... is an example of how technical knowledge exceeds its bounds, and claims control over practical life...The definition of menstruation, menopause, and pregnancy as illnesses insures the claim of male

> scientific authority over the practical (ethical, political) conduct of women's lives" (1985, p. 60).

Nelson makes a similar observation when she states

> "there has been a process of colonization of life events as sites of intervention and training that is normative - critical events have been reshaped as therapeutic opportunities. Nursing is an important part of this array of professions that locate and intercept these subjects at risk of serious disorder or maladjustment." (1994 p. 5).

If most prenatal care in North America is based on the dominant scientific/medical model and dominant administrative technologies, and, as Smith (1984a), and Martin (1992) argue, this can serve to disempower women, there are some ethical considerations to be addressed regarding how and what prenatal care is provided to women. It is clear to me that the system within which I provide prenatal care is organized and managed by those with technical knowledge, and that scientific knowledge is valued over the kinds of experiential knowing that my clients may rely on. The organization of my work is based on the medical model. As a practitioner within the medical/technical hierarchy of the Ministry of Health, I would be expected, for instance, to reinforce the value of scientific knowledge about risks in pregnancy, and impart this scientific and technical knowledge, and the value of this knowledge, to my clients. This research offered an opportunity to investigate how these dominant scientific, medical and administrative technologies organize one prenatal service, and the implications this has for women being served.

All advances in science and technology are contradictory. They bring solutions to some problems while creating new ones. While medical science has greatly influenced knowledge of what supports a healthy birth outcome, the scientific approach to health and the organization of health care has created new problems. In the highly technologically oriented society of North America we have come to anticipate that modern medicine can intervene at the last minute to save a baby or a mom in danger. In a society oriented to quick fix technology the more obvious yet mundane factors that affect infant health, like a healthy prenatal environment, have become overshadowed by the medical/technologic approach to health care. While scientific study provides us with the knowledge that a healthy prenatal environment is vital, there follows an assumption that the scientific/technologic approach can "fix" the health problem. As much of the

feminist literature discussed above asserts, the medical/technologic approach to prenatal care serves to devalue women's situated and experiential knowledge, and undermine women's traditional reproductive practices. The paradox of helpful scientific knowledge and technology contrasted with limitations and difficulties created for women by the scientific approach to care demonstrates a need to consider the complicated character of prenatal services as they exist in North America to day.

Pregnancy and birth are a life-changing experience through which women gain a wealth of experiential knowledge. It has been my experience as a nurse in the health care system that women's own knowledge is undervalued and underutilized. By failing to acknowledge and reinforce experiential knowledge, health care professionals miss a valuable opportunity to build on existing client knowledge. Rather, as practitioners, we participate in maintaining the facade that it is only technical knowledge that is valid. This allows the professions to maintain control of the "care". The professional as keeper of "expert" (scientific) knowledge is a role that I have found serves to devalue and disempower the very clients we are supposed to be helping.

Women who are at highest risk for a healthy pregnancy (ie. First Nations women or women living in poverty (Millar, 1993)), are more likely to be marginalized in society. They are least likely to have a voice in the organization of their reproductive care (Ferguson, 1994b) It is my premise that in order for targeted programs to be effective in addressing the needs of high risk prenatal clients, it is important for those clients to be able to express their issues and concerns and have a voice in their care. This concept of the need for inclusion is supported in the literature by various feminist and participatory action theorists and researchers (Green, et al., 1995; Wharf, 1995; Ferguson, 1994b; Narayan, 1988; Smith, 1987).

The feminist perspective, and in particular the concept of women having **voice**, was used to guide this study. The standpoint of clients of the Westcoast Healthy Baby program was used as the starting point from which this investigation was conducted. The concept of voice, and voice as it relates to community development within the health care system is explored.

**Experiential Concepts That Inform My Standpoint**

As a nurse trained in a hospital setting I was thoroughly indoctrinated into the medical model and the scientifically correct process for providing care. I believed scientific knowledge was essential to restore and maintain health. In the hospital setting I used my scientific based knowledge to provide treatment. In the labour and delivery ward I unquestioningly carried out complete perineal shave preps and "three H" enemas (high, hot and hell of a lot). These procedures were considered at the time to be essential to decrease incidence of postpartum infection in the mother and infant. When in the last stages of labour, I would transfer these women from their bed into a delivery suite, where a "sterile" environment and the latest technologies were at hand. I had witnessed fetal distress and postpartum hemorrhage, so was well aware that women and infants can be saved by these practices. I valued my scientific based knowledge and the practices that ensured the latest knowledge and technology was used.

When I began community health practice I carried many of these values with me. I believed women needed scientific based information to have a healthy pregnancy and infant. I felt that the latest findings from psychological research were essential to be an effective parent. My introduction to community work was in First Nation's communities. While this proved to be initially frustrating, I gradually came to understand the perspective of First Nation's women. This work proved to be one of the most valuable learning experiences of my career. My professionalized values were challenged and I was able to recognize a wealth of knowledge and health practice that exists outside of the dominant scientific knowledge base.

One of the first concepts to be challenged was that reproductive care can be divided up into parts. First Nation's women did not view the prenatal period as distinct from the delivery or the postnatal period. Specialization in care that I took pride in as a professional was simply not valued by First Nations' women. In First Nations' culture there is a belief that a woman begins to parent as soon as her fetus has a spirit (Marshall, 1995). The prenatal period and postnatal period are viewed as part of a continuum, part of a whole that can not be separated out. I found that on prenatal visits I was often involved in discussions about parenting or children's health. In practice, prenatal care, postnatal care and parenting support simply could not be divided up. They were viewed by clients to be connected, the same. To avoid frustration in trying to separate out the various

aspects of care, I too began to consider all of these "specialized" areas of care to be a continuum of "reproductive care".

Another concept that was challenged was that scientific based knowledge was my most valuable professional asset. In practice I found that unless I formed a relationship, understood the woman's circumstance, and valued her knowledge, she would not be interested in my scientific information. My skills at communication were, in fact, a far more valuable asset, and essential to any community practice or interaction. Women needed to participate in sharing knowledge. They did not accept that the scientific knowledge I had to offer was superior or more valuable, but would accept it as part of a sharing interaction.

Documenting my work created a barrier to communication. I learned to separate my documenting responsibilities from my practice. Writing, and written materials, were not valued by those I worked with as much as personal interaction. I found casual discussion of risks or changes in pregnancy was more acceptable than using a book or pamphlet to demonstrate my point.

My concept of risk in pregnancy was based on scientific and epidemiological evidence. Most First Nation's women did not relate to this concept of "**risk**". What I identified to be risk factors were simply part of their circumstance, their way of life. Having more information about risk factors could not change their circumstance. I was aware, however, that increased knowledge of risks to the fetus did influence some lifestyle decisions and ultimately decrease exposure to some fetal health hazards. The scientific based knowledge I had to offer about risks in pregnancy was useful, but only when presented in an acceptable way, as part of a two-way social interaction.

My work in First Nation's communities had a great affect on how I used my scientific based knowledge. My frustration over high levels of violence and lack of women's voice in social organization led me to community development work and helping to establish a transition house and women's center in my community. Though I was indoctrinated into the dominant scientific culture of health care, my community work allowed me to recognize the value of other ways of knowing and other ways of organizing care. I was able to use my scientific based knowledge to identify health and safety risks to women in our communities, and thereby obtain funding, but I also recognized the individual strengths and practical knowledge of women in the community as they established their own services.

As identified above, my standpoint has been influenced by high risk prenatal clients in the Pregnancy Outreach Program. This standpoint is outside of the dominant standpoint within which health care and reproductive services are organized, and within which I work. While I recognize that I have been indoctrinated into the dominant health care ideology, I believe, that reproductive care should support normal reproductive functions of women, and must, therefore be organized to fit with their perspective. While my indoctrinated professional bias values primarily scientific based knowledge, I have come to believe that if reproductive care is to help women, it must be based on ideology that acknowledges women's issues, concerns and circumstance as well as their strengths and practical knowledge.

## Concepts Framing My Study

### Reproduction

The term "reproduction" would seem straightforward. As a mother I assumed everyone conceptualized reproduction the same way I did, a process of having and raising children. It seems it is not that simple. On examining the literature on reproduction, it soon became apparent that reproduction was being conceptualized in a variety of ways. In order to examine the organization of reproductive care practices, I first needed to understand the multitude of ways in which reproduction is conceptualized in the literature.

There seems to be three distinct ways of conceptualizing reproduction in the literature. Human reproduction is represented as either a biologic function, a social function, or as a personal experience. Literature based in the natural sciences focuses on reproduction as a biologic function. Scientific research journals, such as the Journal of Reproduction and Fertility publish articles that examine the biologic processes of reproduction. Research is focused on identifying specific chemical and physical interactions that take place during a normal and abnormal conception, pregnancy, birth, and puepurium. Stages of reproduction are clearly delineated and parenting is excluded. Articles in medical journals, such as the New England Journal of Medicine, the Journal of Obstetrics and Gynecology, and Medical Care predominantly discuss reproduction as it relates to biologic health of the mother and infant. Again, specific stages of reproduction and specific reproductive functions are delineated for study. Social factors in reproduction are discussed in articles in the American Journal of

Epidemiology, but only as they relate to the biologic health of the infant, or less often, of the mother.

Literature based in the social sciences discusses reproduction as it relates to social interaction. Where authors and researchers have an anthropological background, reproductive practices are discussed as being culturally determined and as an important cultural feature of society (Martin, 1992; Leininger, 1978). Sociologists refer to human reproduction as part of the domestic work of sustaining society (Armstrong & Armstrong, 1994; Gil, 1990).

Literature based in psychology and feminist thought discusses reproduction as an experience of women. Psychologists discuss reproduction in terms of the impact it has on the psychological well being of the individual mother. "Pregnancy and childbirth are important life events for women, yet they are often viewed in isolation, not as part of the whole life cycle, making women often feel alone" (Ussher, 1993). Feminist literature tends to focus on reproduction as an experience that is common to women (Jones, 1993; O'Brien, 1989; Graham & Oakley, 1981).

In making reproductive care useful and accessible to women, it would make sense to ensure that human reproduction be conceptualized by a service provider in a way that is compatible with women's own conceptualization of reproduction. As identified above, there are many different conceptualizations of reproduction. In my own experience, the feminist conceptualization of reproduction as an experience common to women, best fits with women's experience of reproduction as a personal experience.

**Reproductive Care**

Reproductive care practices, I discovered, are very much determined by how reproduction is conceptualized. Reproductive care practices are culturally specific (Liu-Chiang, 1995; Martin, 1992). In North America, reproductive care is primarily provided by medical doctors or other providers following medical practices (Martin, 1992; Smith, 1984a; Oakley, 1976). Medical care is based on the definition of health as absence of disease. Medical care in reproduction primarily focuses on treating or preventing biologic disease processes in pregnant women, and providing technical, science based intervention where the biologic health of a woman or infant are at risk. (Ministry of Health Prenatal Risk

Assessment). In North America, then, reproductive care is primarily based on reproduction being conceptualized as a biologic process.

A social perspective challenges this biologic approach to reproductive care, and indeed health care generally. Martin (1992) and O'Brien (1989) point out that pregnancy and birth are not simply biologic processes. Reproduction is not a disease state and reproductive care should, therefore, be different from acute care.

The World Health Organization identified that health care should be based on principles of health promotion, and has redefined health to include social and emotional well being. "Health goes beyond physical capacities, to emphasize social and personal resources" (WHO, 1978). This would place not only reproductive care, but also health care in general, in the "social sciences" paradigm.

Lindsey and Hartrick (1996) argue that the social sciences paradigm and the health promotion approach to health care are dichotomous to the natural sciences paradigm, which presently forms the ideological foundations of existing health care organization in North America. This would suggest that despite growing interest in use of a health promotion approach, such an approach could not fit with the natural sciences approach that is foundational to existing North American Health Care. Merging of two very different approaches whose foundational ideologies are dichotomous could be troublesome, or as Lindsey and Hartrick argue, impossible.

**Risk**

Inequality in health status among specific populations was identified by the World Health Organization as an issue for nations to address (1978). Millar points out that "Infant mortality is one of several internationally accepted indicators of the general health of a society" (1993, p. 23). Infant mortality rates in Canada have been continuously decreasing. In 1962 in Canada there were over 20 infant deaths per 1,000 live births. In 1991 there were under 7 infant deaths per 1,000 live births (Millar, 1993). The single most outstanding exception to this general decline in infant mortality in Canada is in the First Nations population. The infant mortality rate among First Nation's people is 2-3 times the national average. In 1989 there were 22 infant deaths per 1,000 live births in the First Nations population of Canada (B.C. Division of Vital Statistics). The First

Nations population of Canada, then, is the most at risk group for infant mortality within the Canadian population.

The other notable factor identified by epidemiologists to be influencing infant mortality is poverty (Millar, 1993). "Socially-disadvantaged women have a greater risk of poor pregnancy outcomes due to socioeconomic, psychosocial, behavioral and environmental factors" (Minister of National Health and Welfare, 1994). Much of the literature supports the notion that First Nations populations and socially disadvantaged populations should be targeted for improved health care and, specifically, improved reproductive care (Millar, 1993; Foulkes, 1973).

Nationally and provincially, health care policy is being directed toward addressing inequities in health status. On the national level, the "Brighter Futures Child Development Initiative" of the Health Promotion Directorate of Health Canada funds initiatives that address "at risk" children 0-6 years and their parents (Minister of National Health and Welfare, 1994). Provincially the government committed to addressing inequities in health under their "New Directions" policies (British Columbia Ministry of Health, 1993). Governments in Canada are allocating funding to targeted programs that address health inequities of specific populations identified epidemiologically to be at risk in a strategy termed "population health" (Frank, 1995, Labonte, 1995).

In North America medical prenatal care as provided by physicians and health units was not being accessed by all women, and was not, therefore, universal. Those who were identified through epidemiologic study to be most at risk for a healthy birth outcome were, in fact, least likely to access existing services (Martin & Armstrong, 1995). Medicalized care was not “reaching” this “high risk” population and was, therefore, not proving effective for improving birth outcomes in these women (Martin & Armstrong, 1995). Geographic barriers, cultural barriers, language barriers and social barriers limit effective interaction between high risk clients and health care professionals (Leininger, 1978). Professional use of the dominant medical model in designing programs for high risk prenatal clients is particularly problematic. Reproduction is not a disease process and reproductive care based in the medical model is, therefore, misdirected. Foulkes (1973) argues that professionals from the dominant white culture are limited in their understanding of First Nation’s cultural norms, and thus success of medical intervention is limited.

Populations identified to be most "at risk" are more likely to experience barriers to accessing care. If programs are to be planned to address the "at risk" populations, it is vital to consider these barriers to service. The circumstance, issues and perceived needs of the population to be targeted for service must be clear. Many experts in the field argue that if service is to be effective, clients must have a voice and opportunity to participate (Minister of National Health and Welfare, 1994; Labonte, 1993; WHO, 1978).

Studies have shown that low birth weight accounts for almost 75% of early infant mortality (Levitt et al., 1993). Low birth weight infants are also at higher risk for morbidity (Millar, 1993; Aylward et al, 1989; Kramer, 1987). The medical costs and long term social costs associated with low birth weight are high (Casiro, et al, 1993). Preterm birth and intrauterine growth retardation are the major contributors to low birth weight (Martin & Armstrong, 1995). Information about specific causes of these, however, is not available. Researchers have, therefore, focused on determining risk factors associated with low birth weight generally. Studies of risk factors in low birth weight demonstrate that there are many causative factors, and many of these are interrelated (Kramer, 1987) Some of these known risk factors are: maternal nutrition, maternal lifestyle, maternal stress, maternal poverty and maternal exposure to smoke, alcohol, infection, radiation, chemicals or trauma (Martin & Armstrong, 1995).

Traditional medical prenatal care has effectively reduced the rate of adverse birth outcomes for low risk women, but has not improved outcomes for high risk women (Martin, 1995). In British Columbia the approach has been to intervene in high risk populations with programs that target birth weight. Pregnancy Outreach Programs are designed to have an impact on birth outcomes for high risk women. The intake assessment of the Pregnancy Outreach Program screens clients for the known risk factors.

> "The Pregnancy Outreach Program assists high risk, pregnant women by providing individual health counseling and referral, supplemental food, and peer group support...the programs focus on alcohol and drug use, smoking, and diet, with the aim to improve the health of mothers and newborns. Particular attention is paid to the prevention of low birth weight and fetal alcohol syndrome."(McAleese, 1993)

This, then, is the constellation of medical and reproductive health research from which risk emerges as a central organizing concept. Risk is the key organizing

frame for the Pregnancy Outreach Program. This has particular significance for the structuring of programs and program work processes as I will show in later chapters of the thesis.

## Management of Reproductive Care

### Historical Feminist Perspectives

Oakley (1976) and Ehrenreich & English (1973) point out that in ancient times, and until recently in some cultures, reproductive care was very much the responsibility of women. Oakley (1976) states that many cultural myths and taboos surrounding menstruation, miscarriage, birthing and abortion stemmed from misunderstanding and fear. Many societies developed traditions that isolated menstruating women or women giving birth, whether out of respect for the power of reproduction, as some First Nations cultures indicate (Marshall, 1995), or because of cultural belief that reproduction is "unclean", as in some eastern cultures (Oakley, 1976). In all societies, whether out of fear or respect, reproductive care was the domain of women (Oakley, 1976).

Women relied on other women in their family or community for support and information throughout their pregnancy. Often one "wisewoman", or "midwife" would be relied on as the "specialist", and would assist with the delivery (Oakley, 1976). Women who specialized in caring and healing developed their practice through trial and error, passing their knowledge and experience on to other women (Oakley, 1976; Ehrenreich & English). Though some caring and healing practices were shared by men and women, reproductive care was solely the domain of women until the professionalization of "medical practice" was initiated in Europe (Oakley, 1976).

Between the fourteenth and seventeenth centuries in Europe, the practice of "medicine" by male practitioners emerged. Oakley points out that

> "the practice of the early male doctors was very different from the practice of the traditional female healer. While wisewomen operated empirically...male medicine was highly theological and anti-empirical: hence its acceptability to the Church" (1976, p. 29).

Oakley identifies that the transfer of the caring role from women to men was supported by the Church as it sought to control all aspects of social life, including reproduction. Women healers were, in many instances, considered by the church to be witches (Ehrenreich & English, 1973). The Church was the first licensing

body for medical practitioners, and the first to initiate professionalization of medical practice (Oakley, 1976; Ehrenreich & English, 1973).

Despite the emergence of medicine, reproductive care remained largely in the control of women until the nineteenth and early twentieth centuries (Oakley, 1976). Oakley points out that up to this point, traditional caring practices of women were acknowledged to have higher survival rates for women and infants. In the 1850's British medical schools began to teach midwifery. By this point the professionalization process of physicians was well entrenched. In order to be admitted into the profession, one had to attend college, and women were not admitted to colleges. Women became nurses and midwives, and men became physicians and surgeons. Male domination in the control of health care and reproduction began to emerge (Ussher, 1993; Martin, 1992; Smith, 1984; Oakley, 1976).

With the development of the forceps, the scientific method, sterile technique, successful surgical intervention, antibiotics, and anesthetics, medicine gained credibility. Medical control of reproductive care was firmly established, and in 1907 physicians opened schools to disseminate "scientific" knowledge on reproductive and child care to mothers.

"... the prevailing view among doctors and other 'professionals' was that motherhood had to be learnt" (Oakley, 1976, p. 41).

Reproductive care, then, was a process of women sharing information, knowledge and experience throughout the prenatal and postnatal period. Birthing was assisted by a trusted "wisewoman" with experiential knowledge (Oakley, 1976). As professionals and the scientific/medical model began to dominate health care in Europe, there was a shift from wholistic care and support of pregnant women by other women, toward a technical/scientific approach of "teaching mothering" the "right way" (Martin, 1992; Smith, 1984; Oakley, 1976). The "right way" was based on scientific knowledge as opposed to experiential knowledge. Women's experiential knowledge was subsumed by professional knowledge, and women in many industrialized nations no longer had control over, or a voice in, reproductive practices or care (Martin, 1992; O'Brien, 1989; Oakley, 1976).

Professionalization

Medicine was one of the first "professions" to emerge. The Church of England was the first "licensing" body, their interest in this role stemming from a desire to control health and reproductive care (Oakley, 1976). As the positivist paradigm became dominant, professions sought to base practice on scientific "fact". Empirical-analytic methodologies were used to formulate these facts. As identified by Allen,

> "The very form of empirical-analytic science is determined by a fundamental interest in control...The goal of empirical-analytic science is control over the phenomena being studied, which is achieved through development of theories and explanations. As nurses we seek control because we want to have an impact on the situation."(1985, p. 58)

The perception that scientific knowledge is superior to practical knowledge persists in North American society, and thus it is scientific and technical knowledge that forms the basis for social organization, and organization of health care, including reproductive care practices (Martin, 1992; Smith, 1987). There is an assumption that women and families need to be educated about reproduction, yet there is significant evidence in the literature to suggest that reproductive service delivery based on the medical model creates difficulty for women (Ussher, 1993; Martin, 1992)

By valuing only "scientific" methods, professionals dismiss some strengths in traditional caring practices and experiential/contextual knowledge, undermine them, and substitute scientific practices which they alone control. Rather than working cooperatively with clients and communities to build scientific based knowledge into existing caring practices, professional's work toward substituting their scientific practices. As pointed out by Allen (1985), control is inherent in the empirical-analytic ideology into which all professionals are indoctrinated.

In my own experience in working with First Nations people I have found that where the client does not identify with the scientific ideology and process, they ignore or alienate themselves from the service. Thus, we as professionals stereotype these clients as "hard to reach", or "non-compliant". Commitment toward client centered services and a social approach to care, then, can be limited by the natural sciences ideology upon which most of our health system and professions are based.

## Present Directions in Management

### Ruling Relations

The Pregnancy Outreach Program exists as part of the provincially funded health care system. The health care system is part of the dominant organizational structure of the government of British Columbia. Reproductive care in British Columbia is primarily practiced by professionals, and administered by the Ministry of Health. Political, managerial, and professional/scientific beliefs and practices influence health care planning, policy and service delivery.

Smith (1987) points out that extra local ruling relations, or dominant organizational structures within society, organize social interaction. She states that these "ruling relations" that organize the larger society construct how particular local interactions transpire. Though the individual is aware of the dominant textual based social organization and interacts and responds according to these norms, the influence of these ruling relations on a local interaction can become invisible because they are integrated and accepted as part of our every day relations. Smith asserts that interactions can be problematic where there is disjuncture between the organization of extra local ruling relations and the situated knowing of individuals in a specific circumstance. Ruling is an organization of everyday life that benefits others in the organization, and not those being ruled, though this may not be apparent or intended.

Smith's process of inquiry, institutional ethnography, assumes that a specific social interaction can be examined to explicate how the ruling relations in society organize a local interaction. Institutional ethnography allows a researcher to examine the social relations of a specific interaction, explicate the ruling relations that impact on that interaction, and analyze points of disjuncture that may become evident.

### Text-Mediated Management Technologies

Times of fiscal restraint have focused attention on "efficiency", "effectiveness" and "accountability" in the public sector (McQuaig, 1994). These concepts have become central to ruling practice. Governments want to assure themselves, and the Canadian people, that expenditure on public programs is a "wise investment" (Canadian Comprehensive Auditing Foundation, 1987). Efficiency and accountability are increasingly being sought within government organization.

Corporate style management and measures of accountability are seen as a way to ensure efficiency (Canadian Comprehensive Auditing Foundation, 1987). The guidelines of the Canadian Comprehensive Auditing Foundation are being incorporated into the management of government ministries, where "business plans" organize the work to be done. Business plans provide a clear projected budget breakdown and a cost/benefit analysis that treasury and government can use to evaluate programming (Canadian Comprehensive Auditing Foundation, 1987).

Managers in government are being asked for "clear accounts" of the work in their organization (Linton, 1996). Most government organizations now incorporate some form of an evaluative process to ensure specific measures of accountability are readily accessible. The records, or 'representations' "help managers clarify their accountability to governing bodies and to provide better accountability within their organizations" (Canadian Comprehensive Auditing Foundation, 1987, p. 14)

McLeod (1994) writes on how to incorporate these management technologies into professional practice. She points out that managers must be clear what information their funder is likely to want, then formulate an evaluative process that "measures" those aspects of the organization. The manager must consider: what information to gather, how the information can best be gathered, whether the information gathered will accurately reflect or measure what it is intended to (validity), what resources will be required for the process, how the information can be gathered at minimal cost yet accurately reflect the work, and how much information needs to be gathered. She assumes that management technologies must be incorporated into professional practice and can be included as a valuable evaluative tool within that practice.

Other writers offer more critical consideration of such organizational practices. For instance, Mills & Simons (1995) point out that most organizations are based on a single dominant interpretation of organizational theory which assumes that the objective of organization is the attainment of organizational effectiveness and efficiency. They observe that in organizational theory the significance of the organizations in the lives of people is overlooked (Mills & Simon, 1995).

It seems important to explore what is significant about the organizational structuring of reproductive care. One feature might be, as Cassin (1986) and

Smith (1975) argue, that professional control of human service planning and delivery is being increasingly usurped by such managerial based decision making. Health care is being organized to fit with corporate management technologies (Campbell, 1992). Campbell argues that management technologies that are assimilated into health care accountability requirements come to dominate the organization of the services provided. Decisions about health care planning are increasingly organized based on information and economic analyses provided through these management technologies (Canadian Comprehensive Auditing Foundation, 1987) and through scientific based epidemiological studies of population health (Labonte, 1995). A concern considered in this thesis is, at what point do managerial interests supplant health concerns?

The work of health care practitioners is being documented and translated into economic terms to fit with the accountability measurements that managers are now learning to rely on (Waring, 1995; Smith, 1984). Where professionals have retained management functions in health organizations, management technologies are increasingly incorporated into their thinking and practice (Campbell, 1992). Practitioners participate in the new corporate style management technologies by formulating and completing textualized accounts of their work (Campbell, 1992; Smith, 1984).

In the Pregnancy Outreach Program, as in most health programs now, managers are acutely aware that funding is linked to accountability, and proof of cost-effectiveness (Linton, 1996). Targeted programs are presently considered to be the most cost effective way to deliver service in British Columbia (Millar, 1993; Minister of Health, 1993). This combined with concern over fetal alcohol syndrome, infant mortality and morbidity rates in high risk populations, and the high cost of caring for low birth weight infants led to the establishment of the Pregnancy Outreach Programs (Martin & Armstrong, 1995). For accountability purposes, the effectiveness and relevance of these targeted programs must be substantiated through documented studies or accounts. In Pregnancy Outreach Programs the process of intake assessment has been adopted both to guide program eligibility and interventions and as a standard evaluative tool. Data gathered on client intake assessments forms the information base for the annual report (Pregnancy Outreach Program, 1993). The annual report is supplemented by periodic qualitative and quantitative analyses.

For many analysts, the focus on documentation is itself troublesome, as texts stand for what actually happens so that managers can manage from afar. Smith points out that "Advanced contemporary industrialized societies are pervasively organized by textually mediated forms of ruling."(1984, pg. 95). Whereas managers used to rely on personal observation and interaction to monitor and evaluate work, management now relies on textualized accounts about the work, and utilizes these textualized accounts to form the basis for decision making (Smith, 1984). Smith (1987) and Campbell (1994) point out that written accounts cannot fully describe nor capture the context of an interaction. The situated knowledge, which is gained from observing or participating in a local interaction, can not be fully documented, so it is impossible for management to comprehend the actual interaction by reading a textualized account. When a worker documents according to organizational procedure, it must be recognized that the account that is produced is extremely limited and can not represent or make clear the concern and issues. What is textualized is a shaped-up, restricted, manufactured version that restructures the interaction according to norms of organizational reporting and evaluation (Campbell, 1994; Smith, 1987; Smith, 1984). As pointed out by Wharf (1995), Ferguson (1984a); and Smith (1975), the "voice" of the client is effectively eliminated from the organizational structure through management technologies and particularly the practice of using documented accounts for evaluation and in guiding program practice.

**Listening to Clients - Voice**

Text mediated accounts may offer the basis for managerial decision making but they can limit local and situated knowledge that could, perhaps, better inform policy. Management technologies and text-mediated accounts, as discussed earlier, limit the participation and voice of the client. The effects of these technologies in prenatal services, then, must be carefully considered.

Several studies which focused on client satisfaction with prenatal care identified that client - provider interaction was the single most important determinant in women's satisfaction with their prenatal care (Killion, 1995, Lazarus and Philipson, 1990, Omar and Schiffman, 1995). Various aspects of the interaction that were valued by women have been identified. Pregnant

women interviewed by Omar and Schiffman (1995) identified the following to be important if women were to access a prenatal service:

> "the provider's/staff's willingness to answer questions; knowing who the women were; calling the women by their first name; attitude toward young children brought to the prenatal visits; how friendly or rude the women perceived the provider/staff to be..." (pg. 136)

Killion's study (1995) lead her to these conclusions:

> "Nurses should build on the strengths and positive coping strategies of the women. Nurses can be supportive by conveying that they have a vested interest in the woman's health and well being. Active listening without imposing solutions is a beginning."(pg. 55)

Based on these findings it appears that pregnant women indicated that the most important factor in finding prenatal care satisfactory, and indeed acceptable, was a good relationship with their care giver, and further, that a good relationship was identified when the care giver acknowledged the experience, circumstance and strengths of the client.

There is significant evidence in the literature to support that a participatory approach to service delivery can prove very effective, particularly for women (Callahan & Wharf, 1995, Green, 1995, Maguire, 1988). Women are the focus of prenatal care, and it is usually women who are the care givers for infants postnatally. If a participatory approach improves the effectiveness of service delivery to women, and women are the focus of reproductive care, it is reasonable to expect that an approach which includes the voice and participation of women, such as the participatory approach, would be useful in developing effective reproductive care services for a targeted population of marginalized women.

In order for clients to find prenatal services satisfactory, and indeed to even access them, then, interactions that acknowledge their experience, circumstance and strengths are important and must be included in the organization of the service. The women's voice must be included in the organization. The foregoing literature identifies conflicting ideas about reproductive care and how it is organized. Needs of the women, and the organization must be accommodated. My study attempts to weigh how these differing interests converge.

## Conceptualizing Health Programs

### Health Promotion

Health policy in Canada was significantly influenced by the World Health Organization assertion that health was more than a biologic state of well being, and that health promotion should form the basis for national health care strategies (Labonte, 1995; World Health Organization, 1984; World Health Organization, 1978). Scientific evidence that made it clear lifestyle was a large determinant in the health of individuals supported this shift toward health promotion (Millar, 1993). Another factor was the rising cost to the public of acute care. Treatment of preventable disease is expensive (Millar, 1993; Casiro, 1992).

The health promotion model for care shifts the focus of concern from "treating disease" to "preventing disease"(WHO, 1984). In this model the unhealthy social practices or circumstance associated with high rates of disease become primary considerations in health care planning (Minister of Health, 1994). This model for health care is more compatible with reproductive care, shifting emphasis away from existing notions of pregnancy as a disease, and toward supporting strengths and healthy behaviors in pregnant women (Minister of Health, 1994). It also involves an ideological shift from reproduction as a purely biologic process to reproduction as a social process. Though this ideological shift was to be incorporated into Ministry of Health policy and practice, reproduction is still constructed as primarily a biologic process in much of the Ministry of Health literature, such as the standard prenatal assessment form for physicians.

Various strategies have been incorporated into the B.C. Ministry of Health service delivery in an attempt to implement the shift toward a health promotion approach. Two such strategies are community development and population health. These particular approaches were foundational to developing the Pregnancy Outreach Program, and must be considered in this study.

### Community Development

In health, community development is conceptualized as a way of "doing" health promotion.

> "Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to

achieve better health. At the heart of this process is the empowerment of communities." (Health and Welfare Canada, 1986)

Though community development as a concept goes back to times of European colonization of countries, it was adopted as a concept in health care much later. Community development as a concept in health care grew out of the acknowledgment of social determinants of health and growing awareness of the role of the dominant paradigm in disempowering certain social groups. (Labonte, 1994, pg. 19) In order to effect changes in health and social services to address the social determinants of health, a paradigm shift from the positivist medical approach to a constructivist approach that would consider the social constructions that affect health was deemed essential to making health attainable and health care accessible. (Labonte, 1994, Health Canada, 1994, World Health Organization, 1984; World Health Organization, 1978)

In community development projects efforts are made to allow the community itself to identify its problems and work towards its own solutions. A key concept to this approach was that those who had previously been disempowered though the positivist medical institutions would now experience some control over their health services. (Labonte, 1994, pg. 19)

**Population Health**

A downturn in the economy, however, has created yet another shift in health care planning and management (McQuaig, 1993; Labonte, 1995; Frank, 1995). Concern over limited funding for health care has resulted in health care management and policy being primarily directed toward "cost-effective programming" (Canadian Comprehensive Auditing Foundation, 1987). The Population Health Program of the Canadian Institute for Advanced Research has identified major determinants of health to guide health policy (Frank, 1995) These form the basis for identifying populations at risk for specific health factors.

Under "population health", preventive programs are targeted to the "high risk" populations. Epidemiological studies are used to identify which populations are experiencing inequitable health status, and health programming is then targeted to address the health risks in these "high risk" populations (Frank, 1995). The objective of this approach is, of course, the long term economic savings in acute care costs that could be possible if these targeted preventive programs are effective (Canadian Comprehensive Auditing Foundation, 1987).

All of these conceptions of health care and their related approaches have affected the program I am studying, in ways that I return to in the following analytic chapters.

**Research Question**

I am conceptualizing that the Pregnancy Outreach Program exists as part of the dominant ruling relations that organize health care. Their objective is to target prenatal services to women who are considered to be at risk for a healthy pregnancy. My research problematic arises in relation to the intake assessment of the Pregnancy Outreach Program, an interaction that is central to the work of the program, and its documentation. The puzzle I want to explore concerns how the ruling relations shape the work and the experience of both the workers and the clients of the program.

The literature identifies that the organization of dominant ruling relations, management technologies, professional and scientific ideology, and textually mediated organization can all affect the interaction between a practitioner and a client. It identifies that dominant ruling relations in these organizations can marginalize women, aboriginal people and the poor. Management within dominant organizational structures is becoming increasingly focused on efficiency and effectiveness and more reliant upon textualized accounting processes despite observations that textualized accounts can effectively limit the voice of clients (Mills & Simons, 1995; Smith, 1987; Ferguson, 1984).

The literature also identifies that relationship, interaction and acknowledgment of experience, circumstance and strengths are key to whether women access prenatal services or find them "satisfactory" (Killion, 1995, Lazarus and Philipson, 1990, Omar and Schiffman, 1995). The World Health Organization and several academics have stated that a health promotion approach can ensure that health care is more effective and responsive to the health needs of a population (Green, 1995; Labonte, 1993). The health promotion approach is considered to be less controlling and to value the participation of individuals and communities in their health care. This approach is to be integral to the Pregnancy Outreach Programs, as well as the scientifically based and administratively organized approach.

My research provides an opportunity explore the work of the Pregnancy Outreach Program, and consider these approaches in the organization of work

practices. Using institutional ethnography as a methodology I explicate the complex of ruling relations that shape this work and thus gain insight into the problematic. The Pregnancy Outreach Program intake organizes interaction with the client such that planning and accountability for services provided is accomplished according to scientific, professional and managerial relevancies. In doing so, however, the care provided may be compromised, even so far as to create client resistance to being in the program. In making the ruling relations visible I am able to analyze how the organization of these relations support or limit the participation of the client in the Pregnancy Outreach Program.

My research question is: How are the two approaches, risk assessment and community development accomplished, and how are they experienced by women in the Happiest Baby Program?

## CHAPTER TWO - Methodology

Though studies of reproduction are often grounded in the natural sciences where biologic processes are examined for risk or anomaly, human reproduction and prenatal caring practices were a part of social culture long before our industrialized society systematized and professionalized reproductive care. Human reproduction is a necessary function of society and a challenging personal experience for women and their families. My interest is in studying reproduction as a personal experience of women, and is grounded in the social sciences as opposed to the natural sciences.

Martin (1992) points out that some social scientists have necessarily developed a very different approach to research from the natural sciences. She points out that society is constantly changing, what is true of society at any given location may not necessarily be true at another location; what is true at one point in time is not likely to be true at another point in time. While this dynamic quality of society presents challenges to investigation, it is in acknowledging this constant social change that the research can become alive and practical.

Dominant research methodologies and organizing practices have served to perpetuate social constructs and processes that marginalize women, and women's knowledge even in the female domain of reproduction (Bunting and Campbell, 1991; Smith, 1987). As Smith points out, this world view and stance in research tends to perpetuate dominant organizational thought and structures in society, and ignores the perspective of those who experience the world differently.

Institutional ethnography is a specialized investigation of how social interactions are structured. "We take as our premise that the world is organized in understandable ways prior to our entering it, and that our task as researchers is to explicate that organization on behalf of those whose lives are being affected" (Campbell & Manicom, 1995, p. 12). Learning about institutional ethnography allowed me insight into how interaction, or social relations, are organized. It opened my eyes to the possibility that difficulties in a local and particular interaction can be structured into social relations by organizational practices. Institutional ethnography offers a methodology to investigate how organizational approaches such as management technology, epidemiology and health promotion form a complex of ruling relations that organize local and particular social relations in a Pregnancy Outreach Program. Institutional

ethnography was used as the methodology in my study because I wanted to explore the planned, organized and text-mediated structuring of the program. I was not trying to test a hypothesis, but rather explicate 'how things work'.

The reproductive process is a uniquely female experience, but as feminist theorists point out, control over provision of care during the reproductive process has been removed from women and women care givers in industrialized nations (Martin, 1992; Smith, 1984; Oakley, 1986). As pointed out by Dorothy Smith, institutional ethnography addresses "the epistemological and methodological issues arising from the standpoint of an experience situated, as women's has generally been, outside the institutional order that governs contemporary advanced capitalist societies." (1987, p. 152) In other words, this methodology allowed me to explore the intake assessment process of the Happiest Baby Program from the standpoint of the clients it seeks to serve and in a manner that is sensitive to their circumstance and world view.

Institutional ethnography differs from other non-positivist methodologies in that it's primary intent is not to understand experience in a way that claims to get at meanings and intentions of individuals, but rather to understand everyday experience and how that experience is shaped and constructed by ruling relations that organize our society.

In institutional ethnography the researcher must take a standpoint outside of the dominant ruling relations in order to gain insight into what ruling is, how it is constructed, what purpose it serves in social organization, and how it shapes or constructs the specific interaction being investigated. In starting from the lived experience of those in a real life situation, the researcher has a point of entry into the investigation of the ruling relations that organize a specific function or interaction and from which to explore the complex of social relations that are organized around the specific function being investigated. The methodology insists that one's experience is socially organized extra-locally, and through investigating the ruling relations that construct a specific interaction, the researcher can gain insight into why, or how experience happens as it does.

The process of doing insititutional ethnography begins with a problematic, or set of puzzles to be explored. The research begins in the everyday world of people whose lives are "problematic". As discussed earlier, my problematic arose out of the difficulties I experienced as I did the work of the prenatal intake assessment. The puzzles I sought to explore were: why I had experienced

difficulties maintaining a relationship with women as I carried out the intake process, and how was it that client's issues and concerns and circumstance, and work done around these became invisible in the recording and documentation of the program.

Once the set of puzzles to be explored is identified, the institutional ethnographer identifies the standpoint, or situated place from which the inquiry will begin. Smith (1987) argues that rather than seek to be objective, the only way to know a socially contructed world is from within. Because my problematic told me that the issues and concerns of the women in the Pregnancy Outreach Program were made invisible, and this concerned me, my interest was initially in learning how to understand the intake assessment from the standpoint of the women. As I went along, I learned more about how the ruling relations created problems for staff, as well.

Theoretical constructs are then used to inform the research standpoint and guide the inquiry. As discussed in the conceptual framework, the concept that extra local ruling relations mediate local and particular interaction is key to institutional ethnography. Institutional ethnography seeks to explicate and make visible these relations of ruling. Feminist theory told me that women's voice was excluded from these extralocal ruling relations that organize dominant social structures in our society. In collecting and examining data, then, I attended to pieces which gave evidence of relations of ruling, such as management technologies, and in particular, those from which the women, and women's voices seemed excluded.

In institutional ethnography it is conceptualized that text mediated management technologies are used to bring the extralocal relations of ruling into the local and particular interaction. As discussed in my conceptual framework, I was aware that concepts from health promotion, community development and population health were used in establishing the Pregnancy Outreach Program, and I wanted to see how actual practices in the Pregnancy Outreach Program related to, and were structured by these conceptualizations. I wanted to investigate the ruling relations in the Pregnancy Outreach Program, investigate if concepts from health promotion, community development and population health figured in these ruling relations, and, if so, I wanted to explicate how they worked.

Smith (1990) argues that texts stand in for people, carrying ideas from site to site. My experience of working with the intake assessment forms suggested to me that there were some powerful relations of ruling being brought into the interaction with women through this assessment. My conceptual framework consistently drew my attention to texts as part of the interaction, but as a privileged feature of it. So, to understand how the text, or intake form, figured so prominently in the interaction, I had to learn about the origins of the program, how it was thought about officially, and how it appeared in my research site. I had to see how the intake assessment forms, the Pregnancy Outreach Program Handbook, the training materials, and previous reports and studies of the program related to the lived local experience.

I was also looking to see how other data provided accounts of actual worker-client interaction, supervisory staff instruction of counselors, or counselors talking to each other about their work. As Smith (1990) points out, it is those living the local and particular experience who are the experts in that experience. Those who enact the situated local experiences as organized by the ruling relations are the experts in knowing the experience of the work process in the local and situated interaction. Clients were interviewed for experiential accounts of their interaction with program staff. Staff were interviewed for their expert account of how to do their work. In their "talk" I looked for traces of ruling relations, how the local and situated Pregnancy Outreach Program intake assessment accomplished the directives of the Ministry. In analyzing my data I wanted to see how the official version of the program was enacted in every day sites.

My analytic goal was to reflect on my problematic, that women's issues and concerns became invisible at some point in the organization of the local and particular interaction, and that working with this client group through the process of risk assessment created some serious difficulties for staff such that they had to develop creative ways of adding on personalized, or client centered work to the official work process.

In institutional ethnography the researcher begins in the situated experiences and returns to it after explicating how it happened the way it did. From the standpoint the investigation moves backward to trace the extralocal relations organizing the everyday experience, and then returns to the standpoint

to explicate how these ruling relations are enacted, and what, as a result, the impacts are on the local experience.

There is no attempt to sample a population in order to generalize, instead emphasis is placed on explicating how the situated experience happens, how the social relations are organized. As Smith (1987) points out, the situated interaction is likely enacted repeatedly in many ways and settings, but in each and every experience the local enactment is organized by the same complex of ruling relations. In understanding the ruling relations of one situated experience, then, researcher can understand the experience created by the same complex of ruling relations, though it may be enacted at a different site, and different time. Because documentary practices, as in the intake form of the Pregnancy Outreach Program, organize the local and particular interaction, and these same texts and same practices are used in different places and at different times, the ruling relations and subsequent effects of these will, presumably, be present in other sites of the Pregnancy Outreach Program. To that extent, my study's findings are generalizable.

The institutional ethnographer demonstrates rigor in the methodology by clearly identifying the conceptual framework that will form the basis for analyzing the data, and by using a logical process of analysis that could be followed by another researcher given the same conceptual framework and data. The researcher must demonstrate systematically how their standpoint is organized, and must define the empirical process used to gain insight into the social construction of the experience.

Institutional ethnography allows me to explore, describe, and analyze the complex of relations that organize the intake assessment process of the Pregnancy Outreach Program. It will allows me to explicate how the experiences and interactions of women who are clients in the Happiest Baby Program are constructed and shaped by the work processes of the dominant institutions that organize health care in British Columbia. People's lives, actions, and experiences are organized by social relations that I discover and write about using the data I have collected. My research effort is to make a trustworthy analysis, faithful to "what actually happens", but fillin in what is missing to give a proper understanding of it. It is an anlysis that another researcher, using the same methods, could produce. Although validity is not a term used in this

research approach, my research is successful (valid) to the extent that the evidence I provide for my interpretation of events convinces readers.

**The Study**

In order to understand the ruling relations that organize the intake assessment process at a Pregnancy Outreach Program site I used a variety of methods to collect data. Documentary analysis, interviews and observation were all used as methods in my investigation. My proposed research was first discussed with the Provincial Coordinator of the Pregnancy Outreach Program, the Sponsoring Agency, the local band council, and the advisory committee of the Happiest Baby Program. Written approvals for proceeding with my research were obtained from all of these, and included with my proposal to the Ethics Review Committee of the University of Victoria. The research was also discussed with the lay counselor, as I was aware this could possibly have an impact on her comfort in working.

As already discussed, the lived experience of the intake assessment process of the Pregnancy Outreach Program was my point of entry into this investigation. In order to explore the intake assessment process, I observed four separate intakes at the program site that was selected for investigation. I was seeking the experiential account of the lived experience of the intake assessment and since it is assumed in institutional ethnography that extralocal ruling relations organize each interaction in the same way, it was the traces of ruling relations I was seeking to discover in these observations. These four observed intake assessments, along with other extensive observations of the work and interactions in the everyday experience of the Happiest Baby Program provided ample data from which to analyze how the ruling relations were carried out in the local situated experience.

Though I did have some concern that working as the coordinator in the program that I studied might present difficulties for the study by influencing or inhibiting interaction, I was very aware of the advantages it provided. I was not seeking "objective" data, but rather as full an account as possible of how the setting works. Institutional ethnography seeks to know how the world is socially constructed, and this understanding, says Smith (1987), must come from within the social relations being examined. Working in the program, then, more easily allowed me access to study the social relations as experienced from within.

Through my work presence I was better enabled to observe the everyday experiences, and attend to interactions where the ruling relations were evident. Aware that my presence as a researcher may create discomfort, however, I took care to ensure that the lay counselor understood why I was observing the work, and that it in no way was she, or her work, being evaluated. In fact, she became very interested in my research and discussing my findings. Client discomfort, too, was a concern. I introduced my research at two drop-in sessions, and only when I knew that those attending had been clients for some time, and were comfortable with the drop-in itself.

My initial intent had been to interview clients prior to their intake process, then again some time after the intake, to obtain an understanding of how they experienced the intake process. Because of the fragile nature of the early relationship between the client and program staff, however, and my awareness that the initial client interaction was often uncomfortable at the best of times, I deemed it to be in the best interest of the client to wait until a relationship with a program worker was established before including them in my research.

When a client group was comfortable with the service and service providers, my research project and request for volunteers was introduced to clients. I contacted only those clients who had signed a consent to volunteer for a research interview. Four active clients of the program site who volunteered to participate in the research were interviewed. Again, because I sought to understand the experience of the intake assessment in order to find the ruling relations present in that experience, it was the reflection on that experience, and not the numbers of interviews that were important to my study. According to my ethics agreement as previewed and approved by the Ethics Review Committee of the University of Victoria, interviews were taped, with client consent, and transcribed. Data materials were identified only by pseudonyms, other than the consent forms. Tapes are retained solely by the researcher until the research process is complete, then will be destroyed.

Two lay counselors for the Pregnancy Outreach Program were interviewed to gain an understanding of their work, and their perspective of the intake assessment process. One counselor worked at the Happiest Baby Program site, the other worked at a distant site, but had participated in the lay counselor training set up by the Happiest Baby Program. Again, these interviews

were taped and transcribed with their consent, and will be disposed of when the research process is complete.

As already discussed, extensive participant observation of the work at the program site was carried out over a period of two years, and observational notes were recorded. Observations of interactions between clients, between clients and staff, between staff, and between advisory members and staff were carried out during the two year period, and field notes kept. Since I am a staff member, I was able (with prior consent) to treat my work, meetings etc. as opportunities to collect data. Observations of advisory meetings, casual discussions, provincial Pregnancy Outreach Program conference addresses, telephone conferences and office discussions provided rich opportunities from which to pull out the pieces of the extralocal ruling relations that were visible to me in the enactment of the local situated experience.

I also analyzed documents of the Pregnancy Outreach Program to investigate how textually mediated ruling relations helped construct the intake assessment interaction, and other work practices. Documents analyzed included the intake assessment form itself, qualitative and quantitative research reports on the Pregnancy Outreach Program, the Pregnancy Outreach Program manual, pamphlets and materials from "Within Our Reach", a new training program for outreach workers that was developed through the Open Learning Institute.

Once observational data and interview data were gathered and program documents were analyzed for an understanding of the extralocal ruling relations, I returned to my data of the situated experience to analyze how these extralocal ruling relations were articulated in the local lived experience of the Happiest Baby Program.

## CHAPTER THREE – The Pregnancy Outreach Program (POP)

### History

The Pregnancy Outreach Program Handbook identifies that low birth weight is "one of the most pressing issues in prenatal care in the Province and in Canada."(B.C. Ministry of Health, June, 1996) The Handbook goes on to identify the high cost of low birth weight infants to the Canadian health care system. Research indicating that low socio-economic status is related to higher risk for low birth weight infants, and research that indicates pregnancy outreach with nutrition supplements can decrease such incidence of low birth weight, is used as rationale to support the development of the Pregnancy Outreach Program in British Columbia (B.C. Ministry of Health, June, 1996).

The Pregnancy Outreach Program began in 1980 with eight pilot sites. The 1995/96 Annual Report of the Pregnancy Outreach Program states, "The success of those initial projects led the Ministry of Health to expand the Program."(B.C. Ministry of Health, June 1996). By 1998, there are 21 Pregnancy Outreach Program project sites in existence in B.C.

The Pregnancy Outreach Program as a whole is often referred to as "POP". The term "POP" is used in spoken interaction, correspondence, and in literature when referring to the 21 project sites. Local agencies are encouraged to develop Pregnancy Outreach services according to guidelines established in the Pregnancy Outreach Program Handbook. These agencies then contract with the Ministry of Health Nutrition Branch to provide services locally. Contracts are managed by a local nutritionist, who is employed by the Ministry of Health.

Each of the project sites also has their own name. The site chosen as the point of entry for this research is a "POP" project based in a coastal community of B.C. For the purposes of this study the site chosen for this study will be called the "Happiest Baby Program".

### Goals and Objectives

The Pregnancy Outreach Program Handbook states "The goal of the Pregnancy Outreach Programs is to promote positive health practices that contribute to the health of newborn and mothers. The strategies used to achieve this goal are outreach, education, and support **to at-risk parents**."(B.C. Ministry of Health, June 1996, pg. 14, bolding mine) The 1995/96 Annual Report of the Pregnancy Outreach Program states "Our mandate is to provide education and

support to women who are at-risk of having a low birth weight baby. ...Many of our clients do not access traditional prenatal health care services...."(British Columbia Ministry of Health, 1996) The goal of the Pregnancy Outreach Program, then, is to provide targeted pregnancy outreach services to women who are at risk for a low birth weight baby and who may not normally access other health care services.

The Annual Report identifies that "A woman must be at risk of having a low birth weight baby to be accepted into our Program. There are 30 factors (socio-economic, physical, emotional, or lifestyle in nature) that may place her at risk."(British Columbia Ministry of Health, 1996) Under "eligibility", the Pregnancy Outreach Program Handbook states, "Eligibility is based on the existence of a risk factor (physical, substance abuse/misuse, psychosocial or economical) which may have an adverse effect on the pregnancy outcome."(B.C. Ministry of Health, June 1996, pg. 18) An Individual Prenatal Risk Identification lists these specific "risk factors" that are used to determine client eligibility.

The objectives of the program stated in the Pregnancy Outreach Program Handbook are to: improve nutrition, decrease smoking, decrease alcohol use and drug misuse, raise self-esteem, encourage breastfeeding, promote dental health, encourage physical activity, encourage early physician care, and promote social/community support. The Handbook states specific objectives under each of these broad topics that identify specific staff actions or changes in participant behavior that are to be used as "measures of the program's success".

Under "Goals and Objectives" the Handbook states, "It is crucial that the Pregnancy Outreach Program service be client-focused. In collaboration with the client, the client's needs are determined and the specific objectives to be targeted by the Program staff are identified". (British Columbia Ministry of Health, 1996, pg. 16)

**Organization**

The Nutrition Section of the Prevention and Health Promotion Branch of the Ministry of Health and Ministry Responsible for Seniors has provincial responsibility for the Pregnancy Outreach Program. Though the Nutrition Section coordinates the overall planning for the Program, the responsibility for individual programs is shared by a Provincial Advisory, Provincial Contract Manager, Local Advisory and Local Agency. "The aim of this sharing of responsibilities is to

maintain the client focus and to reflect individual community needs and resources." (Ministry of Health, June, !996)

Sponsoring Agency

As indicated above, the Pregnancy Outreach Program is delivered through community based agencies who receive core funding from the Ministry of Health. These agencies must have well established links to the "target group", have proven stability, and do not necessarily have to be "in the business of providing health care" (B.C. Ministry of Health, June, 1996, pg. 10 and 23). The contracting agency is called the "Sponsoring Agency".

Sponsoring agencies are guided by the "Pregnancy Outreach Program Handbook" and their contractual agreement with the Ministry of Health. In order to obtain funding the sponsoring agency signs a contract that states:

"This contract is to provide for a Pregnancy Outreach Program offering counseling and peer support to high risk pregnant women who do not typically access traditional prenatal health services." (Ministry of Health, June 1996, Appendix H) The agency agrees to:

> "1) Provide services according to the Ministry of Health Pregnancy Outreach Program Handbook with specific emphasis on the points outlined in the "Commitment to Program Standards" attached to the schedule.
> 2) Submit audit and evaluation information required by the Ministry of Health, including an unaudited statement of accounts and a Program Status Report on or before April 30.
> 3) Comply with all aspects of the "Service Delivery Model" as outlined in the Ministry of Health's Pregnancy Outreach Program Handbook.
> 4) Ensure that the project staff includes a nutritionist (or nurse) to complement the discipline of the project coordinator.
> 5) Have in place policies regarding the storage and disposal of client records in compliance with the Freedom of Information Act and the Document Disposal Act.
> 6) Comply with the requirements of the Criminal Records Review Act."
> (B.C. Ministry of Health, June 1996, Appendix H)

The Sponsoring Agency is responsible for hiring staff, establishing a local advisory committee, providing administrative support, ensuring required documentation is submitted by staff, and ensuring the standards of the Pregnancy Outreach Program are met according to the Pregnancy Outreach

Program Handbook guidelines. The Sponsoring Agency is to "rely on mandatory advisory committees of health professionals and community leaders for program consultation and direction."(B.C. Ministry of Health, June 1996, pg. 10).

The Sponsoring Agency of the Happiest Baby Program is a First Nation's organization that contracts to provide Pregnancy Outreach Program services locally. The Happiest Baby Program is to provide service in several geographically isolated communities both on and off reserve.

Contract Manager

The "Service Delivery Model" specifies that the Nutrition Services Branch of the Ministry of Health is responsible for "setting standards and policy of the Pregnancy Outreach Program and for evaluation and monitoring of the program".(B.C. Ministry of Health, June 1996, Appendix H) Each project site has a "Contract Manager" who ensures the contractual agreement is met by the Sponsoring Agency, and that "program principles are being followed" (B.C. Ministry of Health, June 1996, Appendix H) .

Contract managers are to oversee the implementation of the project site, monitor program status reports, monitor evaluative information, review the proposed budget, advocate for POP in the local community, ensure Program standards are met, and act as a resource to the project site. Contract Managers are employees of the Ministry of Health Nutrition Branch. Managing a POP contract is one small part of their other duties as community nutritionists. The contract manager for the Happiest Baby program is a nutritionist who provides service to several communities within the region.

Local Advisory Committee

The Pregnancy Outreach Program Handbook stipulates that each program must have a Local Advisory Committee and each Local Advisory Committee must have representation from: the Health Unit, local physicians, Alcohol and Drug Programs, Social Services, aboriginal or ethnic organizations, and clients or client advocates. Representatives from the community or other government agencies are to be encouraged to participate.

The Local Advisory Committee has played a primary role in the establishment, support and management of the Happiest Baby Program. Members of the Local Advisory Committee established a society in order to

obtain contracts with Social Services and the Ministry of Health, thereby enhancing the services that could be offered.

The Local Advisory Committee for the Happiest Baby Program has regular representation from: the Community Health Representative, the Community Health Nurse employed by the Ministry of Health, the Community Health Nurse employed by the Sponsoring Agency, the Ministry of Health Community Nutritionist, the Contract Manager, the local Infant Development Worker, Social Worker, Child Care Worker, and Alcohol and Drug Worker. Other less regular representation has included: the Mental Health Worker, Transition House workers, Children Who Witness Abuse Program counselors, Laleche leaders, Home/School counselors, and former clients. Physician representation has been promised, but is difficult to secure.

Some of the functions that the Pregnancy Outreach Program Handbook suggests the Local Advisory Committee provide are: "professional direction and consultation on clinical issues... community linkages to ensure the program is sensitive to the community needs, advocating for the program in the community, supporting the program through referrals and access to resources, providing the Sponsoring Agency with ongoing evaluations of the service delivery... assisting in selection of staff...(and) training program staff" (Ministry of Health, June, 1996, pg. 25).

In the Happiest Baby Program the Local Advisory Committee provides most of the support and direction for the program. Program activities are reported and discussed at the monthly Local Advisory Committee meeting. A Coordinator's Report identifies the number of referrals for the month, the number of clients who entered the program in the month, the number of births for the month, the number of clients participating in the program within the fiscal year to date, and the attendance at the Drop-In sessions. A "Drop-In Calendar" identifies the planned topics for client Drop-In meetings for the next month. Copies of the minutes of the meeting, the Coordinator's Report, and the Drop-In Calendar are sent to all Committee Members who were unable to attend the meeting, including the assigned physician representative, and to the Sponsoring Agency.

Local program concerns are discussed at Local Advisory Committee meetings of the Happiest Baby Program, and often a "brainstorm" approach is used to resolve any difficulties. Discussion frequently focuses on the lack of local transportation for clients, and the difficulties this creates in making Drop-In

opportunities accessible. Committee members indicated that making service accessible is a universal problem with all local programs.

No specific client data is discussed at these meetings. Committee meetings are spent on general evaluation of the effectiveness of the program in contacting and providing service to pregnant women most "at risk" who live in the communities served. The Contract Manager and Sponsoring Agency ensure that minutes of the regular Local Advisory Committee meetings and the Coordinators report indicate that contractual requirements are being met and "reflect the principles of the Pregnancy Outreach Program".

Provincial Advisory Committee

The Provincial Advisory Committee is based in Victoria, and is charged with the responsibility for overseeing the operation of the Pregnancy Outreach Program as a whole. "Provincial Advisory Committee members reflect the Provincial interagency commitment to the program and include prenatal policy and program experts from: Alcohol and Drug Programs, Ministry of Health; British Columbia Fetal Alcohol Syndrome Resource Group; Family and Children's Services, Ministry of Social Services; Family Health, Ministry of Health; Healthiest Babies Possible Program, Vancouver Health Department; and Native Health, Ministry of Health." (Ministry of Health, June, 1996, pg. 27)

The Provincial Advisory Committee is to provide "direction and support" to the Pregnancy Outreach Program sites by ensuring the Program Handbook is current, coordinating evaluative measures of the Pregnancy Outreach Program, providing expert advice to the Programs, promoting inter-ministerial collaboration on perinatal issues, encouraging networking among the Pregnancy Outreach Programs, reviewing proposals and recommending sites to be funded.

Provincial Coordinator

Though not identified in the Handbook, a program manager in the Nutrition Section of the Prevention and Health Promotion Branch of the Ministry of Health is given responsibility for coordination of the Pregnancy Outreach Program and Provincial Advisory Committee activities. The "Provincial Coordinator" of the Pregnancy Outreach Program has other managerial duties as well as coordination of the Pregnancy Outreach Program.

Staff

**Outreach Workers** are the primary providers of direct outreach service and maintain regular client contact. The rationale given for use of non-professional staff is that many potential clients of the Pregnancy Outreach Program are known to not access prenatal services as traditionally provided by physicians, public health nurses and nutritionists. Outreach Workers who are "members of the community being served" are more likely to "understand the client, build trust and encourage behavior change" (B.C. Ministry of Health, June 1996, pg. 31).

A **Coordinator** is hired to plan, organize, administer and supervise the delivery of services at each Pregnancy Outreach Program site. The Pregnancy Outreach Program requires that a Registered Nurse or Registered Dietitian/Nutritionist with community experience be hired as Coordinator. The Coordinator is "responsible for the standard of service and is accountable to the Sponsoring Agency" (B.C. Ministry of Health, June 1996, pg. 30).

The Pregnancy Outreach Program seeks to ensure that each program site has the benefit of "skills and expert knowledge unique to their (nursing and nutritionist) professions" (B.C. Ministry of Health, June 1996, pg. 31). Where the Coordinator is a nurse, a nutritionist must provide nutrition consultation and direct nutrition counseling to clients with high risk nutritional concerns. Where the Coordinator is a nutritionist, a nurse must provide consultation services to the program, and provide direct client counseling where clients are at risk for emotional or physical factors.

**The Program**

The Pregnancy Outreach Program Handbook states, "There are five essential components to the Pregnancy Outreach Program services. These components were selected based on supporting evidence in the literature and on experience of high-risk counseling programs" (B.C. Ministry of Health, June 1996, pg. 18). Each project site is to offer group sessions, individual counseling (a minimum of 5 counseling sessions), vitamin/mineral supplements, food supplements, and referral.

Group sessions, or "drop-ins" are "to encourage peer support/counseling"(B.C. Ministry of Health, June 1996, pg. 18) and must be offered a minimum of once every two weeks. A "healthy" meal or snack with food

from at least two food groups must be offered at each group session. The Happiest Baby Program "Drop-In" is held weekly.

**Intake Process**

Formal documentation about a client is initiated during a client "intake". On intake, an assessment of client "risk factors" is done to determine whether a client is eligible for the program, or vitamin and nutritional supplements. "It is essential that every participant in the Program be identified as at-risk for having a low birth weight baby or other poor pregnancy outcome before they are accepted into the Program. This is determined by the Individual Prenatal Risk Identification Tool which is based on physical, socio-economic, emotional, and substance abuse factors." (B.C. Ministry of Health, June, 1996, pg. 40)

In order to be eligible for the Pregnancy Outreach Program services, each client must have at least one "risk factor" for low birth weight. Priority is given to clients with higher numbers of risk factors. Only those identified to be "low income clients" are eligible for food supplements and vitamin/mineral supplements.

The Individual Prenatal Risk Identification Tool, which is used to determine a client's risk factors, consists of one tick sheet that divides risk factors into "physical factors", "substance abuse/misuse", and "psychosocial and economic factors".

Twelve physical risk factors listed for assessment are: previous pregnancy loss, illness or disease with an impact on the pregnancy, having a significantly high or low weight pre-pregnancy (body mass index used), having a high or low rate of weight gain, inadequate nutrition, having a previous child with an anomaly, having a previous child that required neonatal intensive care, multiple pregnancy, birth interval of less that two years, having five or more pregnancies, having a genetic risk, or being too young (under 17) or too old (36+).

Four substance abuse risk factors identified are: cigarette smoking, alcohol use, inappropriate use of over the counter or prescription drugs, or other drug use.

Thirteen psychosocial and economic factors listed for assessment are: single parenthood, delayed access to prenatal care, refusal of or resistance to appropriate services, isolation - ethnic, language, or social, limited learning ability or illiteracy, unstable relationship or family violence, mental health problems, low

self-esteem, inability to cope with pregnancy and baby, unrealistic expectations, unwanted pregnancy or denial of pregnancy, financial problems, or inadequate housing.

Each client is to be assessed for these risk factors on intake. The assessment is to be completed within fourteen days of a client referral.

> "Given that pregnancies are only nine months long and that programs have a limited time span in which to influence the outcome of the pregnancy, it is essential that ...contact be made as soon as possible." (B.C. Ministry of Health, June, 1996, pg. 17)

Clients who are less that 28 weeks gestation are given priority for admittance

> "to allow sufficient time for intervention to be effective. However, participants at-risk for substance abuse ... should be admitted at any time in their pregnancy..." (B.C. Ministry of Health, June 1996, pg. 40).

It is recommended in the Handbook that available resources be targeted to those "most in need."

In order to "tick" the "risks" appropriately, extensive interviewing and data gathering must be done. For instance, prior to ticking "Inadequate nutrition", a food recall must be completed, and intake of iron, folic acid, caffeine and water must be assessed. Prior to ticking "rate of weight gain", the client's pre pregnant weight and height, present weight, present gestation, and body mass index must all be gathered. Prior to ticking "Alcohol use" the TACE must be evaluated as follows:

The TACE is a series of four questions with each being given a value of one point except T- tolerance, which is given a value of 2. The questions are:

T- tolerance- How many drinks does it take to make you feel high? A response of two or more drinks scores 2 points.

A - annoyance- Have people annoyed you by criticizing your drinking? A positive response scores 1 point.

C - cut down- Have you felt you ought to cut down on your drinking? A positive response scores 1 point.

E - eye opener- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? A positive response scores 1 point.

> "Studies have shown that questions about alcohol tolerance such as those used in the T-ACE questionnaire may be more effective in obtaining information about a woman's drinking patterns than direct questions about alcohol consumption.

> For the purposes of the Pregnancy Outreach Program evaluation, a client is at-risk for alcohol use, if she has a positive T-ACE (a score of 2 or more)" (B.C. Ministry of Health, June, 1996, pg. 40).

Most of the "background information" required to complete the tick sheet can be gathered by a "Client Data Sheet". Though the Client Data Sheet is six pages long, and does not have to be completed until after the client delivers her baby, most program staff take time to complete it during the initial intake process. Without the information gathered by the Client Data Sheet, completion of the Individual Prenatal Risk Identification would be difficult. Also, the Client Data Sheet and the Individual Prenatal Risk Identification Tool are the formal documents that must be sent on to the Ministry of Health for "evaluative purposes".

> "The effectiveness of the Program is evaluated by assessing any changes in reported health behaviors of clients...information is being collected and recorded about the client at intake, at the last visit prior to the expected due date, and following the birth" (Ministry of Health, June, 1996, pg. 82)

Data gathered during the intake process forms the basis of the client "assessment". The Handbook states that the Individual Prenatal Risk Identification Tool, "not only determines if the potential client qualifies for intervention...but also provides direction for subsequent counseling." (B.C. Ministry of Health, 1996, pg. 41). Goals for "counseling and intervention" are based on "risk factors" that are identified by the Prenatal Risk Identification Tool.

The Pregnancy Outreach Program Handbook states "Experts agree that the prevention of low birth weight should focus on ...modifiable risk factors..." (B.C. Ministry of Health, June 1996, pg. 7). The five modifiable risk factors identified by the Pregnancy Outreach Program are: low pre pregnant weight, poor prenatal weight gain, poor nutrition, smoking, and alcohol and drug use (B.C. Ministry of Health, June 1996, pg. 7). Though other significant risk factors may be identified, "intervention" is to focus on these specific "modifiable risk factors".

The Program Coordinator reviews each client "assessment" to ensure the client is eligible for the program, then program staff are to develop "counseling goals", preferably in consultation with the client. One staff member, usually an Outreach Worker, is chosen to maintain contact with each client and is to work

cooperatively with the professional staff to ensure the client's "counseling goals" are met (B.C. Ministry of Health, June 1996, pg. 18).

A "chart" is kept on each client. Though charts are not standardized throughout the Pregnancy Outreach Program, charts include the Client Data Sheet, the Individual Prenatal Risk Identification Tool, some method of quickly recording dates of client contact, a place to record whether they attended drop-in, a method of recording whether they received their nutrition or vitamin supplement, a graph to record weight gain, food recall sheets, and Progress Notes. "Modifiable risk factors" are recorded on the Progress Notes, along with the "counseling goals".

In the Happiest Baby Program, "SOAP" charting is used on the progress notes. This is a methodical system for recording progress on the specific "problems" identified by using a subjective comment, an objective observation, an analysis of the situation, and a plan for addressing the issue further. If "nutrition" is identified as a problem, for example, this would be numbered. The problem number is then used to identify what the charting will be about. For example:

> 9 Nov. 96 H.V. (home visit) 1 (problem number assigned for nutrition)
>
> S: Edna states is drinking orange juice provided by the program.(clients subjective experience related to the problem).
>
> O: Food recall now shows adequate fruit and vegetable intake. Edna also appears less tired. (staff observations related to the problem)
>
> A: Orange juice supplement is being used and resulted in improved fruit and vegetable intake but iron intake still a problem (an assessment of the status of the "problem" is noted).
>
> P: Continue orange juice supplements and provide information on eating iron rich foods in combination with vitamin C rich foods to increase iron availability.(the "plan" to "work on the problem" is adjusted based on the ongoing evaluation and assessment of the "problem"). The progress sheets are not forwarded as part of the program reporting, but are part of the "working chart". They are used regularly, and stay as part of the "client chart" at the program site.

## CHAPTER FOUR - Risk Assessment - a Barrier to Service

In this first chapter of data analysis I locate the study in the lived experience of the intake process of the Happiest Baby Program. The intake interview is the opportunity for the worker to get to know the potential client in sufficient depth that the Individual Prenatal Risk Identification Tool can be completed. This interaction is key to determining eligibility for the program and identifying client "risks", and thus how future work with the client will be organized. It is also key to how the client experiences their introduction to "the program". It is during this initial interaction that the relationship with the client is established.

As my observations and my own experience of doing intake interviews told me, staff use different strategies to complete the Individual Prenatal Risk Identification form. In the four intake interviews I observed, the worker would sometimes talk at length with the client before completing the form. However, whether or not the interview began immediately with the form, it always became the central and organizing feature of the interview. In this chapter I argue that Individual Prenatal Risk Identification Tool organizes the intake process of the Happiest Baby Program, and in doing so organizes the interaction.

I go on to argue that the work of completing this risk assessment tool is a process of objectifying the client and constructing a documentary version of her that can be "worked on". I argue that the intake assessment creates an objective "problem version" of the client based on the "risks" identified, and that this "problem version" of the client is then used to organize the work done with the client.

Though the program requires that the Individual Prenatal Risk Identification Tool be completed, I argue that building a relationship while doing this work of objectifying is very difficult. I argue that being the "object" of a risk assessment is experienced as distinctly unpleasant for potential clients, and can serve as a barrier to the very clients to whom services are being targeted.

The goal of the program is to provide care to those with epidemiologically significant risks, and program funding is targeted to addressing these risks. Client information is, therefore, objectified to clearly identify only the significant risk factors that will be targeted for intervention. While I acknowledge that the objectification of clients on the intake forms serves very valuable organizational and funding purposes, I argue that the process of objectification creates anxiety

in the clients whom the program particularly seeks to provide services to, and can limit building a meaningful relationship between staff and client. Establishing a relationship is key to the client using the service and staff ability to be "client centered".

**Risk Assessment as it Organizes Interaction**

Smith (1987) identifies that a new reality is created when an event or interaction is textualized. This transformation from what is experienced into a written account of selected details is referred to by Smith as the creation of "documentary reality". Organizational documents routinely "work up" everyday life for action by organizational actors. A documentary reality is an account, says Smith, in which organizational records get embedded within the organization and taken as the same thing as "what actually happens", or "what actually exists". The documented account is accepted as "the truth", and organizational interaction and decisions become based on this documented account. The documentary account is devoid of the context of the human interaction, and cannot, therefore, convey individual circumstance. Rather than reflecting everyday life as it is experienced, the documentary account constructs meaning within the organization, it constructs a new, organizational, reality. Interactions within the organization become based on the new "documentary account" rather than on the local relationship, which is rich with contextual knowledge.

As identified previously, the work of the Pregnancy Outreach Program is organized around the Individual Prenatal Risk Identification Tool. This tool is used to ensure the client is eligible for service. There is an expectation that the "assessment" be completed early in the client/staff relationship.

> "**During the first few client contacts**, the Program staff determine if there are any specific risks, through the use of the Individual Prenatal Risk Identification Tool (Appendix C) and the T-ACE questionnaire (Appendix D)" (British Columbia Ministry of Health and Ministry Responsible for Seniors, 1993, page 8, bolding mine).

Staff identify that in order to complete the Individual Prenatal Risk Identification Tool they must first complete the six page Client Data Sheet.

> "...you really have to do the six pager before you do the Risk ID, it collects all the information you need to do the Risk ID. anyway...and besides, it's easier to get the thing done right away" (Field Notes, office discussion, 14 January 1997).

What staff are saying is, that in order to complete the Individual Prenatal Risk Identification Tool, all seven sheets of the assessment tool must be completed, and since there is an expectation that the Individual Prenatal Risk Identification Tool be completed to ensure a client is eligible for the program, all forms are completed early in the interaction with the client, if not on the first visit. In practice, I saw that the very extensive intake assessment was usually completed on the first visit. This also ensures the documentation is completed to send in for accountability and funding purposes, once the client delivers.

Observing the intake process as a third party allowed me invaluable insight into the difficulties I had myself experienced. I observed that both clients and staff were uncomfortable at various points throughout the intake process. Through closer analysis of the intake observations I was able to identify that discomfort during the intake interaction was always noted when staff re-directed the interaction toward completing the Client Data form. With some intakes the staff initially spent time in general discussion with clients about their pregnancy, circumstance, etc. before directing the clients attention to completing the Client Data form. Some intakes began by completing the "client demographic" portion of the Client Data form. In all instances, however, staff would re-direct the interaction toward "completing the form".

An example of this "redirection" is:

> "Kali is very talkative, seems to want to talk about her pregnancy. She talks freely about her experiences of her last pregnancy and chats about how this pregnancy "feels so far." This ease in interaction is interrupted, however, when it is noted, "The counselor then puts "the form" on the table ...There is some awkwardness as the counselor tries to get "the form" filled out. Age, due date, marital status, education etc. is filled in on the form. Kali becomes less talkative and appears to concentrate on answering questions asked..."(Field notes, client intake, October 18, 1996)

The easy interaction and client "story telling" was interrupted as staff redirect the intake interaction to filling out "the form". Staff redirecting the interaction toward completing the form was noted in every observed intake, and in all cases, a closing off of free flowing conversation ensued.

In another intake it was observed:

> "Though Edna appears nervous, playing with her daughter's hair and choosing to stand, she eventually sits and holds daughter in lap as she talks about past

> pregnancies...Much discussion about past and this pregnancy, and Edna appears more comfortable."

Then later I note:

> "...counselor asks if it is "O.K." to fill out "form". Edna laughs nervously and says, "Oh ya, I went through this last time"... begins to play nervously with daughter's hair again as counselor writes down responses on the form..." (Field notes, client intake, June 14, 1997).

Here I noted that throughout the early interaction the staff member focused a considerable amount of time and energy in building the relationship and trying to make the interaction comfortable for the client. When the client began appearing less distressed, however, the "form" was brought out. At this point the client once again was observed to be nervous and unsure about the interaction. The work of building a comfortable interaction was destroyed.

In observing the intake process I noted how smooth interaction interspersed with 'getting the form done' began to appear like a dance. While involved in general discussion, notations are made of both client and staff attending directly to each other. For example, when the counselor asks about Kali's 'supports',

> "...Kali begins to talk freely about her family history...In talking about how she supported herself while putting herself through school Kali holds herself upright, appears confident, and uses more direct eye contact...Kali's 'storytelling' eventually returns to her first birth experience and she comments how alone she felt and how important her boyfriend was in helping her through the experience. The counselor nods and listens attentively throughout the 'story'."(Field notes, Client Intake, October 18, 1996)

This smooth, cooperative, and balanced interaction is interrupted, however, when it is noted:

> "...when Kali pauses (in telling her 'story') the counselor looks at her watch and says she just has the 24 hour food recall left to do. Kali looks uncomfortable and states that she didn't eat very good yesterday..." (Field notes, Client Intake, October 18, 1996)

It is as if the 'dance' is interrupted as staff re-direct attention to filling out the form. The counselor seems to suddenly take the lead, changing the flow of discussion, and interrupting the smooth flow of 'the communication dance'.

Discomfort of the client is noted when the interaction is redirected to completing the form, and the staff member is noticeably concerned about the time (looks at her watch), and trying to get the form "done" (just has the food recall left).

As staff focus on 'filling out the form', notations are frequently made of clients appearing uncomfortable, and trying to concentrate on giving the 'right' answers. The staff clearly 'know the steps', and the clients become hesitant yet attentive as they seem to focus on 'the steps' that the counselor is striving to lead them through. For example:

> "Kali then appears to again concentrate on giving responses to questions on 'the form'. Information about family alcohol and smoking use is given...she appears to be looking for the counselor's reaction...the counselor nods as if in approval..." (Field notes, October 18, 1996)

I noted after this interview:

> "It is interesting how Kali seems anxious to talk but how the counselor's focus returns to 'finishing the form'. It is also interesting to note how Kali seems to think carefully about her responses and tries to give 'the right answers' when information is obviously being recorded."(Field notes, Client Intake, October 18, 1996).

During the intake process I observed that staff repeatedly redirected attention to completing the Individual Prenatal Risk Identification Tool. The tool effectively orchestrated how staff interacted with the client. Though interaction directed at completing the forms was the most hesitant on the part of clients, this remained the focal point of the intake interaction, as structured by staff.

**Objectifying the Client and Establishing Class Relations**

Smith identifies that the "story" of a client is objectified through the documentary processes of an organization. This objectification of a client serves organizational purposes for uniform reporting and evaluation. The goal of the Pregnancy Outreach Program is to provide care to those with epidemiologically significant risks, and program funding is targeted to addressing these risks. The Individual Prenatal Risk Identification Tool assures that the target group is being reached, and their risks are assessed. However, in completing the Risk Assessment form staff document only those "pieces" of a client that relate to specific "risks". Client information is objectified to clearly identify only the significant risk factors that will be targeted for "intervention".

This is why I argue that the Individual Prenatal Risk Identification and Client Data Sheet of the Pregnancy Outreach Program construct an ideological version of the client. In the constructed version of the client, only selected epidemiologically significant "risks" or "problems" are noted. The client is classified according to her "risk" and has limited opportunity for input into the textualized account of them. Situated information about specific client knowledge, concerns, or circumstance is not identified. Instead, a scientific based "problem" version of the client is constructed, a version that excludes the circumstance of the woman, and tells only of the risk to the biologic health of her fetus. The text mediated process of interacting substitutes administrative/scientific concerns for the human concerns of the woman. This then becomes the embedded, organizational version that is to be "worked on".

Through the intake process, staff are engaged in a process of objectifying clients of the Happiest Baby Program. Where information is not asked directly, it is gleaned from the client story and then translated into an objective "risk". Throughout the intake staff are constantly trying to consolidate the information they are gathering and put it onto the form as data. Clients, initially willing to participate in the interaction, become hesitant when they become aware of the process.

It was noted during observation of the intakes, how information from general discussion, information which is client generated, is never recorded. Specific issues and concerns the clients raised, that they obviously felt were important to discuss were **not** noted during the intake process. An example is where in Kali's intake, she spoke at great length about her difficult circumstance in her early teen years and described how important her boyfriend was in helping her through this and to cope with her previous pregnancy. Yet it is noted:

> "...Though she talks freely and at great length about these experiences it is not recorded in any way by the counselor."(Field notes, Client Intake, October 18, 1996)

The information Kali was giving could not be transposed into a specific risk factor, or "problem". Though key to the interaction and the familiarity of the staff member with Kali's situation, this information did not fit with the data gathering process. It could not be "objectified" to fit within the parameters of the standardized assessment form and the staff member, therefore, could not "use" this information.

Unless a specific "risk factor" was described that could be identified on the form, nothing of the client "story" was written down. Where information is recorded from a client 'story', it is a cryptic notation only, and does not reflect the circumstance or importance of the issue to the woman. For example:

> "When asked re: her health there is a lengthy discussion about ongoing health problems. The counselor listens attentively as Mary explains the difficulties she had with her first birth, and tells a story about the traumatic circumstances that ended in a C-Section with her second pregnancy. As Mary ends her story the counselor notes this as a 'physical risk factor' on the form under 'Illness/condition with impact on pregnancy'. Then counselor turns page of form and asks about alcohol use". (Field notes, Client Intake, November 23, 1996)

Staff were observed to listen to client stories, but were obviously conscious of the need to translate these "stories" into the organizational "workup" of the client. Through my observations it became apparent that local and situated interaction with the client is not of primary concern to staff during the intake process. The focus is to translate the "client story" into "risk factors" that objectify the information. An example that demonstrates this is where Tina is asked about her supports:

> "She says, 'I haven't got any family'...she talks at great length about her family history, being 'in and out of foster homes', etc. 'I didn't stay anywhere long'. The counselor listens and nods...".

Later it is noted

> "Recorded by counselor as 'isolation'...counselor then directs conversation to discussion of diet." (Field notes, client intake, February 19, 1997).

The worker listens, translates story information into "risk" terms, and documents only the objective "risk".

Clients were observed to resist their objectification by providing less information when they seemed to have awareness that a part of their life being discussed might be identified as a "problem". For example:

> "Some discussion re: income being a 'problem'. Intake interrupted as Mary gets up to give dog "heck" for scratching at door, even though it has been scratching from the start" (Field notes, client intake, 23 November, 1996).

The distraction of answering the dogs scratching prevents the staff from obtaining more detailed information about the "income problem". Later in the same intake it is noted:

> "Staff notes low iron intake and encourages Mary to take her prenatal vitamins. Mary states, 'Ya, I know I should, but they make me sick.' Mary goes over and picks up cat. Discussion turns to cats." (Field notes, client intake, 23 November 1996)

Mary's action effectively prevented any further discussion about the need for vitamins, or any further encouragement by staff to continue to take the vitamins that she had obviously already decided not to take.

As demonstrated above, clients showed acute awareness of their "problems", and showed discomfort and effective diversion tactics when staff tried to redirect the interaction to discussion of these "problem" areas. Intake observations are peppered with comments such as: "States 'I know I should eat better.' (seems defensive)" (Field note, Client Intake, March 2, 1997); "seems anxious to tell staff 'good things'." (Field notes, Client Intake, 2 February 1997).

Staff were observed to use explanations to smooth over obvious client discomfort with some questions from the form. Staff explained the rationale for the questions at points in the intake when both staff and client seemed uncomfortable. For example:

> "Tina is asked re: caffeine intake. No response from Tina. Uncomfortable pause. Counselor begins to 'teach' about the effects of caffeine on the fetus. Tina says 'I don't drink coffee'."(Field Notes, Client Intake, 19 February, 1997)

The information the staff provided in this instance also served to demonstrate the ability of the client to "manage" how she was objectified on the form.

> "When asked re: pop Tina says she drinks "a liter of pop a day, usually coke." Later in this intake, however, a 24 hour food recall is done. The only beverages recorded are milk in adequate amounts, and water. (Field Notes, Client Intake, 19 February, 1997)

Tina had learned through the intake interaction that the staff considered the intake of caffeine, whether through coke or coffee, to be "bad". By the end of the intake, when the food recall was done, Tina knew not to relate her intake of coke to the staff. She had learned that water and milk were the "right" choices. This demonstrates Tina's acute awareness that the information about her "coke intake" would be recorded as a "problem". Tina was trying very hard to do impression management, to give the "right" answers so she would be objectified as "O.K." in the documentation of the organization. Observations of client intakes

clearly showed that clients try to give "the right answer", the answer that will not be taken to be a "problem".

Clients were able to reflect on not wanting to provide information they knew would identify them to be "bad" or "having .problems". Mona commented,

> "some of the questions were, well, they were a little too personal...Personally I don't think they would have admitted saying, oh ya, I drink so many beers a day."(Client Interview # 2, May 27, 1997)

Mona was careful on her intake not to indicate that alcohol could be a "problem". This was her second time as a Pregnancy Outreach Program client and Mona was well "educated" about fetal alcohol effects.

The process of completing the intake form, or creating the "documentary reality", takes the interaction from the realm of the local and particular and changes it into "abstracted" forms that can then fit into organizational practices of ruling. (Smith, 1987, p. 3) The abstracted version, says Smith, cannot reflect the local and particular knowledge of an interaction. This process of creating the "documentary reality" (intake forms) in the Pregnancy Outreach Program was experienced by clients to be a foreign and threatening process. Not only did clients feel defensive, they also related that the "documentary version" did not accurately reflect their "risks".

When asked how they experienced the intake process, and whether they felt their chart reflected their concerns in pregnancy, clients commented that not only did they feel "defensive", or "judged", they also felt the information that was documented had been misinterpreted. On Sally's chart, for example, risk factors identified were: Rate of weight gain, Inadequate nutrition, Isolation, Unstable relationship, Financial problems, and Inadequate housing. In discussing her "identified risks" Sally commented,

> "...well, I kinda felt like she was looking for something. She kept asking me things, like about what grade I finished, and I thought, you know, it was a lot...especially about my partner, and...I tried to reassure her that everything was fine...I guess I got defensive."

When asked to reflect on whether the intake identified her own concerns in pregnancy, Sally replied,

> "Not really, because, well what she thought, well ...I was kinda offended, because she put down unstable relationship, yet I had my own resources. Cause I did have my own friends, and I did go to a counselor, and I didn't feel anything like

> that. You know, I was looking for a place to stay, and well, what it said, well, I didn't know she thought that" (Client Interview #1, March 7, 1997).

Sally felt her responses had been taken out of context and used to write down a version of her life that was not consistent with her experience.

Lorraine's chart identified risk factors to be: pre pregnancy weight, inadequate nutrition, cigarette smoking, isolation, financial problems, and inadequate housing. On being interviewed she commented,

> "She was reading into what I said and assuming things, like looking for problems, like for instance financially. I thought that we were doing O.K. because I know how to budget, I know what to eat and what foods to buy, and when she said that was a problem, well..."

In discussing that smoking was identified as a risk factor Lorraine commented:

> "With the smoking part, I did smoke and had just quit. I knew it was bad but, well, that part did help me because it made me realize that, O.K., I am pregnant, and I do have to change and that. It's for the sake of the baby rather than me. Her questions about how much I smoked, and whether I smoked now, and about well, I don't know, I just wasn't too sure about how much I wanted to share. But I knew that, ya, O.K., I did quit..."(Client Interview #3, May 27, 1997)

Though Lorraine had stopped smoking, it was still identified on her chart as a "risk". Despite her comment during the interview that she appreciated the information about the effects of smoking, the fact that it was identified on her form to be a "risk" to her baby seemed to offend her. In discussing her chart, Lorraine could reflect on her circumstance and the risk assessment, and see how the counselor got to the "risks". She was still, however, obviously very uneasy about the way in which the intake assessment and chart seemed to be portraying her.

Mona's identified risk factors included: pre-pregnancy weight, rate of weight gain, inadequate nutrition, cigarette smoking, alcohol use, other drug use, single parenthood, isolation, and financial problems. Mona had been a Pregnancy Outreach Program client during a previous pregnancy, and was very aware that alcohol was a health risk to her fetus. Although Mona denied "alcohol use" during this second intake, it was still considered to be a "risk factor" because of a high "TACE" score. The TACE assessment, as discussed earlier, is a series of five questions about alcohol use where "points" are added for each indication that alcohol use is problematic. Though she stated she did not drink

alcohol during this second pregnancy, alcohol was still considered a risk because of her tolerance. In discussing her identified risk factors Mona commented,

> "Well, it was my second (pregnancy) so I was really different this time and everybody asked me about it, how it was. I did listen and I did make a decision already to quit smoking, but I still had, well, I knew I was still smoking, so it did make me feel guilty about it. But I was appreciative that she did ask, and was concerned, and did tell me to cut back on smoking during pregnancy. I felt O.K. about that, and with the alcohol, she did ask me if I was drinking, and I said 'no'. It wasn't really a problem. It was kinda good because she kept referring everything back to the health of the baby. I never drank this time, though, so it wasn't really a risk." (Client Interview #2, May 27, 1997)

Mona was not aware that her TACE score on the intake arbitrarily identified that alcohol remained a risk factor, and that in her "documentary reality" of this second pregnancy, alcohol was still considered to be a "problem".

All three of the clients interviewed who had more than five risk factors indicated that they did not feel the "Individual Prenatal Risk Identification" accurately reflected their circumstance or concerns. The risk factors identified for the fourth interviewee, Terry, were "pre-pregnancy weight, rate of weight gain, inadequate nutrition, and isolation". Though Terry commented that she was uncomfortable with being weighed, she indicated that otherwise she was comfortable with the intake and appreciative of the information provided through the program. She commented,

> "...it was done discreetly so it was only the counselor and myself that knew about weight being a concern...I really appreciated the information on nutrition and it was great to get together with the other women to talk about it so I knew I wasn't the only one...The nutritionist gave me some really good ideas on eating right during my pregnancy..."(Client Interview #4, May 28, 1997).

For Terry, who did not feel "defensive" during the intake process, the Individual Prenatal Risk Identification was considered to be an accurate assessment of her "risks", and was valued as a good "guide" to improve her health.

This again, however, begs consideration of who is being best served by the intake assessment. Of the clients interviewed, it was the client whose assessment identified fewest risk factors that experienced the intake assessment to be a useful tool. Those interviewed whose intake constructed them as having

many risk factors stated that they experienced the intake as threatening, and commented that it did not reflect their risks or concerns in pregnancy. While the needs of those with fewest identified risks seem well served by the intake assessment, those with apparent greater need seem alienated and offended by it. Use of an intake process that alienates clients with apparently greater "risk" would seem to contradict the program objective of targeting service to those clients **with** greatest risk.

I would further argue that the intake process formalizes the social disadvantage of clients and thus imposes an awareness of class difference between the worker and client. The text mediated process of classifying the client as "high risk" is a process of determining what is and is not "good' about their lifestyle. As discussed earlier, this process is experienced by the client as being judged. The ruling relations of the intake assessment process arbitrarily construct the client as "needy" and thus perpetuate relations of dominance/subordination between staff and clients. Clients experience discomfort when they feel they are being judged, and subjected to having class relations of social disadvantage imposed.

Organization of these class relations is further established through informal instruction on how staff are expected to dress, behave, and speak. A lay counselor commented, "Oh yes, we were taught how to dress, what to say, even how to act to set ourselves apart...it was a way of being safe I guess" (Observational notes, July 9, 1998). Class relations, then, are established in program relationships through the text mediated process of identifying social disadvantage, and reinforced through informal instruction of staff on how to set themselves apart. The intake process not only organizes interaction with the client, then, it establishes class relations.

In regard to documentary administrative practices, Smith (1987) identifies that "ruling relations" are accomplished by documentary processes through which the local experience is transformed into an abstract "manageable" form. In this way the "local and particular actualities" of people's lives are changed into "abstracted and generalized forms" which are then subject to extralocal control. The new "documentary version" of a client's life (risks) is created to serve the organization's administrative purposes. Its use is to manage the program and to influence the women. It is interesting, therefore, that clients were able to express how staff focus on "the form" gave them (the client) a sense of losing control.

For example:

> "I wasn't too sure what kind of information she wanted. She seemed to be very focused on getting information, like my age and stuff. She even wanted my care card number, and I wasn't too sure about that, so I didn't give her that, I just said I didn't have my care card with me...when she handed me the gestation wheel I felt like I had more control. She let me look at it and play with it for a while. Then I felt more comfortable, I think, I felt like I had more control over what was going on."(Client Interview #3, May 27, 1997)

Not feeling in control of the intake interaction was experienced by this client to be very intimidating. The clients interviewed seemed very aware that information they gave was then in the control of the organization.

Another example would be:

> "At first I was really uncomfortable, because I didn't know what was going on...I felt uncomfortable about information about partners, finances, and well, which I felt was too much to give...cause too much information was being written about me."(Client Interview #1, March 7, 1997)

Feeling that she had no control over how the information she gave would be interpreted or used created enough mistrust in the interaction that the client deliberately censored her responses. She was acutely aware that a documentary version of her was being created, and she wanted some control over how this version was constructed.

In reviewing observations of client intakes, a pattern emerges of easy interaction being interrupted by hesitant interaction or defensive behaviors as the interaction is re-directed by staff to filling out the form. This is particularly noticeable when "problems" are identified. As the objective version of the client is constructed, those clients interviewed that had many risk factors reflected that they experienced a feeling of losing control. Though clients were observed to participate freely in the interaction when they were sharing their own "stories", they were observed to be hesitant and defensive during the objectification and documentation process of the intake. When their "problems" were identified, or staff directed the interaction toward discussing these "problems" (risks), clients showed their discomfort in a variety of ways, and also showed skill at re-directing the interaction to "safe" topics, such as children or pets. Though the Individual Risk Identification Tool was observed to become the central organizing feature of

the intake process, this process of objectification was observed to interfere with smooth and non-threatening interaction between the client and staff.

**Objectification Experienced as Threatening**

Smith (1987) identifies that the process of objectifying a client through documentation serves organizational purposes. While I acknowledge that the objectification of clients on the intake form serves very valuable organizational and funding purposes, I argue that the process of objectification creates anxiety in the clients whom the program particularly seeks to provide services to. I observe that the client experiences this "objectification" process as threatening, and argue that this is contrary to the Pregnancy Outreach Program objective of making the service accessible to the targeted group of "high risk" prenatal clients.

Client discomfort during the intake was particularly noticeable when information was sought about specific risk factors that were identified to be "problems" for the client. For example, when Kali is asked about her smoking she states:

> 'I know I shouldn't smoke. I have cut down but I just can't seem to quit.' (Field notes, client intake, October 18, 1996)

A notation in the field notes states

> 'She (Kali) appears uncomfortable, shrugs as she talks...'(Field notes, client intake, October 18, 1996)

Kali, and indeed all clients, were observed to become very uncomfortable during the intake process when their "problems" were identified, objectified and "written down".

As discussed above, clients were often observed to demonstrate this discomfort at having their "problems" written down by using children or pets as distractions. In one interview it was observed that Lisa's son is pulling on her and anxious to leave throughout much of the intake. Only twice during the intake is it noted, however, that Lisa responds to her son's plea for attention. The first time:

> "Lisa states 'I just drink socially' (TACE score of 2 is recorded by the staff)...(Lisa) looks uncomfortable then turns her attention to her son and says 'I'll get you ice cream if you're good.' Her son sits quietly for brief period then again begins wiggling off her lap and pulling at her. He is ignored as the intake continues..."

The second time Lisa turns her attention to her restless son it is noted,

> "Questions on smoking are asked. Lisa does not respond initially. Instead she turns her attention to her son's crayon drawing. When the counselor repeats the question Lisa says, after some hesitation, 'Well, yes, I do smoke, but I cut down to just a few cigarettes a day. That's better than with my last pregnancy'. Staff writes down smoking risk "(Field notes, client intake, March 2, 1997).

Clients attempted distracting, changing topic, or regaining some control over the interaction when "risks" were to be identified on the "form".

Client discomfort at having problems identified and recorded was a consistent occurrence observed through all intakes. In another intake it was observed that a client

> "When asked re: smoking gets fidgety. Plays with daughter's hair...After some hesitations states, 'I tried to cut down...but it's hard, you know, especially if I don't know if I'll be working" (Field notes, client intake, June 14, 1997)

I read these client responses to questions as indicative that the intake process is experienced by clients to be an intimidating and threatening experience. When interviewed about their experience of the intake process clients were able to reflect back and articulate that they felt "defensive" and "judged" by the process. Mona commented,

> "On some of the questions it felt like I was being tested on how good of a person I was "(Client Interview # 2, May 27, 1997)

Lorraine's reflection was,

> "...I was thinking how it kinda felt like a test, you know. I kept looking at her and trying to read how I was doing. I was worried that I wasn't, you know, good enough to be a parent or something. When she smiled and nodded, and then relaxed a bit near the end I knew I was doing O.K." (Client Interview #3, May 27, 1997)

What was expressed clearly by clients was that the intake assessment was a foreign, threatening experience.

It is interesting to note that each client interviewed made a point of clarifying that it was the "writing down" of information, and not the "person" that made them feel uncomfortable. When Sally was interviewed she stated,

> "Well, ya, I was comfortable with her, it was O.K., but I kinda felt like, What are you writing down? It seemed a little bit mysterious to me, but she did reassure me, so I kinda backed down. She was just doing this for me, and the pregnancy, and she did show me that I was doing good things, you know, to improve on my

> nutrition. So she did tell me about the good things, but I kinda was a little bit apprehensive, you know, cause I wasn't too sure what was being written down." (Client Interview #1, March 7, 1997)

Client discomfort and mistrust over having their "personal information" documented was made very clear, yet the clients were careful to state that it was the process, the writing down of their personal information that was threatening, and not the staff member themselves.

It was also observed that staff displayed similar periods of discomfort during the intake process. All staff, at some point in the intake, were observed to state that the "form" was "necessary". Sometimes this comment would come as an introduction/explanation of why the intake was being done. For example:

> "The counselor then puts "the form" on the table and explains that this "intake" must be done to gather information so that the program 'gets its funding'. There is some awkwardness as the counselor tries to get "the form" filled out." (Field notes, Client Intake, October 18, 1996)

On another intake it is noted:

> "Introduction of the form (by staff) as 'necessary'. (Field notes, Client Intake, 19 February 1997).

It was almost as if staff recognized that it was an uncomfortable process for the clients and needed to justify their "work".

Sometimes staff comments about the "necessity" of the form seemed to be used like an apology as client "stories" were interrupted to re-focus on the form. For example:

> "The counselor explains that there are many questions about alcohol and smoking use because "the government" is trying to find out more about the effects of alcohol use on the baby, not only use by the mother, but by others in the family. Mary then appears to again concentrate on giving responses to questions on the form." (Field notes, client intake, 23 November 1996). "...

The clients who were interviewed had been in the program for some time, and were familiar with its organization and work processes. Only those who seemed very comfortable with the staff offered to be interviewed. Though these clients were comfortable enough to express their fear and uncertainty about the intake assessment, other potential clients do not initially have this confidence. One counselor commented,

> "It was too many forms. It scared the heck out of them, I could tell by the look on their faces, so I just said fine, we'll do a food recall and left it at that. We just sent in the forms with any information we could get."(Field notes, office discussion, 7 April 1998)

This counselor was aware that completing the Risk Assessment was experienced as threatening by some clients, and did not, therefore, complete the Risk Assessment. What about where the worker is unaware of the client discomfort?

Through client interviews it became apparent that writing down information on the form was creating anxiety. This anxiety was more acutely felt by those women entering the program who were identified to have greater numbers of risk factors. Since, as indicated previously, one of the objectives of the Pregnancy Outreach Program is to make services more accessible to these "high risk" women, it is particularly important to consider how completing the intake form creates anxiety. Such anxiety can stand as a barrier to interaction and therefore to the "accessibility" of the program to "high risk" prenatal clients.

One counselor told of an intake she did where:

> "everything was going really well. I had discussed the program, the woman was interested, and was sharing a great deal of personal information."

As the counselor relates, however,

> "when I pulled out the form, that client never said another thing."(Field notes, office discussion, September 5, 1997)

When the client became aware that information about her was to be written down she refused any further contact with program employees other that "polite" telephone "chats" in which she shared no further "personal information."

A program coordinator commented,

> "I've never, never had anybody (refuse to complete the form), well, except for once. But usually, once they know that it is under their control, they're quite happy to tell you..." (Within Our Reach Audio Tape, Module 1)

The "one" occasion where a client refuses further contact with the program occurs when clients are uncomfortable with the intake process. This results in women who are least comfortable with the scientific/medical approach, and therefore least likely to access other service, turning away from the only service they will likely try to access.

As identified previously, the number of risk factors identified for each client interviewed seemed to be related to their level of comfort with the intake "form". Those with more identified risk factors tended to be more intimidated by the intake assessment. Clients interviewed who reflected that they experienced anxiety during the intake had significantly higher numbers of "risks" identified on their Individual Risk Identification than a fourth client interviewed. Terry, the fourth client interviewed stated,

> "Oh no, I wasn't uncomfortable at all. Forms are just part of anything now. The questions didn't bother me ... well, the only thing I was a bit uncomfortable with was being weighed. I always had problems with that... but I didn't mind the questions at all, cause it helped me... I learned how to eat a **lot** better." (Client Interview #4, May 28, 1997)

This reinforces the importance of taking a serious look at the practice of standard risk assessment intakes. Those with more apparent risk, and thus presumably more need for the service, identified the intake assessment as threatening. The client with least apparent risk (no substance abuse or psychosocial or economic factors) accepted the intake assessment as a "norm". Despite apparently not requiring the service nearly as much, then, the client who is identified as least in need of services is less anxious about the risk assessment, and therefore more likely to access and use the service.

Clients were observed to hesitate and appear uncomfortable during the intake interaction when staff focus returned to completing the form. In reflecting upon their experience of the intake assessment the clients interviewed who apparently were at greatest risk for a healthy birth outcome stated that they felt defensive and anxious, and that they did not feel "in control". Social relations of the interview structured by the objectification process that occurs throughout the intake are experienced, then, as threatening, particularly by the very clients the program seeks to serve. In fact, these relations of ruling are actually experienced by some clients who are targeted for service to be so uncomfortable, they avoid them.

### Objectification as a Barrier to Building Relationships

Throughout the intake process only selected information about a client is gleaned from the client story. Information that is rich in clarifying client concerns and circumstance is amputated from the epidemiologically meaningful data. This

objective account becomes the "documentary reality" that used to organize the "work" done with the client.

I argue that where work is organized solely by this objective account, vital situated information about the client is missed. The client is known only for their objective risks, and the experiential knowledge and personal strengths of the client are overlooked. Where work with the client is based on an objective organizational account, that work cannot be client centered. I argue further, that building a meaningful relationship with a client is impossible where the interaction is based only on the objective account, and the situated contextual reality of the client is not acknowledged.

The Individual Prenatal Risk Assessment is the objective organizational account that is created by the intake process of the Pregnancy Outreach Program. This account redefines the client in terms of risk to the biologic health of her fetus. As discussed in the conceptual framework, a woman experiences her pregnancy as a personal experience. She does not relate to her pregnancy in terms of "epidemiologic risk". It was identified earlier that clients interviewed experienced this scientific based objectification of them during their intake as threatening. I argue that women, particularly women living in difficult circumstance, reject interaction that is based solely on this objective scientific and technological construction of them, and it is vital, therefore, to consider an alternate approach to providing accountability if the service is to be "user friendly", or acceptable to all clients.

An incident related by a client who had moved from another area provides insight into how focusing on the form as opposed to the situated interaction effectively prevented a meaningful relationship. The client stated she had sought service at a Pregnancy Outreach Program but "would never go back there again". A counselor at the distant program apparently informed the client she was gaining too much weight and shouldn't be taking calcium supplements.

> "She didn't even bother to ask me why I did things. She knew nothing about me, and here she was telling me what was right or wrong. At least I knew not to go on a diet, and I knew I needed calcium because I hate milk and I had leg cramps...there was no way I was going back after that...she made me feel like I was wrong."(Field notes, drop-in, September 5, 1997)

The counselor, by asking only for specific nutrition information as required by the intake assessment, had failed to relate to the client as a woman with prior

experience. In relating to the woman only as constructed by the risk assessment she missed an opportunity to obtain vital information about the client. The woman's own efforts to gain knowledge and adapt to her changing nutritional needs were not acknowledged.

Relying solely on the intake assessment construction of the client resulted in limited information being sought by the staff, miscommunication, and therefore a lack of trust. As a result, not only was poor information provided, but the client withdrew from a service that, according to her risk assessment, she needed. An assumption that the intake form gathers all the pertinent data, and can be used as the sole basis for an interaction can be dangerously misleading, as is evidenced here.

Feminist theory points out that experiential knowledge is valuable but unrecognized (Bunting & Campbell, 1991). Where staff value and use their experiential knowledge gained through the "client story" in their interaction, they have a more rounded picture, and are able to relate how epidemiologically significant risks fit within the overall circumstance of the woman. It is in understanding the woman's personal experience of her pregnancy that staff can understand the significance of the pregnancy to the woman, and build and maintain a relationship with her.

> "...when I talk to them I get the basic information, but I get a lot more than that...there's the other concerns, stress, and a lot of times there might be domestic violence, or their boyfriend isn't there...or it could be the person is really sick and can't get a family care worker. So these things we don't put on the form...even though there could be a lot of time spent on it..." (Lay Counselor Interview #1, March 7, 1997)

Unfortunately, the concept of "risk" is very powerful, and once the difficult life circumstance of a woman are conceptualized in terms of risk, it becomes easy to relate to the woman in terms of her "risks". Though the woman may, for instance, consider her problem to be morning sickness, this is translated into risk terms of "nutrition problem". The "problem", then, is seen as nutrition, and considering such contextual things as nausea, discomfort, difficulties feeding the family in the morning, or inability to work all become invisible. The work becomes focused only on improving nutrition, and not in relating to the contextual difficulties the woman experiences. The focus turns to the constructed "risk" as the reality, and does not consider the woman's contextual reality.

Front line staff interviewed were able to reflect on the limitations imposed by the intake assessment, and describe how they worked through these difficulties. One counselor stated,

> "that form, I look at it initially to get an idea of the person and their background, and that's usually the last time I look at it other than to fill the specific parts that they (head office in Victoria) need to finish the file off. So, I review my charting notes more than anything else. So, no, I don't feel that reflects at all what I do. It's more statistical information than personal stuff, I think." (Lay Counselor Interview #2, May 7, 1997)

Both counselors interviewed commented that though most of their charted work was directed by problems identified on the Individual Prenatal Risk Identification, a great deal of work is done around "personal issues".

> "Actually, that happens a lot (doing work around client issues). Somehow, though, I still manage, because I've got in my mind what I want to discuss...so, we work with her problem and her situation...they feel better, and then they are able to listen to what I have to say about nutrition and stuff." (Lay Counselor Interview #2, May 7, 1997)

This counselor was trying to carry out the formal work of the program, address the risk issues that had been identified on the intake form, but found she was frequently counseling on other issues. She found clients needed to deal with these "other issues" before they could focus on their "risks" as constructed by the intake. Though able to reflect that in order to maintain a relationship with the client she needed to consider the client's contextual reality, this counselor was acutely aware that her work "should be" organized around the risks identified by the intake assessment.

Not only do counselors state that they spend a great deal of time on client issues as opposed to identified client "risks", they also indicate that reporting or recording these "other issues" is not done.

> "If they have personal issues, I'll mark that down to discuss, although I will not chart it. Just because (at this point lay counselor hesitates and seems to choose words carefully) um, I, I'm trying to protect myself. So, I do not chart these things..."(Lay Counselor Interview #2, May 7, 1997)
>
> "If there is a situation that really seems to be bothering them we really discuss it as much as I can to help them...sometimes you can tell they're just not open to listening to anything else, this is the priority and that's all...so a lot of my work is

> on problems the client comes to me with, stuff that is never charted on...I find I do a lot more work than is shown on those forms, like with talking and referrals and phone calls...it just shows up as, like, how many visits I made."(Lay Counselor Interview #1, March 7, 1997)

Though lay counselors may build effective relationships with clients and use a client centered approach to address client concerns, they are taught that this work is outside of their formal work as constructed by the risk assessment. Lay counselors are taught by professional staff how to separate out work as organized by the risk assessment, and chart only this work. They learn that using the risk assessment to organize their work and to chart is a valued skill, and a primary focus of the program. Both counselors interviewed stated they initially charted 'everything I did', and that they had to learn how to organize their work around the risk assessment. One counselor stated:

> "The Risk ID shapes what I chart now.... when I first started I charted way too much. The Coordinator told me to just chart pertinent stuff...now I just chart on their (client) risks." (Lay Counselor Interview #1, March 7, 1997)

The other lay counselor reflected:

> "Well, I've been told I overchart. I've been told I write down a lot of unnecessary information and I have to learn to smarten myself up on that. I usually charted everything that they stated to me that pertained to the pregnancy...if it had to do with whether they suspected they've got AIDS, or if lice is a problem with her family, or so and so has been drinking and bringing friends home, or someone is being abused and that...nowadays I don't chart that...I only chart just strictly objective measurements, how the food recall was, how many cigarettes they are smoking a day, that sort of stuff...It's totally safe, it's all statistical stuff...then my assessment is just a reflection of the factual statement and what my suggestions are to the statement. I chart if they contacted their doctor, guidance, or women's resources, or whatever, but I won't write in what regard they are going to contact them, for instance, I just leave that all out." (Lay Counselor Interview #2, May 7, 1997)

Though taught to organize their formal work around the risk assessment, lay counselors seemed very aware of the importance of building a relationship in order to work with the targeted clients. One counselor, concerned over changes in the program when a new nurse coordinator was hired commented:

> "I'm really worried that we're not reaching the really high risk clients like we used to...It's fine to try to work on their risks but...if we don't treat them as people first there won't be a program...clients just won't come..." (Field notes, staff discussion at provincial workshop, September 19, 1998)

Another counselor stated:

> "It's so important to have a professional you can work with...We really have to de-nurse the nurse before they can relate to our clients...it takes a while for them to really see..." (Field notes, staff discussion at provincial workshop, September 19, 1998)

Both counselors expressed concern that what they considered to be a "professional approach" focused solely on addressing risk factors identified by the intake assessment. They were concerned that work they knew to be vital to client participation was being missed, as work as organized by the risk assessment became a primary focus of their program. They seemed aware of the limitations of this approach in "reaching" their clients, and aware that in order to work with their targeted client group it was vital to use their situated knowledge to do work extra work outside of the formal work as organized by the intake assessment.

It is interesting that both lay counselors that I interviewed considered this focus on the formal work as organized by the risk assessment to be "professional". This fits with my discussion in the conceptual framework that identifies that professionals use a scientific approach to their work, and that this approach creates a barrier to service for marginalized clients.

I would argue that this apparent insensitivity and lack of understanding of the importance of relationship on the part of professionals who are "new" to the program is structured into the organization of their work in the Pregnancy Outreach Program. The risk assessment is a recognized scientific based approach to health care work that organizes standardized work practices toward addressing specific risks, in this case risks known to affect the health of infants. A professional is hired because of their capacity to bring knowledge and familiarity of this scientific approach to their work. The professional is valued in the program for the skill they can bring to the job in organizing work around the scientific approach set out by the risk assessment. They are expected to be skilled at doing and teaching the process of creating the objective "risk" account of the client.

Though some front line workers, when asked, expressed concern that a "professional approach" did not allow them to use their situated knowledge, they were not aware that it was the organization of their work around the intake assessment that effectively limited the scope of their work. Local practitioners who have situated knowledge of their client apparently experience frustration that the formal work, as organized by the intake assessment, does not take into consideration the client circumstance. As made apparent in their comments, the organization of the formal work is experienced by some lay counselors to be limiting to their practice. They are aware that in order for their practice to be successful they must use additional work skills. Without understanding the organizational complexities that construct the limitations of the formal approach to their work, they attach personal fault to "the professional". Organizational constructs are invisible, and it is only the discomfort of the client and the frustration of the worker that give evidence of organizational difficulties that limit effective local and situated practice.

In this chapter I have argued that the intake interaction of the Healthiest Baby Program is organized by the Individual Prenatal Risk Assessment Tool of the Pregnancy Outreach Program. This tool is a risk assessment approach common to most health care services. I have argued that this tool creates an objective organizational account of the client, and that clients to whom the service is primarily targeted experience this objectification as threatening. I point out the contradiction of using such an approach to target services to the very clients that experience the approach as threatening. I conclude with an argument that organizing work practice around the objective account that is created of the client effectively limits establishing an effective relationship with the client, and thus limits the participation of the very clients to whom the service is targeted. Though some lay counselors say they do work other than as organized by the form, they comment that they are often directed by professionals to pay more attention to “risks” as identified on the client's intake assessment.

## CHAPTER FIVE - Form-al Work versus Informal Work

In Chapter Five I argue that there are two distinct work processes carried out by staff in the Happiest Baby Program. In Chapter Four I argued that the Individual Prenatal Risk Identification Tool that organizes the intake process limits participation of clients being targeted for service. Despite this, I recognize that the Pregnancy Outreach Program has proven effective in providing service to their targeted population. This would seem to contradict the strong evidence I present that risk assessment is experienced by the "targeted population" to be a barrier to service.

Repeated comments by clients that it was "the questions" and "the form" that were experienced as threatening, and **not the staff** allowed me to see that relationships between staff and clients were indeed being formed despite the formal intake process. In this chapter I explore how these relationships are formed, and argue that there are, in fact, two very distinct work processes being carried out in the Pregnancy Outreach Program. The formal work process is visible because the documentary processes upon which it is based are a familiar and accepted way of organizing health care. However, I argue it is the less visible, informal work, that is done that is essential to the success of the Pregnancy Outreach Program. Because the goal of the program is to provide service to clients where others have failed, it is important to understand how the program reaches it's goal, how it is has been made successful.

In this chapter I discuss how the two counselors interviewed reflected that they modify the formal work process and use their situated knowledge to develop a relationship with the client. I argue that it is this informal work that is done that makes Pregnancy Outreach Program services acceptable to clients (user friendly), and thus successful. Program staff gain situated knowledge about clients through their interaction. They become familiar with the issues, concerns, problems and circumstance of each client. Though not identified in the documentation, these other issues or client concerns are "worked on". It is this informal work, I argue, that is essential to the success of the program.

I go on to argue that front line staff are faced with balancing these two work processes. On one hand they must organize their work around the objective account and charting processes of the program while on the other hand they must make the service acceptable to the target group. I argue that staff continually balance the formal work process as constructed by the intake

assessment with their everyday interaction with clients. Work that is organized by the intake assessment I refer to as the "form-al" work, as this is work directed at completing the required forms, or documentation of the program. Work that is directed at establishing and maintaining relationships in the program I refer to as the "informal" work.

I argue that because the form-al work of the program is more visible, familiar, accepted within health care organization, and directly related to funding, it tends to be focused on. The textualizing of client risk factors on the intake form legitimizes the form-al work done. This form based work, or form-al work, becomes acknowledged by most staff and some clients to be the "real work" of the program. Smith identifies that "contemporary industrialized societies are pervasively organized by textually mediated forms of ruling". (Smith, 1984, pg. 95) A textualized work process is acknowledged to be the "legitimate" organizational process, or work and is, of course, enforced as such. It is accepted practice within dominant western organizations that the social relations of people within an organization be "concerted" by the textual communication of the organization. I argue that this acceptance of textual mediation as the valid way to organize work sets out a belief that work that is done but not textualized is not legitimate work, and thus is not to be valued.

Though the success of the program is dependent on the informal work being done, this informal work becomes invisible. Client directed interaction, though considered valuable by clients, and identified by staff to be a large part of the work done in the program, is not recorded. Despite it being acknowledged that this "other" interaction comprises a large part of the working time, and that it makes the program more accessible and acceptable to the "target group", the fact that it is not recorded, or textualized, reinforces that it is, therefore, not "legitimate" work and thus not valued organizationally.

**Form-al Work**

As identified previously, the form-al work of the Pregnancy Outreach Program is organized around the "Individual Prenatal Risk Identification Tool". I argue that this form-al work constructs for the ministry an account of "high risk" pregnancy that allows epidemiological accounts to be made, and effects of service to be studied and evaluated. Workers' attention is directed to doing this form-al work because it holds them to a work process that is believed (on

scientific grounds) to be making "better babies". I argue that in focusing on this form-al work, the importance of the informal to this achievement is overlooked.

Initial comments by all levels of staff were very supportive of the value of the intake process and intake forms in their work,

> "The intake form is a good guide for teaching and reminding counselors to ask about some potential problems. The form gives a focus, an excuse to bring up potential problem areas... It's good for starting discussions" (Field notes, office discussion, January 14, 1997).

The strengths that a scientific/medical approach offers, such as organized methodologies for information gathering, and clear data outcomes were identified by staff to be very helpful.

There is also an underlying assumption that instruction about nutrition and lifestyle will make the difference to a healthy birth outcome"

> "It's useful to sorta keep in mind, like, why we're here, like why the program was set up. We do need guidelines, I do believe that, just to get the basics. Whether it be nutrition, lifestyle information..." (Lay Counselor Interview #1, March 7, 1997).

Counselors were able to reflect on how valuable the assessment process was for focusing their work on the "problems".

> "I review the intake, like, all the forms, and I pinpoint by the intake if they're a heavy smoker, say. Then, I make myself a note on the file that we will be discussing that...I will pull out all the information I can...I have it all pre-prepared, so when I do set up the appointment everything is ready. So, I do jot down a plan before I make the appointment. I know what I will be discussing with them and I will have the information for them if they are willing to read it. If they're not, then we discuss it together...I stress to them that what we're doing is teaching them good habits, and it's not just for them, but it is also for the future for their kids" (Lay Counselor Interview #2, May 7, 1997).

Another strength of the intake form was brought forward by a Program Coordinator,

> "We need to record just the pertinent information. Why gather all kinds of personal information, it won't make a difference to the clients or the funding?" (Field notes, office discussion, January 14, 1997)

The Provincial Coordinator for the Pregnancy Outreach Program emphasized the value of the intake form for funding purposes when she stated,

> "The data collection system we have will stand the Pregnancy Outreach Programs in good stead. Programs able to show results in terms of ongoing measurements will be much more sure of being funded. The Regional Operating Officers will be evaluated based on performance, their ability to demonstrate results of their work. If we give them clear results our funding will be secure" (Address at Pregnancy Outreach Conference, May 13, 1997).

Staff have been given a very clear message that funding of the program is directly tied to completion of the Individual Prenatal Risk Identification Tool, and the Client Data Sheet. A counselor commented,

> "I understand that we need to do the forms to get funding..." (Field notes, Advisory Meeting, 22 November 1996).

A program coordinator commented,

> "Forms are evidence that clients have risks and of the numbers of clients. Programs are funded according to the numbers of clients" (Field notes, Advisory Meeting, 22 November 1996).

A Contract Manager from the Ministry of Health responded,

> "Intakes give quantitative data for evaluation. Programs need good evaluative data to support their existence" (Field notes, Advisory Meeting, 22 November, 1996).

A client said,

> "Forms are just part of anything now" (Client Interview #4, May 28, 1997).

It is understood throughout the program, by some clients, all staff, and representatives of the funding Ministry, that funding is directly tied to completion of the required assessment and client data forms.

Staff had learned to see the value of the intake assessment and the "form-al" work in the program. A coordinator commented,

> "They're (intake forms) really good for organizing work around addressing client risk factors. They make sure we are all working in the same way and on the same problems. It gives some uniformity, some quality control to our work" (Observational Notes, office discussion, 14 January 1997).

For these reasons associated with structuring the content of worker-client interaction, the form filling was considered useful.

Throughout the research it was repeatedly identified that the "form-al" work was the real work of the program, and that focusing on risk factors as identified by the intake forms was a priority for staff. One counselor stated,

> "I've got in my mind what I want to discuss...we work with her problem and situation as much as I can...after that ...they are able to listen to what I have to say about nutrition and stuff...then I can work on my priorities (risks identified on the intake)" (Lay Counselor Interview, May 7, 1997).

Though the counselor indicates she does work with the client's problem and situation as "much as she can", she clearly feels an obligation to return the focus of the interaction back to "the risks" at every opportunity. Focus on "the risks" as constructed by the intake assessment is clearly a priority for this lay counselor.

On a tape that is used for training outreach workers for the Pregnancy Outreach Program a Coordinator is interviewed about her work. In discussing her own work practices she restates that the primary focus of the Pregnancy Outreach Program is the form-al work.

> "The first interview is always at least an hour, so we do go through a certain set of questions...Assessing risks, social, emotional, physical and economic will help you identify women who are not caring for themselves." (Within Our Reach Tape, Module 1)

The Coordinator being interviewed reinforces not only the concept that gathering data for the intake assessment is a primary focus of her work, but also that the client assessment is completed on the first interview. There is a clear assumption that the intake assessment has the power to identify the "real risks" of the women. By presenting the form-al work as a primary focus the Coordinator imparts to new outreach workers that work done around the intake assessment is essential and valuable. It amplifies the notion that work done around the intake assessment and "forms" should be a primary focus of their work.

In my interviews with staff it became apparent that they assumed that the intake assessment identifies what the clients "real needs" are. There is not only the assumption that "work" should focus on "risks", but that "the forms" are somehow better indicators of client need than any other source of information, including that gained through personal interaction with the client.

> "It's a real balance between being client centered and **doing exactly what they need.**"(Within Our Reach Tape, Module 1, bolding mine)

Client concerns gathered through interaction are not valued as a legitimate indicator of client need. Issues and concerns that the client may express are seen as "wants". It is only the "risks" identified by the intake assessment that are identified by staff to be client "needs".

It's as if the intake assessment form somehow legitimizes that the identified risk factors are the "real needs" of a client. Risk factors are used by staff to identify "priorities" for intervention. Therefore, there is an assumption that these should be made client priorities as well. A Coordinator tries to reinforce this concept to outreach workers who will be listening to the training tape:

> "Within that it's always important to know what are the client's priorities, but we always have our priorities...you have to say here's the statistics, here's your risk..."(Within Our Reach Tape, coordinator discussion, Module 1)

In this the coordinator shows that she not only does the work of the risk assessment, but has incorporated the concept of "risk" into her thinking as a valuable process that needs to take precedence in the work. She assumes that the epidemiological approach can identify "true risk".

Through outreach training and orientation to documentary practices of the Pregnancy Outreach Program, then, staff learn that their interaction with clients should focus on completing the intake assessment and addressing "risk factors" identified on that assessment. They learn that this formal work practice will address the "real needs" of the client. In the construction of risk assessment it seems there is an assumption that the priorities the women identify are somehow not important. In this way, the women's priorities are subsumed by priorities identified by the epidemiological construction. The way in which the woman experiences her world, and her difficulties, then, is devalued.

Lay counselors are taught that they should "support" women, and presumably empower them, but are also asked to work within the context of the constructed "risk" version of the woman. The latter insists on an epidemiologic approach to the work that ignores how the woman experiences her difficulties, and thus devalues her situated knowing. These are contradictory. In teaching the lay counselor to do risk assessment, they learn to value a way of working that actually undermines the work of supporting and empowering women.

The intake assessment, and work of completing the forms of the program, effectively focus staff priorities on the form-al work in the Pregnancy Outreach Program. Though clients identify that this form-al work is the most intimidating and least popular part of the program, and indeed creates a barrier for some in accessing the program, it is this form- al work that staff are taught to value. The specific objective of the Pregnancy Outreach Program to change participant

behavior to: improve nutrition, decrease smoking, decrease alcohol use and drug misuse, seek dental and physician care, and seek out and utilize community supports, become a priority of staff through the form-al work processes of the program. Staff are indoctrinated, through outreach training programs and documentary practices, to value the "form-al" work. This form-al work then supersedes any work that is done around issues the client may identify to be a priority for them. Specific training and supervision of lay counselors on the documentary practices and reporting of the program entrench this as an organizational priority. The documentary practices of the Pregnancy Outreach Program effectively focus staff work practices on epidemiologically identified risk factors and thus a "scientific approach" to their care.

Though staff identify that "client centered" interaction is necessary to build a relationship, this is not acknowledged to be "relevant" to client "risk factors", and is, therefore, not considered to be "real work". Clients consider the sharing of experiences and knowledge at Drop-In sessions to be valuable, but are also aware that these opportunities are not focused on by staff in the same way that their "risk factors" are. Client centered interaction and informal sharing of information is not recorded and is, therefore, outside of the textual-mediation of that organizes the intake process, and formal work of the Pregnancy Outreach Program.

**Informal Work**

Though staff identify that their "real work" is focused on addressing risk factors that are identified on the intake assessment, all were very clear that they did a considerable amount of "other work". This other work is done around client issues, concerns and priorities, and is not directed at completing the intake assessment or client data forms. Because this work is not focused on completing the forms, or formal documentation for the program, I refer to this work as the "informal" work of the program.

I argue that it is this informal work that is the substance of the program and the reason for its continued success in reaching the "target group". Through the informal work the front line workers build relationships, encourage clients to reflect on their circumstance, provide role modeling, and are a reliable source of emotional support through the trying experience of pregnancy and childbirth.

The women, in turn, respond to staff being able to relate to their circumstance, their personal experience of the pregnancy.

> "when she (the counselor) gave me good feedback, I felt O.K. about that." (Client Interview #1, 1997)
>
> "We always managed to get off track and talk about things of interest to us...I learned more... I just felt that I was much more wiser because of all the information (Client Interview #2, 1997)

Though not legitimized through documentary practices in the program, lay counselors in particular understood that real life issues important to the women themselves should also be the focus of some attention. Staff are able to reflect that though it is not recorded in any way, a significant proportion of their work time is spent on working with clients around issues that the client themselves bring forward as "priorities".

Staff acknowledge that clients often have concerns or issues to deal with that are unique to their circumstance and must be considered in their care. For example,

> "Well, the women, they don't have enough money to feed themselves, house themselves, or cloth themselves properly, or the baby. They're at risk for being in abusive relationships and being manipulated...they're afraid to go out on their own because there aren't the resources out there for them...there are many needs. It's only when you do a home visit that you can see them." (Within Our Reach Tape, Module 1)

The Coordinator being interviewed on the training tape is clearly identifying for outreach worker trainees that most clients who come into the program have life circumstances that are far reaching and very limiting. Through her work experience she knows that the client's issues will be far beyond the scope of the intake assessment, and that it is only through doing a home visit and building a relationship with the client that a worker can understand the context within which the risk factors must be addressed. This Coordinator tries to build awareness and sensitivity to the local and particular circumstance of the client, and alludes to the extensive "other work" that is done. She infers that investigative work beyond the scope of the documentary practices of the program must be done so that the circumstance of the client can be considered, and care provided can be appropriate given the client's circumstance.

Staff are aware that client concerns may have nothing to do with their "identified risk factors", but must be acknowledged and considered a priority. For example,

> "What we try to do is meet them where they're at, and if their nutrition is atrocious and all these things are going on, if their priority is finding a place to live, then that's where we start."(Coordinator Discussion, Within Our Reach Tape, Module 1)

This Coordinator is able to identify that the form-al work she wishes to do can not be done until she does informal work around an issue that is a client priority. Though this worker acknowledges the importance of addressing the client concern, there remains an underlying assumption that this is simply work that must be done in order to get to the "real work" or form-al work of addressing the nutritional risk.

Not only can the form-al work not be accomplished until the informal work is done, often it is the informal work that accomplishes the intent of the form-al work, but by other routes. For example, when concern was expressed by staff that a client was eating poorly, the client identified she had been unable to eat because of stress in her relationship. The counselor proceeded with an informal work process of listening to the client's concerns about her relationship, and helped her explore her feelings and consider her options (Field notes, March 1997). The problem solving done by the client not only helped in coping with her relationship, but ultimately achieved better nutrition, a form-al objective of the program.

As identified previously, the informal work that staff do is vital in understanding client circumstance, allowing the client to identify and discuss their own concerns, and in building relationships.

> "So, we work with her problem and her situation as much as I can. If I feel it's just out of my league, I will suggest referrals, or often, give phone numbers. I ask them if they want me to go with them. I'm willing to go with them. After that I usually find that they feel different. They feel better...I guess you have to kinda feel the situation...If there is a situation that really seems to be bothering them then we really discuss it as much as I can help them...(Lay Counselor Interview #2, May 7, 1997)

This counselor was clearly aware that not only could the client identify their own issues, but that understanding these issues and building a relationship with the

client was key to further interaction. Indeed, she also went on to identify that this informal work in building a relationship with the client was essential before any form-al work could be done. This counselor recognizes the experiential knowledge of the client and uses her experiential knowledge to relate to the client. Though aware she must return to working within the context of the risk assessment construction, and obviously valuing that as the "real work" of the program, she realizes that she must add another way of approaching her work if she is to be accepted by the client as helpful or understanding.

This awareness that interaction must be client centered, or client directed if they are to maintain a relationship with the client is demonstrated by the following comment:

> "You really have to make it comfortable for them so they really wanta come there...because they may not show up next time" (Coordinator discussion, Within Our Reach Tape, Module 1).
>
> "We want to be sure we listen to where they're coming from and what's the best way to help them, to just go in the right way...Building a relationship with mutual respect and trust are key ingredients."(Coordinator Discussion, Within Our Reach Tape, Module 1)

These workers identify for outreach worker trainees that relationship building is an expected part of their work practice. Though not part of the form-al work, the Coordinators acknowledge that client comfort is important, and that relationship building and addressing client concerns are key to client comfort.

Front line staff are acutely aware that the circumstance of their client, and the situated knowledge that they have of the client allows them to see informal work that must take precedence over the form-al work as identified by the intake documentation on the client. Staff acknowledge that there is a "bigger picture" beyond what is documented or charted.

> "It's so hard, sometimes there are so many (problems) you just have to take one thing at a time. Like if a woman has been really isolated...then sometimes it will be the children, sometimes it will be food, finances...you know, those are **all piled on top of the risks**...a lot of times when they're in need to vent they don't really know where to go or who to talk to, and sometimes we're the ones who see them so we're just there at the right time to say, 'I'll help you make the phone call', or 'you need papers'...or whatever...So that's the kind of thing more time is spent on rather than writing and charting" (Counselor Interview #1, March 7, 1997).

The counselor is obviously thinking of "risk" as separate from the lived experience of the woman, as something that her life is "piled on top of". In separating these two conceptualizations of the woman, she is able to use her situated knowledge of the client to do informal work around issues that the client identifies as distressing. She went on to reflect that it was this "other work" that was important to the moms.

Relationship building was part of the informal work that was identified by staff to be essential to completing their form-al work effectively.

> "It really depends on the client. Some are very, very open and they'll discuss anything. Others are a little more closed...eventually, you know, they let me know what's bothering them. But, it's a trust thing. Sometimes it takes longer with some than others...so we do have contact with every one of our girls, either by phone or in person, every week, because...well, often we have a difficult time reaching them"(Lay Counselor Interview #2, May 7, 1997).

As identified by this counselor, "reaching them" (the clients) can sometimes be the biggest challenge faced by the workers. In order to achieve their form-al work goals staff must learn to interact effectively with the target group. Establishing the interaction becomes part of the informal work practice of the program, in the same way that work related to client priorities did. This interaction is essential in making the service acceptable to the target group. In assuming this work will be done without recognition that it is valuable, and indeed essential, the work itself is undervalued, and, as discussed earlier, easily undermined. To do this work the counselor must have some experiential knowledge in order to relate to the client and her circumstance. She must also be skilled at understanding the client's experiential knowledge, and relating to her based on this. The skill and knowledge this requires becomes invisible in the same way that women's work generally, as identified by Smith (1987), becomes invisible.

Clients interviewed and drop-in discussion not only identified that the casual interaction with staff and other clients in the program was valued, they stated that it was because of this interaction and the food supplements that they continued to access the program after the initial intimidation of the intake assessment.

> "All those questions, I thought 'I'm never going back' but...the milk really helped out, and I knew ...(staff and other clients) really cared about me and the baby" (Client Interview #3, May 27, 1997)

Though clients displayed discomfort during the intake process, and stated they felt defensive, many positive comments were made about the Happiest Baby Program. Most of these related to the sharing of information and ideas at the group Drop-In sessions.

> "There was always topics to talk about and we always managed to get off track and talk about things of interest to us. We could just sit together as a group and discuss things, whether it was the topic or not."(Client Interview #2, May 27, 1997)

The comfort level of clients at Drop-In sessions was observed to be significantly greater as compared to during the intake process. One client put this observation succinctly into her own words when, on being asked if she planned to go to a Drop-In, she stated,

> "Yah, I'll be there. I like going cause I can ask questions. I always feel stupid when I ask doctors or nurses stuff, like I should know it. At Drop-In I'm not afraid to ask."(Field Notes, November 1, 1996)

This comfort, and willingness to access information at the Drop-In, is likely related to the very different approach that is used there. Whereas the intake process is very much based on assessment and documentation, which comes out of the dominant scientific/medical model, the Drop-In sessions of the Happiest Baby Program are based more on what appears to be a feminist approach. At the Drop-In sessions the experiential knowledge of the clients is a valued part of the interaction. Shared knowledge among the women comprised much of the Drop-In interaction observed.

An example of this is where the Drop-In topic was immunization. The Drop-In began with preparing the food and beverages. During this time there was a casual discussion of food likes and dislikes initiated by the women.

> "This changes to a discussion about changes in food likes during pregnancy. Discussion is very evenly directed among the group with feedback from all present, including staff. Comment, 'I didn't like milk while I was pregnant so didn't drink much. Now my teeth hurt and my hair falls out. Would Tums help that?' Another client responds, 'Oh, my hair did that too, after my first baby. It was really gross. I would brush my hair and it would all fall out.' Third client concurs, 'Mine did that too, it would be all over the sink.' Several nods of agreement. Fast discussion back and forth sharing postpartum experience of hair loss and milk intake. Staff member states that hair loss is due to changing hormones. 'But what

about my teeth, can't that be because of calcium?' Discussion of calcium needs and staff provides 'scientific' information on importance of increased calcium intake in pregnancy, which is attended to but discussion continues. 'I take calcium pills because I can't stand drinking milk.' 'Can you take too much? Again staff volunteers scientific information about importance of drinking lots of fluid to avoid 'kidney stones'. Client comments. 'Really? I never drank anything when I took my Tums and I never had any problem!' Discussion turns back to hair loss, Caroline points out how far back her hairline went and shows how it has grown back in. Client with the original concern about hair loss has been listening intently throughout and finally says, 'Ya, but it isn't very nice.'"(Field Notes, November 28, 1996)

Through sharing of experiences, clients learn that hair loss is a common postpartum experience, that it is related to hormone changes, that calcium needs increase in pregnancy, and that some women take calcium supplements and some take Tums to compensate for their inability to drink more milk. Valuable learning is taking place, yet the information is shared casually and all voices are listened to. Though the staff corrects misinformation, there is no single "expert". The environment is comfortable and interesting, and the shared experiences of others provides valuable information.

Immunization is then brought up by staff as "the topic". Though the scientific information on communicable diseases and immunizations is presented, client comment and personal experiences round out the discussion. For example,

"Colleen says "pertussis" is one disease immunized against and comments that her cousin's baby got pertussis and almost died, 'now he keeps getting sick.' Discussion, questions and comments accompany each piece of scientific information about immunization. Emotions included in the discussion, "I don't like bringing my baby for shots. I always cry and get mad at the nurse."(Field Notes, November 28, 1996)

There is a notation that after this Drop-In ends

"Schedules with names of vaccines handed out but not one client took this information with them." As clients and staff do the clean up, "Rhonda (a client) states ... 'that was good on immunization.' Julia (a client) comments that 'the discussion about hair loss was valuable.' (Field Notes, November 28, 1996)

Observation that subjective knowledge, or knowledge gained through experience as opposed to scientific/technical knowledge, is still primarily relied on by women (Bunting & Campbell, 1991, Martin, 1992, Smith, 1987) is certainly supported through the observation of the Drop-In sessions. Though scientific information provided by staff was politely attended to, it was the "rounding out" of this information by client participation in discussion that made the information meaningful. At the Drop-In women were able to learn the information through sharing knowledge based on personal experience. The information shared was rich with emotion, description, and situated knowledge. Women were observed to be significantly more comfortable in the Drop-In interaction as opposed to the more formal intake process. This increased comfort level in a situation where their participation was welcomed would support feminist thought that women rely much more on the "relationship" to a subject or other members of the group than to formal roles and knowledge (Bunting & Campbell, 1991, Smith, 1987).

The valuing of "relationship" is also made visible by this client comment at a Drop-In session:

> "I met my best friend at the Program. We were both having babies, we both had only our boyfriends, you know, our families live a long way away." (Field Notes, November 28, 1996)

To this client, not only was participating in drop-in discussion valuable, but through sharing common experiences at the drop-in she was able to create a supportive friendship. Gaining the friendship was valuable in decreasing her isolation and ultimately addressed what was identified by the assessment to be a formal risk. Here again, the feminist concept of valuing "relationship" was supported by the drop-in piece of the program, and as such was key to the success of the program in providing service to this client.

The importance of "relationship" with staff to client participation was also made clear during client interviews. Comments such as

> "But I was appreciative that she did ask, and was concerned..." (Client Interview #1, March 7, 1997)

show how important the relationship with staff is to the client.
The feeling that staff genuinely care for their well being and that of their infant is paramount to client comfort and participation in the Program.

Another "key" to participation at drop-in was identified by a client who commented that she watched who was going in before she would decide whether to attend.

> "I had to feel safe, you know. If there were too many workers, well, I knew I wouldn't be comfortable...It's like they have control then, it's not our drop-in anymore."(Field notes, 7 April, 1998)

For this client it was the cooperative participation and sharing with other clients that made the interaction feel comfortable and "safe". This client was acutely aware that she and other clients were not comfortable participating freely in the drop-in when there were "too many workers". She could distinguish between the informal interaction and forma-al interaction and was aware that, somehow, the women "lost control" in the more form-al interaction. It is through participating and sharing that the clients gain a sense of "control" over the drop-in interaction. Just how important this sense of control, of ownership, was to this client's comfort was made very clear.

Not only does the Drop-In support a more feminist approach to sharing knowledge and allow for participation through relationship building, it may, perhaps inadvertently, support a traditional First Nations approach to knowledge. An elder at a Drop-In commented,

> "We were taught we take in knowledge as we eat. Mealtime was when important information was passed on to the young. Kids were to listen then as they ate. It's good you feed the women when you teach them."(Field Notes, drop-in discussion, November 2, 1996)

Each drop-in begins with preparing a snack or meal and then sharing it as a topic is presented or discussed. As identified by the First Nations elder, the taking in of knowledge while sharing the snack supports a First Nations tradition of sharing food at the same time as knowledge is shared so that the knowledge, like the food, will be retained and help the person grow. A First Nations client stated,

> "It's nice to know I can come in with my kids and have a snack. I eat lunch and feed my kids before I come, but it's like a nice break." (Field notes, drop-in discussion, November 2, 1996)

Food supplements were identified as another factor to client participation.

> "I didn't know if it was worth the hassle (the intake) but I did take advantage of the milk coupons..." (Client Interview #1, March 7, 1997)

Several clients identified that the food supplements were appreciated and helped their nutritional status. One client also commented that the vitamin supplements "Were really expensive" and thus she greatly appreciated getting them through the Program. (Drop-In Discussion, November 2, 1996)

Some comments indicated that the blend of experiential sharing of knowledge and scientific based knowledge is appreciated.

> "I found the nutrition information the most valuable part. I enjoyed the Drop-In too, meeting the other women and all, but I think I learned the most from doing those food recalls and things."(Client Interview #4, May 28, 1997)

What this client is commenting on is that scientific information provided through working one-on-one with a counselor was a valued part of the program. Through individual counseling, information is provided that is specific to their needs. Usually the information that is provided in these sessions is based on what the intake assessment identifies to be risks. The counselor determines what information would be useful to the client, and provides appropriate information over a period of time as a relationship with the client is established.

Though clients indicated they were very uncomfortable and intimidated by the intake assessment, and that it did not reflect their concerns, they also were clear that there were aspects of the Happiest Baby Program that they found very valuable. Their comments indicate that the drop-in opportunities were highly valued. Not only was the opportunity to share experiences valued, having a safe and comfortable environment to ask questions, gain new information and build new relationships was verbalized. They were able to reflect that they appreciated the information provided by counselors, and felt good about the knowledge they had gained. The relationships, both with staff and other clients were valued, and indicated to be important to their participation in the Program. The food supplements, food at Drop-In and vitamin supplements were also key to client participation. Though the intake assessment was generally a negative experience for the clients with more risk factors, then, the one on one counseling, food and the drop-in opportunities were "redeeming factors" that allow the service to be acceptable to the target group and therefore successful.

The informal work in the program, then, acts as a bridge between the extralocal ruling relations (such as the risk assessment), and the lived experience of the women. Workers skilled at doing the informal work are successful in encouraging client participation, and thus in ensuring the program

goals are met. Though this work is invisible, and subsumed by the form-al work, it is important work. It is the means by which it is possible for the extra local organization of the work to be translated into a local experience in a way that is accepted by clients being targeted for service.

Doing this work requires experiential knowledge, and skill in identifying and acknowledging women's circumstance and relating to them based on this. Just as the informal work is invisible and subsumed by the form-al work, however, the knowledge and skill involved in successfully doing the informal work is also invisible. Feminists identify that women's work is made invisible in society (Bunting and Campbell, 1991, Smith, 1987). This invisibility relates to being marginalized. It is apparent that the informal work of the staff in the Pregnancy Outreach Program is marginalized in much the same way. It is expected work, yet invisible and unrecognized. Skill and experience in doing the work is necessary for the success of the program, and yet it is the form-al work that remains dominant and visible.

**The Balancing Act – Bridging Two Worlds**

The form-al work practices and informal work practices I identified in the Happiest Baby Program are carried out daily by front line workers. Though these two kinds of work practices are very different, and require a completely different approach, staff were observed to try to incorporate the two work practices into their care. As pointed out by one Coordinator, however,

> "It's a real balance ... it's always important to know, what are the client's priorities, like, we always have our priorities, but what we try to do is meet them where they're at."(Co-ordinator Interview, Within Our Reach, 1996).

This statement reflects the Coordinator's awareness of a dichotomous work relationship that most front line workers in the Pregnancy Outreach Program experience. Front line staff are continually balancing the two work practices, one they acknowledge to be "legitimate", and the other they know to be "essential" for client participation.

Form-al work practices such as completing the client assessment and data sheets, charting regularly on the identified risk factors, researching materials related to these risk factors, and counseling clients on their identified risk factors was observed to be a part of each front-line worker's practice. Informal work practices such as acknowledging client circumstance, working with

clients on their priorities and concerns, and being alert to factors that limit client comfort and participation, was also observed to be part of all front line workers' practice. These "pulls" between the two work processes are acutely felt by front line staff. Though necessary, and as some staff noted, time consuming, client centered interaction often does not directly relate to identified risk factors, and thus falls outside of the textual organization of the Pregnancy Outreach Program. Work done around the forms that are submitted to the Ministry of Health is valued as "the real work" by program staff. Staff try, therefore, to focus their work on practice related to documentation for the organization. Comments staff make indicate that they are always striving to, "get back on track" to do the "real work" of the program. For example, a Coordinator with a nutritionist background comments:

> "There was a client I had, she was having all kinds of problem. She developed AIDS, her partner had AIDS, her first child was HIV positive, she was in all this trauma and I'm sitting there trying to talk about broccoli. What we came up with was, how is she going to survive. Just talking about the immune system...(relates how nutrition is important to healthy immune system) that gave her an idea of why she needed to take care of herself...then that comes back to, well, here's my mandate, I'm an outreach worker who is a nutritionist."(Coordinator Discussion, Within Our Reach Tape, Module 1)

This Coordinator felt good that she was able to use her informal work practices of listening to client concerns and yet relate these back to her formal work practices, of providing nutrition information. The nutrition information she could provide not only applied to the client concerns about surviving with AIDS, it also related to a healthy pregnancy, the nutritionist's "mandate".

The balancing act of every front line employee in the Pregnancy Outreach Program, then, becomes one of understanding and acknowledging the circumstance and concerns of each client while trying to instill knowledge and behavior change to address the risk factors identified on their Individual Prenatal Risk Identification. One Coordinator put this dichotomous role of the outreach worker rather succinctly when she said,

> "You have to adjust and learn how they grew up, what they learned...and then try to introduce what we do here at the program."(Coordinator Discussion, Within Our Reach Tape, Module 1)

Though the form-al work of the Pregnancy Outreach Program is a process of risk assessment and providing information regarding these risks, I have identified that there is a great deal of informal work done in the program that revolves around building relationships, and considering client issues. It is this informal work that allows the targeted group of clients to feel comfortable accessing the service, allows them to feel their needs are addressed, and ultimately allows staff to proceed with their form-al work. It is this informal work that brings women to the program and is, therefore, responsible for the success of the program.

The use of experiential/personal sharing of knowledge mixed with scientific based knowledge has value in bridging the "two worlds" that clients are experiencing. One client commented,

> "Well, there's just one more thing I'd like to say. When I was in the program I met lots of people in other services, and this opened up a door for me. If I hadn't gone to the Happiest Baby Program I wouldn't have met the lady I'm working with now, or got a job. So, one really good thing is the contacts and the knowledge the program gave me." (Client interview #3, May 27, 1997)

Though initially introduced to the program through a formal assessment that was experienced as uncomfortable, this client's comfort and confidence in interacting in the program was increased through building a relationship with program staff, gaining information and thus self confidence about her own knowledge, and by gaining a sense of control and belonging through the more feminist approach at Drop-In sessions. This exposure to scientific based knowledge within the context of a feminist interaction increased the client's confidence and comfort in dealing with her experience of the "two worlds".

Though the informal approach was observed to be incorporated in staff work practice, there was clear valuing of the formal work as the legitimate work of the program, and that which must be primarily attended to. As discussed in Chapter Four, clients clearly identified that the form-al work process was threatening. In this Chapter I identified that the informal work is acknowledged by staff to be a large part of the work they do. I also identified that clients value this informal work, and state that the informal approach is the reason they use the service. Despite this, the primary focus of the program remains on the form-al work.

The Pregnancy Outreach Program Handbook identifies that the group of women targeted for service were not accessing the other medical services already established for prenatal care. The other services likely used the dominant medical approach. This research confirms that this approach, particularly where practices such as risk assessment are used, creates a barrier for women using the service. If services are to be targeted to a group of clients who find the informal approach acceptable, and resist the formal medical approach, it is important to consider the value of each approach, and what the limitations are. Where the form-al approach is experienced as a barrier to service by a group being targeted it does not seem reasonable for this to be accepted within the program as the "real work", and to be a primary focus. It is particularly troublesome that this form-al work process organizes the first interaction the client will have in the Pregnancy Outreach Program.

The value of the informal work to the success of the program is neither well understood nor acknowledged. While textual practices of the program reinforce that the form-al work should be focused on, I argue that the informal work is key to program success as measured by participation of the "target group". The significance of this informal approach in targeting service to marginalized groups needs to be acknowledged by program staff, administrators and the Ministry. It is only through recognition of the vital importance of this informal work that it will be valued throughout the organization, and thus be a priority in the approach to all front line practice.

## CHAPTER SIX - Epidemiology, Administrative Technologies and Community Development Collide

In the early chapters I stated my own puzzlement with inadequacies and contradictions in the way the intake process of the Happiest Baby Program seemed to structure the work. This prompted me to initiate this piece of organizational research. Through observation and interviews I was able to identify that clients experienced discomfort with the intake process, enough in some cases to create a barrier to joining or staying with the program. Despite this initial discomfort, many women who were targeted for service did access and use Happiest Baby Program Services. I identified that there was "invisible work" done in the Happiest Baby Program that countered the initial discomfort of the intake process, and made the service "user friendly".

The "balancing act" of front line staff between the visible and valued, and invisible and informal work practices, was discussed in the last chapter. In Chapter Six I pursue my investigation of why these two very different work processes exist within the Happiest Baby Program. I argue that both work processes are legitimized in official program materials. The Handbook for the Pregnancy Outreach Program describes two very different approaches that are to be used in establishing program sites, and in the front line practice of the program. I argue that the foundations of these two approaches stem from very different ideological approaches to the work of health care, and that use of these conflicting ideologies within a single program can be problematic for front line staff.

The Pregnancy Outreach Program is based on beliefs about how to build better babies. These beliefs are supported in the literature, but unfortunately, each has very different foundations. I argue that the formal work of the program is based on an epidemiological approach that builds on the medical model. This is a standardized approach to health care that is accepted practice in the Ministry of Health. The risk assessment is a programmed method of interaction that is enforced through the standardized administrative technologies. The administrative technologies support the epidemiological approach and are, in themselves, a standardized and accepted way of "doing business" in the Ministry of Health. The informal work, I go on to argue, is building on the community development research. This research supports a community driven approach to

health care, and argues that clients must be active participants in planning in order to ensure services are useful and acceptable.

I argue that there are inherent contradictions between the epidemiological/administrative technology approach to health care and the community development approach. These contradictions are carried into the front line work of the Happiest Baby Program through program requirements. While the formal work, as supported by the epidemiological/medical technology approach demands a focus on documentation, the informal work as supported by the community development approach demands a focus on relationship with the client. Even though both of these approaches were observed in carrying out the work of the Happiest Baby Program, conflict did arise where there was lack of understanding that both were legitimate work practices. My data gives some insight into the difficulty that is created for workers where the organizational complexities of incorporating two approaches in a single program are not well understood.

**Foundations in Epidemiology - a Population Health Approach**

Through documentary analysis I was able to identify that concern over cost effectiveness in health care and the use of epidemiology, a very specialized branch within the medical administrative model, underpin the rationale for establishing the Pregnancy Outreach Program.

> "The overall objective of the Pregnancy Outreach Program is to promote healthy lifestyle changes among women who may be **at risk** of having low birthweight babies or poor pregnancy outcomes. These **high-risk** babies have higher morbidity and mortality rates. Often their health care costs are greater..."(British Columbia Ministry of Health, April 1990, pg. 1-bolding mine)

Through targeting services to the at risk group, preventative funding is provided to avoid "greater health care costs" that are incurred by the low birthweight babies. The form-al work practices of the program consist of identifying the existence of specific factors for each client that put them "at risk" for having a low birth weight baby, and providing information and support to address and these risks, thereby ensuring a healthy birth outcome.

The study of epidemiology has its foundations in the medical model. It was noted that disease often affected whole populations, not just the individual, and that specific lifestyle factors could be identified that would influence whether

a whole population was susceptible or resistant to a disease. (ie. open sewers made whole populations in Europe more susceptible to "the plague") Such observations about the incidence of disease in whole populations prompted the development of community health, and the study of epidemiology. Through epidemiology the medical model of "treating disease" was expanded from treating the disease of an individual to assessing prevalence of disease states in whole populations, or the "community".

Epidemiology was developed to look at "the big picture" of disease states in whole populations. In epidemiological study, statistical data on the health/disease trends of large populations is used to identify where there are "significant **health risks**" to a given population.

> "Epidemiology seeks to identify those factors that increase the risk of disease."(Spradley, 1985, pg. 198)

Rather than "treating disease", as in traditional medicine, epidemiology seeks to "prevent disease".

The term "**risk**" is used in the field of epidemiology.

> "Epidemiology is concerned with identifying factors that are thought to be causally related to a disease outcome. Identifying associations is the first step toward inferring causality...Some individuals, because of unusual exposure to a given factor, carry additional **risk**. It is this additional **risk**...that epidemiology attempts to identify."(Spradley, 1985, pg. 198 -bolding is mine)

The term "risk" is used throughout the Pregnancy Outreach Program literature, and it is a fundamental part of the assessment process. In order for a woman to be eligible for the program she must be

> "identified as **at-risk** for having a low birth weight baby or other poor pregnancy outcome."(British Columbia, Ministry of Health, March 1993, pg. 31)

All of the data collection and reporting done in the Pregnancy Outreach Program is based on identified client "**risk factors**". As identified earlier, low birth weight was identified through epidemiologic study to be the primary identifiable cause of infant mortality (Martin and Armstrong, September 1995, pg. 1).

Causal factors of low birth weight identified through epidemiologic study and set out in Program materials are:

PHYSICAL

Previous pregnancy loss, Illness/condition with impact on pregnancy, Pre-pregnancy weight-body mass index, Rate of weigh gain, Inadequate nutrition,

Previous child with anomaly, Previous child requiring neonatal intensive care, Multiple pregnancy, Birth interval, Grand multipara-5 or more pregnancies, Established genetic risk, Age 17 and younger/36 and older.

SUBSTANCE ABUSE/MISUSE

Cigarette smoking, Alcohol use, Inappropriate use of over the counter and prescription drugs, Other drug use.

PSYCHOSOCIAL AND ECONOMIC FACTORS

Single parenthood, Delayed access to prenatal care, Refusal of/resistance to appropriate services, Isolation-ethnic, language and social, Limited learning ability/illiterate, Marital problems/unstable relationship/family violence, Mental health problems, Low self-esteem, Inability to cope/anxiety regarding pregnancy and baby, Unrealistic expectations, Unwanted pregnancies/denial of pregnancy, Financial problems, Inadequate housing.

These risk factors are the foundation for the intake assessment. Since it is this intake assessment that forms the basis of the form-al work of the program, and these **risk factors** were identified through epidemiologic study, it is clear that the form-al work of the program is based on epidemiology. Since it was previously identified that documentary practices, data collection and evaluation of the Pregnancy Outreach Program were designed to fit with Ministry of Health practices, and epidemiology is used for that data collection, it is clear that epidemiology is an accepted practice within the Ministry of Health. Form-al work practices of the Pregnancy Outreach Program are not only firmly imbedded in the administrative technologies of the Ministry of Health, then, concepts and practices from epidemiology and the medical model form the foundation of the documentation and organization of form-al work practices of the Program.

As discussed in the conceptual framework, a medical approach to care in pregnancy is problematic for women. The medical model that underpins health care services in North America has historically marginalized women and women's experience in health and health care (Martin, 1992; Smith, 1984a, and Oakley, 1976). If the medical model marginalizes women, and risk assessment, a process used in the medical approach is incorporated into a service that targets care to an even more marginalized population of "at risk" women, it is reasonable to expect that these women will experience anxiety and feelings of loss of control when being “worked on” in this way. Indeed, as identified in Chapter Four, clients did identify that the intake process was experienced as

intimidating. The form-al work of the Pregnancy Outreach Program, with it's practices founded in epidemiology and the medical model, is experienced by clients to be a barrier to accessing the service.

The medical approach is designed to address disease states and conceptualizes pregnancy as a biologic process (Martin, 1992; Smith, 1984a). Women conceptualize pregnancy as a normal process and a personal experience. There are inherent differences in these two ways of conceptualizing the pregnancy. Since the medical model and epidemiology are accepted practices by the Ministry of Health, most services for pregnant women are based on the concept of pregnancy as a biologic process. The use of epidemiology in the form-al practices of the Happiest Baby Program indicates that, though targeted to "high risk women" the form-al work process also conceptualizes the client's pregnancy as primarily a biologic process. The form-al work practices, therefore, are not grounded in an ideological stance that is compatible with the women's concept of their own pregnancy.

The form-al work of the Happiest Baby Program, as identified earlier, is a process of assessing which epidemiologically significant risk factors each client has that make her at risk for a low birth weight baby. The process of assessing risk factors is based on a purely epidemiologic/medical approach. The risk to the biologic health of the fetus is evaluated. The client's pregnancy is conceptualized solely as a biologic process which may be at risk for a disease state. The woman's concept of her pregnancy as normal personal experience is not included. In not considering the women's concept of her pregnancy during the intake assessment process, women's experience is not part of the assessment process. Since the intake assessment is the greater part of the documentation of the program, and the client's concept of her pregnancy and experience is not included in this documentary practice, the client's voice is effectively eliminated from the documentary practices of the Happiest Baby Program. This can serve to marginalize the clients and limit their participation in the form-al work practices of the program.

The women's discomfort with the intake process, where the epidemiologic approach is primarily used, is understandable given that they feel their own concept of their pregnancy is not recognized or accepted. Women's experience of being marginalized in the medical system, as discussed in Chapter 3, is being

reinforced through the Pregnancy Outreach Program's continued use of a medical model and epidemiologic practices in the form-al work of the program.

Where health programs are targeted to already marginalized groups, the continued use of practices that are known to marginalize that group is problematic. The use of the medical model and epidemiologic methodologies for assessment of women in pregnancy is a practice that needs to be reconsidered. It is vital to be aware how the form-al work practices of the Happiest Baby Program, and all Pregnancy Outreach Programs can create a barrier to providing service to the population that is being targeted.

**Practices in Administrative Technology**

The work practices of the Happiest Baby Program are primarily based on the "guidelines" established in the Pregnancy Outreach Program Handbook. Indeed, all Pregnancy Outreach Programs in British Columbia must abide by the guidelines within the Handbook in order to be funded as a Pregnancy Outreach Program through the Ministry of Health (now the Ministry for Children and Families). I argue that these guidelines and the documentation that is required for "evaluative purposes" comprise the administrative technologies of the Pregnancy Outreach Program. It is these that enforce the medical/scientific approach to the form-al work of the program. Tying the objective scientific based reporting on each client to program funding effectively enforces that the primary focus of work practice will be based on the scientific/epidemiologic approach.

Though provided through contracted local agencies, Pregnancy Outreach Program sites were, until recently, primarily funded through the Ministry of Health, monitored by contract managers from the Ministry of Health, and held accountable to the Ministry of Health for submitting detailed data on each client (Individual Risk Assessment and Client Data forms). Accountability to the Ministry of Health was built into the very detailed guidelines for the Pregnancy Outreach Program, as presented in the Pregnancy Outreach Program Handbook.

> "An overall evaluation of the Pregnancy Outreach Program was planned by the Provincial Advisory Committee when the first Guidelines for the Programs were being developed...The implementation questions (are) addressed in the evaluation process (through statistical analysis of the client evaluation forms and Program Status Reports)...The effectiveness of the Program is evaluated by

> assessing any changes in reported health behaviors of clients...information is being collected and recorded about the client at intake, at the last visit prior to the expected due date, and following the birth..."(British Columbia Ministry of Health, 1993 and British Columbia Ministry for Children and Families, 1997/98, pg. 81).

It is primarily Ministry of Health staff, who were familiar with Ministry administrative policy and procedure, that compiled the Handbook. Ministry of Health staff are instrumental in establishing Pregnancy Outreach Program sites, and are responsible, as contract managers, for monitoring these sites to ensure program goals, as outlined in the Handbook, are met.

The Pregnancy Outreach Program was developed by Ministry of Health staff and consultants to the Ministry of Health. Of the fifteen individuals acknowledged as contributors to revisions in the March 1993 Pregnancy Outreach Program Handbook, nine are Ministry of Health employees. Of the others consulted for the handbook, one is employed by a city health department, one is a private physician with expertise in Fetal Alcohol Syndrome, one is a lactation consultant, two work in alcohol and drug prevention, and one was administrator of a Friendship Center. All who were involved in the development of the Handbook, that continues to guide Pregnancy Outreach Program practices, work within, or are familiar with, the dominant medical model and administrative technologies that underpin health services in British Columbia.

The Pregnancy Outreach Program Handbook identifies that members who established the first Pregnancy Outreach Program pilot projects recognized that their programs were being established

> "in response to an evaluation of existing data. They understood and appreciated the validity and role of evaluation and took steps to incorporate it into their program. The group members and Sponsoring Agency also understood that the program would be under intense scrutiny from the outside and from mainstream health services. The group understood the necessity of evaluation in gathering any future support." (Ministry for Children and Families, 1997/1998, pg. 102)

These founding members made conscious effort to ensure that the evaluation measures of the Program fit with existing Ministry of Health data collection practices.

To ensure there was support for these programs there was considerable effort to include a process of data collection that could be translated into Ministry of Health terms of "good program outcomes".

> "With assistance from the Health Unit and the Ministry of Health, the Building Better Babies Program was able to implement appropriate data collection related to client intake. Though the evaluation process involved collecting data over a long time frame it was nevertheless undertaken. Program design and delivery were also examined."(Ministry for Children and Families, 1997/1998, pg. 102)

It is this evaluation process described in the Handbook that forms the basis for the form-al work of the Pregnancy Outreach Program. This process is also a prime example of the administrative technologies that Smith (1984) describes. It is through incorporating the administrative technologies of the Ministry of Health into the work and reporting of the Pregnancy Outreach Program that the program becomes part of the organizational structures of the Ministry of Health, and, therefore, is acceptable as a legitimate program. The intake assessment forms are not just the basis for the documentary practices of the program, and the foundation for guiding all of the form-al counseling practices, then, as discussed in the last chapter. More importantly, they are a source of data about the "target group", a means of program evaluation, and presumably a means of reviewing outcomes with respect to program funding. All of the form-al work practices of the Pregnancy Outreach Program, then, were developed with the objective of collecting client data and evaluative data that would ensure accountability to the Ministry of Health.

The work practices of the Pregnancy Outreach Program, then, clearly fall within the traditional administrative structures and framework of Ministry of Health programs. Practice within the Pregnancy Outreach Program is guided by Ministry of Health policy, practice, and accountability models. The form-al work practices in the Happiest Baby Program, and all Pregnancy Outreach Programs, were created to satisfy the administrative technology practices within the organization of the Ministry of Health. The administrative technologies enforce the use of an epidemiological approach to the form-al work of the Pregnancy Outreach Program.

The form-al work that I observed being done in the Happiest Baby Program met the Ministry of Health requirements that the program be epidemiologically sound, and fit with the administrative technology requirements for evaluation that are integral to the organization of the Ministry. Since it is acknowledged in the Handbook that the program would be "under intense scrutiny", and funding would depend on having "valid" evaluative data for

"gathering any future support" (Ministry for Children and Families, 1997/98, pg. 102), it is certainly understandable why a primary focus in the work practice of the program is directed toward completing the form-al work. Indeed, all involved in the program, clients, lay counselors, coordinators, sponsoring agencies, and contract managers were able to clearly articulate their understanding of the necessity of collecting data in order to ensure the continued financial support for the program. The form-al work done in the program, then, is directly linked to the very survival of the program services within the existing structure and climate of the Ministry.

The Ministry of Health is founded on the medical science and administrative technology models that were discussed in the Introduction and Conceptual Framework. As noted in these earlier discussions, the use of the medical model and dominant administrative technologies to provide services to women, particularly services around reproduction, has been extensively questioned (Martin, 1991, Smith, 1987). The Pregnancy Outreach Program, though designed to provide reproductive services for marginalized and socially disadvantaged women, has perpetuated the use of the dominant ideologies prevalent in North American health organizations. The marginalization that these women experience as a result of the use of the medical model and administrative technologies is perpetuated through the form-al work practices of the Pregnancy Outreach Program.

**Practices from Community Development**

In seeking the foundations for the informal work that is done in the Happiest Baby Program, that which is done but not accounted for in written form, I again turned to the Handbook. What in the literature or practice of the program encourages staff to act on the local and situated knowledge they have of their client? Front line staff did acknowledge and attempt to address difficulties their clients were having other than the "**identifiable risk factors**". One lay counselor stated,

> "There's lots of stuff I do that pertains to the pregnancy that is never written down... I only chart if the objective is strictly measurable but I won't write in what regard they are going to contact women's resources, for instance. I just leave that all out." (Lay counselor inter view #2, May 7, 1997)

What supports this client centered work that I observed being done, but which is never charted?

Pregnancy Outreach Program literature identifies that

> "The traditional approach to prenatal care with its focus on medical management doesn't address the psychological and social barriers to prenatal care. In addition, traditional prenatal care does not focus on the social and behavioral problems of high risk women, problems that impact on pregnancy."(Martin and Armstrong, September 1995, pg. 7)

The literature of the Pregnancy Outreach Program shows there was clear awareness of the limitations of the medical model in providing service to pregnant women. As stated in the Handbook, there were conscious efforts made to overcome the barriers to prenatal services that are inherent in the medical approach.

In order to make the Pregnancy Outreach Program accessible to women who were **at risk** for having a low birth weight baby, an "innovative approach" was proposed.

> "Traditionally, prenatal services have been provided by physicians, public health nurses and nutritionists. As many potential clients of the Pregnancy Outreach Program do not access these traditional providers, an alternative service was sought" (British Columbia Ministry of Health, March 1993, pg. 22).

This innovative approach that was used for program mobilization was community development (British Columbia Ministry of Health, 1997/1998, pg. 97).

The Pregnancy Outreach Program Handbook explains the innovative approach in a section on community development. This section describes a community development process that was used to establish the Building Better Babies Program in Nanaimo. Though it is acknowledged in the Handbook that

> "Each community is different, thus other resources and methods must remain a part of each unique process" (British Columbia Ministry for Children and Families, 1997/1998, pg. 102),

all Pregnancy Outreach Program sites are to be established using a similar community development approach. A community development approach, then, is considered to be a fundamental requirement of establishing Pregnancy Outreach Program services. The Handbook goes on to identify that it is through the community development process that service is to be made accessible to the

target group. The community development process is meant to overcome the barriers to service that are created by the medical approach.

There is debate in the literature, however, on what community development actually is. The Handbook describes one approach to community development, but one which Labonte would say is simply consultative. Labonte states that

> "Most health agencies work from a community-based rather than community development perspective, but subsume both types under the single moniker of community development, thus burying the importance of how, and by whom, health problems are named. They make invisible the power differences that characterize community group\institutional relations." (Labonte, 1993, pg. 32)

Labonte goes on to identify that community based programming is a process whereby health professionals and/or agencies define the health problem, develop strategies to remedy the problem, and then involve local community members and groups in solving the problem by transferring the major responsibility for an ongoing program solution to local community members and groups. (Labonte, 1993, pg. 33)

Labonte's understanding of community development is that it is a process whereby the community group itself identifies their issues and embarks on a process to resolve those issues. (1993, pg. 33) The fundamental difference, states Labonte, between community development and community based programming is in who names and legitimizes health concerns.

> "Allowing the individuals and groups to name their own health concerns or issues (which may be quite different from how health agencies or professionals view health problems) is one of the most important axioms of an empowering health promotion practice." (Labonte, 1993, pg. 32)

An example of community based programming appears in the Handbook.

> "the Building Better Babies group in Nanaimo found the data on perinatal mortality alarming and outlined clearly that in their community this was unacceptable..."(British Columbia Ministry for Children and Families, 1997/98, pg. 97)

Later it is identified that the Nanaimo Building Better Babies group "included initially only staff members of the Health Unit" (British Columbia Ministry for Children and Families, 1997/98, pg. 98). It appears that the "issue", then, was named by Health Unit employees before efforts were made to involve the

"community". Rather than being named by the community, the issue of high rates of low birth weight babies was identified by Ministry staff. This would indicate that, according to Labonte (1993), a community based approach was used to in "naming the issue", rather than a community development approach.

The community development process in the Handbook describes ways to ensure there is community involvement while initiating Pregnancy Outreach Program services. Rather than supporting communities in identifying their issues, however, the Handbook offers:

> "one community development process which covers practical steps to follow in mobilizing the community to support and participate in a new or ongoing Pregnancy Outreach Program site." (British Columbia Ministry for Children and Families, 1997/98, pg. 97)

Not only does the community not define the issue, but apparently the solution (Pregnancy Outreach Program services) had already been proposed. The Ministry of Health had a program solution for the issue that they themselves identified through epidemiological research. The community development process described is simply mobilizing the community to support and participate in developing the Pregnancy Outreach Program service locally. As argued by Labonte, this is not community development but rather a community based approach.

The community development approach, states Labonte, is alien to bureaucratic organizations because goals and objectives cannot be predetermined. When strategies are developed to resolve issues identified through a community development process there must be acceptance of deviation from original planning and goals. Indeed, it is these deviations that are valued as being a vital part of the process. (Labonte, 1993, pg. 32)

In discussing community involvement and networking the Handbook states that part of the process should be to

> "formalize the roles of such partners to ensure that 'ownership' does not become an issue later. This may have the effect of redefining the Program's goals and possibly losing the original focus and ultimately the Program." (British Columbia Ministry for Children and Families, 1997/98, pg. 98)

Not only were the "issue" and "the strategy to remedy the problem" predetermined, then, but directives are given in the Handbook to ensure community input does not jeopardize the goal of establishing Pregnancy

Outreach Program services. The process described for Pregnancy Outreach Program site development would support Labonte's assertion that the bureaucratic organization of health services will not support his vision of a community development approach and the possibility of deviation from programming goals. Although it appears to validate a community development approach, then, the Pregnancy Outreach Program Handbook in fact supports the coercion of "community" to value and support the development of the services as outlined in the Handbook.

There is a fundamental difference between how the Ministry of Health conceptualizes community development, and how it is conceptualized in the literature by Labonte (1993). A comment by the Provincial Coordinator of the Pregnancy Outreach Program supports this key conceptual difference. When asked if the Pregnancy Outreach Program used a community development approach, the Provincial Coordinator for the Pregnancy Outreach Program stated,

> "Yes, that's all we do now. Consult, consult, consult." (Field notes, May 1996)

Whereas this consultative concept of community development supports inclusion of "community" in a Ministry process, Labonte's concept of community development is to empower the community to develop their own process. When the community owns the process they are free to identify their own issues and seek and develop their own solutions. But such an approach would disorganize the Ministry's accountability processes as built into the Handbook's version of the program.

In "community development" as conceptualized by the Ministry, only a limited voice of community is encouraged. Consultation is a means of allowing input by community members, but with no commitment to following their lead. It appears that the community "voice" is supported by the Ministry only in so far as it is compatible with the Ministry identification of issues and their program solution. The "voice" of community and those impacted by the service that is developed is limited to "being consulted".

From a community development perspective (eg. Labonte, 1993) it is the community "voice" that drives the process. Community development would ensure community member's voice are included within the organization of a service, and ensure the service is responsive to their particular circumstance. In making programs accessible for pregnant women who are, as identified in the

Handbook, known to experience barriers to service, to be marginalized, it is Labonte's conceptualization of "community development" that would allow the "voice" of the women to be heard and included in the "solution". Through inclusion of the women their conceptualization of pregnancy as a personal experience could be centralized and the service made more responsive to the circumstance of "the target group".

Though the community development process as conceptualized by Labonte is not present in the organization of the Pregnancy Outreach Program, there was a suggestion that barriers created by the medical model needed to be overcome in order to provide service to the "target group". As discussed earlier, it is also clear that some pieces of the program do allow Pregnancy Outreach Program services to be acceptable to the target group. Three features of the Pregnancy Outreach Program that differ from traditional prenatal services, and are likely central to the Ministries limited conceptualization of a "community development approach" are:

1. to provide prenatal services through

   "community agencies which have well established links to the target group", (British Columbia Ministry of Health, March 1993, pg. 22),

2. to employ outreach workers who

   "bring to the job their life experiences rather than a recognized formal training program" (British Columbia Ministry of Health, March 1993, pg. 22), and

3. to provide a regular group session where

   "there may be a presentation on a topic selected by the clients...there is a great deal of exchange, support, and interaction among the women."(British Columbia Ministry of Health, March 1993, pg. 11)

Though these three strategies are not, in themselves, a community development approach, they do differ from other conventional prenatal services. Through these the program picks up certain community based practices that help to ground the work in women's everyday experience. These are the basis of the informal work practice that clients had identified to be a valuable part of the program, and that workers identified as essential in order to maintain a relationship with the client. It is these that make the Pregnancy Outreach Program "user friendly".

Making services available through existing agencies ensures that the program is physically accessible to the target group. The drop-in is the one

feature that was, as previously noted, identified by clients to be valuable, and non threatening. This is a key piece in making the program acceptable and accessible to the target group. Another feature of the Pregnancy Outreach Program that differs from other health services and is key to it's success is the hiring of lay women as outreach workers.

**Lay Counselor Role**

Outreach workers are also referred to as lay counselors or front line staff. They are

> "primarily involved with direct outreach services to clients, as the primary service provider under the supervision of the coordinator. The day-to-day activities of the Program (food supplements, drop-ins) are also duties of the outreach workers..." (British Columbia Ministry of Health, March 1993, pg. 22).

The lay outreach workers "bring their experience" to their work.

In evaluating Prenatal Health Promotion Programs, Health Canada identified that

> "fear of being judged by health professionals' middle-class values ... keep clients away. Indeed, studies of poor pregnant women have found that a fear of health care professionals was the single most important factor preventing access to health care services...At the minimum, single mothers and women from different cultures feel uncomfortable in the mainstream prenatal groups. At the worst, pregnant women who fear they will be judged fail to seek medical attention or prenatal services until the last minute. Professionals are perceived as being in a "power position", questioning their parenting skills or judging the stability of the home environment. Poor women who are addicted to alcohol and drugs also fear apprehension of their baby if they are identified as drug or alcohol users."(Health Canada, 1994, pg. 2--22)

The limitations of "traditional prenatal services who employ professionals" in reaching the target group is acknowledged in the Pregnancy Outreach Program Handbook. The Outreach Worker, therefore, is employed as the "primary service provider".

> "The Outreach Worker's familiarity with the target client environment enhances the Outreach Worker's ability to understand the client, build trust and encourage behavior change." (British Columbia Ministry of Health, 1997/1998, pg. 23)

The situated knowledge of the Outreach Worker, then, is considered key to the success of the Pregnancy Outreach Program. The link to the "community" of the target group is through this worker.

Hiring lay counselors that can relate to the client's experience and therefore build effective relationships with them, then, is a key feature of the informal work of the Pregnancy Outreach Program. Allowing inclusion of lay counselor "experience" could help them relate to the experiences of the clients. As identified in Chapter Four, it is the relationships that are valued by clients, and make the service acceptable to them. In the conceptual framework I discussed that it is identified in feminist theory that women relate to their world through their relationships. By including lay counselors, with an identified role of supporting relationships with clients in the work practices of the Pregnancy Outreach Program, opportunity is given to include a process that, according to feminist theory, is key to validating and supporting women. In allowing space for supportive relationships there is opportunity created for inclusion of women's way of interacting with their world that could allow them a familiar and comfortable space in the organization.

I identified in the last chapter that much of the informal work that I observed being done was around relationship building. Through hiring lay counselors and encouraging them to build relationships with the targeted client group, the informal work could be supported within a program. This, then, is likely the foundation for the informal work that I saw being done in the Happiest Baby Program. This part of the community development approach that was intentionally included in the Pregnancy Outreach Program could allow a space, though informal and often invisible, for the feminist concept of relationship building to be included in the work practices of the program. This particular piece can make the service acceptable to the target group.

In bringing their experience to their work, the lay counselors can also bring an awareness that women conceptualize their pregnancy as a personal experience. As lay counselors attempt to build relationships with a space for sharing their personal experiences of pregnancy can, informally, be created. This sharing fits with women's conceptualization of their pregnancy as a personal experience. It can offer them an opportunity to share their experience within the informal work practices of the program.

Staff identified that it was vital to understand the circumstances of their clients, "where they are coming from". Though this was not identified by staff to be the "real work", it was observed to be done as part of the informal work of the Happiest Baby Program.

The inclusion of the lay counselor in the organization of the Pregnancy Outreach Program could support another feminist attribute. Where the lay counselor becomes skilled at the informal work there could be opportunity for the client to share their experiences of their pregnancy, and thus feel they are being "heard". Though only informally, and only within the context of the relationship, then, there is a limited space in the organization where it could be possible for the client to have "voice". Though this voice can not, within existing organizational structures of the program, be central to the organization, it could be included in the informal work practices through the sharing of client experiences with the lay counselor, other staff, and other clients. Perhaps it is this limited inclusion of client "voice" in the informal work practices of the organization that is another key to making the program acceptable to the women it serves.

As noted in the conceptual framework, feminist and organizational theorists identify that women's voice has been excluded from dominant organizations in our society, including those responsible for the delivery of reproductive care (Green, et al., 1995; Wharf, 1995; Ferguson, 1994b; Martin, 1992, Narayan, 1988; Smith, 1987). They identify the need for inclusion of women's voice in organizations in order to centralize women and their experience. Though lay counselors are hired to ensure "relationship building" in the Pregnancy Outreach Program, this remains outside of the organization of the formal work of the program. Indeed, client voice continues to be excluded by the form-al work practices of the program.

Though it is "experience" the lay counselor brings to the job that is identified in the Handbook to be the desired asset, the lay counselor is also expected to carry out the form-al work of the program. The Handbook states that Outreach Workers must have a "minimum standard of training" which includes

> "completion of Within Our Reach: A Self-Study Training Program for Perinatal Outreach Workers, in-depth review of the Nutrition Education and Counseling Resource Manual and familiarization with all facets of the Pregnancy Outreach Program...content areas of the training include fetal growth and development,

> nutrition, communication skills, normal pregnancy changes, birth control, breastfeeding, alcohol and drug misuse, and available community agency services." (British Columbia Ministry of Health, 1997/1998, pg. 23)

Though hired for their knowledge and understanding of the target group and their ability to interact with them, lay counselors must be also be familiar with the risk assessment process, be able to provide information to clients about their risks, and be able to chart changes in client behavior related to their "identified risks".

Though the success of the program depends on the workers skill at the informal work, and making the program acceptable to the targeted clients, these same workers are trained to understand the medical approach, use epidemiologic practices in risk assessment, and participate in the form-al work practices acceptable to the Ministry of Health. In being taught the Ministry of Health work processes lay counselors are taught to value skills that allow them to do the form-al work of the program. The medical/epidemiological/administrative work is thus forwarded to the front line worker. The form-al work processes as organized by the intake become an accepted work process of even the lay counselor. Through instruction in the form-al work practices, then, the lay counselor learns that the form-al work takes precedence over the informal. The informal community based work by which the lay counselor role could enrich the program, then, is subsumed by their orientation and indoctrination into the form-al work practices.

One lay counselor, reflected on her own training to be an outreach worker when she was asked to provide orientation to a colleague.

> "At first I was told the only thing I had to do was make the clients feel comfortable, bring them to drop-in and make them feel welcome. Then they started to train me on how to do charting and teach them about their risks...I would go in with the nutritionist when she was counseling my client and the nutritionist would say, 'Do this' or 'Don't do that', and I'd have to calm them down after she left...now I mostly teach about their risks..."(Field notes, 28 April, 1998).

In reflecting on her own training this counselor was able to identify not only how her role changed as she had more training, but that she was able to act more as a client advocate when her role did not include the form-al work of the program.

Through informal work processes, the outreach workers could use their situated knowledge to develop a relationship with the clients. In translating this interaction into objective "risk data" that can be charted, however, they suspend

their relation as the same kind of woman as the clients, and differentiate themselves as classifiers of them. Though the outreach workers were observed to be skilled at performing this translation from the local and particular interaction into written "risk" documentation, this form-al work was identified by most clients to be objectionable. As identified earlier, clients reflected that it is the informal work, the ability for the outreach worker to relate to their local and particular situation, that makes the service acceptable. Instructing the lay counselor on how to do the form-al work of the program, then, undermines informal work practices that the community development approach could bring to the program.

The structure of the program as outlined in the Pregnancy Outreach Program Handbook ensures that lay counselors are the primary client contact. It is this structure that supports informal work that is done, and it is this informal work that makes the service acceptable and accessible to clients. Though the outreach worker, then, could act as the bridge between the Ministry of Health conceptualization of pregnancy and that of the client, the organization of the form-al work limits this role. Indoctrination of lay counselors into the form-al work practices of the program subverts the potential of this informal work. The informal work that is valuable to the success of the program becomes invisible. Form-al documentary practices do not bring forward an account of the informal work done. Thus, the importance of the informal work to the success of the program is made invisible, and easily overlooked.

Though the role of the outreach worker was included in the organization of the Pregnancy Outreach Program, there is no clear direction given in the Handbook that the lay counselor role of relating to the clients is essential to the success of the program and must be supported. On the contrary, there is direction given that the lay counselor must be trained to do the form-al work of the program. This undervaluing of the informal work is exactly why it is informal, and is relegated to secondary status to the form-al work. The effectiveness of the lay counselor role is undermined by the documentary practices of the program, and entrenched beliefs that practice that is guided by scientifically based documentary processes should be the primary practice in an organization.

**The Drop-In**

The Pregnancy Outreach Program Handbook states that regular drop-in sessions must be offered as part of the work practice of every program site.

> "Group sessions are an essential component of the Pregnancy Outreach Program." (British Columbia Ministry for Children and Families, 1997/1998, pg. 11)

This drop-in is another piece of the community development strategy that, as previously discussed, was included in the work practices of the program to overcome the barriers of a medical approach and make services accessible by the target group.

Formal documentation is not completed on drop-in interaction, and thus the drop-in becomes another part of the undocumented, informal work that is done in the program. Though the drop-in is not made central in the organization through documentary practices, the Handbook identifies that

> "For clients who participated in the Qualitative Evaluation in 1993, fellowship at the group sessions was clearly the most popular aspect of the program." (British Columbia Ministry for Children and Families, 1997/1998, pg. 11)

Observational notes and client interviews during this research confirm that the Drop-In is indeed one of the most popular components of the Happiest Baby Program. Though not part of the form-al work of the program, the value of the drop-in to client participation is recognized, and thus is supported as a work practice of the program.

Program literature, however, does not explore why the drop-in opportunity is valued by clients. The Handbook states,

> "Client feedback has stressed the importance of creating a comfortable environment, one in which clients can make their own space. Creating a homelike setting is desirable, for example, having comfortable couches instead of office chairs is appreciated." (British Columbia Ministry of Health, 1997/1998, pg. 25)

Though having a comfortable physical space is acknowledged in the Handbook as important, clients in this research were able to identify that it is having a social space that they valued.

> "I liked getting together...we could see how really the same everybody is. I think that helped a lot of people." (Client Interview #2, May 27, 1997)

It is the ability of staff to make the Drop-In a familiar, comfortable, and safe social environment that allows the clients to "feel O.K. asking questions". (Observational Notes, November 23, 1996) As described earlier, it is the local and particular knowledge (or "insider knowledge" as described by Narayan

(1988)) of the outreach worker that can make the creation of such a space possible, and therefore makes the drop-in acceptable to the target group.

It was identified in Chapter Four that clients appreciated sharing their experiences of pregnancy at the drop-in. It was also discussed earlier that it is through sharing of their experience of pregnancy with lay counselors and other clients that the inclusion of client voice is provided for in the informal work of the program. The drop-in is one work process where the voice of women is supported. Though there are no documentary practices that organize this sharing of experiential knowledge, inclusion of the drop-in as an informal work process is key to clients accessing program services.

In the conceptual framework it was identified that according to feminist theory, women value experiential ways of knowing. By including a space for women to share their experiences of pregnancy, the Pregnancy Outreach Program is not only allowing the women's conceptualization of her pregnancy as a personal experience to be acknowledged, and their voice to be heard, it is supporting a valuing of experiential knowledge. The informal work practice of sharing experiences at the drop-in supports the feminist concept of valuing experiential knowledge.

It is a strategy that clearly forms the basis for clients valuing the drop-in sessions. The informal sharing of experiences is key to the success of the drop-in, and to the Program's success. It is an important piece of the informal work of the program that is supported by the underlying community development ideology.

The Handbook identifies that

> "An important part of the group session is the provision of a healthy meal or snack...The food often serves to draw clients to the drop-in, and provides an opportunity for modeling and learning about nutrition concepts...The importance of nourishment to the success of the drop-ins was clearly recognized as the Program evolved."(British Columbia Ministry of Health, 1997/1998, pg. 12)

It was also identified in this research, as stated in Chapter Four, that food at drop-in and the nutrition supplements were key to client participation in the program.

A quote from the Health Canada evaluation of health promotion programs may also provide insight into why providing food is important to the success of the Drop-In.

> "The women also expressed...seeking prenatal care for a future event was not seen as important...**Priorities such as obtaining food** and shelter for their families override the importance of seeking prenatal services." (Health Canada, 1994, pg. 2--22)

The food, then, is meeting the client's immediate need.

Including the provision of nutrition supplements in the work practice of the Program also supports the informal work that is done. Staff must be familiar with the client's circumstance to identify whether the client is eligible for the nutrition supplements. Discussing the client's circumstance supports the informal work of the program of relationship building. Through staff seeking an understanding of client circumstance, they also come to understand the client's concept of their pregnancy as a personal experience. They can identify with the client's immediate need for the nutrition supplements. The informal work of the program, as identified in the last chapter, then, is supported by the program practice of providing nutrition supplements.

It is the entrenchment of the three community development strategies that makes the Pregnancy Outreach Program accessible to women in the target group. Clients who are made to feel extremely uncomfortable as the form-al work process is carried out begin to accept the program because of informal work that is being done. Those in the high risk target group were able to reflect that they felt intimidated by the form-al intake process, and some simply refused to participate where an informal approach was not incorporated. Staff were able to reflect on their frustration that much of what they felt was their valuable work was not recorded or officially acknowledged. Administrators acknowledged that client centered work was necessary before the "real work" could be done. It is inclusion of the informal work that allows the Happiest Baby Program to be successful in its goal of targeting service to high risk pregnant women.

It is the acceptance of Outreach Workers, with their situated knowledge, as the legitimate workers of the program that allows for the creation of a comfortable space for clients. Though Outreach Workers identify that it is their form-al work that is being evaluated, they also seem acutely aware that without creating a comfortable space for clients, the clients would not use the service. Without using their "insider knowledge" to work with clients, the service would not be as successful, indeed may fail.

**The Medical Model and Community Development Collide**

Two very different ideologies, then, are supported by the structure and work practices of the Pregnancy Outreach Program. Inclusion of community development ideology is supported in front line practice by using local recognized contractors, entrenchment of lay counselors as the primary workers, and entrenchment of Drop-In sessions as an expected work practice. These support the vital informal work of the program, and have been intentionally included in program practice in an attempt to successfully meet the goal of ensuring services reach the target group. Although less open and flexible than some analysts see community development programming to be, these features allow the program counselors to respond as women to their clients. Inclusion of the medical model, epidemiology and administrative technologies ensure that services are cost effective through high risk targeting, that scientific based evaluation is integral to the program, and that practice is acceptable within the organization of the Ministry of Health. It is this ideology that is the basis for the formal work in the Pregnancy Outreach Program. The approach requires strict adherence to defined program assessment protocols and standard reporting requirements.

There is no apparent awareness or concern over the implications of using two differing ideological approaches in developing the work practices a single program. Unfortunately, it is the Outreach Worker who, as the primary front line worker, is faced with the dilemma of balancing the form-al organizational requirements of the program with the informal work that is also mandated through prescribed work practices, yet apparently not valued. The co-existence of two very different foundational ideologies in this single program repeatedly creates situations of conflict at many levels. It is the conflict that is created for clients and front line workers that will be considered in this section.

The ideologies involved in establishing these two approaches to work practice are very different and often conflicting. Community development ideology seeks empowerment of clients. (Labonte, 1993) Ideology of the Ministry of Health seeks behavior change of clients. (Ministry of Health, 1993) Here I discuss incidents of conflict that were observed and how these directly relate to the two ideological approaches. I identify that conflict is inherent in trying to balance these two approaches.

Throughout my investigation of the local and particular interaction of the Happiest Baby Program, I began to note that there were two "points of view" expressed by staff. One newly trained Outreach Worker stated she was "getting fed up with doing 'the program'.

> "...most of the women come in to talk about family violence...how can I teach them about nutrition when they have so much stress sometimes they can't even eat...the program didn't help me with this, and it's most of my work" (Observational Notes, 15 January, 1997).

The workers frustration was brought up at an Advisory Meeting where another lay counselor commented,

> "that's not her job. She's just supposed to counsel about the pregnancy" (Observational Notes, 22 January 1997).

In these interactions there are two very different views expressed about what the "work" of the program is, and what the role of the lay counselor is.

The new lay counselor is trying to establish new services in her community and does not have the direction of a professional to guide her. She is acutely aware of the needs of her clients and the importance of establishing working relationships. Her observation that clients feel a greater need for counseling around family violence than assistance with nutrition is supported by national research on high risk pregnancy.

> "The stresses of poverty are often exacerbated by other problems including abuse and violence, illness, multiple partners, close birth intervals, racism, isolation and a lack of social support. Pregnancy-which is seen as a natural process-may be the least of a poor woman's problems" (Health Canada, 1994, pg. 2--22).

The new counselor, then, is in touch enough with the clients to see that what they identify to be concerns is not what is reflected as a priority to be addressed in the form-al work processes of the Pregnancy Outreach Program.

The more experienced lay counselor has learned to focus on the form-al work of the program. She identifies that

> "we can't change how people live" (Observational Notes, 22 January 1997).

For her, the direction provided by the intake assessment allows focus on providing information that can broaden the scope of choices for clients. She feels it allows her to actually "do" something according to the form-al expectations and documentary practices of the program.

The approach of the new counselor in relationship building is experienced much more positively by clients. As discussed in the last chapter, this approach makes the program more accessible to more marginalized clients. The approach of the more experienced counselor in focusing on "risks" identified on the intake is experienced as threatening.

Both approaches are supported by program ideology. Relationship building is supported by the "community development" ideology and informal work processes, while addressing client risk is supported by the form-al work processes. Though each lay counselor uses a very different approach, both approaches are within accepted program work practice, and are supported by program ideology.

The newer Outreach Worker is including a great deal of relationship building and inform-al work in her local work practice, but she does not see this a being a part of the "program". The more experienced Outreach Worker has a background with extensive training by Ministry of Health nutritionists and nurses, and has worked many years as a lay counselor. She was very clear in her statements that work of "the program" should be focused on the form-al work, and that interaction with clients around other issues, such as family violence, is not the role of the lay counselor.

Conflict occurs when there is not a balance of the two approaches. As identified earlier, many experienced workers are acutely aware of the balancing act they continually do. The new lay counselor has not accepted the form-al work processes of the program as part of her routine work practice, and does not balance her informal work with form-al work around addressing risk factors. The experienced lay counselor values the form-al work processes and tries to re-focus even her informal work around "risk factors". Both lay counselors approach their work very differently based on which program ideology they value as a priority. Neither is aware that both practices are supported within the documentation of the Pregnancy Outreach Program. Both assume that because documentary practices organize the form-al work, this forma-al work **is** "the program".

Another incident of conflict that demonstrates this different valuing of ideologies was noted during a telephone conference of facilitators of the Within Our Reach pregnancy outreach training. One community health nurse acting as

a facilitator commented on the broad spectrum of material that was covered in the training package, and stated,

> "How can we control what information is given out. I mean, all of this information is being given out by lay counselors who don't really have the background knowledge to be doing this. Who is responsible if misinformation is given? Are there some boundaries, some guidelines for appropriate referral?" (Field Notes, Telephone Conference, March 1997).

This nurse was identifying a professional need to "control" what information is given to clients, and ensure there is a scientific approach. This approach to Pregnancy Outreach Program work is supported by Handbook directives that state that a professional nurse or nutritionist is to coordinate all program sites and provide "professional" direction to lay counselors. It fits well with the risk assessment and the controlled approach to providing information and support around only the identified risks. This comment also identifies that the nurse does not understand that the lay counselor is expected to bring their experiential knowledge to their work, and this is relied upon, though through informal work processes.

As discussed in the conceptual framework, the controlling aspect of professions was identified to be a barrier to providing services to women. This "barrier" created by a professional approach is identified by a nurse coordinator of an outreach program who comments,

> "In our area if the Outreach Workers don't address client issues they simply aren't addressed...we do not have appropriate professionals available to refer to ... where a referral is made the professional is so geographically and socially distant that they can never make the connection with the client that the Outreach Worker did...the professional may never be able to provide as effective support as the lay counselor" (Field Notes, Telephone Conference, March, 1997).

A nutritionist coordinator supported this view commenting:

> "Research has shown that Outreach Workers who have common history and living situations with clients can make more effective contact and provide more effective intervention with these clients" (Field Notes, Telephone Conference, March, 1997).

Whereas the Community Health Nurse was concerned that the focus of the Outreach Workers practice should remain on their risks as identified by the intake assessment, the Pregnancy Outreach Program Coordinators showed

awareness of the informal work that the Outreach Workers did. She was aware of the experiential knowledge of the lay counselors, and the skill they bring to the articulation of formal work processes to the local and particular interaction with the client. The former view is supported in the program by inclusion of scientific ideology and enforced through textual mediation. The latter view is supported in the program by inclusion of community development ideology but only supported where there is situated awareness of the necessity of informal work to the success of the program.

I have argued that the form-al work is more highly valued, and that the scientific approach that underpins the form-al work is familiar to professionals and accepted by the Ministry of Health. I have argued that the administrative technology and textual mediation processes of the Pregnancy Outreach Program enforce form-al work as the primary work of front line practice. These organizational features of the Ministry of Health ensure the Pregnancy Outreach Program can be validated as a successful undertaking within the Ministry's mandate and will, therefore, attract scarce funding.

However, I argue that these form-al work processes overshadow and even compromise what I consider to be the most critical work of the program. I have argued that it is the non-textualized work of the Pregnancy Outreach Program that makes it different from other dominant health organizations in our society. I argue that it is this alternate, non-textualized approach to relationships in the organization that make the Pregnancy Outreach Program unique, and more acceptable to the high risk, and often socially disadvantaged clients that it seeks to provide service to. Though not legitimized or enforced through textualizing, front line workers recognize that building relationships and client directed interaction is valuable, indeed essential to the success of the program.

Though front line workers acknowledge that this informal piece of their work allows them to fulfill the form-al requirements enforced by documentary practices of the program, they do not value this informal work as "real work", and do not see it as "doing the program". Perceptive workers who acknowledge that they must address the clients issues or "start where they're at" initiate the informal work process but have no awareness that this informal work is supported by the Handbook, which states a community development approach must be used.

Where staff recognize only the form-al work process as "real work", there is no support for the informal work of relationship building. Unless staff are very clear of the benefits that both approaches bring to their practice there is a strong organizational influence through textual mediation to focus only on the form-al work. At present, it is only through situated awareness that front line staff become aware of the vital importance of their informal work, and become skilled at incorporating both form-al and informal approaches into their front line work. It is only where staff understand that building relationships is key to client participation that there is support for the informal work.

My research suggests that there is an apparent lack of awareness within the Ministry and administration of the Pregnancy Outreach Program that it is the informal work that is done that is key to the success of the program. Thus, the training process and supervisory staff emphasize the statistical data collection and focus on working around identified risk factors. I argue that if this informal work is to be supported and further developed within the Pregnancy Outreach Programs there must be awareness and acknowledgement that the informal work ensures services are accessed by the target group.

## CONCLUSION

This thesis can be read as a critique of one instance of population health. The concept of targeting preventative health service to only those assessed by scientific/rational devices to be "at risk" would seem to be a cost effective way to maintain a healthy population. Because of increasing demand for economic efficiency and effectiveness in the health care system, such new approaches are being used. I demonstrate that there are dangers in this targeting of service. The notion of targeting is tied to the notion of risk and it is in these conceptualizations that difficulties were created for clients and staff. The very real danger lurking in these is that, as shown by this research, the process of risk assessment, while providing data to "prove" the targeted population is being reached, ultimately alienates the very clients it was designed to serve.

I found that the relations of ruling as organized by the risk assessment of the Pregnancy Outreach Program construct social difference. Difference between lay counselors and clients arises (for clients) as they find themselves assessed as "at risk". They feel this as somehow being judged as unworthy, and this undermines client empowerment. Rather than organizing work to build supportive relationships between the women and front line staff, so that health issues could be dealt with in the context of the women's lives, the risk assessment organizes the form-al textualized work around the targeted risks, as objective "problems" that need to be addressed.

This thesis has also compiled evidence strongly suggesting that the form-al work as organized by the risk assessment is enabled by informal work practices of the Program. I have identified that non-textualized work practices based on community development ideology comprise a significant part of the work done. I refer to these as the informal work practices because, though justified in the planning documentation of the Pregnancy Outreach Program, they remain outside of the organization of the form-al textually mediated work processes. The research identifies that, though this informal work is made invisible and subsumed by the form-al work processes, it is, in fact, key to the success of the program in meeting its goal of targeting service.

The form-al and informal work practices of the program are based on two very different, and I argue conflicting, approaches. I demonstrate that the ruling relations that subordinate the informal to the form-al work practices create a unique set of difficulties for front line staff. The enabling of the form-al textually

mediated work through informal work practices is achieved only at a cost to the women who are the front line workers. It is important to understand that the informal work is valuable, and allows the form-al work to be done. Yet, the experiential knowledge of the worker and her skill in articulating the extralocal ruling relations to the local and particular interaction is not acknowledged. I point out that, though it is expected that both the form-al and informal work will be done, the situated knowledge, creativity, skill and emotional commitment required to successfully do this remain invisible.

This is the kind of contribution of women to everyday life that feminists have argued is routinely ignored and its value overlooked. Lay counselors in the Pregnancy Outreach Program play a key role in making this program successful but what they do remains largely unrecognized, even marginalized. This community development work is always in danger of being seen as "not the real work", and thus of not being supported. In the last analysis, then, this thesis offers a feminist perspective on the continued success of this program. To see its success as a product of targeting a population and its health risks, and working on changing those, is to see only half the story.

# REFERENCES

Allen, D. (1985). "Nursing Research and Social Control: Alternative Models of Science that Emphasize Understanding and Emancipation." Image: The Journal of Nursing Scholarship, 17 (2), 58-64.

Armstrong, H. & Armstrong, P. (1994). The Double Ghetto. Toronto: McClelland & Stewart.

Aylward, G., Pfeiffer, S., Wright, A., & Verhulst, S. (1989). Outcome studies of low birth weight infants published in the last decade: A meta-analysis. The Journal of Pediatrics, 115(4), 515-520.

B.C. Division of Vital Statistics. Selected Birth Statistics. Quarterly Digest, (3)2.

British Columbia Ministry of Health, (1993). New Directions for a healthy British Columbia: Summary of the highlights. Victoria: Ministry of Health

British Columbia Ministry of Health and Ministry Responsible for Seniors. (March 1993). Pregnancy Outreach Program Handbook. Victoria: Community and Family Health Nutrition Branch.

British Columbia Ministry for Children and Families (1997.98). Pregnancy Outreach Program Handbook. Victoria: Regional Support Division.

Bunting, S. & Campbell, J. (1991). Voices and Paradigms: Perspectives on critical and feminist theory in nursing. Advances in Nursing Science, 13(3), 1-15.

Callahan, M. & Wharf, B. (1995). Strengthening families through empowering women phase 2. Victoria: unpublished research report.

Campbell, M. (1994). The structure of stress in nurses' work. In Organizational context of practice in health and social services. Canadian Scholar's Press, 1995.

Campbell, M. & Manicom, A. (1995). Knowledge, experience, and ruling relations. Toronto: University of Toronto Press.

Canadian Comprehensive Auditing Foundation (1987). Effectiveness: Reporting and auditing in the public sector - summary report. Ottawa.

Casiro, O., McKenzie, M., McFadyen, L., Shapiro, C. Seshia, N., MacDonald, N., Moffatt, M. & Chiang, M. (1993). Earlier discharge with community based intervention for low birth weight infants: a randomized trial. Pediatrics, 92 (1), 128-134.

Cassin, M. (1980). Federation of Women Teachers' Association of Ontario, Affidavit. In M. Campbell (Ed.). Knowledge and Inquiry. Canadian Scholar's Press, 1995.

Chinn, P. & Jacobs, M. (1987). Theory and nursing. Toronto: C.V. Mosby.

Ferguson, K. (1984a). The client as the second sex. In M. Campbell ( Ed.) Organizational context of practice in health and social services. Canadian Scholar's Press, 1995.

Ferguson, K. (1994b). On bringing more theory, more voices and more politics to the study of organization. In M. Campbell ( Ed.) Organizational context of practice in health and social services. Canadian Scholar's Press, 1995.

Foulkes, R. (1973). Health Security for British Columbians. Victoria: Minister of Health.

Frank, J. (1995). Why population health? Canadian Journal of Public Health, 86(3).

Gil, D. (1990). Unraveling social policy. Rochester, Vmt.: Schenkman Books.

Graham, C. & Oakley, A. (1981). Competing ideologies of reproductions: Medical and Maternal perspectives on pregnancy. In Roberts, H. (Ed.) Women, Health and Reproduction. London: Routledge.

Green, L., George, M., Daniel, M., Frankish, C., Herbert, C., Bowie, W., & O'Neill, M (1995). Study of participatory research in health promotion. Vancouver: University of British Columbia.

Jones, K. (1993). Compassionate authority: Democracy and the representation of women. London: Routledge.

Killion, C. (1995). Special health care needs of homeless pregnant women. Advances in Nursing Science, 18 (2), 44-56.

Kramer, M. (1987). Intrauterine growth and gestational duration determinants. Pediatrics, 80, 502-511.

Labonte, R. (1993). Health promotion and empowerment. Toronto: Centre for Health Promotion/Participaction.

Labonte, R. (1995). Population health and health promotion: what do they have to say to each other? Canadian Journal of Public Health, 86(3).

Lazarus, E. and Philipson, E. (1990). A longitudinal study comparing the prenatal care of Puerto Rican and white women. Birth, 17 6-11.

Leininger, M. (1978). Transcultural nursing concepts, theories and practices. Toronto: John Wiley and Sons.

Levitt, C., Watters, N., Chance, G., Walker, R. & Avard, D. (1993). Low birth-weight symposium: summary of proceedings. Canadian Medical Association Journal, 148(5), 767-771.

Lindsey, E. & Hartrick, G (1996). "Health-promoting nursing practice: the demise of the nursing process?". Journal of Advanced Nursing, 23, 106-112.

Linton, J. (1996). Provincial Coordinator for the Pregnancy Outreach Program in discussion with researcher about the intake assessment.

Liu-Chiang, C. (1995). Postpartum worries: An exploration of Taiwanese primiparas who participate in the Chinese ritual of Tso-Yuen-Tzu. Maternal-Child Nursing Journal, 23(4), p. 110-122.

McAleese, S. (1993). Pregnancy Outreach Program qualitative evaluation report, March 1993. Victoria: Ministry of Health.

McKenzie, B. & Wharf. B. (1995). Connecting Policy and Practice in Social Welfare. University of Victoria: Victoria.

McLean, K. (1990). Pregnancy Outreach Projects: a qualitative evaluation report. Victoria: Ministry of Health.

McLeod, B. (1994). Program Evaluation for Health Professionals. Toronto: Miles Canada Inc.

McQuaig, L. (1993). The wealthy banker's wife: Assault on equality in Canada. Toronto: Penguin Books.

Marshall, R. (1995). Westcoast Healthy Baby Program lay counselor presenting information on First Nations tradition in reproductive care at drop-in.

Martin, C. & Armstrong, R. (1995). The impact of prenatal behavior modification on maternal and infant outcomes: British Columbia's Pregnancy Outreach Program. Victoria: Ministry of Health.

Martin, E. (1992). The woman in the body: A cultural analysis of reproduction. Boston: Beacon Press.

Millar, J. (1993). A Report on the health of British Columbians Provincial health officer's annual report, 1992. Victoria: B.C. Ministry of Health and Ministry Responsible for Seniors.

Minister of National Health and Welfare, (1994). Prenatal health promotion project report. Ottawa: Supply and Service Canada.

Minister of National Health and Welfare, (1994). Strengthening prenatal health promotion for disadvantaged families. Ottawa: Supply and Service Canada.

Narayan, U. (1988). Working together across difference: Some considerations on emotions and political practice. In M. Campbell (Ed.) Knowledge and Inquiry. Canadian Scholar's Press, 1995.

Nelson, S. (1994). Nursing Practices: Body and Soul.Presented at the Fifth Annual Critical and Feminist Perspectives in Nursing Conference, Bothell, Washington, March 11-13, 1994.

Oakley, A. (1976). Wisewomen and Medicine Men. In J. Mitchell and A. Oakley (Eds.). The Rights and Wrongs of Women. New York: Penguin Books.

O'Brien, M. (1989). Reproducing the world. Boulder: Westview Press.

Omar, Mildred A. and Schiffman, Rachel F. (1995). Pregnant women's perceptions of prenatal care. Maternal-Child Nursing Journal, 23 (4), 132-142.

Shiva, V. (1996). Ecofeminism. Lecture at Praxis Nexus Conference, Victoria, February, 1996.

Smith, Dorothy (1987). The Everyday World as Problematic. University of Toronto Press: Toronto.

Smith, D. (1984a). The renaissance of women. In M. Campbell (Ed) Knowledge and Inquiry. Canadian Scholars Press, 1995.

Smith, D. (1984b). Textually mediated social organization. In M. Campbell (Ed) Organizational context of practice in health and social services. Canadian Scholars Press, 1995.

Smith, D. (1975). The social construction of documentary reality. In Campbell, M. (Ed.) Knowledge and inquiry. Canadian Scholars Press, 1995.

Spradley, Barbara (1985). Community Health Nursing Concepts and Practice. Little, Brown & Company, Toronto.

World Health Organization, (1984). Health promotion: A discussion document on the concepts and principles. Copenhagen: WHO.

World Health Organization, (1978). Primary health care: Report on the international conference held in Alma Ata, September, 1978. Geneva: WHO.

Ussher, J. (1993). The psychology of the female body. New York: Routledge.

Wharf, B. (1995). Organizing and delivering child welfare services. In Hudson, J. & Galaway, B. (Eds.), Canadian child welfare: Research and policy implications.

Wetzel, J. (1986) A Feminist World View Conceptual Framework. Social Casework 67*(March)*.

# VITA

Surname: Siga Given Names: Vaida Colleen

Place of Birth: Edmonton, Alberta, Canada

Educational Institutions Attended:

University of Victoria 1979-1981

Royal Alexandra Hospital School of Nursing 1973-1976

Degrees Awarded:

BSN University of Victoria 1981

Honours and Awards:

---

Publications:

## PARTIAL COPYRIGHT LICENSE

I hereby grant the right to lend my thesis to users of the University of Victoria Library, and to make single copies only for such users or in response to a request from the Library of any other university, or similar institution, on its behalf or for one of its users. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by me or a member of the University designated by me. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Title of Thesis/Dissertation:

Ruling Relations in the Intake Assessment of a Pregnancy Outreach Program

Author 

Vaida Colleen Siga

August 16, 1998