

# Public Health Nurse Perceptions of Empowerment and Advocacy in Child Health Surveillance in West Ireland

Teresa Cawley and Patricia Mannix McNamara

**ABSTRACT** *Objective:* The objective of this study was to analyze public health nurses' perceptions of empowerment and advocacy within a child health screening and surveillance program in West Ireland. *Design and Sample:* This study combined both qualitative and quantitative research methods. A purposive sample of 9 public health nurses (PHNs) (phase 1) participated in 2 focus groups and a purposive sample of 43 clients attending the child health screening service completed a questionnaire (phase 2). *Measures:* Focus groups and Questionnaires were used. *Results:* Thematic content analysis revealed that PHNs in the study did not perceive themselves to be empowered in their work. They attributed this to workload, lack of professional advocacy, and restricted access to power and opportunity, while also identifying the need for continued managerial support and feedback. *Conclusions:* The results suggest that PHNs need to be empowered in order to facilitate client empowerment. PHNs struggled with empowerment and client advocacy. There is a need for professional development for PHNs in order to support them to more critically engage with empowerment and self-efficacy in their work. This needs to be done within organizational structures that support PHNs to critically analyze the role of advocacy and empowerment in their practice.

Key words: advocacy, empowerment, health promotion, public health nursing.

Public health nursing is complex because it incorporates an expectation of empowerment and advocacy on the part of the public health nurse (PHN) in three functions: curative engagement, health promotion, and political advocacy. This is in contrast to the traditional nursing role, the dominant focus of which is helping people to cope with ill health. The growing

complexity of their role is challenging for PHNs, particularly if they experience limited professional autonomy. This paper examines PHNs' attitudes to and understanding of empowerment, and is underpinned by the argument that if PHNs are to fulfill their varied role, it is essential they are empowered in order to effectively advocate for themselves and their clients.

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## Background

The PHN role in child health is similar to that of the health visitor in the United Kingdom and the PHN in the United States and Canada (Cohen & Reutter, 2007). In this role, empowerment is important in building relationships with clients to aid them in making healthier choices. Advocacy can often be a manifestation of empowerment in action and there are frequent calls for nurses to become more political. Rodwell (1996) argues that advocacy is fundamental to nurses developing their empowering role. Indeed, empowerment is a central principle of health

promotion, and its centrality to the client/practitioner relationship within health care is well established (Ryan, Mannix McNamara, & Deasy, 2006). Notwithstanding this, a dilemma facing the health practitioner with regard to empowerment is that they are expected to engage in processes that are empowering for clients often without consideration as to whether they experience themselves as empowered practitioners (Ryan et al., 2006). There are many historical examples of those who are disadvantaged helping others, but the authors suggest that to optimize empowerment potential, practitioner empowerment is important, while acknowledging that not being empowered does not necessarily preclude facilitating the empowerment of others.

Advocacy is cited as one of the five action areas of significant importance in the Ottawa Charter (World Health Organization [WHO], 1986). PHNs are being challenged to broaden their focus into sociopolitical contexts that influence the health of both individuals and communities (McDonald, 2002); therefore, empowerment has a key role. Empowerment and advocacy are interwoven as the capacity to advocate is enhanced or restricted by one's own levels of empowerment. Published literature in this field evidences themes such as broadening of the sociopolitical contexts of PHNs (Falk-Rafael, 2000; Reutter & Duncan, 2002), PHN autonomy, development of client-centered practices, and the complexities of PHN/client relationship development (Falk-Rafael, 2001; Reutter & Ford, 1996).

Empowerment is synonymous with gaining mastery over one's life or work (Freire, 1970; Rappaport, Swift, & Hess, 1984; Wallerstein, 1992). Empowerment is also about ongoing processes of enablement (Jackson et al., 1996). Nevertheless, terms such as power and empowerment are often so overused that they become jargon and thus devoid of meaning. Carey (2000, p. 8) notes that limited understandings of empowerment can lead to the perception that empowerment can be "the universal cure-all for all the ills of the post industrial age." In health promotion discourse, what is regularly referred to as empowerment usually means the types of relationships the practitioner endeavors to create with their client in order to encourage the client to take responsibility for prioritizing a healthier lifestyle. However, it is unreasonable to expect that a practitioner can excel in facilitating in their clients that which is denied them in their own practice (Ryan et al., 2006). Also, it is doubtful whether disempowered practitioners can

effectively advocate for their clients. Empowerment is not simply a process; it is also a psychological state (Menon, 2002) that is linked with the concept of self-efficacy (Bandura, 1977). Falk-Rafael (2001) identifies empowerment as a process of consciousness-raising, which is characterized by client centeredness, reciprocity, mutuality, respect, enhancing dignity, being non-judgmental, and creating a safe environment for the development of a trusting relationship. The authors of this study were also influenced by Foucault (1997), who argues that power and knowledge are intricately linked. Foucault critiqued the medical profession for centralizing knowledge within the preserve of the expert practitioner, often resulting in the alienation of clients. However, health professionals continue to be positioned with more power than their clients (Aston, Meagher-Stewart, Sheppard-Lemoine, Vukic, & Chirop, 2006; Du-Plat-Jones, 1999). In addition, research indicates that PHNs recognize their traditional teaching/learning practices to be problematic and they link this to a current lack of focus on client empowerment (Aston, 2002).

The approach taken to empowerment in this study emphasized the importance of empowerment in PHN nursing practice and in particular the effectiveness of individual capacity to engage in action to support others (Rodwell, 1996). Empowerment was understood as both a process and an outcome and the approach adopted in the study took into consideration the self-efficacy of the individual. Thus, for the authors, empowerment is about building personal capacity so as to have the *power to* engage in action rather than *power over* another.

### **Research question**

The aim of the study was to explore PHNs' perceptions of empowerment and advocacy in the context of the child health screening and surveillance program in the West of Ireland and to consider their significance for future public health nursing practice.

## **Methods**

### **Design and sample**

The research design comprised of a two-phased study using both qualitative focus groups and a cross-sectional survey design. Two focus groups with PHNs were conducted, followed by a questionnaire that was distributed to clients who accessed the child health services of the PHNs.

The inclusion criteria for the focus groups were PHNs working within the child health screening and surveillance program within a defined geographical area. The sample ( $N = 9$ ) was generated via purposive sampling through an open invitation to all PHNs (who then self-selected to participate). The characteristics of this sample are outlined in Table 1. The inclusion criteria for the quantitative sample were parents, currently with infants who attended the child health screening and surveillance program within the same defined geographical area. Out of 107 mothers who were asked to take part in the study, 43 completed the survey; the response rate was therefore 40%. Descriptions of this sample are outlined in Table 2.

Ethical approval was sought from and granted by the local Health Services Executive Research Ethics Committees in the defined geographical areas and also from a University Research Ethics Committee where this research was located. Ethical standards and protocols were adhered to throughout the study to ensure confidentiality, anonymity (where appropriate), and informed consent. As per the Helsinki declaration (World Medical Association, 2004), participants were given oral and written information detailing the research, a letter outlining the protocol and procedures, following which they signed a consent form agreeing to participate in the study.

**Measures**

The focus groups were conducted by the first author. A topic guide was employed for the focus groups, the

TABLE 2. Client Sample Characteristics ( $N = 43$ )

Variable	%
Age	
25 years or less	9.3
26–30 years	27.9
31–40 years	60.5
41–45 years	2.3
Nationality	
Irish	90.69
British	4.65
American	2.32
Scottish	2.32
Number of children of parents surveyed	
1 Child	30.2
2 Children	41.9
3 Children	23.3
4 Children	2.3
6 Children	2.3
Marital status	
Married	86
Cohabitation	12
Single	2
Tenure	
Full-time stay at home parent	44.2
Full-time workers	28.0
Part-time workers	25.6
Other	2.2
Employment	
Stay at home parent	30.2
Production line worker	2.3
Managerial	9.3
Clerical	14.0
Professional	7.0
Manual	4.7
Other	9.3

TABLE 1. Focus Group Participant Characteristics ( $N = 9$ )

Variable	Focus group 1	Focus group 2	Total
Participant number	4	5	9
Age range			
35–40 years	2	2	4
45–50 years	2	3	5
Setting			
Rural	2	2	4
Urban	2	3	5
Years in public health nursing services			
<5 years	1	2	3
Between 5 and 9 years	1	1	2
Between 10 and 14 years	1	1	2
15 or more years	1	2	3
Work tenure			
Full time	4	5	9

themes of which were: to ascertain how they understood the concept of empowerment, their perceptions of their own levels of empowerment, their perceptions of their role in client empowerment, and perceptions of their empowerment needs. The focus groups were 3 hr in duration and were recorded and transcribed verbatim. Transcripts were returned to participants for verification. The questionnaire was constructed post preliminary analysis of the focus group data. It examined clients’ perceptions of the empowerment approach and strategies of the PHN and their perceived outcome on themselves.

**Analytic strategy**

The analytical process applied Burnard’s (1991) thematic content analysis, together with the three-stage method of open, axial, and selective coding advocated

by Kumar (1999) and Skelton (1997). Open coding meant dividing the data into large categories, and then axial coding meant reviewing these large categories and reassembling them into smaller more interconnected ones, identifying the relationships between themes. Finally, selective coding meant grouping the data into overall core categories that were relevant to the research objectives. Bias was controlled for by having the analysis independently reviewed by the second author and two critical peers. The statistical package for the social sciences was used to support quantitative data analysis. Quantitative data were analyzed for descriptive frequencies.

## Results

The data analysis identified three central categories: PHN understanding and experience of empowerment; the advocacy role of the PHN; and client experiences of empowerment.

### *PHN understanding and experience of empowerment*

The data revealed that participants were unable to provide specific clarification of what they considered empowerment to be, but rather linked it to relationship building with clients, listening skills, and confidence building. PHNs in the study linked empowerment with advocacy and autonomy but they were clear that they did not perceive themselves to be empowered in their professional lives. A majority attributed their disempowerment to organizational factors and to issues of professional identity, which they argued was influenced by the low profile of public health nursing within the nursing profession generally. Constraining organizational factors identified included: constraints of role, workload, management structures, and hierarchy. PHNs voiced the negative impact of political constraints; by this, they meant the lack of government investment in service provision and the lack of managerial advocacy for their service. They also articulated concerns about what they termed lack of political will by the health services executive (in particular their managers) to advocate on their behalf for service provision.

So the assessments, from our point of view, are done and we recommend X or Y or Z from home help through to home support, but if the political will is not there to provide the services, we're not empowered to help (P3, FG2).

They indicated some tension because of an increased expectation from clients who felt limited by restraints within their organization:

There is a lot more demanded and expected of us by the public and we can't always meet it because of political and financial restraints. We are stuck (P2, FG2).

The PHNs in the study described themselves as potentially intimidated by other nursing disciplines:

We can be intimidated by other disciplines within the profession (P2, FG1).

Some PHNs described their experience of client perception of their role as having lesser status than the hospital-based nurses, for example:

You did great, did you ever think of working in a hospital? You would be fit for work in a hospital you know (P2, FG1 *nurse quoting client*).

Participants perceived a connection between their own empowerment and that of their client:

If I am empowered hopefully the clients will be empowered (P4, FG2).

PHNs articulated that to support their own empowerment, they needed to have access to resources, information, opportunity, and support in their work environment. They viewed education and knowledge development as vital. Some voiced the frustration they experience in attempting to access basic services:

We were basically beating our heads against a brick wall and [it took until then] that we got the training and all of the extra knowledge which empowered us to make decisions (P3, FG1).

### *Advocacy role of the PHN*

PHNs in the study communicated awareness of their need to more effectively advocate for themselves and that their sense of their own autonomy was limited. They saw their role in advocacy in terms of a professional imperative that would lead to better service provision and professionalism:

We need to stand up for ourselves and our expertise instead of seeing ourselves as the poor sisters (P1, FG1).

We should be lobbying for services which we require to deliver a professional patient centred service that is fair and equitable and supported by ongoing research and good practice, carried out by professionals to ensure the highest standards possible (P1, FG2).

However, PHN engagement in client advocacy was inhibited. Some PHNs believed that they had fulfilled their advocacy role by submitting requests for services for their clients. This was implicit in the belief that they did not expect the recommended service to be provided. One PHN stated that they were not advocating for its provision, but rather that they submitted the application, so that there was a record kept of the request.

We make a recommendation [to the client to access a service] based on the needs assessment. But we don't keep looking for the service, we know they [service] may not come out; we are not looking for it from them. I'm putting in the application, because it is down on paper like it is dated (P5, FG2).

At times, PHNs also expected lobbying from clients on their behalf, with one stating:

Our clients should be lobbying for us (P1, FG2).

### ***The experience of empowerment by clients***

The findings from the survey revealed that 78.3% of clients in this study who had accessed the services of the PHN indicated that they generally found the relationship with the PHN, at their children's development check, to be supportive. However, only 2.4% saw it as parent led, which raises some questions with regard to the translation of empowerment strategies between practitioner and client. The balance of power rested with the practitioner as was evident in the language of responses to the question "Which of the three statements below best describes the process of the relationship you had with the PHN at this developmental check?" For example:

I trusted her and I believed we were in good hands heading in the right direction (R22).

When questioned as to whether they felt listened to by their practitioner, 98% of clients responded that they did, which is particularly positive.

During the study, clients were asked whether during their interaction with the PHN they were encouraged to feel like an expert in their child's care and 69% responded positively, with 31% disagreeing. One respondent stated:

I felt ignored and as if I was being judged because I was a young single parent. Everything I know about babies I learned from my mother and with no help from the PHN. I feel the PHN only came to visit me because it was part of her job. I didn't feel she helped

me. I couldn't say that I could rely on her in any way. I was on my own (R14).

This respondent was the only single parent in the sample, and thus meant that there was no opportunity for the authors to test this against other similar respondent characteristics. The level of empowerment of the specific PHN in this client/PHN relationship is not known and while this is a limitation, it does raise questions with regard to how the needs of vulnerable clients are being met.

## **Discussion**

The study indicates that empowerment was something that the PHNs were concerned with in their practice. It was clear that these PHNs saw client empowerment as something they could possibly support if the circumstances permitted and if their empowerment was supported. However, they did perceive themselves to be experiencing varying levels of disempowerment. They attributed this to organizational factors. This reflects the experience of nurses and midwives in Ireland generally (Department of Health and Children [DOHC], 2003). These PHNs placed their clients' needs as central to their practice. The links they made between their own empowerment and that of their clients reflects the findings of Falk-Rafael (2001); however, the extent to which these PHNs understood the complexity of empowerment practices and how realistic it was within their work context was not evident. This reflects and supports the argument proposed by McDermott, Heather, Spence Lashinger, and Shamian (1996) that nurses need access to resources, knowledge, and organizational support to be effectively empowered. In the study, participants equated expertise with empowerment because they were aware that that expertise garnered respect from colleagues but whether this actually impacts on client empowerment was unclear.

An expert model of practice sits uneasily with client empowerment as is evident from the wealth of critique of the medical model (Illich, 1970; Ryan et al., 2006). Professional and client empowerment are complex issues, particularly the range of influences that can affect them. The lack of support within strongly hierarchical models of practice can adversely impact on practitioner empowerment. Institutionalized power in terms of managerial hierarchy and dependence on political good-will can mean that the

very organization within which PHNs operate could potentially be complicit in their disempowerment. An in-depth understanding of how empowering relationships are created from both individual and organizational perspectives is needed to guide emancipatory nursing practice (Aston et al., 2006).

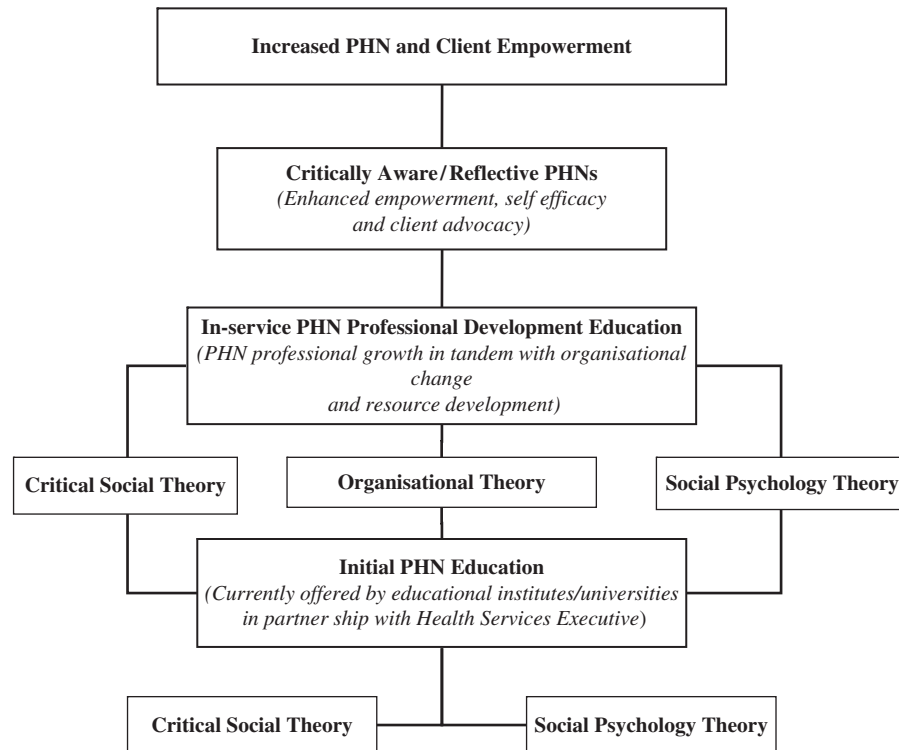
The authors suggest that PHNs need to be clear about the aim of their advocacy role and how to effectively engage with the organizational constraints, which frustrate it. They also need a better understanding of the theoretical and professional requirements needed to address problems of empowerment and advocacy. It was evident that different forms of disempowerment were experienced, ranging from resource to status-based disempowerment. The lack of capacity for organizational lobbying could be linked to uncertainty of status or role and to resource constraints. The experiences of empowerment and advocacy by the PHNs in the study reflect Seedhouse's (2001) argument that, in nursing, designated channels for advocacy are constrained by government policies and procedures. Clearly, the hierarchical model within which these PHNs operate is not effectively serving their empowerment potential. Disempowered PHNs may revert to the traditional medical model of expert to restore their professional autonomy. This potentially impedes PHNs' ability to facilitate client empowerment. Their capacity to effectively advocate for themselves and for their clients has been found to be significantly related to their perceptions of their immediate manager's power within the organization (Haugh & Spence Laschinger, 1996). Within this study, practitioner frustration with management provision of the support services necessary to facilitate client issues was manifest. Thus, the capacity to advocate in public health nursing is deeply influenced by the hierarchical nature of the nursing profession and the cynicism that can at times permeate organizational culture. Participants in the study believed that they needed to become more political (by this, they meant access to shared governance and decision making) and this reflected Clarke's (2004) argument that PHNs need to develop their political role. In order to do this, as argued by VanderPlaat (2002), PHNs need to see themselves as potential social activists, committed to an emancipatory ethic, who challenge barriers that stand in the way of meaningful social change not only for their clients but also for themselves. If PHNs are to engage in political activism in order to effectively lobby management and government

agencies for support, they need, as suggested by Falk-Rafael (2005), training, education, and professional development in the skills necessary to effect such action. Empowering PHNs needs to start in initial professional education and continue through in-service professional development coupled with supportive organizational structuring (refer Figure 1).

These findings suggest that while the PHNs paid significant attention to the building of relationships with their clients, power still clearly rests with the practitioner. Confidence building and reassurance (skills clients clearly wished to gain) were available in good measure: however, empowerment that would see the practitioner encourage the client to critique PHN practice and to lead interactions was not in evidence. This may be linked to the lack of empowerment that the practitioners themselves seemed to experience. While there was a general consensus in the study that empowerment was important and was something that they should be striving for, there was also evidence that the PHNs were not always certain about what exactly empowerment means or how it can be achieved.

#### ***Fostering of the PHN empowerment role***

Traditionally, the role of the PHN was seen in curative terms; however, the focus has shifted to the current emphasis on population health and health promotion. Within public health nursing, health promotion is for the most part articulated as an important aspect of practice (DOHC, 1997). However, in reality, given the increasing workloads and geographical regions that PHN cover, they readily admitted in the study that the health promotion aspect of the practice took a back seat in the drive to meet the curative needs of the client. The authors suggest that PHNs are uniquely positioned to influence the development of healthy choices among clients and to influence public policy via their in-depth knowledge of their clients' lifestyle issues. Such a position suggests "a moral imperative, not only to attend to the public health needs but also, as Nightingale encouraged, to work to change the societal conditions contributing to poor health" (Falk-Rafael, 2005, p. 219). It is here that advocacy plays a central role. The principles of health promotion, as outlined in Ottawa (WHO, 1986), are in keeping with the mission of public health nursing in the support for the development of personal skills, supporting community action, the creation of supportive environments, the reorientation of health services to a



**Figure 1. The Theory Basis for Enhancing PHN and Client Empowerment**

health promotion agenda, and the building of healthy public policy through advocacy. The findings suggest that the PHNs did not fully understand empowerment and did not feel equipped to advocate for themselves or their clients. While, in general, clients felt the practitioner/client relationship was very good, they did not indicate experiences of empowerment. Thus, PHNs may need to be supported to arrive at a coherent conceptualization of empowerment and of advocacy so as to be able to effectively integrate advocacy and empowerment into their practice. Empowered PHNs are potentially more successful advocates for their clients, but PHNs need support to work via active agency rather than the current approach of mediation to address the health inequalities in the communities within which they work.

While PHNs in the study strongly argued that they require support and empowerment, they also need to be open to functioning within a supportive framework if it is provided. The challenge is to support the development of professional autonomy for the PHN while also fostering a commitment to the relinquishing of attachment to an expert model of practice. Supporting PHNs to be more socially critically aware via education and professional development would aid them in in-

creasing their commitment to and engagement in client advocacy. This needs to happen within a more responsive health service, which actively supports practitioner empowerment. PHNs in this study, when under pressure, reverted to a traditional expert role that potentially interferes with their efforts at professional advocacy and empowerment.

The authors do not seek to generalize from the data presented here. This research is limited, given that this was in effect a small focus group study with a small-scale client survey. While the themes raised here may be relevant to some PHNs globally, the authors do not assume they are relevant to all. Rather the focus of this paper is to shed light on the issues explored that may be of some international interest. This exploratory research points to the link between organizational structures and practitioner empowerment, and in particular, the impact of resource-based disempowerment on professional status and PHN advocacy. Further research into the organizational structures within which PHNs function would serve to increase what is known about how supported they are in practice to facilitate empowerment and health capacity building for their clients. This research also indicates a need for further research into the link

between PHNs' own levels of empowerment and its impact on client support/empowerment and advocacy.

In order to successfully facilitate client empowerment, practitioners need to perceive themselves as autonomous, empowered practitioners. The PHNs in this study had clearly considered empowerment, with many citing experiences of structural disempowerment as negatively impacting on their practice. They were committed to supporting their clients; however, this did not translate into client empowerment to any great extent. PHNs need organizational supports in order to more effectively engage their clients in empowering ways. The development of PHN advocacy for and on behalf of clients requires much consideration but can only be effectively achieved in a sustainable manner if PHNs have access to the resources needed. The authors recommend that PHNs gain opportunities to critically reflect on the implications of their current practice. In order to achieve this, including raising PHN self-efficacy, continuous professional development together with a strong emphasis on personal development and ongoing support is needed. The provision of structured opportunities for PHNs and their managers to undertake a critical analysis in relation to their autonomy, and the nature of the hierarchy within which they operate, will create opportunities for organizational change that could better serve both practitioner and client.

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