

# The advocacy process in Canadian community health nursing: A collaborative ethnography

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## Abstract

**Aims:** To shed light on the process of advocacy in the context of community health nursing, through a methodology inspired by the epistemologies of the South.

**Design:** We conducted a collaborative ethnography in a community health centre in Canada.

**Methods:** de Sousa Santos' epistemologies of the South, a typology of advocacy and main themes from historic research informed the methodology. Data were collected between 2016 and 2018 through 420h of fieldwork observations and three group discussions, including a collective process to co-construct interpretations with participants. Twenty-one nurses participated in the study.

**Results:** Nurses had sufficient work flexibility to practice advocacy actions focused on individuals and groups. They also engaged in attempts at policy reform in the form of defending access to appropriate care and changing the mode of care organization. However, these were curbed by bureaucracy and administrative rules, resulting in the eventual dismissal of health promotion actions and experiences of moral distress.

**Conclusion:** Despite the political climate of their work environment impeding social justice agendas, nurses' advocacy practices showed a persistence of moral values and ideals in coherence with the regional nursing legacy.

**Implications for the Profession and/or Patient Care:** Acting at the organizational level and involving field nurses in decision making are potential avenues for increasing policy advocacy efficacy.

**Impact:** Examining contexts through another epistemic lens and methods of research drawing on history and anthropology has shed light on a process of advocacy. This research shows that organizations need to equip themselves with mechanisms to promote the sharing of realities between nurses, thereby building collective advocacy.

**Reporting Method:** The research adheres to the EQUATOR guidelines with SRQR and COREQ methods.

**Patient or Public Contribution:** No patient or public contribution.

## KEYWORDS

advocacy, community health, ethnography, health equity, health promotion, nursing, qualitative approaches, social justice

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## 1 | INTRODUCTION

Growing social inequalities are a major concern in the twenty-first century and have dramatic consequences on public health that have been exacerbated in the pandemic context (Nassif-Pires et al., 2020). In order to efficiently reduce social inequities, the focus of advocacy conducted by nurses needs to shift from patient advocacy to policy advocacy. However, the literature reports many obstacles for nurses trying to address the structural level of policy advocacy, and very little empirical research exists to show how nurses respond to these obstacles and the resulting impacts on the effectiveness of policy advocacy. In this article, we present the results of research conducted in a community health centre in Canada that was inspired by an epistemic lens from the South and methods borrowed from the humanities. We discuss the types of advocacy practiced by nurses who provide direct care and how they deal with contexts that may hinder their capacity for advocacy.

## 2 | BACKGROUND

Advocacy has been defined by nursing scholars in various ways. Studies performed in curative care settings tend to focus on patient advocacy, where the nurse's role is directed towards defending individual rights, whereas the fields of public health and community health nursing also incorporate policy advocacy to bring structural changes (Ezeonwu, 2015; Kalaitzidis & Jewell, 2015). Ezeonwu (2015) places her concept analysis on community health nursing advocacy within a social justice approach by specifying the need to address both individual and structural levels of change. However, structural-level changes appear difficult to achieve; the nurse's path to practicing this advocacy is impeded by many obstacles. Some studies report individual barriers, such as a lack of personal skills, confidence, motivation and training (Rasheed et al., 2020; Valaitis et al., 2014). These gaps may explain the abundance of calls by nursing leaders to increase advocacy skills and practice. However, studies also reveal that, despite receiving advanced training, nurses' political efficacy and their participation seems limited to modest, indirect actions such as voting (O'Rourke et al., 2017), indicating that education may be insufficient for successful advocacy. Regarding the role of education in social transformation, it has been reported that it is exaggerated, particularly by intellectuals from Northern countries influenced by a Western perspective, and that its potential harms are underestimated (Laperrière, 2018). Also, studies have shown that even well-trained nurses experience structural obstacles, such as working within the biomedical paradigm (Adams & Carryer, 2021; Farrer et al., 2015; Poghosyan & Carthon, 2017), poor care organization (Poghosyan & Carthon, 2017), gender issues (Rasheed et al., 2020), lack of organizational support (Chiu et al., 2021; Poghosyan & Carthon, 2017; Rasheed et al., 2020) and governance style (Chiu et al., 2021). Recently, researchers

denounced the tendency of health institutions to offload advocacy responsibilities onto the shoulders of individual healthcare professionals (Hubinette et al., 2014; Martin & Bouchard, 2020). We affirm the need for research to go beyond simple observations of obstacles to understand the processes within which nurses navigate in order to succeed—or not—in carrying out advocacy actions. Studying processes of advocacy under the circumstances of these obstacles is central to identifying ways to perpetuate nursing advocacy despite contextual changes.

Advocacy is indeed needed in both community health nursing practice (Dupin, 2015) and emancipatory nursing praxis (Walter, 2017). With COVID-19 and other potential pandemics, the involvement of nurses in the social justice realm and in workplaces outside hospital settings becomes crucial. Previous literature identified very little empirical research on nursing advocacy, especially in community health (Chiu et al., 2021), and a lack of qualitative research (Rasheed et al., 2020), which could shed light on what nurses actually do in the face of the organizational obstacles they encounter when attempting to carry out advocacy actions. The province of Quebec, Canada, has a history of community health that peaked during the 1970s. Formerly institutionalized through health facilities and nursing associations run by Catholic religious congregations (McCready & Thifault, 2020), Quebec society shifted in the 1960s towards secularization in the management of health, social services and education. Inspired by a few health clinics that sprung up in six working-class neighbourhoods, the Castonguay Commission (Gouvernement du Québec, 1970) resulted in the creation of a model of local community health centres (Gaumer & Desrosiers, 2004), which has served as an inspiration until today (Mariette & Pitti, 2021). The richness and legacies of successive decentralized community health models in Quebec, and the participation of nurses in these models, suggests that Quebec represents a fertile ground for studying advocacy processes. To advance nurses' capacities to perform effective advocacy, we argue that research must examine the particularities of the contexts in which advocacy takes place and how community health nurses react to structural obstacles. We contend that using another epistemic lens and borrowing from the humanities to craft a methodology holds the potential to uncover the dynamics of nursing advocacy experiences.

## 3 | THE STUDY

### 3.1 | Aim

The aim of this study was to uncover the process of advocacy experienced by community health nurses, specifically, to describe the types of advocacy practiced (or not), the contexts in which advocacy is practiced, how nurses respond to obstacles encountered and related consequences. A second aim was to show how an innovative methodology borrowing from the epistemologies of the South and the humanities (anthropology and history) could produce knowledge on the process of advocacy in nursing.

## 4 | METHODS

### 4.1 | Design

Collaborative ethnography (Lassiter, 2005) was chosen for this study, given our hypothesis that certain nursing practices remain unseen in the face of many obstacles. Ethnography draws on observational data to highlight elements that are not necessarily put into words as well as actions that are automatic and familiar to practitioners (Beaud & Weber, 2010). Our approach was in keeping with constructivist epistemology, which enables examinations of interactions between nurses, patients and other stakeholders in the healthcare system. Ethnography provides access to informal conversations, to the emic perspective and to complex social interactions, allowing researchers to characterize gaps between formal policies and what is actually being done (Lassiter, 2005; Ryan, 2017). We studied nursing practices as "pragmatic agreements that show how [nurses] 'get around' certain institutional constraints or social pressures on a daily basis" (Morrissette, 2011, p. 12, free translation). Ethnography shows a diversity of perspectives and reports the influence of various contexts on the provision of care (Bourbonnais, 2015; Khan et al., 2016). We specifically chose a collaborative type of ethnography to co-construct interpretations of the data with participants (McCall, 2011). Dialogue on the nursing contexts under observation and the meaning nurses ascribed to these work settings led to an interpretation of their actual practices (Monfette & Malo, 2018).

### 4.2 | Theoretical framework

We analysed the nursing practices in a community health centre in the province of Quebec, Canada, using epistemologies of the South, a perspective developed by Portuguese sociologist Boaventura de Sousa Santos (2014). In *Epistemologies of the South: Justice Against Epistemicide* (2014), de Sousa Santos reports how different perspectives of social movements and southern Indigenous groups build other forms of knowledge to which thinkers from the North are blind. de Sousa Santos systematized this knowledge, which he himself witnessed in the resistance of oppressed people in local communities in Brazil, leading to the creation of alternatives to the Western hegemony of knowledge production. He then invited other global sociologists to contribute to the perspective of the South. After the initial analysing of the relationships between groups in Brazil and thinkers from the North, de Sousa Santos explains that these types of North–South relationships extend beyond racial affiliations or geographical locations. The global North represents a transnational Western political thought that brings suffering to certain populations, and the global South represents those that are victimized yet resist through their alternative practices.

Drawing on the philosopher Walter Benjamin's allegory of history, de Sousa Santos claims that Western knowledge is reduced to a 'monoculture of linear time, the idea that history has a unique and well-known meaning and direction' (p. 173), often referred to as

progress. According to the sociologist, this logic produces 'nonexistences' or 'wastes of knowledge' that fail to recognize that different ways of being contemporaneous exist. The ecology of temporalities is suggested as a way of thinking to avoid the waste of knowledge. This ecology rests on the assumption that there are other conceptions of time, such as circular or cyclic time. Therefore, rather than conceiving societies as homogeneous groups functioning in similar ways at a given point in time, it is suggested that investigating the political and organizational behaviours of certain groups of people at a specific point of time, what de Sousa Santos calls rearguard theory, allows for the production of another knowledge, more capable of grasping complexity, and bearer of another possible future. De Sousa Santos also advocates an ecology of knowledge, which would include other forms of knowledge in addition to the scientific knowledge that tends to be hegemonic in Western societies. Alternative forms of knowledge that would be valuable are those which makes it possible to assess social acceptability, equity and longer-term consequences for humans and non-humans. Studying the alternative knowledge developed by nurses enables an understanding of the patterns of domination they face, and the inventiveness they demonstrate in escaping the constraints put in place by domination mechanisms. Epistemologies of the South have been used in previous studies about nursing knowledge and health issues (McCready & Ouimet, 2018; Pereira et al., 2012). We believe that conceptualizing nurses as a group of oppressed feminine professionals through the lens of epistemologies of the South represents a promising avenue for generating new knowledge about how nurses react to obstacles they face while practicing political actions. For example, because nursing knowledge is built on both knowledge acquired in academic contexts and that induced by experience and care contexts, de Sousa Santos' ecology of knowledge focuses the researcher's lens on those aspects of nursing work that are not predictable, a characteristic linked to advocacy skills given its equally less controllable nature.

### 4.3 | Study setting, recruitment and data collection

Our research site was a community health centre in Quebec, where the first author, a doctoral candidate, had volunteered since 2014. Founded several decades ago, this health centre serves residents of a formerly working-class urban neighbourhood that is now characterized by significant social and spatial inequalities. The researcher, who practised for 9 years as a community health nurse in another health centre, launched this study with a 4-month exploratory phase to document the nurses' work contexts, identify research questions and select the methods that were best adapted to the health centre's organization of work. During her volunteer activities, the researcher had not come into contact with nurses, as she was involved in a committee that did not include any. Her volunteer experiences had therefore given her some knowledge of the organization and its history, but not of the nursing work taking place there. The dichotomy between the political activities of the nurses and those of the volunteer group influenced her choice of subject for advocacy. Through their

interactions, the researcher's and participants' cultures grew closer, with a view to produce a written report on the nurses' experiences that would be both meaningful and useful to them (Lassiter, 2005).

All nurses at the health centre were invited to take part in the exploratory, ethnography and/or collective processes. Those who accepted signed a written consent. The ethnography involved shadowing the nurses in their daily tasks. The collective process consisted of five monthly 2-h meetings held in small groups that were self-formed by participants. Discussion topics included narratives of why participants chose the community health nursing profession, their representations of care and their success stories. Eleven nurses took part in the collective process, in three small groups. During the collective process, meetings were recorded. The first three sessions were transcribed by the first author. Some nurses participated in two or three components (see Figure 1). In all, 21 of the health centre's 33 nurses took part in the study. Reasons given for non-participation included being a recent hire at the centre, difficulty getting a release to take part, lack of interest and unstable employment conditions. However, the researcher had access to several informal spaces and team meetings to gather further observations about the nurses' interactions with their colleagues and supervisors. A total of 420 field hours were completed between 2016 and 2018. The study covered the six services/programs offered at the health centre: childhood-family, youth, school health, adult mental health, home care and routine care.

The observation chart used was constructed after the exploratory phase and drew on two pillars: (1) the National Collaborating Centre on Determinants of Health (NCCDH) types of advocacy action (2015); and (2) themes that arose from a historical study (McCready & Thifault, 2020). The first pillar consisted of the advocacy typology from NCCDH (2015) reporting on four types according to two axes: goals (protection and prevention or empowerment) and focus (individuals and groups or policies and structures). The types of advocacy are as follows: (1) representation or patient advocacy (protection/prevention and individuals/groups); (2) community development advocacy (empowerment and individuals/groups); (3) policy reform advocacy (protection/prevention and policies/structures) and (4) community activism advocacy (empowerment and policies/structures).

The second pillar corresponds to four themes from the findings of historical research on the community work of Franco-Catholic

nurses in Canada from 1934 to 1959 (McCready & Thifault, 2020). The primary sources used for that research were texts from a bulletin of the Association of Catholic Nurses in Canada, published six times per year, in which the first author looked specifically at the conceptions and practices of nurses working outside of hospitals. The four themes were as follows: (1) a philosophical approach to contesting social orders to act on the causes of poverty; (2) a supporting organization (association of nurses) encouraging nurses' political actions; (3) resistance to techno-bureaucracy in care and (4) preservation of human dignity by preventing the separation between the body and the social mission of humans. These pillars guided the researcher's view during field observations to 'see' the types of advocacy practiced (or not) and the elements of advocacy that were in continuity with or disconnected from the legacy of knowledge specific to a group of French-speaking nurses in Canada.

#### 4.4 | Data analysis

A content analysis (Elo & Kyngas, 2008) was conducted for each group, and themes were identified using the observation chart. These themes, consisting of concepts, practices and nurses' concerns about contexts influencing their ideal practice of care, were presented to participants for validation and co-analysis at the fourth group meeting. The fifth meeting was dedicated to discussing dissemination of the findings. Data from ethnographic observations were collected using methods developed by Beaud and Weber (2010) and recorded in a field journal that included both objective and subjective data, which were analysed at various points (see Figure 1) for comparisons over time. At the last two points, themes emerging from the three groups were compared with observational data to identify elements that repeated or appeared to be priorities for the participants.

#### 4.5 | Ethical considerations

The study was approved by both the health centre and the University of Ottawa's Health Sciences and Science Research Ethics Board (# H05-17-12). An agreement was drafted and signed with the

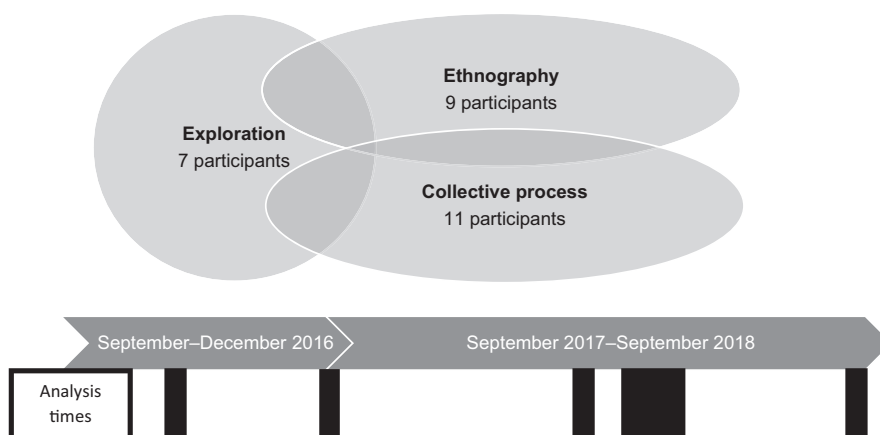


FIGURE 1 Data collection, participation and analysis process.

health centre's administrators, and an advisory committee was set up to define the stakeholders' involvement and address potential ethical issues. When the nurses were providing care to the patients, the researcher or nurse verbally asked the patients for permission for her presence (in advance when possible). To write the final results report, the researcher offered participants the opportunity to rework how they told their stories and to remain anonymous.

#### 4.6 | Rigour

Several precautions were taken to ensure the rigour of this study. The study was enhanced by the choice of a rich but small field setting, receptivity to adapting the data collection method to report unexpected data, the long data collection period and alternating between data collection and analysis (Royer, 2016). The collaborative approach included the involvement of participants in interpreting elements the researcher perceived to be relevant, the expression of findings using the participants' own vocabulary, the emphasis on dialogue between researcher and participants and the usefulness of the research for the individuals involved (Lassiter, 2005). The study's credibility was enhanced by the researcher's volunteer involvement in the field and her work with community stakeholders in designing data collection methods, co-analysing data and deciding how to disseminate findings.

### 5 | FINDINGS

In the following pages, we present findings according to the first pillar of the observation grid. Therefore, we present the types of advocacy that were present, then the types that were absent and finally what emerged through the contexts of advocacy practices (i.e. its process). The extracts presented are of two types: quotations from participants (with pseudonyms), or observations by the researcher noted in her field diary (in italics), which are identified by diary number and page. Participant characteristics are profiled in Table 1.

#### 5.1 | Types of advocacy practiced by community health nurses: Patient advocacy and community development advocacy

Observations of nurses' daily actions showed that participants often practiced advocacy. Participants carried out patient advocacy actions by strengthening the capacities of patients living in unfavourable conditions. When nurses noticed precarious economic, social or material conditions, they prioritized these conditions in their assessments and interventions. Aware of the delays that can occur when referring patients to social workers and community organizations, some nurses went so far as to cook meals or pick up groceries for a family. The study participants emphasized the impossibility of separating 'the social from the medical' in patients' situations, particularly in the area of housing:

TABLE 1 Participants' sociodemographic characteristics (2018).

Characteristic	# nurses (n = 21)	% nurses
<b>Age</b>		
30 years and under	4	19.0
31–40	4	19.0
41–55	7	33.3
56 years and over	6	28.6
<b>Experience in community health</b>		
0–5 years	7	33.3
6–10 years	3	14.3
11–20 years	7	33.3
21–30 years	3	14.3
31+ years	1	4.8
<b>Employment status at the health centre</b>		
Full-time position	16	76.2
Part-time position	3	14.3
Occasional (on call)	2	9.5
<b>Initial training in nursing</b>		
College diploma (3 years)	17	81.0
University degree	4	19.0
<b>Highest level of education completed</b>		
College diploma	8	38.1
Undergraduate certificate	5	23.8
Undergraduate degree	7	33.3
Master's degree	1	4.8

I have a man right now who has a bathtub without a pipe. So, he has developed bacteria on his skin, causing him sores. I am looking for a place for him to shower. My job is to manage chronic illnesses, monitor medication, provide wound care. But all of this is done very slowly, because we have to deal with bedbugs, or a fridge, a faucet, a shower, a bed that broke... (Danielle)

Taking care of people's material conditions, whether or not a social worker was involved in their care, was therefore a must. Due to such precarious living conditions, unforeseen circumstances often arose during nurses' tasks:

*The patient, who is elderly and diabetic, is sitting in his office chair. He's an obese man, wearing shorts only. He has abrasions on his knee and nose. His computer and his medication are sitting on the table next to him. He is drinking a soft drink and a case of it can be seen next to the refrigerator. He talks very slowly. He has put all his medical supplies on the table. Patricia checks his blood sugar and asks him about results that were too low last month. He doesn't answer. She continues by asking him about the changes the pharmacy made to his medication. When we leave, Patricia voices her concerns to me.*



*She is worried about his ability to take his medication on his own, especially since the pharmacy made changes to their medication delivery. Does he know what to do about his blood glucose results? She tells me about two falls he had this week and wonders if they could be linked to taking the wrong medication for high blood pressure. Patricia is late in her visits; she tells me that this last visit lasted longer than scheduled. (7–50)*

Nursing intervention in a context of disadvantage involved more frequent reassessment of the situation on several dimensions such as self-care knowledge, lifestyle habits and social and material conditions (e.g. living alone or unhealthy housing). The nurses were skilled at adjusting and reacting quickly to unexpected situations, such as the presence of bedbugs, the sudden onset of acute respiratory difficulty secondary to a heatwave, or the interruption of care by the presence of pets. However, they did not all have the same flexibility in managing their time. In programs where the need for curative care was very acute, nurses had less freedom in terms of responding to unexpected events and providing the planned care. In more flexible programs, nurses modified their schedules to accommodate patients with special needs, such as young people or patients with mental health issues or addiction. This freedom allowed nurses to exercise their judgement and adjust to differentiated needs. Similarly, they could also choose the most appropriate location for the care they delivered:

*Nicole brings me along for lunch at an organization that offers many services in the community. For her, it is important to meet people in the neighbourhood, and she calls herself a “person of action”. In the large dining room, I notice families with children, homeless people and construction workers, among other lunch-goers. We eat with a community worker from the organization and a woman who tells Nicole she has a bad cough. Nicole explains that it would be good if she could listen to her lungs and invites her to come to the clinic later that very day. Nicole later tells me that when she has lunch at the organization, she is Nicole and not “Nicole the nurse”. This allows her to have different kinds of interactions and to provide services to people who do not come in asking for them. (2–43)*

Such outreach work enables neighbourhood residents who tend not to come to institutional facilities to build a relationship of trust with the nurse on their own terms. Thus, this action was done in favour of access to care and attesting to the primacy of adjusting care to the needs of patients.

Other nursing actions were focused on community development advocacy but were never named as advocacy. Some nurses became facilitators in the community in order to create a climate of social cohesion. For example, one nurse paired immigrant mothers as a way of countering their isolation. Building mutual support within the community was also done through sharing material goods. One child-family nurse collected objects from more affluent families to

give them to families in need: ‘I am a recycler. I received three baby carriers from a patient’s aunt, and I put them back into use. They are now being passed from one mom to another. I pick up clothing and toys for all the underprivileged cases’ (Brigitte).

Through their actions, nurses made sure not to connect anyone that was isolated with community resources:

*Elianne invited me to walk with her to “her” school, where she was meeting with a parent. She told me about a child who had nosebleeds. Elianne sent him to the hospital for tests, and he was later diagnosed with hemophilia. After several attempts to meet the father, who was often away for work, she suggested they meet in his home. Elianne built a relationship with the grandmother, who was allophone and very lonely. She referred her to French courses at her grandson’s school and to the collective kitchen in a nearby organization. (2–53)*

Another nurse worked to support community workers through the creation of a community of practice:

*Maud has been working in the Mental Health program since 2002. She explains to me that 5 years ago she created, in collaboration with other partners, the Sharing Space. This initiative was created because of difficulties expressed by several community organizations in the neighborhood who claimed to feel helpless in the face of citizens who showed signs of distress or disorganization. She then committed to participate in these meetings to share her knowledge of mental health and, more broadly, her experience as a professional in the health network. The purpose of these meetings is to provide space for exchange and support between community stakeholders, so that everyone is more comfortable in their role in complex or difficult situations. There were several issues to discuss: how to ensure the confidentiality of people showing signs of distress or “disturbing” behavior and how to ensure that everyone around the table feels confident in order to share their limits in these situations? The first three meetings were dedicated to establishing an ethical framework for future meetings. Since then, these have taken place three or four times a year. The initial group has changed, some members have left and others have joined. Particular attention has been paid to ensuring that newcomers understand the issues and integrate well into the group. Maud says that her “expert” knowledge combined with the experiential knowledge of community workers allows them to solve problems present in the daily life of the community, facilitates the social integration of citizens presenting mental health problems and supports or validates the community workers in their practices. (2, 1–3)*

The nurses contributed to (re)building a community around these patients, sign of their adherence to a definition of health that is inseparable from social participation. Nurses committed therefore to reducing social inequities by alleviating the burdens experienced by families living in more deprived conditions.

## 5.2 | Types of advocacy not practiced by community health nurses: Community activism advocacy

Participants of this ethnographic field study did not practice community activism advocacy. These activities, which aim to change macro-policies through actions such as forming coalitions, were performed by community organizers in the health centre. Very little collaborative work was observed between the health and social services professionals and the community health workers at this centre.

As for policy reform advocacy, it was in their attempts to exercise this type of advocacy that nurses encountered the most context-related difficulties. We report on these contexts in the next section.

## 5.3 | Contexts surrounding attempts at policy reform advocacy: Emergence of a process of policy advocacy

It was in participants' attempts at policy reform advocacy that a process of advocacy became visible. Although patient advocacy and community development advocacy can be actioned through building relationships between the nurse and the patient, families and groups at the local level in the community, policy reform advocacy requires that specific situations be raised with colleagues in decisional positions who are capable of changing the organization of care, rules or policies of the health organization. Therefore, these attempts by community health nurses took the form of defending access to appropriate care and changing the mode of organization of care.

Nurses who had been working in the neighbourhood for 10 years or more reported observing a trend towards dehospitalization (i.e. patients being discharged more quickly than previously). This has led to an increase in the acuity and complexity of the medical and social conditions of patients, which in turn has intensified nursing interventions. Participants reported that the severity of medical conditions and poor housing situations often warranted longer hospital stays. However, these patients were sent home too soon, and subsequent attempts to work collaboratively with hospitals often resembled a 'battle'. Even occasional hospital consultations could lead to increased care demands in the community. Nurses reported having to 'pick up the pieces' by consoling, reassuring and rebuilding trust after a hospital visit went badly, then following-up with hospital staff to make sure patients were better served the next time:

Last week, I received a woman for a urinary tract infection, and I see that she is very emotional... I don't quite understand, so I say: "Are you alright?"

"No. I went in for a colposcopy this week and I was received like... they would have been robots these people and it would have been the same. Nothing human. I was so upset and hurt, I cried all evening when I came back home. They did not explain anything".

So I received her in that experience and said: "Listen, there's nothing I can do because it is now done, and that is sad. Maybe it was the context that made people act like this. I wish it was not like this all the time". It was hard for me to regain trust from that patient. I had to reassure her, explain to her what had not been explained at the hospital. We are the people who get them back, these patients that are scared. I told her: "Don't go back alone to this hospital. That's the best I can tell you. That way, if you are upset or hurt, you have someone with you, who can support you". I had to stop referring to this hospital because I received many complaints from patients... and it is happening again. So now, I will call the doctors and check with them what is happening. (Lucy)

What was not done appropriately at the hospital caused extra work for the community health nurses and resulted in the necessity to take advocacy actions. The repetition of this type of experience demonstrated the absence of structural change, creating a feeling of powerlessness among nurses.

Advocacy was also deemed necessary within the health centre. Some programs adopted procedures to distribute tasks among professionals:

To request services, you have to wait until the following Tuesday. If I'm absent, the client doesn't receive the service on time. Often, the file has to go through the rehabilitation technician, who is often overloaded but still has to make sure the "right" equipment is in place. Unfortunately, clients often don't have the money to adapt their homes, and this means even longer delays. Then there is the clinical coordination stage, where requests are discussed. Sometimes we have to justify ourselves: I can't ask for a hygiene assistant if I haven't filled out the Multi-Clientele Assessment Tool, if I haven't documented their need, if I didn't make the referral to the rehabilitation technician. I also have to make sure that everything is there: the bath mat, the bath, the bench, the proper shower curtain, and make sure that her cat is going to be in another room, that her daughter is going to have prepared her clothes the day before... All of that,

before I go to service allocation and say, "Can we give her a bath?". (Danielle)

Nurses knew what was needed to meet patients' needs, but faced constraints in implementing interventions. In the face of such bureaucracy, study participants spoke of their exasperation at constantly having to 'negotiate' services for their patients:

We have direct contact with the client. We know exactly what they need, and we know what the level of urgency is. So, it can be frustrating when we have to negotiate with other people who don't know the client. Administrative frustration, because you have to fill out a form, another form, three forms... And then wait for the other person, whose job is to manage a budget, maybe that person also has constraints... Between the human side of things, with what we experience—because we're in touch with the client, we understand their reality—and all the paperwork, that inert lifeless matter, it's tough. If we're frustrated, it's because we're doing good work and taking the person's best interests to heart. If we only had to do paperwork and deliver our goods, we wouldn't feel like that. (Hilda)

Many nurses had difficulty conveying their relationships with patients to the 'administrative machine', which is necessary for obtaining care. Some even questioned the organization of care provision:

*In mental health team meetings, Justine and Nicole report that an intermediate resource centre often seeks their help for clinical care, such as urinary catheters, anaphylactic reactions and wound care. Residents are*

*housed there primarily for mental health issues, but they also have chronic physical illnesses. The nurses are concerned about the lack of nursing care in this centre, the urgent one-time needs of some residents, hospitals referring residents to the centre when they require nursing care and the need for periodic re-assessment of residents' health status, which is not being done. (2–65, 3–77)*

Nurses perceived certain populations as not being seen by others, and they tried to get their colleagues and supervisors to recognize the needs of these populations. However, their attempts were sometimes curbed by administrative rules that stemmed from the very structure of public health programs, from agreements with other healthcare institutions or from internal rules about how services operate. Also, given the acuity of cases in the community, nurses had to choose between curative care, preventive interventions and health promotion activities. When they met with patients, many nurses ended up 'putting blinders on' in order to limit the scope of their assessment to curative care, which they considered to be the most urgent (see Figure 2).

Although many contexts required nurses to take advocacy actions, they often felt that their concerns were not being addressed:

Your heavy caseload isn't solved just because you hand off a patient or two every day to someone else. By delegating your patients when they're stable, someone else goes to visit them. Then, when you haven't seen [the patient] for a month or two, and things have changed, your colleague reports back to you. And so, at the end of the day, you've got just as much work. People will tell you, 'Great, you're up to date on all your paperwork!' but that's not going to solve the patient's problem. And when I say this, it's like it's not

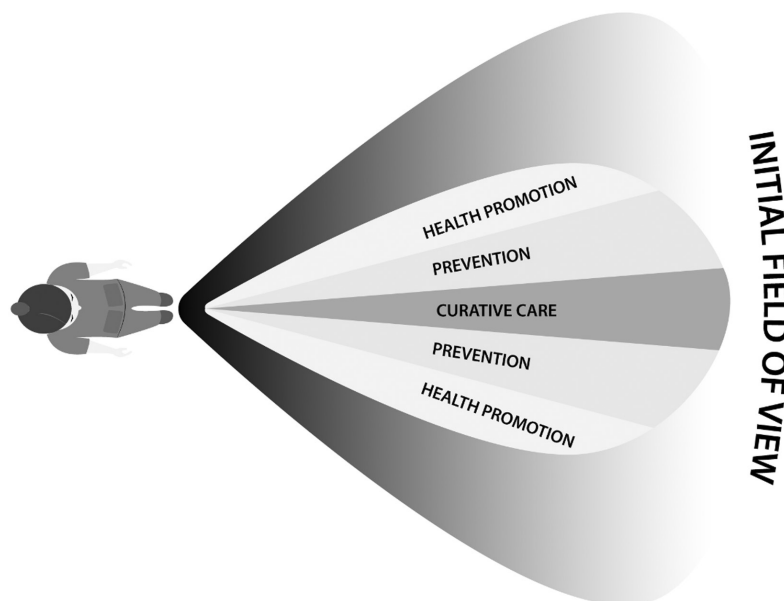


FIGURE 2 'Putting blinders on': limits to the community nursing evaluation and intervention. Credit image: IMPAKT Scientific.



taken seriously. People say you must not be managing things right, so you start to doubt yourself. Because it's no longer about the organization more generally, it's about you as a person. I go to work in the morning and I'm not satisfied because I can't prioritize the cases I find most important. (Solange)

Solange's experience shows the individualization of responsibility that occurs in the healthcare organization. Coupled with constraints during the practice of advocacy and work with disadvantaged populations, the risk of experiencing moral distress was heightened. On a collective level, after witnessing the devaluation of colleagues' work, some nurses chose to keep silent and not speak about their interventions aimed at improving the social and material conditions of patients. Nurses who took part in the collective process all reported that their participation was motivated by their desire to be recognized for their work. The lack of acknowledgement of their observations and judgements was a source of moral distress for many, who had to continue providing care even when facing the consequences of insufficient or inadequate care.

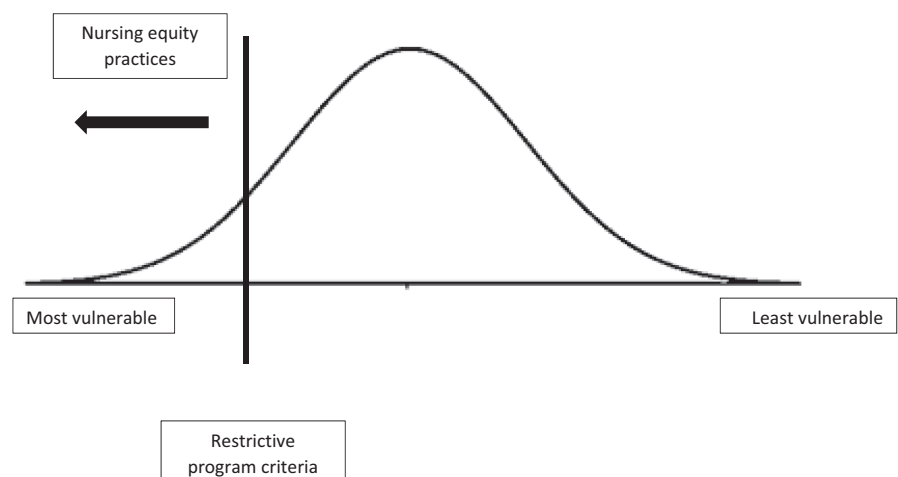
Our ethnographic observations showed that meetings, whether among nurses or between nurses and other coworkers, were often used for protocol development, training, work allocation, administrative processes and accountability mechanisms. Little discussion time during meetings was allocated to nurses' concerns, particularly those related to transforming the organization of care or politicizing certain health issues. For some nurses, their very availability to participate in meetings was constantly jeopardized by their workload. The 11 nurses who took part in the collective process seized the research project as an opportunity to collectivize their experiences and considered the study a rare chance to discuss their practices more freely and to reflect upon them. However, when it came time to decide how to disseminate their practices, only one nurse was willing to do so on her own.

## 6 | DISCUSSION

Findings showed that the study participants' work reflects health equity practices (Falk-Rafael & Betker, 2012). By responding to

material needs and advocating for access to care, nurses demonstrate their efforts to deconstruct the obstacles keeping the most disadvantaged patients from experiencing better health. Health equity can also be seen in the redistribution of resources to accommodate those most in need (NCCDH, 2015). Their in-depth knowledge of programs and target clientele allows them to 'play with the rules'. By raising restrictive thresholds to increase program accessibility for disadvantaged patients (see Figure 3), nurses ensure that this population's needs can be more adequately met. The great effort required of nurses to make services accessible for some of their patients demonstrates that the structure of community health programs is aligned with the principles of market justice, which assert that individuals are entitled only to the goods and services they deserve (NCCDH, 2015). In contrast, the nursing practices observed in this study are in keeping with a contextual definition of equity (Wilmot, 2012); indeed, they represent a political position that fosters social justice, i.e. a balanced distribution of society's benefits and burdens among all citizens and optimized social participation (Buettner-Schmidt & Lobo, 2012).

Previous studies have shown a lack or absence of policy advocacy (O'Rourke et al., 2017; Rasheed et al., 2020). Here, the wealth of observational data contextualizes the advocacy practices of nurses, revealing the emergence of a process of advocacy and related explanations for the absence of policy advocacy. Findings show that nurses attempted policy reform advocacy when they were confronted with a schism between their values and those of the health centre. Moral distress, a known concept in nursing (Salari et al., 2022), acts as a trigger of engagement in structural advocacy, as well as an ending point when nurses go unheard in their advocacy attempts. When nurses face obstacles voicing their concerns about access to care—the very definition of policy reform advocacy—they sometimes chose to hide their equity practices. By doing so, nurses shelter these practices from an organization that does not value them, a gesture that is useful to ensure the viability of equity practices. However, hiding equity practices can also have adverse effects. Because effective advocacy requires action that changes structures and policies (Reutter & Kushner, 2010), silencing situations rather than voicing them does not contribute to the reduction



**FIGURE 3** Representation of nursing equity interventions against the contexts of population vulnerability distribution and restrictive program access.

of social inequities and, therefore, adds to the burden of curative work in community health. Also, silence can be a sign of moral distress, raising the importance of advocacy opportunities which could reduce its occurrence among nurses.

Participants experienced difficulties practicing health equity practices in the face of an administrative apparatus that slows the response to patients' health needs. The work environment of nurses in Quebec has been infiltrated for about two decades by new public management, aiming 'to strengthen systemic efficiency, in particular through the increased use of technologies or standardized clinical tools for assessing user needs' (Couturier et al., 2018, p. 116; free translation). Here, a paradox emerges: this political environment is both a significant trigger for community nurses to engage in policy reform advocacy and a major obstacle to the success of this very advocacy. The ineffectiveness of this type of advocacy can be explained by the fact that the techno-bureaucratization of care has several deleterious consequences, reported by other researchers, such as a loss of power experienced by professionals, a lack of support for their practices, mistrust of leaders, feelings of injustice, insecurity and anxiety, individual and collective demobilization, the abandonment of the practice of partnership with the community and of services intended for the most vulnerable as well as the absence of support from managers, unions, professional orders and colleagues (Couturier et al., 2018; Grenier & Bourque, 2018; Martin & Bouchard, 2020). This climate undermines the practice of community health within social justice agendas.

Participants' practices aligned with social justice values, showing that nurses carried out types of advocacy in continuity with practices dating from before the Quiet Revolution in Quebec. Practices focused on individuals and groups were very present, which is in line with the pursuit of Catholic values inspired by personalism, advocating for the indissociation of the body from its social and spiritual mission (McCready & Thifault, 2020). Thus, the nurses who practice community health today seem to share common values with those who preceded them several decades ago. These results suggest that a persistence of moral values and ideals is possible in the collective memory of community health nurses, despite successive waves of reform to the health network and new public management, which have altered the work environment in community health (Grenier & Bourque, 2018). The rearguard theory of de Sousa Santos (2014), therefore, renders visible the acts of resistance of contemporary nurses. However, whereas the nurses of the past benefited from significant support for their political actions from Catholic associations (McCready & Thifault, 2020), those of today face a lack of organizational support. These results are aligned with other studies showing a lack of organizational support (Chiu et al., 2021; Poghosyan & Carthon, 2017; Rasheed et al., 2020) or even constraints such as repressive measures and censorship (Martin & Bouchard, 2020; Gagnon et al., 2022).

As recent studies have shown, organizations play a crucial role in attaining equity in health practices. They do so through the following ways: supporting overburdened staff, ensuring that professionals practice to the full scope of their expertise, tailoring services to

needs, aligning organizational ideology with that of practitioners and supporting emerging situations and knowledge sharing (Lavoie et al., 2018; Meagher-Stewart et al., 2010; Wong et al., 2014). However, findings showed that these organizational characteristics were not often present to support community health nurses' policy reform advocacy. The process of advocacy shows that care can become inequitable when the experiences and knowledge of field nurses are not taken into account. Unacknowledged by supervisors, nursing practices are, as de Sousa Santos (2014, p. 151) says, 'a waste of knowledge'. Furthermore, when colleagues and supervisors are unable to dedicate time to recognizing nursing knowledge, moral distress can occur (Falk-Rafael & Betker, 2012), which can have drastic consequences on the sustainability and quality of care provision in the community. As reported elsewhere (McCready & Laperrière, 2023), imperatives to carry out advocacy initiated by academic nurses can also lead to moral distress among nurses in the field. Moreover, the involvement of those concerned (Nedlund & Bærøe, 2014) is necessary to any equitable organization of care. Community health nurses provide the full continuum of care phases identified by Tronto and Maury (2009), from identifying needs, coordinating care and directly delivering this care to ensuring that the patient adequately receives it. For this reason, their observations should be considered in decision making about how care is provided, an avenue praised by many scholars (Butterfield, 1990; Chiu et al., 2021; Martin & Bouchard, 2020; Rasheed et al., 2020).

Strengthening nursing policy advocacy could be done by improving the receptivity of nurses who hold positions of influence and their solidarity with field nurses. It could also be attained by building legitimacy in partnership with citizens' groups, as has been successfully attempted elsewhere (Martin & Bouchard, 2020; Nedlund & Bærøe, 2014). To reinforce the legitimacy of nurses, it is necessary to take into account that healthcare institutions and nursing associations tend to shift the responsibility for advocacy to individual professionals rather than fostering collective advocacy (Hubinette et al., 2014). Because nurses do not all have the same opportunities for effective individual advocacy, its collectivization would indeed benefit all nurses. This type of advocacy is often overlooked in the literature on nurses' political actions, even though collective advocacy fits into feminist strategies to be heard (Hooks, 2000). We point out that nursing advocacy will only be effective when field nurses have the necessary venues and resources to combine their voices, to bypass organizational obstacles and to minimize the consequences of advocacy on individuals.

## 6.1 | Limitations

A limitation of this study was that the participation of newly arrived nurses and those in more precarious employment positions lower than that of others may have created bias resulting in an overestimation of the level of political engagement of nurses. The act of creating a collective space for research that did not exist otherwise

could have also provoked advocacy actions. The perspectives of nurses in other roles, such as managers, were not explored, which could have revealed other contexts for nursing advocacy. Also, the perspectives of nurses providing direct care, who tended to transfer obstacles to policy advocacy actions into factors extrinsic to themselves or to the profession, were favoured. This may have reduced the perceived contribution of other influences, for example that of the professional identity of the participants with regard to their own role. Patients' perspectives were also not included, limiting the assessment of the adequacy of nurse's care in terms of its reception by patients. In the co-analysis process, subjects on which there was consensus were retained to the detriment of those which tended to divide nurses.

## 7 | CONCLUSION

This research provides novel insights into the process of nursing advocacy. Behind the apparent invisibility of nursing advocacy on policy, explanations of its process shed lights on acts of nursing resistance in face of hostile organizational climates and the links between experiences of advocacy and moral distress. In addition, this research takes a specific look at the historical continuity of nursing practices rooted in social justice values that make up a legacy specific to French Canadian nurses. These are findings from a minority group of nurses who are not always well represented in mainstream research. Contemporary nurses may benefit much less from organizational support to transform policies in their advocacy attempts than their counterparts working 80 years ago, limiting policy changes that would benefit population health and social justice agendas. 'Rediscovering' nursing practices from the past can serve to mould researchers' views of actual nursing practices in the face of constraints. These results were found because of an original methodology of collaborative ethnography based on a theoretical framework combining Epistemologies of the South (de Sousa Santos, 2014) with historical research specific to the group studied. The innovative methods of investigation borrowed from the humanities (history and ethnography) may inspire other researchers in the nursing discipline. Finally, this research opens up future avenues for further investigation and detailing of the links between advocacy practice and gender issues in nursing.

### AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE\*): (1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content. \*<http://www.icmje.org/recommendations/>.

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No conflict of interest has been declared by the authors.

### PEER REVIEW

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### DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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### ENDNOTE

<sup>i</sup> In these circumstances, the researcher was studying the practices of the participating nurses, including their interactions with other people. She was not studying the practices of the other people present. However, the researcher did see fit to verbally request permission for her presence when these occasions arose. The researcher introduced herself and her research objectives at a staff meeting at the beginning of insertion into the research field, so she was known to the others present.

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