MARKETING THE SERVICE: BASIC SOCIAL PROCESS IN HEALTH VISITING.

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor of Philosophy in the Faculty of Medicine.

C. de la Cuesta.

Department of Nursing.

JUNE 1992

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

ABSTRACT

The present study was undertaken to provide an understanding of the processes underlying health visiting practice. The research strategy selected was grounded theory (Glaser and Strauss 1967, Strauss 1987, Strauss and Corbin 1990). A total of 21 female health visitors from a District Health Authority in the North West of England participated in the study. Data was collected by means of 20 formal interviews and 41 days of participant observation in four different health centres.

To recognize the basic social process in any interaction is one of the major aspects of grounded theory. This requires the identification of the "Phenomenon" which motivates the development of a process and the conditions under which it operates. The basic problem or phenomenon in health visiting uncovered in the data was **"Securing Life Trajectories"**. This forms the core of the health visitor's work. The general set of conditions that influence health visiting work was identified as **"Working Between Two Worlds"**. This is used to describe the health visitor's position between the policy agenda and the client's agenda. The process revealed in the data that health visitors use to respond to this overall problem was **"Marketing Health Visiting"**. This refers to the different tactics that they use to introduce the policy agenda into the client's domain. During this process the policy agenda is adjusted to fit the client's circumstances. Three major strategies

are identified in this process: 1) Promoting the service, 2) Adjusting delivery and 3) Tailoring the content.

This study found that "Marketing Health Visiting" is a gradual process in which the health visitor wins grounds as time passes. As marketing strategies are implemented the conditions influencing the interaction change. Hence it moves from taking place in what is labelled in this study as "Dissociated Context", to a "Convergent Context" and finally to a "Shared Context". The final consequence of implementing marketing strategies is that of constructing "A Common Agenda" with clients. This agenda is basically the personalisation and contextualization of health visiting services. To build this common agenda it is of crucial importance that the client should see and feel the need for the health visiting service as well as the development of trust between the professional and the client. Hence the relationship that is developed between them acts as an enabling factor for reaching mutual collaboration.

The discussion of the study focuses on its significance within the actual debate on health visiting about introducing new ways of practice. The health visitor's overall role is examined and the importance of developing relationships with clients is also highlighted.

ACKNOWLEDGEMENTS

Many people have given me generous assistance in doing this study and I would like to thank them here. The first debt is to the General Directorate of Health Planning at the Spanish Ministry of Health who financed my work for two consecutive years and to the Social Security Fund for Research (FISS) who financed it during the third and last year. This work could not have been conducted without such generous financial support. I am also indebted to the Assistant General Director for Primary Health Care, Dr Garcia Encabo who granted me permission to be absent from work in order to pursue the PhD studies.

I would like to thank especially the participants of the study who were not only generous with their time but honest with their opinions and courageous in letting me observe their practice. Their willingness to collaborate in this study made its development possible. Professor Karen Luker, my research supervisor, gave me expertise, support and confidence throughout the research project. I am thankful for her help and understanding from beginning to end.

Many thanks are also due to all the staff at the Department of Nursing in the University of Liverpool who helped me in many ways and made the task of this research easier. I would especially like to thank Janet Evans and Kate Cernick, lecturers in health visiting, for reading early manuscripts, lending

me their books and sharing with me their knowledge. Dr. Nicky Cullum gave me great help and support in organizing the data base for the report references and Jackie Lucock was always willing to help me with the technicalities of processing the text in the computer. I thank them for making this work so much easier. I also had help and encouragement from Ann Pursey, my fellow graduate student, Ann Louise Caress, Margaret Ling and Sue Kirk, research assistants at the Department of Nursing.

During the phase of analysis, I benefited from insights received from Dr. Robert Dingwall, Jenny Popay, Peter Sainsbury and Alex Scott Samuel. They all gave me willingly their time and expertise. Dr. Karen Chalmers read parts of the analysis, commented on it and gave me useful suggestions. I thank her for her generous help. Special thanks are due to Dr. Hildegard Peplau who gave me support, sensible advice throughout all the research study and facilitated my visit to the School of Nursing at the University of California San Francisco (UCSF). Here, Dr. Ann Davis arranged the programme of interviews and, together with Dr. Virginia Olesen, commented constructively on this work. I appreciate very much the time and good advice which Dr. A. Strauss gave me during this visit as well as his commitment to continue to help in the future. Dr. Shizuko Fagerhaugh and Dr. Holly Wilson generously shared with me their expertise in grounded theory. Dr. Janice Swanson provided me with insights into the practicalities of grounded theory, made many useful comments on my work and, despite her busy work schedule, was always willing to help. I thank her very much for her valued assistance.

Finally, I am indebted to Miss K. McNutt who corrected all the drafts of this report and transformed them into understandable English for the reader. I thank her for undertaking this task with such generosity and concern.

I am also indebted to Dr. Brenda Roe who not only gave me support during all the research study but also reviewed the final draft of this thesis ensuring the appropriateness of the language. Many thanks are also due to Julie Hotchkiss who did the final proof reading of the report in her own spare time.

TABLE OF CONTENTS

FIGURES LIST

TABLES LIST

"Theory functions in the service of action - it has no other purpose-but effective (and moral) action is possible only thorugh theory that apprehends the true nature of reality".

(Strauss 1978 p.23)

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND

This thesis presents a grounded theory study of health visiting. To recognize the basic social process in any interaction is one of the major aspects of this approach. This requires the identification of the "phenomenon" which motivates the development of a process and the conditions under which it operates.

My interest in examining processes underlying health visiting practice was aroused because of the changes that were advocated for nursing in the community and my involvement in the Spanish primary health care reform.

Since the late 70's changes in health care systems have been advocated in order to achieve the World Health Organization (WHO) goal "Health for All by the year 2000" (WHA 1977). Primary health care (PHC) was identified as the key element to achieve this goal and nursing was highlighted as leading the way to it (Mahler 1985).

The "Health for All" movement had great repercussions in Spain. 1984 saw the start of a major reform in health services delivered outside hospitals.

This reform involved the setting up of a model of PHC along the lines stated in the Alma-Ata declaration (WHO 1978). PHC centres were built and teams were set up to serve populations between 2,000 and 25,000. In 1988 about 30% of the population [1] was covered by this new model of health care.

For nurses working in the community this reform implied the transition from a passive and subordinate role of medical curative services to an active role in PHC. Hence, nursing began to move from being the resource of the medical profession to becoming a community asset (de la Cuesta 1991). The potential of nursing in contributing to the advancement of the reform in Spain was broadly acknowledged (INSALUD 1985, G. Encabo 1990). During the early days, theoretical and functional bases were laid down in official publications (Ministerio de Sanidad Consumo 1986, INSALUD 1987) and at practice level nurses' new role started to evolve.

All these events influenced me greatly. Since 1984 I was actively involved in the development of community nursing services within the new model of PHC. I became increasingly interested in knowing about the processes underlying practice and felt the need for reflecting and analyzing community nursing. Beside this I also had the personal aspiration of completing my formal academic education with a doctorate programme.

---

[1] This refers to areas where the social security system was not yet being transferred to the Regional Government.

It was not feasible to pursue a research project of this kind in Spain. I came to the UK, a country with a long and well established tradition in community services. Although desirable, it was not feasible to study both district nursing and health visiting. Since health visiting practice is close to that proposed in "Health for All" it seemed appropriate to decide to focus the present study on health visiting.

During the research project I lived in one of the poorest districts of inner Liverpool. This has undoubtedly had a bearing on the study. It has clearly increased my sensibility to some of the realities that health visitors encounter in their daily practice. Participating in the every day life events of a deprived area has provided me with an insight into the living conditions of a inner city. Living in this area has certainly stimulated my imagination and helped me in the generation of questions posed to the data during analysis.

1.2 AIM AND PURPOSES

The overall aim of this study was to gain insight into the processes underlying health visiting. The study began with a general concern to know **how** health visiting is practised rather than **what** health visitors do. Four purposes guided the development of the study, thus:

1) To construct a picture of health visiting practice from the practitioner's point of view.

2) To identify and describe the general context in which health visiting is practised.

3) To identify and describe the strategies that health visitors use in solving contextual problems.

4) To ascertain the influence of these strategies in health visiting practice.

A qualitative research method was selected as it would facilitate a description of health visiting from the practitioner's point of view. Among the different strategies used in qualitative research, grounded theory (Glaser and Strauss 1967) was chosen as it brings process into the analysis of data (Hutchinson 1986, Wilson 1989, Strauss and Corbin 1990). It is informed by the theoretical perspective of symbolic interactionism (Blumer 1969) which regards individuals as active agents involved in an ongoing process of shaping their environment and dealing with problems within the limitations imposed by structural conditions. This perspective sits comfortable with my own views and with the purposes of the study.

1.3 ORGANIZATION OF THE THESIS

The thesis is organized into eight chapters. The first three chapters introduce the study, the relevant literature and its methodology.

The analysis of data is presented in four chapters. Thus, chapter 4 focuses on the general context in which health visiting takes place ie: working between two worlds. Here, the concept of life trajectory is explored and the major components of the policy agenda are depicted. Chapter 5 highlights the basic social process in health visiting, that of "Marketing health visiting". Here causal and intervening conditions are identified as well as its major strategies. Chapter 6 examines and describes "Fringe work", a tactic that health visitors use to tailor their services to a client's circumstances. Chapter 7 examines the consequences of using marketing tactics. Creating contexts is identified as the major consequence. The issue of the relationship between the professional and the client is addressed in some detail. Also the negative consequences of marketing are discussed.

Finally, chapter 8 discusses the significance of the present study within the actual debate in health visiting about introducing new ways of practice and examines the importance of developing relationships with clients.

CHAPTER 2

INTRODUCTION TO THE AREA OF STUDY

2.1 INTRODUCTION

For qualitative research which aims to generate substantive theory, it is not appropriate to use existing theory as a starting point (Hutchinson and Webb 1989). Hence, this research study is not set within a particular theoretical framework. However it draws upon previous knowledge of health visiting. A review of the health visiting literature provided a general background for the study, acting as a framework to facilitate conceptual entry into the area of study, namely, health visiting processes.

This is consistent with grounded theory principles, which is the research methodology employed in this study. In grounded theory the researcher begins with an area of study and what is relevant to that area is allowed to emerge. Thus, the literature is used as source of data that contribute to the forward thrust of the study (Strauss and Corbin 1990). As Stern (1985) has pointed out, in grounded theory, the literature search is made prior to the study and then again as the study progresses.

As an "outsider" to the health visiting system and having been unaware of its evolution since I was trained in 1977, it seemed appropriate to learn how

health visiting was currently presented in the professional literature and what was known about practice from research and other sources. In addition to this, as I had experienced in Spain the impact of the World Health Organization (WHO) "Health for All" strategy in health policy and in the development of nursing practice, it seemed appropriated to ascertain to what extent this movement was influencing health visiting in the UK.

The guiding questions in this search of the literature were: What are the current issues discussed in health visiting practice?, Are there any new developments in health visiting?, What is known about the approaches in health visiting? Has the international movement of "Health for All" had any impact on health visiting?

This chapter examines first the origins and development of health visiting and comments on the current changes that are taking place in the health care system. Next it examines the debate that is taking place in health visiting. Research studies and accounts of innovative practice are used as a means of ascertaining the significance of the debate in health visiting practice. Lastly the "Health for All" strategy is examined and its components linked to the characteristics of the debate in health visiting.

2.2 HEALTH VISITING: DEVELOPMENT AND CURRENT SITUATION

2.2.1 Origins of health visiting

Health visiting originated in the 19th Century in the industrial cities of the United Kingdom (UK) when there was a public alarm about cholera epidemics and when it was realized that the health of the poor and working classes would be inseparable from that of the rich and middle classes. It was initially a voluntary service provided by middle class women. This consisted primarily of the visiting of people in their homes. Later women began to be employed to do this work and this was a strategy to reach into the working class home. The "Mission woman", whom the Manchester and Salford Ladies Sanitary Association employed in 1867, is regarded as the first health visitor. The aim of the visits was to improve the hygiene of the people, to protect the middle classes against epidemics, and, as a measure of social reform to instruct people about sanitary measures. This instruction was given by health visitors' persuasion and by example (Dingwall 1976b and 1977a, Dingwall and Eekelaar 1988).

The origins of health visiting are connected with a religious model. In fact it has been pointed out that the language to describe this work was "Urban Evangelism" and that the use of a "Good poor woman" was a missing link between Christian ladies and the class in need of reform (Dingwall and Eekelaar 1988 p.176). These origins are also related to the transmission of

middle class values and the moralization of working class people. Hence the "Social reform" was in fact the social control and reform of the poor. This view is consistent with Florence Nightingale's ideas about community nursing. She saw it as one means of "Depauperising" the poor. For Nightingale pauperism was not only being poor but a state of mind similar to that which, at the time was called "Culture of poverty" (Monteiro 1985).

Although it has been said that when health visiting services were taken over by the Municipal Authorities, these were "Comprehensive and collectivist" (Dingwall 1976b), it is clear that health visitors' interventions were mostly of an individualistic nature. Health visitors' work reflected a philosophy that saw the cause of the problem as the weaknesses of the individual rather than the defects of the social system. This is consistent with the prevailing ideology of the time about the causes of poverty. Whereas public health at the time grew from a basic sense of social justice and pointed to the role played in the cause of ill health by inappropiate infrastructures in towns and cities (Ashton and Luker 1991), poverty was believed to be due to lack of character or moral failure (MacGregor 1981). Thus, the need to "instruct" and individually reform all of the poor. It is important, here, to draw attention to the difference between the universalization, or extension, of a service and the strategies that are used in delivering it. What has changed over the years in health visiting is the type of client to whom services are given and the scope of their role in health services.

2.2.2 Development of health visiting

The turn of this century showed the beginning of personal as opposed to public health services, especially for children, and also the identification of health visiting with infant welfare and school health services (Rcn 1983). It also began the transition from a privately founded and organized service to a State scheme, originally at individual local authority level. Health visiting became a welfare measure which was adopted to improve the conditions of the poor in order to produce fitter workers and soldiers and to buy off socialist demands for radical change. Its attention was increasingly concentrated on mothers and babies (Dingwall 1976b). The maternity and Child Welfare Act of 1918 enabled local authorities to set up services for mothers and children and confirmed the concentration of health visitors in this area of work (Rcn 1983). In time health visiting became involved with all working class mothers and children and after the first world war also with middle class families. In this period health visiting developed in both numbers and in its scope by being involved for instance in ante natal care (Dingwall and Eekelaar 1988). Also at this time, the regulations for health visitors' training were developed and its links with nursing and midwifery established (Dingwall 1977a).

After the mid 20s the rationale for developing health visiting disappeared and during the second world war health visiting was drastically cut back and lost ground (Dingwall 1977a). Dingwall and Eekelaar (1988) had argued that

health visiting at that time failed to resist the encroachment of social work in its traditional domain of child welfare. Despite health visitors' purported responsibility for other client groups such as the chronically ill, the handicapped and the mentally disordered, they have never developed this aspect of their work.

The years after the second world war saw the revival of individualism but this time the agent was the State and not the private charities. It was argued that with the establishment of the Welfare State in 1948, the problems of ignorance, sickness and poverty would be solved by providing free education, health care and full employment. Hence, the remaining problems were due to individual deficiencies requiring individual treatment (Dingwall 1976b). Health visiting remained a universal service provided without a test for need, but it was delivered on the basis of a client's vulnerability to some particular social or medical problem (Dingwall 1977a). The pre 1946 practical orientation towards the care of mothers and young children and the legislative definition of health visiting in 1946 which reinforced this, justify the statement that this is the traditional work of health visitors (Health Visitors Association [HVA] 1987c).

With the establishment of the Welfare State two trends were initiated and continue in health visiting: the removal of functions which were once part of health visiting to specialist agencies, and the administrative separation of services to meet health and social needs. The structural and policy

changes that took place in the National Health Service (NHS) in the subsequent years, did not benefit health visiting. Health visiting found itself constricted by the "Developing Empires" of social services, hospital dominated health services and general medical practice (Rcn 1983 p. 13). Since the post war years, health visiting has been in a policy vacuum, not so much for lack of a policy for health visiting but for a lack of follow through or because of rival interests (Dingwall and Eekelaar 1988).

To sum up: Health visiting has developed from being a voluntary service to the "deserving" poor, that is those entitled in the 19th century to charity, to become a universal State service to all mothers and young children. From being a service delivered by middle class ladies it has become a part of nursing. From having strong links with public health measures it has become a child welfare service. Lastly from increasing its numbers and scope it has decreased them, losing its identity and becoming, on Dingwall's (1976b) terms "Stagnated" ever since the mid 20s. Hence its "Development" appears to be more of a "Backsliding". However, all along, it has remained an instrument of social control based on individualistic measures of intervention. Its "Development" has been closely linked with the policies on child welfare.

2.2.3 Current changes

In recent years there have been Government proposals that affect the structure and the organisation of community nursing. There are three major documents: 1) Government's White Paper on Primary Health Care (PHC) Promoting Better Health (DHSS 1987), 2) The Griffiths Report on Community Care (Griffiths 1988) and the follow up White Paper Caring for People: Community Care in the Next Decade and Beyond (DOH 1989a), and 3) The NHS Review Working for patients (DOH 1989b).

The Paper on PHC (DHSS 1987) aims at transforming the NHS from a "Sickness" service to a "Health service" by putting the emphasis on health promotion and disease prevention. However the invisibility of nursing here (Clay 1988) has been pointed out and claimed that it is medical services which increase General Practioner (GP) power and threaten the health visitor's role (Fatchett 1990). The community care proposals focus on the community care for the mentally ill, mentally handicapped, elderly and physically disabled groups and aim at providing more care and support for these groups in their own homes . However, there is little mention of the role of the health visitor. Health visitors are left once more to focus their work on child welfare with the aggravation that in the PHC paper (DHSS 1987) part of this territory is now being passed over to the GP (Fatchett 1990). The NHS review (DOH 1989a) proposes a separation between purchaser's and provider's functions. Health Authorities would not then be

involved in provider issues but focused on the monitoring and evaluation of the services that they "Purchase". This review places the GP at the centre of the PHC team. It expands GPs role in child surveillance and health promotion. The implementation of these changes would effect a change in the health visitor's role in child surveillance and health promotion.

It seems that health visiting is again in a situation similar to that of the post war years, that is of being in a policy vacuum. The Government papers (DHSS 1987, DOH 1989a) refer vaguely to health visiting and the NHS review (DOH 1989b) implies that the health visiting policy would be dealt with by management at the local level. In this NHS review (DOH 1989b), Health Authority operational and management functions are delegated or contracted out. The Report on Community Nursing (DOH 1990) reflects this point clearly. Here the need is stated for the providers of services to issue a "Mission statement" or "Shared vision of care" which will set out the overall goal of the organisation. This statement will act as a framework to an agreement on priorities, responsibilities, resource allocation and service delivery. Hence it will determine to a large extent the role and scope of health visiting. It is worth noting that this report focuses on the organization and management of nursing services in the community. It offers different models of organization but it does not set guidelines about the content of the services to be delivered. General statements are made about the need for joint efforts, putting patients first, assessment of needs and commitment to quality. Policy issues seem to be left to managers.

However, the Government document Health of the Nation (DOH 1991) can be regarded as an opportunity for development in health visiting. It sets out proposals for the development of a health strategy in England in which health promotion and disease prevention are the core aims. It includes several targets for improving the health of pregnant women, infants and children. However, bearing in mind that GPs would be at the centre of the PHC team and that they would have the facility to "Purchase" services, this could mean a missed opportunity for health visiting.

2.2.4 Definition of health visiting

The statutory definition of health visiting is found in the NHS regulations of 1972 (Health Visitors' Association [HVA] 1987c). Here it is stated in a succinct way, that health visitors' educative and preventive work in the home is to focus on maternal and child health and the control of communicable diseases. This definition sets a rather general framework which does not provide for a clear identity in health visiting nor for guidance in developing the health visiting role in accordance with population needs and changes in the system. Health visitors' organizations have developed the scope of the health visitors' work. Hence, under the auspices of the Council for the Education and Training of Health Visitors (CETHV) there began in 1974 a major analysis of health visiting practice, which resulted in the development of a definition of health visiting and the principles underpinning practice.

Health visiting was defined as:

> *"The professional practice of health visiting consists of planned activities aimed at the promotion of health and the prevention of ill health. It thereby contributes substantially to individual and social well being, by focusing at various times on either the individual, a social group or a community. It has three unique functions:*
>
> *1) Identifying and fulfilling self-declared and recognized as well as unacknowledged and unrecognized health needs of individuals and social groups.*
>
> *2) Providing a generalist health agent service in an area of increasing specialisation in the health care available to individuals and communities.*
>
> *3) Monitoring simultaneously the health needs and demands of individuals and communities; contributing to the fulfilment of these needs; and facilitating appropriate care and service by other professional health care groups."(CETHV 1977 p8).*

Four principles were identified to achieve health visiting goals: 1) The search for health needs, 2) The stimulation of the awareness of health needs, 3) The influence on policies affecting health, 4) The facilitation of health enhancing activities (CETHV 1977 p 9). The CETHV's statement shows a shift in the previous conceptualization of health visiting services. It widens the scope of health visiting actions by including interventions at group and community levels. It positions the profession not as an agent of control but of social development and puts the emphasis on health and needs rather than infirmity and problems. However, the idea of a participating community, the basis for a collectivistic approach as opposed to the

traditional individualism, was not tackled. This came in the subsequent years and forms very much part of the actual debate in health visiting.

Despite numerous policy documents issued by professional organizations about the role and contribution of health visiting (CETHV 1977, 1982, RCN 1983, HVA 1987c) they have not made an impact on the Government's health care proposals discussed (Section 2.3.2). Nor do they solve the "Dilemma of identity" that Hunt (1972a, 1972b) addressed twenty years ago. The Government did not consider health visitors' concerns for clarifying their role. Thus, it did not undertake a national inquiry into the proper role and functions of both health visitors and school nurses requested in 1982 by the HVA (Editorial 1982). Furthermore, the traditional approach to health visiting practice has been questioned. Hence the question of how to reconcile, in health visiting, an individualistic approach with one which concentrates on group needs rather that individuals has been highlighted (RCN 1983).

The next sections focus on the current debate that is taking place in health visiting about its approach to practice. It will highlight the tension between traditional and new ways of practice represented by "Individualistic" or "Collectivistic" visions of practice.

2.3 THE DEBATE IN HEALTH VISITING

In recent years a change in health visiting practice has been advocated in the professional literature. The proposal is to move away from the traditional individualistic mode of practice connected to the health visitors' role in social control, to a "Collectivist" or community oriented approach which regards health visiting as enabling and supporting social change. New ways of health visiting are proposed as an alternative to traditional ways which are thought to belong to other times and circumstances. The debate is hence about health visiting development versus the stagnation that has remained unchanged since the mid 20s (Dingwall 1976a).

This section examines the discussion and highlights the features of both the new ways of practice which have been advocated and the traditional ways which are now discouraged. Research reports and accounts of innovative practice are commented on to shed light on the reality of this debate.

2.3.1 A "New" approach to health visiting

The inclusion of new ways of health visiting practice has been advocated from different professional sources, such as the Health Visitors' Association (HVA) and the Royal College of Nursing (Rcn), to health visitors educators and practitioners. The reason the different authors give for advocating a "New" approach in health visiting is the need to respond to the population's

health needs. However, here is proposed a "Collectivist" or "Community" approach to practice, which puts the emphasis on joint action and people's capabilities. Consistently with this view, "Community work" in public health has been defined as work that is based on the belief that people have the capacity to join together and take action on their own behalf. Community work engages groups rather than individuals and priority is given to interventions based on local needs (Ashton and Luker 1991).

The recurrent themes or major traits proposed in this approach to health visiting practice are:

- To focus on the Community and groups by mostly two means: Assessing community needs and intervening at group level.
- Needs oriented practice or "Proactive approach" as opposed to a passive or reactive health visiting.
- Partnership with clients. Community and the client's participation in their care.
- Facilitative and empowerment style when relating to clients.
- Team work with other health care professionals.

In some recent reports and publications, the HVA has included the majority of the above features. Thus, it is suggested that health visitors should work in partnership with clients and hence the need to empower them in order to enable their participation in health care. Also the necessity to include the wider community in the health visitors' assessment of needs and interventions has been stated. Hence group work as a method of practice is supported. It is also considered necessary to place more emphasis on health promotion and primary prevention, and to assume an enabling and facilitative style in health visiting (HVA 1985, 1987a, 1987b, 1987c). These views clearly emphasise a community or collectivistic dimension in health visiting. The RCN (1983) in its previous document, contains the above elements. When it comments on unannounced visits to clients, states that "Social policing" is not a part of the health visiting role (p. 46).

Goodwin (1988), speaking as General Secretary of the HVA, proposed a framework for future health visiting practice which included these issues and pointed to the need to assess community health needs in consultation with other agencies and representatives of the community. She also highlighted the need for health visitors to work more closely with members of the PHC team and with other local agencies.

These views were also reflected by the National Standing Conference of representatives of Health Visitor Education and Training Centres (NSC). In a report this organization expressed the need for health visitors to elaborate

and use community health profiles as a basis for practice, to empower individuals to participate in health care, and to work in collaboration with other members of the health care team. It also stated the need to attain a proactive approach in health visiting practice (NSC 1989).

Other authors, from both health visiting practice and education, reiterate some of these ideas. The necessity for assessing community health needs in health visiting has been stressed for the past ten years (MacFarlane 1982, Orr 1985, Boomer 1987, Denny 1989, Gooch 1989). Caseload and health visiting profiles are thought to be the methods to achieve this aim (Orr 1985, Boomer 1987). Partnership with clients and a "Consumer" oriented health visiting service has also been highlighted in the literature (Orr 1980 and 1985, Fatchett 1989, Gooch 1989). Group and community work, considering clients' expressed definitions of need, are identified as the means for a more community oriented health visiting service (Drennan 1988a, 1988b).

In this context, it is proposed that health visitors should act as agents of social change (Boomer 1987). In the literature the means to achieve a community approach to practice and group work are even regarded as legitimate "political action" (Rcn 1983 p. 51). The implications for practice are not discussed. The debate about new ways in health visiting tends to elude the political dimension of this approach. Community work aims at changing the environment or situation rather than to adapt people to it

(Ashton and Luker 1991). Hence it clearly aims at social change and thus has political implications.

The above proposals are not new in health visiting. The concepts of proactive health visiting, partnership with clients, team work and consumer participation are included in the five principles of health visiting (CETHV 1977). The contribution to social change is considered to be a health visiting activity. However, as was previously commented (Section 2.4 p. 13) the role of the community in promoting change is not considered. Clients, to a certain extent, were still regarded as passive recipients of, in this case, "Change".

It is necessary to draw attention to the fact that these proposals do not intend that health visitors substitute group and community work for individual work with children and mothers. The aim, as expressed in the documents consulted, is to enlarge the health visitor's scope of action in order to meet the client's health needs in a more effective way. This idea is clearly expressed in the report of (NSC) when it identifies three complementary approaches to practice: 1) One to one, 2) With small groups, 3) With the wider community (NSC 1989 p. 17).

This shows a clear attempt to incorporate both individualistic and collectivistic approaches in health visiting. While this is acknowledged as a dilemma (Rcn 1983 p. 25) the contradiction of this proposal is not explored

in the literature. Both approaches have a different ideological basis. Individualism tends to regard the person as the one responsible for his/her health and puts the blame on the individual when he/she becomes ill (Crawford 1977). This view gave ideological support for the "Social reform" of the poor in 19th Century which in fact was their social control, and health visiting was one of the measures taken to achieve this. Contrary to this view, community work considers the material and social conditions as the precipitating factors for ill health, and places the power to change, not on the professional, but on the people. It can be said that while individualistic approaches have the effect of disabling people, community or collectivistic approach empowers them to produce change.

This discussion about health visiting practice has not being echoed in the Government's proposals about community care (DHSS 1987, DOH 1989a and 1989b). The exception is the "Cumberlege" report which studied nursing services in the community (DHSS 1986) and took into consideration some of the issues proposed by the HVA (HVA 1985). In its proposals the report includes the concepts of a proactive and a team approach to practice; states the need to work in partnership with clients, to deliver services with an enabling style and to consider neighbourhood profiles as a basis for practice. However, the recommendations of this report have hardly been implemented. This hints at insufficient commitment at National level towards more community orientated nursing services.

At the National nursing policy level there has been another initiative that could have backed up a change of approach in health visiting practice. The document on general Strategy for nursing, issued by the Department of Health (DOH 1989c), includes all the components mentioned in the "New" approach. Although targets for practice are set in the document which include the need for the client's participation, health promotion and relevant practice according to the client's needs and to existing knowledge, specific time for completion or providing for the resources needed to implement them are not included. It only states that managers of health services, nurses, midwives and health visitors should examine the targets for action and should set a timetable for implementation. Thus the strategy is poorly focused and ineffectively committed towards its implementation.

Regarding policy, support for a change in health visiting is similar to that of the post war years (Dingwall and Eekelaar 1988). There is a vacuum of policy about health visiting development (Section 2.3 p. 10) and a lack of follow up to proposals that could bring about some change in health visiting along the lines just discussed. However, the Government's proposals on the "Health of the Nation" (DOH 1991) could be a back up for both the strategy in nursing and for the introduction of new ways of health visiting practice.

2.3.2 Accounts of innovative practice

In spite of the absence of a clear policy to support the changes advocated, some of the traits described in the "New" approach to health visiting are evident in practice. The literature on innovations in health visiting provide us with examples of implementing new ways of practice.

This section does not pretend to be an exhaustive account of all the innovations that have taken or are taking place in health visiting. This is out of the scope of the present study. It will, however, aim at giving the reader an idea about the nature of innovative practice, and of supporting the claim that practitioners are seeking different ways of working. However, it could not be assumed that all the innovations are relevant to the client's needs or that they are effective. While some of the experiences reported in the literature clearly stated that it was a response to clients' needs assessed in some objective way (for example questionnaires, health profiles) in others this has not been clearly acknowledged. Evaluation of the experiences are not always included and some of them are pilot studies or activities that have no continuity.

Nevertheless, innovations in health visiting seem to be quite widespread. In 1984 the HVA conducted a survey to ascertain the involvement of Health Visitors in community initiatives. This survey provided information from 96 of the 206 Health Districts in England, Wales and Northern Ireland. Here it

was concluded that in each Health District there was a minority of health visitors involved in community health initiatives and "It was not necessarily a feature of their work throughout the year" (Drennan 1985,p.6). They were implicated in a wide variety of community groups and organizations, also in different initiatives such as health campaigns, screening schemes, provision of market stalls or shops fronts, involvement with the local media to give their point of view on health topics, and in developing information directories (Drennan 1986a). Innovation in health visiting seems to be not only widespread but the need for it is felt by many Health Visitors (West 1989). In a study about innovation in health visiting, it was concluded that the health visitor's role was seen as one demanding change and innovation. It was reported that 45% of the participants said that they needed to improve the way in which they delivered services whereas 18% did not feel this need[2] (West 1988).

The content analysis of the innovations consulted reveals four categories namely to:

1) Extend the availability of the service to other groups.

2) Introduce novel work methods group work and assessment means.

3) Provide a different approach to practice.

---

[2] This article does not state the total number of participants in the study. For the research methodology employed in this study, the reader is referred to a previous article which states that 92 health visitors participate in the study (West M, Jones A, Savage I. (1988) "Stress in Health visiting: A Quantitative Assessment" Health Visitor 61 (9) 269-271).

4) Become involve in innovative programmes.

1) Several studies reported in Baker, Bevan, McDonnell and Wall (1987) describe the extension of the availability of health visitors' services to other groups. Some of them are about making the same type of services more available. This is clearly the case of schemes for extending the health visitor's time availability in a "Crying baby service" and telephone advice on child health problems. This shows that the focus of the service has not really changed. However, other reports give accounts of making health visiting available to other groups of the population such as intravenous drug users, by setting up a "Drop in" centre at night (Thompson 1989); the elderly by introducing routine visiting (Neil 1982), sections of the community in general by setting up a 24 hour health visiting service supplemented by evening clinics (Haylock 1981).

Examples of establishing "Well Man" clinics reported in Baker et al (1987), setting up market stalls (Copenhall 1990) and health shops (Robinson and Roberts 1985, Peen Green Experience, undated leaflet) also show health visitor's attempts to reach other sectors of the population. However, these reports do not highlight a community approach to practice. This becomes very clear in the next category.

2) Introduce novel work methods. Group work is an example of health visitors' attempts to introduce change in practice. Health visitors' experiences in group work are well documented by Drennan (1985 and

1988b). According to her, the term group work has been used frequently but rarely defined. When she identifies the different types of activities that group work incorporates (Drennan 1988a) she provides an operational definition of the term. These range from those forms that can be regarded as current ways of health visiting such as teaching health education topics to a group of people in a structured formal manner, to the most innovative, such as health visitors' influencing policy. Following Drennan's classification (1988a), the types of group work which had a connection with a community approach are as follows:

a) Sharing health information in a dialogue with a group that is already formed. The examples of this category given by Drennan (1988a) are a health visitor work with a community based mothers' group in which she joined offering her knowledge in an informal way, and another health visitor's involvement in a local women's health group already established. In these experiences the group members used health visitors as resource persons. Drennan (1988a) points out that health visitors are increasingly looking at this category as a means of supporting and empowering people.

b) Forming and/or supporting groups for the purpose of self help, mutual support and health information. Examples of this category are Dunscombe's (1985) experiences of setting up groups for single parents; Hiskings' (1981) account of establishing a postnatal support group and withdrawing when group leaders were identified; Pettigrew and Falconer (1982) report of the

slimming group that they set up; and Palfreeman's (1982) account of the mother and toddler groups.

Drennan (1988a) notices that the majority of groups initiated by health visitors seem to involve women with young children and states that this reflects their caseload. However, drawing on the findings of the 1984 HVA survey she further comments that health visitors are involved in groups of a wider range such as pensioners, menopause support, bereavement, smoking cessation and exercise groups (Drennan 1988a).

c) Becoming part of a group, made up of local people and/or professionals, formed to influence policy and/or services. As examples of this category Drennan (1988a) reports the health visitor's involvement in a campaign for a community centre for elderly people and the health visitor's participation in a housing estate campaign to provide a family centre.

Other examples within the category of health visitors introducing novel work methods, are the reports about health visitors' involvement in developing or using assessment tools such as the development of a child health record booklet (Owen 1982), a scoring system to set priorities (Hills et al 1980) and the use of a vulnerability index to identify at risk families (Burns 1985).

3) Different approach to practice. Here examples refer to team approaches to the child abusing family (Laing 1986), the use of an empowering style in

the Child Development Project (CDP 1984) and, working in partnership with clients (Billingham 1989, Sloan and Webster 1989).

4) Involvement in innovative programmes. Finally, there are projects such as the Oxfordshire "Change for the better" which uses a needs based approach and community health profiles to deliver health visiting services (HVA undated). According to Goodwin (1988) this project is the best known current example of the systematic attempt to change health visiting. Dauncey (1988) has reported some of the results achieved by the project, such as increased immunisations rates and higher level of activities toward promoting health. Another project is the Riverside Child Health project (Pearson 1985) which provides a good example of practice based on the client's needs, client's participation and a team approach.

From what has just been described, it can be said that health visitors engage in innovative practice in three different ways: 1) By setting up themselves a particular scheme or service, 2) By collaborating in a general project launched by the health care sector, and 3) By supporting lay and local initiatives aimed at influencing policies and services.

However,it can be argued that the above experiences do not have similar degrees of innovative work. Scott Samuel (1989) believes that innovations range along three broad types, thus:

1 - **Progressive conventional.** That is those experiences which have an apparent modification of current practice but the underlying principles remain the same, ie: an individualistic ideology. This can be the case in preventive campaigns and the introduction of some clinics centred on pathology or symptoms where professional roles are practically, not altered. It can be said that these innovations create the illusion of a change.

2 - **Introduction of progressive services.** This refers to experiences where professionals are doing "Unusual" things for clients and in a different manner. This can be the case in the examples given in health visitors' support to already established self help groups.

3 - **Community development** experiences which involve a major change in the approach to the delivery of services and in the role played by professionals and the community. These are the examples which reflect more closely a "Collectivist" or "Community" ideology. Examples of this are health visitors participation in local groups to influence policy or services, and the schemes in which health visitors use an empowering or enabling approach to clients.

The innovations discussed incorporate some of the components advocated as new ways in health visiting practice. These innovations can be regarded as a response to the call for changing practice, as well as a response to

population needs. On the whole they are advancing professionals' aspirations for change in practice.

2.3.3 Traditional ways of health visiting

When a different approach to health visiting is advocated in the professional literature, quite frequently undesirable ways of practice are referred to. These are called "Traditional" and act as a background against which changes are proposed.

A traditional approach to health visiting practice is associated with the following traits:

- Individually focused and child centred.
- Mechanistic and task oriented.
- Authoritarian and directive.

Goodwin (1988) while she was General Secretary of the Health Visitors Association, (in her key note speech at the Association Conference), made a comprehensive statement of this approach in health visiting. According to her, traditional health visiting is individualistic and child care is based on a medicalized model in which health visitors have a directive style with their clients. She also drew attention to a routinized, mechanistic and check list approach in health visiting as exemplified by developmental screening. On

similar lines, Fatchett (1989) also refers to a traditional approach in health visiting in which the client is a passive recipient of services. The health visitor's work is individually focused, task oriented and peformed using a directive style. Further, she claims that activities are mostly reactive, that is they respond to immediate health problems and needs instead of anticipating them. Several other authors have emphasized the individualistic (Rcn 1983, Drennan 1985 and 1988b, Denny 1989, Copenhall 1990) and authoritarian approaches in health visiting (Drennan 1988b, Smith 1989).

Goodwin (1988) pointed out that because health visiting is trapped in the traditional routine home visiting, child centred model, it is responding to historical health needs rather than present ones. Indeed, traditional traits just described had their roots in the origins and development of health visiting during the late 19th and early 20th Century (Sections 2.2.1 and 2.2.2). They are part of the individualistic mode of practice which is connected to the health visitor's role in social control.

2.3.3.1 Research studies

Research studies in health visiting give some evidence of the presence of these traits. However, there are shortcomings. Much of the research on health visiting in the past three decades has sought to describe the work of health visitors with little analysis. Its focus is to address the issue of what health visitors do rather than how they do it. The lack of research into health

visiting skills and expertise was noted by Luker in 1978. Hick's (1976) account and Clark's (1981) review of 37 studies shows clearly this phase in health visiting research. Most of these early studies used a quantitative approach which for the most part used survey techniques and focused on counting or classifying the client's contacts into various categories. These studies were poorly reported, the instruments were not adequately tested for reliability and validity and the sample size was frequently too small (Clark 1981, Chalmers 1990). From the 1970's qualitative studies in health visiting began to be undertaken seeking to describe the processes involved in practice. An emphasis was also placed on effectiveness and consumer views formed part of this evaluation.

Research shows that children are the major concern of health visitors both in terms of time spent, pattern of interaction and focus of work. Clark's (1981) review concluded that the major component of health visitors' clientele are families with young children. The Office of Population Census and Surveys (OPCS) survey also found that most of the time spent by health visitors in clinics and home visits was concerned with babies and children (Dunnell and Dobbs 1982). This trend is confirmed in the latest publication of national statistics. Here it is shown that in 1987/88, health visitors visited 113 %[3] of live births and 65 % of under five years of age

[3] Each person is counted at the first visit in the year in a district, by any member of the health visiting staff. A person moving to a new district will be counted more than once.

population, whereas the visits to the elderly reached only 5.3 % of all of them (DOH 1990b).

Consequently, studies in the late sixties and early seventies reported by Clark (1981) that looked into the topics discussed during visits found that those were concerned with child care issues. Later on, Turner (1982) found in her study that 25 out of 37 topics discussed in a home visit were related to problems specific to children. Qualitative studies also inform us that the centre of the health visitor-client interaction is the child (Robinson K 1986b) and that health visitors see their work as focusing on women and children (Drennan 1986b). In this sense, Connolly (1983) claims that health visiting has not changed much over the last 100 years and that the major areas of health visitors' concern, throughout the century, has been health education and work with children.

Referring to work methods, studies tend to confirm a predominance of individualistic techniques in health visiting. Clark's (1981) review of 25 research studies found that one third of the health visitor's time was devoted to home visits. In her previous research study, she found that this was the activity preferred by health visitors and considered to be most important (Clark 1973). Two more recent qualitative studies have similar findings. Drennan (1986b) reports that health visitors perceived home visits and work with individuals as important areas of their work, and Gregory (1982) found that the majority of health visitors interviewed tended to

spend their time focusing on individuals. Almost 20 years ago Hobbs (1973) found that group teaching in health visiting was considered an optional extra. Later Drennan (1988) found that, when it is undertaken, it is largely as formalized teaching. It seems then, that an individualistic approach to practice dominates health visiting.

Although it has been found that health visitors plan and initiate most of the contacts with clients (Clark 1973, Wiseman 1979), this proactive approach does not necessarily mean that interventions are based on an assessment of needs. Indeed, in a exploratory study, Bolton (1980) found that health visitors were vague about the assessment of priorities. Harrison (1986) found that health visitors in setting priorities tended to adhere to a traditional model of health visiting, ie: antenatal visits, visits to the under fives and child health clinics. In a further study she concluded that the health visiting service is not planned on the basis of the health needs of the population (Harrison 1988).

Other research studies, most of them qualitative, give some insight into the health visitor's general style or approach to clients. Although clients prefer a partnership style in health visiting (Cameron 1990, Foster and Mayall 1990) and an informal and non-authoritarian approach (Orr 1986, Cameron 1990), this tends not to be the norm. Health visitors tend not to encourage clients to participate and use a dominant style of interaction. Hence Orr (1980) reported that clients felt themselves not included in the assessment

of their babies and that they were given little explanation. Sefi (1985) found that the style that was adopted by all the health visitors within the interaction was largely educational and therefore health visitors were placed in a dominant position. Foster and Mayall's (1990) work shows similar results. They report that the majority of the health visitors interviewed stated that they used a top down style of education aiming at changing the mother's behaviour. On similar lines, Robinson K (1986a) found that in home visits professionals control the conversation thus playing a predominant role in the interaction.

These findings contradict to some extent Watson's (1981) study as she found a degree of equality between health visitors and clients. Also Warner (1982) in her research found health visitors using more commonly a "Supporter role" than a "Detector role". This apparent contradiction suggests that even in a traditional model, health visiting is variable.

When discussing the reasons for these traditional ways still being in place, some authors mention the influence that the prevailing individualistic and physical oriented model of health care is having on health visiting (CETHV 1977, Orr 1980 and 1986, RCN 1983, Robinson 1985, Goodwin 1988, Denny 1989,). Linked to this, nursing traits such as focusing on individuals and being task oriented, transferred to health visiting, are also thought to have a bearing on traditional approaches to health visiting (Rcn 1983, Orr 1985, Drennan 1988a).

In this respect, research studies point to several factors, some of them are linked to the individual practitioner, some to the area where he/she works and the type of clients the health visitor encounters. Thus, Hobbs (1973) found that the amount of group teaching undertaken by health visitors varied considerably between both individual and group practitioners while Luker (1978) highlighted health visitors' personal preferences in setting priorities in their work. Health visitors' ages have been identified as a factor in influencing health visitors' styles of interaction. Hence Clark (1973) accounts for young health visitors using a less dominant approach and Watson (1976) found a directive style among older health visitors.

Further, the area where health visitors work has been considered as influencing practice. In areas of non poverty Harrison (1988) found that there were more visits to children within the assessment programme and more visits to the elderly. In areas of poverty very little health education was carried out. Lastly Drennan (1986b) reports that health visitors recognized that a certain amount of their activity was shaped by the client's own perceived need and by the inadequacies of other services.

Authors also refer to management policies as promoting a traditional approach (Goodwin 1988, Orr 1980 and 1985). Indeed Luker and Chalmers (1990) argued that the use of authoritarism in health visiting is sometimes part of a strategy to gain access to clients. Child surveillance is clearly, part of health visiting policy.

The above factors account for an apparently outdated practice. However, there is an overall embracing issue that is: The relevance of the health visitor's traditional ways to current practice. Health visiting is still an instrument of the State's control of family life which is appropriate in liberal democracies (Dingwall and Eekelaar 1988, Dingwall and Robinson K 1990). Child welfare is a Governments' responsibility and health visitors are important instruments in surveying this welfare. Health visiting contributes to the Welfare State's basic functions ie: 1) The provision of health and social services, and 2) The regulation of private activities (Gough 1982). Consequently, the health care structure and management policies reflect and reinforce traditional traits in health visiting. For example, policy to appraise health visiting efficiency and resource allocation reflect traditional ways. The criteria tends to be on the visibility and on the measurable aspects of professional activities (Goodwin 1988). Hence, the statistics for appraising health visitors' work tend to be focused on the number of contacts with different clients giving high priority to the under fives, and on where the contact takes place giving priority to the home. Thus traditional ways in health visiting are reinforced.

Research into health visiting suggests that traditional traits are still in place in health visiting practice. Studies report that generally health visitors' major concern is children and that they focus work on the individual. It has also been reported that services tend not to be based on clients' needs and that health visitors are inclined to adopt directive styles leaving little room for

clients to participate. However, recent qualitative studies suggest that this could be a tactic to gain client's collaboration. In discussing the presence of traditional traits in health visiting, structural, contextual and personal factors have been identified. Policy plays a major role in encouraging traditional health visiting whereas professional leaders are encouraging a different way of practice.

It seems then that the debate on health visiting goes between policy rules that are individualistic and reflect the State's role in controlling family life and a professional view of practice that is close to a collectivistic ideology, which does not consider the need to control people but to support them in achieving better health. The next and last section attempts to trace and examine the origins of the collectivistic or community vision.

2.4 THE WIDER SCENARIO

The discussion that is taking place in health visiting is connected with a major revision of the health care systems that started in the mid seventies and reached its peak when in 1984, The World Health Organization's (WHO) member states endorsed 38 targets to reach better levels of health for all the people in Europe. Underlying this plan of action is the issue of collectivist or community development views versus individualistic approaches to health care. This section examines the movement of "Health for All", which was launched by WHO and gives direction to change

proposed in health care systems, and discusses its implications for nursing. It shows the connection between the changes advocated in nursing in order to contribute to this goal and to those proposed in health visiting and previously discussed (Section 3.1).

2.4.1 Health for All

"Health for All" is a global strategy which was launched by the World Health Organization (WHO). It dates back to 1974 when the World Health Assembly (WHA)[4] recognized the striking disparities in health and in health services between countries (Reid 1986). In 1977 the WHA resolved that the main social target of governments and WHO in the coming decades should be "The attainment by all citizens of the world, by the year 2000, a level of health that would permit them to live a socially and economically productive life" (WHA 1977). Here Primary Health Care (PHC) was identified as the means to achieve this goal and, in 1978, a declaration which defines its principles and activities was endorsed. This has become know as "The Alma Ata declaration".

A common policy to attain "Health for All" in Europe was approved in 1980. This European Strategy called for a basic change in countries' health policies. It urged member states to give higher priority to health promotion

---

[4] The WHA is the governing body of the WHO. It is made of WHO member state delegates and WHO Executive Board. It meets once a year at WHO headquarters to discuss, monitor and endorse the Organization's policy. Their resolutions are unanimously endorsed.

and disease prevention, it stated the need to involve all sectors that have an impact on health including the community, and finally to use PHC as the major approach to bring about this change. The 38 targets to achieve this goal were approved in 1984 (WHO 1985). Europe had now a specific plan of action for achieving better health by the year 2000.

The European targets refer to the specific improvements to be made by the year 2000, to the changes needed to bring them about, and to the support needed for these changes (See appendix 1 for list of the targets). It is important to notice that these targets are directed not only at changing people's behaviour but also at changing the environment and the health care system. They put the emphasis on community participation in health care recognising people's capability to produce change. Thus, there is clearly a move away from individualistic ideologies which place the blame on individual behaviour and undermines people's capacity to participate. In addition, the targets address the need for policies that support a change in the health care system and, in this document, it is acknowledged that there are "Prerequisites" for health such as equal opportunity for all, satisfaction of basic needs and social support. Without providing for these, the targets would not be reached. This reinforces the displacement of individual blame for ill health and points to considering it as a "Social failure". Hence the need for a community oriented approach to health care.

Consequently, "Health for All" has important political implications. The 38 targets place health in a wider context: that of a basic human right in which policies and social material conditions play a major role. Indeed in "Health for All" health is considered as a social rather than a physical concept in terms of social and economic development (Maglacas 1988). Health is regarded as a basic human right and a worldwide social goal. Further, health is considered as a resource for life (WHO et al 1986). Thus, the previous WHO definition of health which states that it is "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1948) is broadened by pointing to the social material conditions for achieving it. Thus, unless efforts are concentrated on all the targets, they could merely represent a wish list. The temptation is, obviously, to concentrate on just those targets that address life styles and health care services, leaving out those that refer to changes in policy and the environment. By doing this an individualistic approach to health would be reinforced.

2.4.1.1 Key features

In Health for All there are two key features interlinked that address the values underlying the strategy, these are: 1)-Equity and 2)-Primary Health care.

1) Equity. From the beginning the movement "Health for All" was motivated by a desire to achieve equity in health. Dr. Mahler, Director General of WHO at the time, stated that in Alma Ata it was declared "That the health of hundreds of millions of people in the world was unacceptable" (Mahler 1987). Hence, the principles of Alma Ata represented a "New form of social morality" which considered paramount the needs of the poorest and most vulnerable (WHO 1988).

Indeed, the WHO General Director pointed out that "Health for All" was not just an epidemiological truism but a moral obligation (Mahler 1988). Years later, when discussing the concepts and principles of equity and health, the ethical and moral dimension was highlighted. Hence it was stated that the term "Inequity", as used in WHO documents, refers to differences in health that are not only unnecessary and avoidable but also considered **unfair and unjust** (Whitehead 1990. My emphasis). Equity in health care was defined in terms of equal access to available care for equal need, equal utilization for equal need, and equal quality of care for all. It was stressed that, in order to promote greater equity in health and health care, it was necessary to improve living and working conditions, to enable people to adopt healthy life styles and to encourage people to participate in the policy making process (Whitehead 1990). Thus, equity in health incorporates a community oriented view which addresses political issues, ie: the need for improving living and working conditions.

The evaluation of the impact of "Health for All" after ten years, showed that the basic problem of inequality still remained. Hence it was decided to maintain "Health for All" as a permanent goal of all member nations beyond the year 2000. It was recognised that while some progress had been made such as increasing immunization rates and decreasing infant and maternal death, this had not been uniform (WHO 1988). Some of the prevailing unacceptable gaps were, for example, only 40% of the world population had a life expectancy of 60 years or more, and that countries representing 45% of the world population had infant mortality rates higher than 50 per 1000 live births (Maglacas 1988).

2) Primary health care. The Declaration of Alma-Ata defines PHC as:

> *"Essential health care based on practical, scientific sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where the people live and work, and constitutes the first element of a continuum health care process" (WHO 1978).*

This declaration makes clear that PHC it is not just a medical issue. Indeed, it requires the involvement of all the health care professionals.

Further it should also include the following principles:

a) Universal coverage of the population and provision of care according to needs.

b) Services that are health promotive, preventive, curative and rehabilitative.

c) Services that are effective, culturally acceptable, affordable and manageable.

d) Community involvement in the development of services, in order to promote self-reliance and reduce dependence.

e) Approaches to health that involve other sectors such as education, environment and social services (Bryant 1988).

Vuori (1984) has approached the meaning of PHC in a quite enlightening way. He states that PHC incorporates four elements. Hence it is: 1) A philosophy embodying principles of social justice and equity, international solidarity, self responsibility, and the acceptance of a broad concept of health; 2) A set of activities specified in the Declaration of Alma Ata; 3) A strategy to structure the health care system since it gives direction to legislation, professional education and health care planning; 4) A level of care as it is the first contact of people within the health care services.

According to this view PHC is not solely a technical issue. It clearly embodies a system of values. In addition, to placing PHC as the central function and main focus of a country's health system, it also implies a move

away from the prevailing bio-medical model that focuses on diseases. This actually requires a shift in most of the health care systems.

From this discussion, it can be concluded that "Health for All" has important political implications and policy issues. Some of the consequences of implementing this strategy relate to the changes that are required in both the structure of the health care system and in the professionals who work in it (WHO 1988). The WHO General Director at the time, put this bluntly when he stated that "Health for All" meant a revolution and decentralization demanding change of "Every health professional at every level of the health system" (Mahler 1988). However, these changes refer to the re orientation of existing resources and the way in which health issues are approached. The next section explores some of these implications for nursing.

2.4.2 Nursing response

From the early days of the Health for All movement, Nursing organizations endorsed (WHO 1979, 1982, 1989) both the Alma Ata Declaration and the strategy.

WHO considered that health professionals, due to their knowledge and influence within the community, could act as an important force to mobilize support and initiate the changes needed to achieve "Health for All" (WHO 1986). Because of nurses' close contact with individuals and because of

their numbers, the WHA drew attention to the importance of nurses in supporting national plans for PHC (36 WHA 1983). Further, the WHO General Director pointed to the potential of nurses to take a place at the forefront of the "Health for All" movement (Mahler 1985).

The role of nurses in achieving the European targets was discussed in a consultative document (WHO 1986). Here it was shown that the nurses' contribution to the targets is grounded in one basic idea: nurses are front line workers and a nexus of union between different services and the people. Therefore it was highlighted that they are in an privileged position to detect health needs, to act as a channel of communication and as coordinators of different services (WHO 1986). The implementation of Health for All strategy was regarded as an opportunity for the estimated 2.5 million nurses in Europe to make "A profound contribution to the health and well being of the people" (WHO 1986). Their role was envisaged as advocacy and it was believed that it would take them into the political arena (WHO 1986).

However, for nurses to actualise this role, changes would be required in nursing education and practice. It was identified as paramount to extend traditional roles in nursing. Nursing practice was regarded principally as concerned with curative services. It was agreed that nursing services should be based on the health needs and participation of the population. The direction of the change pointed towards increasing the emphasis on the

preventive, promotive and rehabilitative aspects of care. (WHO 1982). Further, an action plan to implement this between 1988 and the year 2000 was endorsed by European Nurses' representatives. Here, it was decided that innovative services should be developed and that they should focus on health rather than disease; and should draw or modify legislation to enable nurses to meet their responsibilities in PHC as well as to restructure nursing education. It was clearly acknowledged that this plan implied changes in both the profession and the health care system and that these were bound together (WHO 1988).

Hence, the implementation of the "Health for All" strategies involves the adoption of a different model of nursing professional practice the major traits of which are: To focus on health; to be community centred; to use a multisectorial approach to health issues; to be comprehensive and proactive. Within this framework services would be delivered by a professional team in partnership with the community.

These traits are similar to those proposed for new ways of health visiting practice (Section 2.3.1) and could be identified with a community oriented approach to practice. Indeed, underlying this model of professional practice there are a set of values which correspond to those involved in Health for all and PHC. Accordingly, health professionals require the attitudes that correspond to these values, otherwise the implementation of new ways of practice would produce the illusion of change as in the examples of

progressive conventional innovations in health visiting (Section 2.3.2). The adoption of an ideology connected with the values entailed in Health for All and the development of health policies that promote this approach seem to be key factors for a real shift in the approach to health visiting practice.

3.5 CONCLUSION

The literature search showed that a change in the practice of health visiting had been advocated in the professional literature in order to replace undesirable ways of practice, labelled by the authors, as "Traditional". Research studies provide some evidence that these traditional ways are still being used in practice. The accounts found in the professional literature on innovative work in health visiting, point to the implementation of some of the changes being advocated. What seems to be at the heart of this debate is the question of "Individualistic" or "Collectivist" ways of interpreting health visiting practice. The review of WHO documents on "Health for All" show a similarity between the changes proposed in health visiting in the UK and those advocated in this strategy. It also shows that the implementation of "Health for All" involves both the development of a health policy to enable the changes proposed, and the assumption of a given philosophy at all levels of the health care system.

Given this context it was considered useful to undertake a qualitative study to examine the general approach of health visitors to practice. It was

regarded that this study would uncover the processes underlying health visiting and thus contributing to its knowledge base. Next chapter presents the methodology used in this study.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

This chapter provides an overview of grounded theory placing the emphasis on its analytical procedures. The methods of data collection and the analysis carried out for this study are presented.

3.2 RESEARCH DESIGN

The study was a qualitative project aimed at bringing understanding into health visiting practice from the practitioner's point of view. Grounded theory was the research method selected for two reasons: 1) It is a qualitative method which places emphasis on an individual's own definition of the situations and 2) It is informed by a sociological perspective that regards the individual as an active agent involved in an ongoing process of shaping her/his environment, I share and feel comfortable with this view.

The research design in this mode of inquiry implies a progressive building up from data to substantive theory to grounded formal theory (Glaser and Strauss 1967). In grounded theory data collection, analysis, and theory stand in reciprocal relationships to each other. Hence in this approach the

study does not begin with a theory to be tested but rather one begins with an area of study and what is relevant to that area is allowed to emerge (Strauss and Corbin 1990). Hence, as the study develops, the research design emerges and unfolds (Lincon and Guba 1985).

Grounded theory requires a naturalistic approach to data collection, this is achieved with what is called "Field work" and has been described as the best way to understand people (Schatzman and Strauss 1973, Lofland and Lofland 1984). The field methods of data collection selected for this study were: Participant observation and interviews with health visitors. Participant observation was chosen in order to get participant's perspective of the situation and events, to test the information given during the interviews and to uncover patterns that participants do not verbalize or are unaware (Gold 1958, Schatzman and Strauss 1973).

3.3 QUANTITATIVE AND QUALITATIVE RESEARCH

There has been a long standing divide between the qualitative and quantitative approaches to research. In broad terms quantitative research is associated with theory modifying and hypothesis testing and qualitative research with theory developing and hypothesis generating (Field and Morse 1985).

The quantitative approach is based on the natural and physical sciences and is promoted by those who give pre-eminence to a systematic and "Objective" ways of gathering data. Advocates of this approach are called "Positivist". For them the idea of "Objectivity" has two main aspects: 1) Neutrality between positions which encourages the conception that the researcher should be "Value free" and 2) Mind independence which encourages the researchers' detachment from the area of study. Positivists, hold the view that the world exists "Out there", independently of the people and has its own laws of behaviour regardless of what people think about it. Two objections have been made to the notion of "Neutrality". On the one hand it is argued that the objectivity of science is achieved at a collective level, it results from mutual criticisms and in effect the cancelling out of individuals biases. On the other hand Marxists argue that the positivist approach may be appropriate for understanding nature, but it cannot be applied to social life since they believe the truth is not achieved through impartiality. Regarding the idea of "Mind independence" it is argued that independence of reality is an assumption since an individual's capacity to observe something depends upon the individual's theory about it. Further, those who follow the "Understanding approach" to research, object to this view since they consider that people interact guided by their understanding of the events, hence social reality is not independent of people (Cuff, Sharrock and Francis 1990).

Qualitative methodology does not place so much emphasis on predicting human behaviour, as quantitative does, but in understanding it in the tradition described by Weber (1947) as "Werstehen". Here the central idea is that, to explain human action, the understanding of meaning is essential. Hence one must "Take on the role of the other" in order to capture meanings (Mead 1934). Therefore, in this approach one is closely involved with the persons and social groups being studied (Schatzman and Strauss 1973, Lofland and Lofland 1984). One implication of this view is that one "Constructs" rather than "Collects" data, hence the process by which it is constructed should be monitored and explained (Cuff and Payne 1984).

Consequently with the above view, one of the most outstanding differences between qualitative and quantitative research is the mode of analysis. For Strauss and Corbin (1990) the term qualitative research means "Any kind of research that produces findings not arrived at by means of quantification" (p.17). They argue that while some data can be quantified in this mode of research, the analysis itself is qualitative. Thus, findings are derived from a nonmathematical analytic procedures.

3.4 GROUNDED THEORY

Strauss (1987) states that grounded theory is not really a specific method or technique but rather a style of doing qualitative analysis. It intends to generate theory from data collected in a natural context (Glaser and Strauss

1967). Grounded theory seeks to discover basic social-psychological problems and processes inherent in groups. A theory is built around the social process, that accounts for the behaviourial variations in a given situation (Wilson and Hutchinson 1991). Thus, research findings in grounded theory constitute a theoretical formulation of reality (Glaser and Strauss 1967). There are three pivotal issues in grounded theory research: 1) Data is collected in a naturalistic way, 2) Analysis focuses on processes, 3) Analysis aims at discovering and building theory (Strauss and Corbin 1990).

The strategy for generating theory is comparative analysis. This can generate two basic kinds of theory: substantive and formal. Substantive theory is that developed from an empirical area of social inquiry. Formal theory is that developed from a conceptual area of social inquiry such as stigma and deviant behaviour. Since substantive and formal theory differ only in terms of degree, each can shade into the other at points in the same study (Glaser and Strauss 1967). The theory that is generated must "Fit" the situation being researched, that is, categories and concepts must be easily applicable to and indicated by the data. Theory must also "Work" when put into use that is, categories must be meaningfully relevant and able to explain the behaviour under study (Glaser and Strauss 1967). Under this approach, theory is developed close to the data and one, as a researcher, must be fully aware that one is the instrument for developing it (Strauss 1987).

Grounded theory falls into the group of qualitative research and was first developed by Glaser and Strauss in 1967 (Glaser and Strauss 1967). While it has not changed since first introduced, the specifity of its procedures has been detailed as the method has evolved in practice (Corbin and Strauss 1990). In their first text, Glaser and Strauss (1967) acknowledged that guidelines not rules were given as to how to develop theory grounded in data. Since this original work, the method has been more clearly delineated and many grounded theory studies have been reported in the literature. It is increasingly being used in nursing research perhaps because grounded theory is considered important for the development of a practice based discipline (Strauss and Corbin 1990).

It has been pointed out that the method has been interpreted in different ways because of the use of the langauge (Stern 1985). Indeed grounded theory has almost a language of its own. Terms and concepts such as axial coding, conditional matrix, dimensionalization of a property, the coding paradigm, causal and intervening conditions were developed to operationalize the method and have a specific interpretation in grounded theory research. It can be said that one of the major tasks of the neophyte researcher is to grasp these new meanings and be able to apply them when analyzing the data. The different interpretations given to grounded theory are also due to the way in which the method was initially transmitted. Hence Chalmers (1990) draws attention to the fact that, in the early days,

grounded theory was learned largely through apprenticeship, the students learned the approach through seminar training with Glaser and Strauss.

In this sense it is interesting to note that the idea of learning grounded theory in the apprenticeship mode is still held true by some. Hence Schatzman (1990) believes that the way to learn grounded theory is by watching Strauss in action, that is coding data and doing analysis. Wilson (1990) on a similar line of thought, recommends to read grounded theory research reports as a way to grasp the method. Although I do not fully share Schatzman's observation, I found the last one to be true. Thus, it is important for the novice researcher to be guided by someone who both understands and sees data within a grounded theory perspective. Reading research reports helps greatly to understand and apply the method, mostly in the initial phase of coming to terms with the new terminology and concepts.

3.4.1 Symbolic interactionism: basic premises and methodological implications

Grounded theory is derived from a tradition within social science philosophy named "Interactionism". Central to this philosophy is the consideration of human beings as active creators of their world. While Mead (1934) articulated the interactionism thought, Blumer (1969) termed it symbolic interactionism (Wilson and Hutchinson 1991). In Mead's philosophy

individual selves and social actions are united and mutually influence each other. He developed a conception which made inseparable individual identity and action, on the one hand, and society and social structure on the other (Schwartz and Jacobs 1979).

According to Blumer (1969) symbolic interactionism rests upon three premises. The first is that human beings act toward things on the basis of the meanings that the things have for them. The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with others. The third premise is that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he or she encounters. Hence, for the interactionism the individual is not moulded once and for all by external factors. Rather the individual learns from society and, at the same time, modifies society (Cuff and Payne 1984). Under this perspective interaction is seen as emergent, and negotiated. Interaction is symbolic because it involves the manipulation of symbols such as words, meanings and languages (Denzin 1978).

Symbolic interactionism requires a naturalistic approach to research, that is the examination of social life events as they occur in their usual settings (Blumer 1969). Human interaction then is the source of data (Denzin 1978).

Two broad principles are drawn in grounded theory from this perspective. One is that events are not conceived as static but as continually changing in response to evolving conditions, hence an important component of the method is to build flexibility into the method. Second is that actors are seen as having the means of controlling their destinies by their responses to conditions. Hence grounded theory seeks to uncover relevant conditions of the phenomena under study, to determine how the actors responded to changing circumstances and to reveal the consequences of their actions (Corbin and Strauss 1990).

3.4.2 Data and sampling in grounded theory

In grounded theory data is collected from interviews, participant observation and documents such as caregiver diaries, letters and any other document that can inform the study (Wilson and Hutchinson 1991). The literature can be used as secondary source of data, hence quotations and descriptions from other studies can be analyzed in the grounded theory mode (Strauss and Corbin 1990).

Theoretical sampling is a means whereby one decides on analytic grounds what data to collect next and where to find it; data collection then is controlled by the emerging theory (Glaser and Strauss 1967). Events or incidents and not persons per se are sampled. Sampling is done on the basis of concepts that have proven relevance to the evolving theory. Hence in

theoretical sampling one takes emergent concepts from the analysis and asks specific questions about them in subsequent data collection (Wilson and Hutchinson 1991). It has different features according to the phase of the analysis, it occurs in tandem with the analysis guiding the data collection (Strauss and Corbin 1990).

Sampling continues until all the major factors that have evolved from the data are explored and the categories that pertain to them are saturated (Corbin 1986a). Saturation takes place when one can answer, via the data, questions included in the coding paradigm of the particular code (Hutchinson 1986). However, Schwartz and Jacobs (1979) maintain that in the final analysis there is no certain way to establish whether one has stopped the process prematurely or gone on too long and come up with redundancy. The development of the "Conditional Matrix" by Strauss and Corbin (1990) helps in making these decisions. The matrix is an aid for considering the wide range of conditions and consequences related to the phenomenon under study.

3.4.3 Mode of Analysis: Procedures

Strauss (1987) defines grounded theory as a mode of analysis within the basic procedures of data collection, coding and memoing. Coding is the discovering and naming of categories. Memoing aims at linking observations, making hypotheses and inferences from data. Data collection and analysis

are conducted concurrently, hence coding and memoing are done early and continuously during the research study. The analytical procedures generate hypotheses that are formulated in a provisional and conditional way; they guide sampling which aims at capturing variations that distinguishes the central phenomena being studied (Strauss 1987).

In grounded theory analysis the discovering, building and linking of categories are crucial activities for theory building. The category is the conceptual element of the theory, it depicts the essential relationships between data and theory (Glaser and Strauss 1967). Electing and naming the category is the first step in the process of coding, the second is establishing relationships between them (Swanson 1986a).

Once categories have been built and linked, theory is pulled together around a core category. A core category is that under which the other categories fit and to which they all relate (Corbin 1986). Glaser (1978) has suggested a criteria for recognizing a core category. According to him it must be central, that is it can easily be related to all other categories; it must recur frequently in the data; it must make sense to the people in the study setting; it must allow for dense explanations by incorporating a great deal of descriptive variation. The core category can be any of the theoretical codes identified during analysis.

Refining the theory is the final stage in grounded theory analysis, it continues up to the writing of the report. It aims at making the theory coherent and tightly integrated. The phases of the analytic process tend to overlap, hence categories may still emerge, be developed and densified during the refining phase (Corbin 1986a).

According to Strauss and Corbin (1990), through the above phases writing memos and diagramming are strategies that advance the analysis. They help in gaining analytical distance from the data. Memoing and diagramming begin at the inception of the research and continue until the final writing, they should never be omitted from the process of analysis. While memos represent the written form of one's abstract thinking about the data, diagrams are the graphic representations of the relationships between categories. Memos contain the products of coding, theoretically sensitizing and summarizing notes, and they give direction for sampling. Memos and diagrams evolve. As the analysis progresses they grow in complexity, density, clarity and accuracy. In fact, for each type of coding the memos and diagrams will look different (Corbin and Strauss 1990).

2.4.3.1 Coding: Central activity in grounded theory analysis

Coding is the central process in grounded theory analysis. It involves the operation by which data is broken down, conceptualized and put back together in a new way. Two analytical procedures are basic to the coding

process: making comparisons and asking questions (Strauss and Corbin 1990). By asking the data questions, categories are discovered. When making comparisons one looks for their full range and hence categories are built (Corbin 1986b).

Coding is guided by the "Coding paradigm" which acts as a reminder to code data. One is alerted to look for the conditions under which interaction takes place, the interaction among actors, the strategies and tactics that actors use, and the consequences of their action/interaction (Strauss 1987). Conditions that lead to the occurrence or formation of a phenomena are labelled "Causal" and those that facilitate or constrain the development of strategies are identified as "Intervening". However, these terms might be misleading for the reader since they are easily associated with a deterministic view. To use terms such as "Precipitating" and "Mediating" might well be more appropriate (Pearson 1992). In this study grounded theory terms are used as coined by their originators.

The classification of codes vary slightly among different authors. For instance, Corbin (1980) and Swanson (1986) refer to substantive and theoretical codes. Hutchinson (1986) identifies three levels of codes: level I or substantive code, level II or categories and level III or theoretical codes. Wilson (1989) distinguishes three major types of codes in grounded theory: Substantive, selective and theoretical. In the last work on grounded theory by Strauss and Corbin (1990) the three major types of coding are identified

as: Open coding, axial coding and selective coding. This is a good example of the different interpretations of grounded theory and how its language might confused the novice researcher. However, there is agreement among the authors about the content of the analytical procedures. It is clear that, as analysis progresses, coding becomes more conceptual.

In grounded theory analysis the first step is to conceptualize data and this is done by open coding. According to Strauss and Corbin (1990) it is the process of breaking down, examining, comparing, conceptualizing and categorizing data. It fractures data and leads to the identification of some categories, their properties and dimensions. Dimensions represent locations of a property along a continuum. Both properties and dimensions are important because they form the basis for making relationships between categories. Sampling here aims at uncovering as many potentially relevant categories as possible. Electing categories is very important since it forms the basis of the theoretical sampling.

This early phase of analysis presents challenges for the inexperienced researcher. It is very difficult to distinguish in the data properties since they are often found in their dimensional forms (Strauss and Corbin 1990) and the category is in the process of being built. I found this to be the most difficult phase of analysis in grounded theory, here there is a need to keep the analysis as open as possible in order to discover categories but at the same time avoid being flooded by numerous codes.

In axial coding, the second stage in analysis, data is put together in new ways by making connections between a category and its subcategories. Through the "Coding paradigm" subcategories are related to a core category. The focus in axial coding is on specifying a category in terms of the conditions that give rise to it; the context in which it is located; the action/interactional strategies by which it is handled, managed, carried out; and the consequences of those strategies. Sampling is focused on uncovering and validating these relationships, hence they are tested against data (Strauss and Corbin 1990).

In this phase of analysis I found that in order to link categories one needs to have some idea of what is the core category and this is not found unless categories are linked. Hence the same category could be a condition, a strategy and a consequence depending on the core category. For example in this study the category "Compromising" was built and coded as a strategy to gain ground. However, it could also be regarded as a consequence of unbalanced relationships. At this point I found that I had to make provisional decisions regarding linkages and see how they worked in relation to the emergent theory. Memos and diagrams were of great help in this phase of analysis.

Lastly, Strauss and Corbin (1990) define selective coding as the process by which all categories identified during the analysis are unified around a core category, and categories that need further explication are filled in. In this

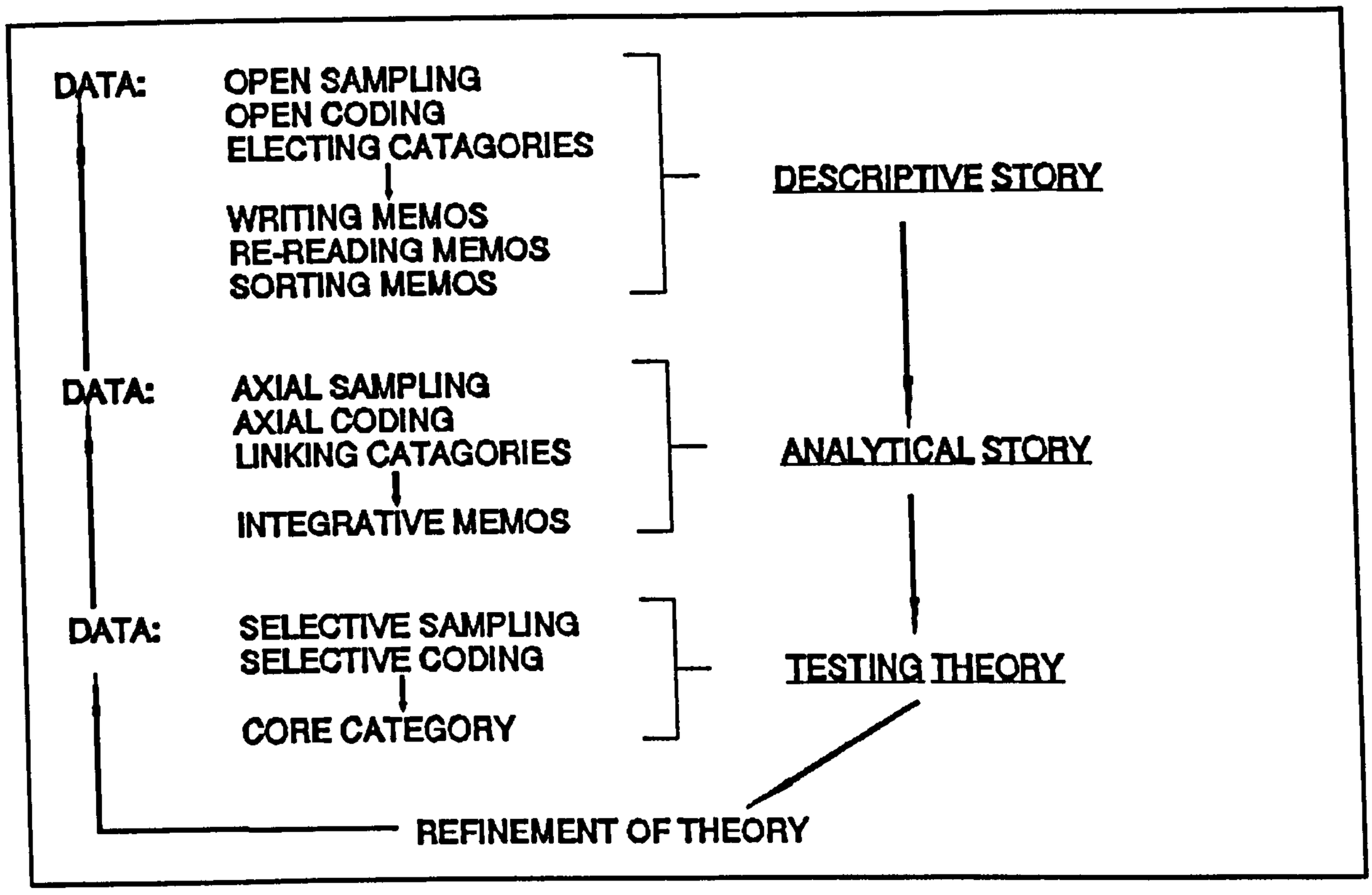
phase sampling is directed and deliberate, Strauss and Corbin (1990) named it "Discriminate sampling". Here data is collected to verify the core category, the relationships between the categories, and to fill in those that are insufficiently developed.

Throughout the process of analysis one moves from depicting a descriptive story to constructing it in an analytical way, to finally arrive at a grounded theory. Figure 1 attempts to summarize the different stages in grounded theory analysis.

3.4.4 Validating and generalizing grounded theory

In grounded theory research, the emergent theory is constantly validated against data. Interviews observations and other means of data collection are also used as a way to check the soundness of one's conceptualizations. As well validity is checked by having participants to respond to the theoretical proposals resulting from the analysis and interpretation of data (Wilson and Hutchinson 1991).

FIGURE 1 - SUMMARY GROUNDED THEORY ANALYSIS



According to Corbin and Strauss (1990), the generalizability of a grounded theory is partly achieved through a process of abstraction that takes place during the research process. The more abstract the concepts, especially the core category, the wider the theory's applicability. This is consistent with Hutchinson's point (1986). She states that a substantive theory is valid only for the studied population. However, she believes that the basic social process identified in grounded theory is also relevant for the people in general.

Corbin and Strauss (1990) propose that systematic and widespread theoretical sampling together with completeness in the discovery of conditions and variations, will permit theory's greater generalizability,

precision and predictive capacity. According to them, a grounded theory is generalizable to the extent that it specifies conditions that are linked through action/interaction to specific consequences. They point out that if a grounded theory fails to account for variation that has been uncovered through additional research, the new specifications can be used to amend the previous formulation.

3.5 EXPLORATORY STUDY

An exploratory study was conducted for the following reasons: 1) To provide me with the opportunity to practice in the role as observer, 2) To ascertain whether the methods of data collection would provide the data sought, 3) To discern how to inform and present myself to participants, 4) to find out whether the observer role could be implemented as planned and, 5) To assess how I would cope with the workload. In addition, the exploratory study would up date my knowledge as a health visitor trained in the UK some years ago.

The study was conducted in a inner city health centre covering a highly deprived area. Poverty, unemployment, poor housing and drugs were the problems reported by the participating health visitors. Access to the setting was granted by the sector manager and one health visitor prepared the visit programme. At first there was a confusion about the purpose of my visit. Health visitors at the health centre considered me as a visitor from abroad

on a visiting tour seeking as much information as possible about health visiting in the UK. Hence I was given a tight schedule of visits. I had to explain that I intended to do a exploratory study for my research. By the end of the study participants considered me as a colleague doing research. Being with them at social events and sharing lunch helped greatly in establishing a good relationship with participants and also helped to clarify my role.

However, being from abroad proved advantageous all through the study, it enabled me to adopt the role of naive observer and participants were willing to share with me information. As an outsider I was not a threat to them and in general they felt comfortable expressing their opinions to me.

Four different health visitors were observed during four consecutive days. Observations took place at the health visitor's office, in client's homes and during clinics. This involved observing 18 health visitor-client interactions and a total of 17 hours of field work. On the spot questioning was also used as a way to gather data. Notes were recorded in the field at intervals of one to two hours of observations, most of them were taken covertly. Notes were fully processed the same or the day following the observation. They were organized into observational notes, theoretical notes and methodological notes (Schatzman and Strauss 1973). Also personal feelings in the field were recorded in the form of personal notes. These referred mostly to my concern not to interfere in the natural setting and to feelings

of tiredness and stress. A total of 70 pages of raw data was produced during this exploratory study.

While doing field work I tended to wear classical garments of dull colours, the aim as expressed by Field (1990), was to be "Melted with the furniture". I was introduced to clients as a health visitor from Spain doing research into health visiting. It was stressed that my concern was with professional issues not with the client or the specific situation. However it was emphasized that the information gathered during the interaction was confidential. Clients always granted access to their homes.

Beside the observations, three health visitors were interviewed. Access was granted directly to me, the interviews were conducted after I was out in the field with the participant. The first interview took place in the seminar room of the health centre. Since this room was very formal subsequent interviews took place in a less formal room, that is the dining room. This change was advantageous, here participants felt more comfortable and at ease; it was credible to conduct an interview in a conversational manner in such an environment. The duration of the interviews ranged between half an hour to an hour, they were tape recorded. A provisional interview guide was developed with the following issues to be discussed:

1 - On what grounds do health visitors intervene

2 - From where do health visitors get the information to act

3 - Who identifies the need for action

4 - What are the types of interventions. To whom they are directed

5 - Type of area where they work and caseload

As part of this exploratory study I analyzed some of the data collected. I spent five additional days in transcribing the relevant parts of the interviews and in open coding all the field notes. This produced a very long list of codes and an analytical memo titled "Gate keeping" which referred to the health visitor's role as middle person or mediator.

The exploratory study showed, in general terms, the feasibility of the research project. However, based on the experience and analysis, the following decisions were taken:

- To address directly potential participants as a way to gain their voluntarily co-operations and avoid misunderstandings about my role.
- As a way to reduce the impact of being tape recorded, to conduct interviews with participants after being a few days with them in the field.
- In order to cope with the workload of collecting data and concurrently analyzing it, to take one day off after every two days of field work and week ends to process notes and start open coding. As the research progressed, I

would consider staying in the field for just a half day sampling events.

- As participants repeatedly stressed that health visiting would be different in an affluent area, to conduct field work in both affluent and deprived areas.

- Since all the visits were made to under fives, to ask participants, whenever possible, to select visits to another age groups. This initially would give me a more comprehensive insight into health visiting.

- Re-arrangement of interview questions. As a way to break the ice, to start the interview by asking health visitors to tell me about the characteristics of the area where they work.

3.6 THE MAIN STUDY: PARTICIPANTS

2.6.1 Access to participants

Participants for the main study were contacted during a meeting at the University of Liverpool Department of Nursing. Taking the opportunity, as field work teachers and assessors from the Region were congregated at the University, I presented myself to them and asked for their cooperation. For that purpose I prepared a written statement (Schatzman and Strauss 1973) which included information about my professional background, the aim of

the research project, methods of data collection, and how much it would demand from participants. The voluntary nature of taking part in the study, the anonymity of participants and the confidentiality of the data collected was stressed (Appendix 2).

During the verbal presentation I stressed that I was a health visitor myself qualified in 1977 hence interested in up dating my knowledge of health visiting. The aim of this presentation was to remove participant's feelings of being threatened by the study, to raise interest in the subject and to make them aware of the importance of their collaboration. After the presentation I circulated forms for those interested in the study to fill in their names, years of experience and work addresses. A total of 40 volunteers was drawn from different Areas of the Region.

Once volunteers were selected (see next section for selecting criteria) for the study I contacted them well in advance to arrange a convenient time for the visit and I sought the permission of their manager for going out with them. Since I had more volunteers than those needed for the study, I wrote to those who were not selected thanking them for their interest and informing them of the future availability of the research findings (Appendix 3).

3.6.2 Participants and sites

A total of 21 female health visitors participated in the study. Twenty of them were interviewed and ten were observed working for a period of 2-5 days. Their age range were from mid twenties to mid fifties. Accordingly their professional experience varied from 9 months to 29 years. All of them but one were trained in Liverpool and the majority were married with children. Most of them worked on a full time basis on a geographical based scheme. Participants were health visitors, field work teachers, and student assessors (Appendix 4).

The selection of participants was guided by two basic criteria: 1) According to the area where volunteers worked and 2) According to their years of experience. Hence it was sought to have a mixture of deprived and affluent areas as well as a combination of recently qualified and highly experienced health visitors. This criteria was adopted as participants on the early days of the research, emphasized the differences in approaches to practice according to these issues. Within this framework I sought to have participants with different personal and professional experiences. As the analysis proceeded, theoretical sampling replaced the initial selection criteria.

The sites for the observation visits was four health centres. One of them was in a highly affluent area, the other in a very deprived area, and the other two in areas with a mixture of affluence and poverty. All of them were part

of the same District Health Authority. Interviews took place in the health centres where health visitors worked.

3.7 THE MAIN STUDY: DATA COLLECTION

Data was collected by means of participant observation and formal interviews. Participant observation involved 152 hour of observations, several informal interviews (Chenitz 1986) and on the spot questioning (Schatzman and Strauss 1973) during 41 days. A total of 198 health visitor-client encounters were observed. Of those, 121 took place in the home where visits to under fives were predominant, and 77 took place in clinics (Appendix 5). A total of 20 formal interviews were conducted in a conversational manner, all of them were carried out in health centres. Data collection yielded 1,260 pages of raw data for analysis.

Theoretical sampling guided the collection of data. During interviews participants were asked questions to build and confirm the emerging categories. For instance in the early interviews some participants mentioned their role as "Middleman". On subsequent interviews I asked other participants if they felt that way and, if so, under what circumstances they undertook this role and what were the type of activities they perform. "Negotiating" was a category that emerged in the analysis of early interviews and was built during the following interviews and field observations. Thus this category was built by identifying negotiating tactics

such as "Turning a blind eye", "Toning down" and "Settling for the lesser of two evils". During field observations home visits were sampled. Hence I requested that health visitors made home visits to certain type of clients such as elderly, handicapped, affluent and deprived clients.

Events were sampled from field notes in the later stage of the analysis. On the final stage, selective observations were conducted for three days, they aimed at filling in categories and corroborating the core category.

3.7.1 Participant observation

Participant observation is believed to be one of the few methods available that is well suited to an analysis of the form of symbolic interaction (Denzin 1978). In grounded theory studies participant observation is used conjointly with informal interviews and this heightens the researcher's ability to collect and validate data (Chenitz 1986).

On the spot questioning (Schatzman and Strauss 1973) is used to clarify meanings and to validate insights. The informal interview also contributes to the collection of new data (Chenitz 1986). It is conducted in a conversational manner and therefore does not have a particular meeting time, place or time prearranged (Chenitz 1986). During the present study most of the informal interviews were conducted in health visitors' cars after

visits to clients' homes. Also some of them took place at the health centre after clinics and at lunch time.

In participant observation the researcher might adopt different roles. Gold (1958) identified four "master roles" in which he distinguished at either end of the continuum the complete participant role and the complete observer role. For this study I adopted most of the time the role of observer as participant (Gold 1958). My role as researcher was in the open, much of the time was spent in observing interactions. However I related briefly with participants during on the spot questioning and in some social events. The participation in the setting under study could be considered as "Moderate participation" (Spradley 1980) as I sought to keep a balance between being an insider and an outsider, between observation and participation.

Nevertheless it must be remembered that "Master roles" are ideal types and that during field research all the roles might be used (Burgess 1982a). Indeed in the course of the present research I adopted on one occasion the role of complete participant when I accepted an offer to do the distraction during a hearing test in a client's home. This experience was recorded in the field notes. It helped me to build the relationship with the health visitor and gave me an insight into the health visitor's role. During most of the home visits I adopted a complete observer role. As one health visitor put it I was like "A fly on the wall" (JT May 1990). Some clients interacted with me by

asking me about Spain and how I enjoyed Liverpool, my relationship with them was courteous.

The relationships I built with participants were in terms of me being an "Acceptable incompetent" (Hammersley and Atkinson 1983). Hence I adopted a "Learner" role (Lofland and Lofland 1984). Being a foreign nurse qualified as a health visitor in 1977 made it possible for me to adopt this role, hence I was able to ask very naive and common sense questions without arising irritation.

Following Schatzman and Strauss' (1973) recommendation I tried to create situations which invited visibility and disclosure. In order to build up trust with participants I used different tactics to convey the message that I was actually "One of them" but doing different work. Hence I talked about myself and my interests as a person, I expressed feelings about my work and accepted social outings. I answered the questions participants asked me about the progress of the research taking the opportunity to validate my insights. Also I repeatedly assured participants that I was not judging them but learning about practice and gaining understanding. My constant attitude with health visitors while in the field was that of not obstructing their work. Understanding and sympathy were natural feelings that observations aroused in me, I tried to convey this to practitioners. On the whole I had a very good relationship with participants, all of whom expressed interest in

the results of the project and invited me to contact them if I require further information.

Observations were mobile, participants were followed throughout a working day (Schatzman and Strauss 1973). As analysis progressed and sampling took place, some observations were single, hence health visitors were observed at the office and in clinics.

2.7.1.1 Field notes

Data from the observations and the informal interviews were recorded in field notes which were recorded what the observer sees, hears, experiences and thinks in the course of collecting data (Field and Morse 1985). Field notes were taken covertly. However, participants were aware that I was recording observed events. Mental notes were taken during the observation. After 20-30 minutes of observation jotted notes (Lofland and Lofland 1984) were taken down. These notes are little phrases, key words and quotes that have the function of prompting the observer's memory at the time of writing field notes (Lofland and Lofland 1984). Hence the fieldwork record was made of condensed accounts and expanded accounts (Spradley 1980).

Schatzman and Strauss (1973) have noted that notes lose value after 2-3 days of recording them, hence they have to be fully processed during this period of time. In this study, the full version of field notes was written

promptly, usually the same day, just after being in the field. Periods of observations were arranged in such a way that they gave me time for processing the jotted notes. It was clear that it was of no value to make observations if afterwards I could not recall them accurately. Hence, I found that the maximum time I could observe on any day was 3-4 hours. This allowed me to fully process field notes with precision and to observe without being too tired.

Field notes contained the date, time, location and details of the participants. They were duplicated for analysis and storage in different places as a precaution against damage (Burgess 1982b). In order to keep track of the events observed I developed some forms in which daily activities and total activities in the health centre were recorded (See appendix 6 for samples).

One day of observations tended to produce an average of 20 pages of notes which took about 4-5 hours to process. Taking into account the time involved in preparing notes for analysis and open coding, I found that observations generated three times more the amount of time employed than the observation itself. Hence one hour of observation meant three additional hours of work to get a preliminary analysis on which to base further sampling. I tended to leave the weekends for open coding, preparing notes for analysis and developing analytical memos.

While taking and processing notes I took events at face value, believing everything and nothing (Lofland and Lofland 1984). As Schatzman and

Strauss (1973) put it, I wondered first and made judgements later. Words and events were taken as facts for analysis.

As during the exploratory study, field notes were organized into observational, theoretical and methodological notes (Schatzman and Strauss 1973):

1) **Observational notes.** THese are the statements of what is being watched and observed, they contain as little interpretation as possible.

2) **Theoretical notes.** They go beyond the facts and attempt to derive meaning from observations. Here private declarations of meaning are made.

3) **Methodological notes.** Are instructions, a remainder or a critique of one's field work tactics.

In addition to the above, I took "Personal Notes". These were the record of my feelings during field work. Samples of the different types of notes are found in the Appendix 7. Following Mills (1959) and Spradley (1979) suggestion, I also kept a journal during the whole research study. Mills (1959) advises us to use life experience in the intellectual work, hence he recommends putting together in a journal what one is doing intellectually and what one is experiencing as a person. According to him, this is to engage in the controlled experience (p. 195). On similar lines, Spradley

(1979) comments that making an introspective record of field work enables one to take into account personal biases and feelings, to understand their impact on the research (p. 76). Keeping this journal has indeed made me aware of assumptions and has helped me to reflect about the research process.

3.7.1.2 Minimizing reactivity

The impact that the observer has on the setting under study has been well documented. Hutchinson (1986) points out that although participant observation may initially influence the setting, social and organizational constraints will neutralize this effect; hence participants will be more concerned with meeting the demands of their own situation than with the researcher. Davis M (1986) comments that field researchers are aware that they do have some effect on the situation they are observing and advises us not to spend energy in questioning whether or not it exists. Instead she suggests focusing on how to diminish their effect on that being studied, how to make it a strength in the research and how to control the objectivity of the data.

Paterson (1989) reviewing the recommendations made in the literature to prevent or reduce reactivity in participant observation, found five different types of strategies. These were followed during the present field work.

Thus:

1) Know and reveal the researcher as the instrument of the inquiry. This refers to the researcher's self reflective attitude towards participant observation. The personal notes taken during field work and the diary I kept helped in this reflexive approach. Here I reported feelings, attitudes and behaviour that may have influenced the study.

2) Consistently account for possible observer effects. To do this I asked participants in what ways they were influenced by my presence; identified the data that was not provided spontaneously; compared behaviour when my presence was very noticeable and when participants were not so aware of it; and finally I contrasted what was observed against available knowledge and what is known to be a common experience among experts not participating in the research.

3) Data quality control. This refers to the researcher's tactics to ensure that the data which is collected portrays the situation being observed. Writing field notes shortly after the observations and not discussing them until they were fully processed were the methods I use to maintain the quality of the data.

4) Clearly identify researcher's role. Participants knew that I was doing participant observation and that I had to observe events without taking part

of being involved in them. They also agreed to grant me informal interviews to discuss issues further.

5) Spend appropriate amounts of time in the field. I left the field in times of fatigue and when this was not feasible, I stopped observing when I was tired or just bored. I also avoided remaining in the field for long periods of time.

The relationships I established with participants together with my physical presentation also helped in reducing reactivity. Hence during field work I wore garments similar in style to those used by health visitors. I attempted to be identified with a "Marginal outsider" (Lofland and Lofland 1984).

2.7.2 Formal interviews

Beside the informal interviews carried out while doing field work, 20 health visitors were interviewed formally in their health centres. This sample size was satisfactory and confirmed the literature which states that 20-50 interviews are sufficient to elect the major themes of the topic under study (Swanson 1986b). Interviews lasted 30-50 minutes, were tape recorded with a professional tape recorder and fully transcribed, shortly after, by an audio typist. Each participant was given a code before transcription, hence I was the only person who knew the name of the participant. Following the interview, field notes were also taken to record the additional information

given once the recorder was turned off, and to note the participants reactions to the interview. Ten health visitors interviewed were also observed during field work. The period of observation was used as a way to establish rapport with those participants. In this case the interview was also an opportunity to discuss in more detail the issues highlighted during observation.

Formal interviews are those carried out according to a prescribed plan of action and when the researcher desires in depth information that can be best obtained from participants previously recruited for that purpose; time and place are explicit and prearranged (Swanson 1986b). They are of two types: structured and unstructured. In structured interviews the interviewer uses an interview schedule and does not deviate from the questions in sequence or wording. In the unstructured interview, the interviewer introduces a pertinent theme and questions are framed to pursue the development of the theme (Swanson 1986).

The interviews conducted during this research fall into the category of unstructured. Participants were approached in a conversational manner (Schatzman and Strauss 1973) with an open general subject, ie: to discuss how they feel about or see health visiting practice. I had in mind a list of issues to discuss but they were flexible in the order and wording (Appendix 8). What I had to ensure was to convey with the questions, the right meaning and to maintain, as far as possible a natural flow of conversation.

However, the first interviews were very much structured, I was anxious to get "Facts", straight answers. Once I had begun to grasp the principles of grounded theory and qualitative research the subsequent interviews were very open. Hence I would use a general statement such as: "I would like to know how you see health visiting practice, so perhaps we might start if you tell me something about your caseload". Further questions were based on the information that the participant was giving. This is consistent with Schatzman and Strauss (1973) view. They assert that early interviews look more like "Guided conversations". As the analysis progressed interviews became more structured. Beside the open general theme, I had specific issues such as negotiating care, giving things to clients and the role of trust which I explored with participants. These issues were part of the theoretical sampling and were addressed in order to validate previous information given or analysis insights. Hence, as Antle May (1989) has noted, the distinction between unstructured or structured interview in qualitative research has more to do with **when** in the process the interview takes place.

This last point leads to an important question raised by the same author, that is the delicate balance between flexibility and consistency in data collection (Antle May 1989). She notes that this is a challenge for researchers and that consistency is usually more difficult to achieve. According to her in qualitative research, the goal of consistency is to assure that questions that appear to be important at a given point in the research process, are asked of as many participants as possible so that subsequent

interviews can be informed by them. This problem arose early in this research. Combining field observations with formal interviews helped greatly in maintaining this balance. I was able, via informal interviews, to discuss with different people the same issues as those posed during the formal interviews.

Before the interview took place, participants were informed in general terms about the study, the theme of the interview, its length, that they could stop at any time they wished and that they need not answer a question if they did not feel like it. It was stressed that the information given would be treated confidentially and that I would rather not have answers that contained inaccurate information. Emphasis was put on my genuine interest for understanding health visiting practice and that I was looking forward to learning the participant's point of view as opposed to the standardized theoretical version contained in some text books. Permission was also sought for tape recording the interview. All the participants gave their consent to be taped. This was a short introduction that I usually gave while setting up the tape recorder. This was done following Whyte's (1982) advice when he states that the first concern of the interviewer is to establish a relationship in which participants will feel comfortable and confident while talking to the researcher.

Further, in order to build rapport, I started the interview with some social talk (Swanson 1986b). This tended to be about the health centre or how

I found the site. During the interview different tactics were used to elect and validate data. I posed hypothetical questions in terms of "What if...?"; I validated data by stating "Someone told me or I observe... what do think about it?". Chronological, detail, clarification and explanation probes were also used (Schatzman and Strauss 1973). Hence I used questions worded in terms of "When it did happen?"; "How do you mean?"; "Tell me more about it"; and "Am I correct if I say that...?". The role I adopted during the interview was that suggested by Field and Morse (1985), that is guiding the direction of the interview, probing, understanding and encouraging respondents. Interviews did not come to a formal end but were "Suspended" (Schatzman and Strauss 1973) so that after examining it I could contact the interviewee for clarification if needed. Hence, as recommended by Field and Morse (1985), the relationship with the informant was left open for the possibility of coming back after the transcription of the tape. All participants consented to being contacted at a further date if needed. However, it was not necessary.

Once the interview was completed I took notes about the non verbal clues participant gave during the discussion. In few occasions participants made comments on further issues when I was getting ready to leave. In these instances, jotted notes were taken outside the health centre and expanded on arrival home the same day.

It took about 7-10 days for the typist to transcribe each tape. Hence in order to continue with the theoretical sampling and the analysis, I listened to the tape before handing it to the typist and took notes on the major issues. This usually took me about 2 hours. Transcripts were checked, before coding, for accuracy in the transcription. This involved one hour's work. Thus, before I could code the data from the interviews I had to invest 3 hours. On the whole, an interview yielded the same amount of work I put into one day of observation before I could start the formal analysis. I found that doing one interview per day and a maximum of three a month enabled me to cope with the amount of work involved to meet the research schedule.

3.7.3 Ethical considerations

Throughout the research study, participants were aware of my role as researcher. No data has been collected without their permission. Health visitors' clients were also informed of the research and their consent was asked to make observations in their homes and while in clinics.

Health visitors' managers also gave permission for conducting field work in the different health centres. To do that they asked to be given information regarding those who agreed to participate. A list with the name of all the volunteers were sent. However, it was not stated who were finally selected for the study. Health visitors and managers from the area knew the health centre I was visiting but information about the specific persons I was going

out with was not disclosed. Obviously colleagues and sector managers at the health centre concerned knew who was participating. The research supervisor and I, myself, were the only persons who knew the identity of all the participants.

The data collected was handled in a confidential and anonymous way. Hence the participants names and places in both field notes and interviews were coded. Data was stored in locked cupboards, I was the only person who had access to this information. The interpretation of codes was kept in a separate file from the data. When discussing findings with colleagues and at seminars, the codes for the places and participants were also used.

3.8 MAIN STUDY: ANALYSIS

The central analytical approach to develop a substantive grounded theory is process analysis (Glaser 1978). When analyzing data for process one aims at accounting for change in the social phenomena being studied over time (Fagerhaugh 1986). According to Strauss and Corbin (1990) process is:

> "The linking of sequences of action/interaction as they pertain to management of, control over, or response to a phenomenon" (p. 143).

The terms used in the literature to refer to the above process are either just "Process" (Strauss and Corbin 19990) or "Basic Social Process"

(Fagerhaugh 1986) and "Basic Social-Psychological Process" (Hutchinson 1986, Wilson 1989).

In the present study, data analysis began shortly after the first days of field work. From here onwards data collection and analysis were done concurrently. Analysis directed the collection of data.

To store the data and the product of analysis in an organized way, the three different type of files suggested by Lofland and Lofland (1984) were used. Hence the information relating to participants phone numbers, profiles and work addresses, and the location of data was filed in the "Mundane FIle". Memos, and diagrams were part of the "Analytical File". Field notes and the transcripts from interviews conformed the "Fieldwork File". In addition I kept a "Personal File" which included the diary, the personal notes taken during field work and the methodological decisions taken during the research.

3.8.1 Coding

Open coding took place on the second day of field work. By analyzing field notes line by line I focused on interactions and gave conceptual labels to incidents or events (Corbin 1986b). Examples of these early codes are "Anticipating", "Pacing" and "In between". Codes were written on the margins of the field notes and transferred later to cards. I kept two records of field notes, the original and a copy. The copy was used for data analysis

and broken down into the units of analysis or codes. The integrity of the original record was maintained for contextual reference if needed.

Once the field notes were coded, I transferred the information to eight by five inch cards. Each of them had a xerox copy of the incident already coded in the field notes. In the top left margin the code was written in pencil. At the back of the card I wrote information regarding the person involved in the event, where it took place, the date and the code as localized in the original record of field notes.

To start with the analysis I followed the procedure suggested by Lincoln and Guba (1985) to operationalize the constant comparison that grounded theory requires. Hence I piled the cards that "Felt alike" or "Looked alike" and gave the pile a name. The names I came up with were my initial and provisional categories. I placed the cards in carton boxes separated according to this provisional categories. Examples of these categories are "Tailoring", "Filling gaps" and "Getting the shape". In addition to this I started an index of codes (Wilson 1989). This list was reviewed from time to time to keep track of the codes and to place them in categories. As data collection and analysis proceeded codes and categories were refined, some deleted and new ones added. For example the code "Years of experience" was abandoned as the analysis moved forward, the category "Giving things" was refined to be called "Relief work" and the code "Client ask" was transformed into the category "Client's agenda".

Categories using the coding paradigm were linked. Hence I looked for the axial codes, that is for conditions, strategies and consequences of the events that I had previously open coded. On the same card I entered the open code I had recorded, I entered the axial code in the top right margin. During this phase of axial coding the cards were re classified on their boxes according to categories and theoretical codes.

By sorting out cards, moving the order of the categories in the boxes, changing the label of theoretical codes, and constantly reviewing the index of codes, I managed to unify the categories around a provisional core category. Thus, in this stage of selective coding, I mostly rearranged and classified the data at a higher level. I also coded data selectively. I coded only the information that shed light on the links I was making around the core category. Thus, for example I focused on coding data that refered to the consequences of a health visitor's compromising tactics and I confirmed its link with "Selling health visiting" which was the provisional core category. After the final analysis it was refined and became "Marketing health visiting".

The coding process involved the production of 1,900 units of analysis or index cards which were condensed into 55 cards that referred to the initial categories. All the cards were kept in boxes with a name referring to the overall content. The physical organization of the cards helped greatly in the analysis. To have to store with some sense, this vast amount of cards, and

to have to give labels to boxes and a pile of cards forced me to synthesise, conceptualize and link data.

3.8.2 Memoing and diagramming

After five days of field work and starting coding data, I wrote the first analytical memo. Writing memos was a constant activity during the whole process of analyzing data. I produced a total of 370 memos. Most of them were cumulative. That is, they referred to an issue that expanded as analysis and data collection progressed. Memos were sorted occasionally and classified according to the theme in a loose leaf folder. On the whole, they were filed in five different folders which had the same function, that of the card boxes: to help me to conceptualize data at higher levels.

Memos were written following the indications of Strauss (1987) Corbin (1986b) and Wilson (1989). Hence they were dated, labelled with a code or title, kept separated from the data and when appropriate, cross-referenced to illustrations in the data. Memos were kept conceptual, containing at first one idea at a time. In the subsequent stage integrative memos were produced (For a sample see Appendix 9). In the latter phase of the analysis memos were like a safe ground where I could test how the evolving theory stoo, where I could see how well an idea was written out. They were crucial elements for both developing the analysis and writing up the theory.

Diagramming took place during the process of axial coding until the final version of the present report. Diagrams were used to visualize the relationships among the categories (Strauss 1987). I produced 30 diagrams that showed the different ways I had linked codes first and categories later. As when classifying data, diagrams helped me greatly to impose some order in seemingly chaotic data.

Without the memos and diagrams I could not have reconstructed reality, previously broken down during the coding process, in a different and meaningful way. They were the foundations of my analysis and writing.

3.8.3 Validating analysis and writing up the theory

Throughout the process of data analysis, categories and their linkages were validated with research participants and experts. In addition to the regular validations I made during the interviews and field work, the core category with its major strategies was presented to three participants. They found it relevant and meaningful to their practice.

At different stages of the analysis, a total of 14 interviews were conducted with professionals from different fields and countries. They came from the UK, Canada and the USA. During these interviews, they helped greatly in clarifying issues and suggested areas of further analysis. The coding sessions I had with my supervisor and another health visitor researcher

helped also in defining my thoughts and validated the insights against current knowledge.

Also a formal validation seminar took place at the University, Department of Nursing. It was attended by health visitors researchers and lecturers. I presented the major components of the final analysis focusing on the "Fringe work" category. Participants made valuable contributions to the analysis and validated that the issues brought up were common practice. They also found the analysis meaningful.

The writing of the theory started after the final integrative memo was validated during the above seminar. Lofland and Lofland (1984) however highlight the creative effort of writing. They point out that when one begins to write one starts to get new ideas, to see new connections and to remember material that had been forgotten. This was true in my case. While I was writing new ideas emerged and the analysis was refined. I had some times to go back to the data to fill in categories and to look for evidence that supported the new insight. Melia (1981) reported similar experience, the real shape of her categories took place when the writing started (p. 113). Quite rightly, Strauss (1987) considers the writing as an integrative mechanism for the theory.

Following his advice (Strauss 1987), the integration that I achieved during the first draft was carefully reviewed before writing the second one. The

theory was more tightly constructed in this second draft. It was here that, for instance, the essential organization and links made in chapter 7 emerged. Thus, I carried out the analysis up to the final draft of the report.

3.9 CONCLUSION

The present study was undertaken to provide an understanding of the processes underlying health visiting practice. The research strategy selected was grounded theory. Grounded theory is a way of analyzing data, collected in the natural setting, that seeks to discover the basic social-psychological problems and processes inherent in groups.

Data was collected by means of 20 formal interviews and 41 days of participant observation. Analysis began shortly after the first days of field work. It was done concurrently with data collection guiding it.

The next four chapters present the findings of this research study. The general context in which health visitors' work develops is first depicted, then the basic social process in health visiting and the consequences of implementing different strategies are described. The categories that emerged during the analysis of data are organized following grounded theory theoretical codes, that is the conditions, strategies and consequences of the action interaction.

CHAPTER 4

BETWEEN TWO WORLDS:

GENERAL CONTEXT IN HEALTH VISITING

4.1 INTRODUCTION

This chapter examines the general context in which health visiting takes place. This context is defined as "Working between two worlds" and is a way of describing the health visitor's position between the policy agenda and the client's agenda. Both act as conditioning factors in health visiting practice. This chapter highlights the components of the policy agenda leaving client's conditioning elements to be discussed in the following chapters.

Having described the health visitor's context, the following chapter goes on to explore how health visitors implement the policy agenda in practice. The basic process called "Marketing" is identified as the way by which health visitors introduce their agendas into the clients' sphere. The elements described as the health visiting context serve as a backdrop to understanding the implementation of the "Marketing" strategy in health visiting.

4.2 WORKING BETWEEN TWO WORLDS

The health visitor's main work is the unsolicited routine visiting of parents with children under five years of age. Thus, health visitors have caseloads but not clients. In addition to this, they receive notifications to visit other people who usually have not requested the health visiting service. Therefore they are not as yet health visitors' clients.

This situation conditions health visitor's work circumstances. The overall context in which health visiting takes place can be described as that of "Working between two worlds". Health visitors are placed between the "Policy" world and the "People" world. Each of them has a set of expectations and views about health care and needs. These views are expressed in their respective agendas. The health visitors' policy agenda is concerned with delivering preventive and promotive services to families. The underlying aim of this agenda is to enable or secure life trajectories. This refers to the expected unfolding of client's life, the organization of work done and its impact on those involved (Strauss, Fagerhaugh, Suczeck and Wiemar 1985). Thus, health visitors are placed between a prescribed solution to a forecast need (Policy) and the clients' definition of their needs. It is in this context that discrepancies may arise. The community as Orr (1986 p. 189) has pointed out, is the place where women are in direct contact and confrontation with the State as represented by services such as housing, welfare and health.

The literature gives accounts of other health professionals also being placed among two systems. General practitioners are thought to be the "Hinge" between local lay systems and "Outside" professional system (Friedson 1960 p. 376). The psychiatrist's position between different loyalties has been described by Szasz (1973) as that of being "Double Agents". The nurses dual position between care and cure structures of the hospital has been analyzed and it has been argued that although they are employed as an agent of the care structure, the activities of the cure process take most of their time (Mauksch 1966 p 129).

Research studies in health visiting in the UK and public health nurses in North America, touch the issue of Health visitors dealing with the client's and the policy agendas. Thus, De Silva (1988) found that approaching clients, in public health nursing, involved choices between working within the client's boundaries or working within the professional's framework (p. 120). Mayall and Foster (1989) in their comprehensive account of health visiting gave many details of the health visitors being between the policy and the people they encounter: When describing the policing aspect of the service and the need for client's cooperation in taking up the service, they implicitly acknowledge the existence of two worlds (p 147).

The people whom the health visitor encounters have specific life circumstances and have their own agendas which might not relate to the professional's agenda. A different agenda is shown when, for instance,

clients are about to leave the home when the health visitor comes to visit them; or when they introduce a topic that the health visitor did not anticipate; or when they do not cooperate in an assessment. Clients have particular circumstances, attitudes and opinions that are reflected in their own agendas. These can be thought of as daily life agendas as they refer to people's everyday life events, in which there might not be room for a health visitor.

A client's world, acts as a conditioning factor in health visiting. This research highlights issues that stem from this world and have an important bearing on health visiting. They refer to a client's freedom to take up health visiting services, the privacy of the place where they live, the attitudes towards health care and health visiting services. They relate also to the practical constraints that clients might face in terms of social and economic resources, and to the dynamic nature of their specific problems and needs. These factors are discussed in following chapter (Section 5.3) as causal conditions for health visitors implementing marketing strategies.

To overlook the issue of the client's world will conceal the basic context in which the health visitor works and their need to build a common agenda with their clients. During one interview, the issue of transforming the policy agenda was commented on by a health visitor.

She was discussing the way she organized her work and stated:

> **"Health visitor** - *When I say am (pause) it's automatic, that I will always see a mother at six weeks, whether she's having problems or not having problems, I will nearly always see a mum at six weeks, unless she's away on holiday or whatever. Um, because my aims at that time would be to discuss family planning, and you know immunisations, that's sort of coming in two weeks, and also how she's feeling, how her postnatal went, and just generally, um you know, that everything has been alright. So that's what I call routine visits, and (pause) there are certain visits that I do routinely as well as those visits that I identify on my rounds.*
>
> **Researcher** - *Right. So there is work that you will do anyway, to every one...*
>
> **Health visitor** - *Yes, yes.*
>
> **Researcher** - *And you also do specific work depending on what you have identified...*
>
> **Health visitor** - *Yes, I have um (long pause). I try to give everybody sort of basic routine visiting, but within that routine visiting, I also try to give those that have more needs extra. (TB 9-10. My emphasis)*

This quotation clearly shows the interplay of factors in health visiting work: 1) A policy agenda, that is the routine work which motivates the contact between the professional and the client; 2) The client's agenda which is manifested by client's specific needs; and 3) The health visitor's agenda which merges both 1 and 2. Thus, as the interaction takes place, the policy agenda is gradually tailored to client's specific circumstances and needs. In the above instance, the health visitor's agenda consisted of adding extra visits to the routine in order to respond to the client's situation.

During another interview, a health visitor gave an account of how the two agendas are accommodated during a birth visit:

> *"...I mean over the years in my actual health visiting, my routine health visiting, I will go about and do a birth visit, and surely I will look at the child, and establish that that child is in peak, peak health. It looks like it's functioning at a normal development level.But I'm more interested in the woman, because my attitude is that if she's OK, the child will be Ok as well. Um (pause) and that is the sort of basis on which I actually walk through a door. Um, whilst I will do the usual business of, you know, health history, names, etc, etc, um (pause) I then generally put that aside and then 'Right, well how are you, how are you coping with all of this'. I mean I might not put that question like that, but, you know, that would be perhaps what's underlying my motivation if you like". (VW 3. My emphasis)*

This quotation shows that by merging agendas, a case is transformed into a client ie: The standardized procedure in a birth visit becomes a personalized visit to a particular mother. This reveals that although health visitors can be regarded as agents to deliver prescribed solutions to the client's needs, they, in the interaction process, modify, to some extent, the norm. Luker (1982b) identifies these tactics as micro processes for delivering individualized care. This basically constitutes the health visitor's agenda. In chapter 5 (Section 4.3) this issue is discussed as the "Tailoring strategy". The quotation also highlights the issue of a life trajectory. When this health visitor refers to assessing whether the child is in "Peak health" and whether it is functioning "At a normal development level" she is using an expected life trajectory as a reference point.

It is in this context of a client's agenda, that health visitors implement the policy of securing life trajectories. The next section examines the concept of the life trajectory and other basic elements of the policy agenda.

4.3 LIFE TRAJECTORIES

Health visiting work evolves around people in vulnerable situations. Most health visitors' clients are dependent on someone who takes care of them. The clearest example is that of children under five. The elderly are also part of their clientele and the handicapped might well be. The core of health visitors' work is directed towards securing the dependant's life trajectory.

4.3.1 Definition

The term "Trajectory" is taken from Strauss et al's (1985) study into hospital work. They differentiate between course of illness and illness trajectories thus they state:

> ***"Course of illness** is, then, both a commonsense and professional term. In contrast **trajectory** is a term coined by the authors to refer not only to the physiological unfolding of a patient's disease but to the **total organization of work** done over that course, **plus** the impact on those involved with that work and its organization" (Strauss et al 1985 p. 8)*

Although the distinction between course and trajectory was first utilized in Glaser and Strauss in 1968, the 1985 study focuses on some more subtle features of the type of work involved in illness trajectories. Roth in 1963 used the term "Career" which has similarities with that of trajectory, it is defined as the same series of events that many people go through (P. 93). The term trajectory seems to be more appropriate for the present study since it includes the concept of the organization of work undertaken and its impact on those involved.

During field work, while observing health visitors doing clinics and home visits, it became apparent that their work involved securing a trajectory. Thus, during clinics, babies are weighed, measured and inspected. Health visitors ask the mother about the infant's nutrition, meal times, sleep patterns and general activities that maintain and develop life. The mother is also asked about how she is feeling or managing with the child. Once the consultation is over, the baby is seen in another scheduled time. Underlying this activity is the monitoring of a life trajectory. Here it is shown that the health visitor is assessing both an expected course or career (Roth 1963), and the work involved to maintain it.

During an interview with a health visitor, the concept of securing a life trajectory became clear.

When she was asked to comment on what she hoped to achieve after five years of contact with families, she replied:-

> *"Well at the end of five years you will have hoped that you have got a healthy (pause) healthy, sociable, independent human being. That it has been given, and has been able to take the best of the environment. It doesn't mean that two five year old will be the same, will be at the same level. This is what you have to, to channel yourself all the time and to apply yourself at different, um, levels..." (PS 32)*

Mayall and Foster (1989 p. 34) have noted that health visitors view the child as an incomplete person to be moulded, taught and managed in the interests of long term goals. The quotation sustains this observation, and shows that securing a life trajectory could be expressed in idealistic terms. It also illustrates the health visitor's accommodation of different circumstances.

4.3.2 Types of trajectories

According to the literature, there are different types of trajectories. Thus "Downside trajectories" are associated with some chronic illness's (Zuckerman 1984). Geriatric patients are regarded as being in a downward phase of the "Social trajectory", and pain has its own particular trajectory (Fagerhaugh and Strauss 1977).

The analysis of data collected during the present study led to the identification of three broad types of life trajectories with which health visitors deal: **Developmental, deterioration and awkward.**

1) **The "Developmental life trajectory"** is a life course that goes upwards. It is about progressing from a highly dependent situation to independence. This is the case with a child. Here the trajectory is developing in a given direction and there is a blue print to assess its progress, which basically consists of achieving independence from the mother, to reach adulthood. A health visitor, commenting on the reason for visiting families, highlighted this point during the interview:

"Oh, again, you have got your aims....and really when you go to visit, you go to do a visit, now, 'Who am I going to visit today? Johnny, he's three months old, <u>what should I be expecting</u>. And you walk into the house, you see, and you know, you are looking at the child <u>developmentally</u>, you know. (PS 31. My emphasis)

The quotation illustrates the taken for granted view considered as "Typical psychological" (Qvortrup 1990). Here childhood is anticipatory and determined by an adult perspective. This approach is individual, biographical and personality oriented (p. 9). It has been noted that this perspective excludes societal parameters, thus it is being proposed an approach that will facilitate the integration of childhood in society . The emphasis is placed on the idea that,

although the child develops into an adult, childhood persists as part of the social structure (Qvortrup 1990 p. 11).

The quotation also shows the use of a predetermined blue print. Luker (1982a) also drew attention to this issue when she stated that health visitors mainly use a developmental model to approach practice. The blue print is based on what is considered to be normal development in childhood. There is extensive literature in child development (Sheridan 1973, Illiworth 1983, Bee 1989) and during health visiting training considerable time is devoted to this topic. The basis of child development is that of reaching milestones at a given age, these are sequential, that is the child has to reach a degree of maturity in order to progress to the next landmark. Reaching a milestone is the basic criteria for assessing child development. The next section discusses further the framework that health visitors use to assess this life trajectory.

2) **The "Deteriorating life trajectory"** is the opposite of the development trajectory as it goes in a downward direction. It is characteristic of elderly people. While the child moves towards independence, the elderly move towards dependence on equipment and people. To assess deterioration or the degree of dependence the health visitor uses mainly a "Functional model" based on the performance of activities of daily living. The focus thus is on how elderly people can

function on their own, whether the basic needs and life activities are impaired. If "Holes" in this functioning are found, the attempt is to fill them with aids or supportive mechanisms. Thus, the focus of the intervention here is that of palliating deterioration and this is normally achieved through referral.

During field work, data were collected on visits to elderly people. The aim of these visits was to assess the degree of deterioration and managing capabilities (Field notes HR, April 1990; JT May 1990; TB, DB 5-7 August 1990). This finding is consistent with other research, which established that health visitors focus on negative aspects of their client's lives, ie: deficiencies and problems (Fitton 1980). It also was quite frequently found that once the assessment was made, the continuous monitoring of this life trajectory was delegated to less qualified personnel, ie: health visiting assistants or student health visitors (Field notes TX February 1990; TE May 1990; BV August 1990; AW April 1991).

During one interview, discussing with a health visitor her work with elderly people, when asked about continuity of contact with the client once assessed, she highlighted the points just made:

"No um (pause) I always say to them (elderly clients), 'I'll pop back and see you, er, meantime I'll refer it to Cathy the health visitor assistant', and I'll say (to assistant) 'Can you keep an eye on her once a fortnight, once a month, once every three

weeks' you know. I mean I've got a lady of 89 who, really, only wants yearly visits, 'cos she is fine. She's got good family support, she's fully ambulant, she is chirpy .....and we have organised her home help, and she doesn't need me to visit her, she doesn't need a health visitor. Once a year, I like to go in and see her, as the winter coming on, just to see if she has deteriorated since the last time I saw her, remind her about keeping warm, and this sort of thing. But her family are marvellous.She leads a independent life, she socialises, she's well cared for, she's a valued and loved member of society, you know. It's the ones with no family support, who don't have any value, that you've got to keep an eye on, because some of them want to died" (RB 50. MY emphasis and clarifications)

The above quotation illustrates the "Functional-Dependence" model that health visitors use to assess a deteriorating trajectory. If health visitors feel that the elderly person is keeping independent and there is no risk of decline due to lack of care or support, they do not see the need to visit them. Thus, when a declining life trajectory keeps steady, it is not considered to be necessary to intervene. Health visitors, in that way, intervene mostly in deteriorating circumstances and when there is a risk factor, such as cold weather which jeopardizes this steadiness. Monitoring the trajectory can then be delegated to less qualified staff. Also, health promotion activities are usually omitted in this life trajectory.

Elderly people have a similar situation to that described by Roth (1963) with patients who do not meet a career timetable, ie: the sequence and timing of events, for recovering and learning. They are placed in a "Chronic sidetrack" where they receive largely

maintenance care rather than active treatment. This is also a "Dead end track". The policy about contacting the elderly illustrates this point. In the Area where the research took place it was a norm to discontinue visiting the elderly if in a period of three months everything was "satisfactory" or if there were no changes. Their notes were placed in a "Dormant file". This approach did not apply to families with children under 5 years of age.

3) **The "Awkward life trajectory".** This refers to life trajectories that are not developing or moving as expected mostly due to intrinsic difficulties. They have somehow gone "Out of course". The clear case is that of physical and mentally handicapped people when they go to hospital on a regular basis due to a chronic disease or another serious condition. In these instances the trajectory is usually managed and supervised by specialized professionals. Thus health visitors do not normally deal with this type of client. However, they sometimes intervene mainly to assess the situation, that is, whether carers are coping well or whether the person is having the support needed. Most of the time cases are referred to health visitors.

During field work, only a few instances of health visitors visiting a handicapped child were recorded, hence the analysis of this category is limited and suggests the need for further research.

In one instance:

"The health visitor went to visit a family with a 3 yrs old handicapped child. It was referred as the child was about to move to primary school. The health visitor was asked to do a report about his needs for care. At the time of the visit the mother was on her own and the child at the nursery. During this visit the health visitor asked the mother several questions about the different things that the child could do on his own like feeding and how the mother was coping. The health visitor asked the mother if she had decided about which school she would like her son to be in. She had not and had visited two schools already. The mother expressed concern for the child's need for a physiotherapist during vacations. The health visitor mentioned the service of a community physiotherapist although acknowledged that she did not know the type of children with whom he was involved. The mother did not respond to this lead. The suitability of the house for the child to live in was also discussed. The mother hoped in the near future to move to a better house. The visit was closed by the health visitor mentioning the need to do a report of the child's needs and asking mother's permission for seeing the child in the nursery. The mother agreed and we left. Next day we (the same health visitor and the researcher) went to see the child in the special nursery for handicapped children. Here the health visitor interacted first with the child's guardian. She asked questions such as the help the child needs for feeding, whether he was potty trained or taking any medication. After talking to the guardian, she went to talk to the child. The health visitor asked standardized test questions about the child's name, his age, if he could recognize objects, whether he could fit a cube in a hole and so on. There was a lack of response from the child. After observing quietly the child for a while and engaging in social conversation with the guardian, we left the nursery". (Field notes[5] HR 2-5 April 1990).

[5]The passages described as extracts from the field notes have been changed in style, ordered and edited so as to give an unbroken account of the case involved but there are no changes of meaning.

As the field notes show, the model of assessing needs is similar to that of the elderly, in the sense that it is a model to ascertain the performance of activities of daily living. However, interventions are mostly directed towards maximizing potential, that is: To gain with special training, abilities that are not well developed. Awkward trajectories tend to be referred to health visitors and, securing them is not their major task, however those who are responsible for the trajectory, turn to health visitors for additional help. Health visitors' involvement with awkward trajectories is usually sporadic, it aims at supporting those who are managing them, whether they are professionals or lay carers. It is not in the health visitor's realm to secure them but mainly to co-operate with others.

4.3.3 The blue print to assess trajectories

It has been mentioned before (Section 4.3.2 "Developmental trajectory") that a blue print is used to assess the point at which the client is located in the life trajectory. This is particularly obvious when dealing with children's trajectories.

Health visitors assess children against a development chart that acts as criteria to decide how "normally" the child is progressing. This framework is quite clear cut and stable. It gives health visitors reference points and guidelines as to when to make this appraisal. Screenings and assessments are the technical words that they use to refer to the activity of monitoring

the child's trajectory. During field work it was observed that at several of these visits, health visitors used a standardized card containing crucial areas of development. The child was observed or asked to preform certain activities to demonstrate ability in a number of domains (See Appendix 10 for a sample of the card). Carers were also asked about child progress.

During one interview the idea of a chart and schedule came clearly, a health visitor discussing baby clinics stated:

> *"It is not compulsory. Some people come every week, some people only come when they are sent for, for the injections, the hearing test. You only need to set foot into the clinic five times a year, five times in the first year and that will be fine."(MT 35. My emphasis).*

The use of signposts to mark the point of a career has also been described by Roth (1963). He states that these reference points signal the progress in a given direction, whether it is towards discharge from hospital, adulthood or attaining an occupational position (p.99). A career timetable is thus divided by these points of events. On similar lines, Glaser and Strauss (1968) divided the dying trajectory into "Critical junctures" which were directly handled by the temporal organization of the hospital work (p.6).

Indeed health visitors use the developmental chart as a way to organize and initiate home visits to clients. Some health visitors keep an extended

developmental framework. They add other turning points to the ones that are normalized. Hence during an interview a health visitor commented:

> *"...I mean I might see a child for its 18 month assessment and it's not due another one until it's 3, but I nearly always see every child at 2. That is because I do that, because that's my routine" (TB 11).*

This also indicates the existence of a health visitor's own agenda. In addition to the policy related work, health visitors do have their own routines which are a tailored view of the policy agenda.

Together with the marks in children's timetables for development, health visitors recognize "Critical times" in the life trajectory. During one interview this was highlighted, a health visitor commented:

> *"I think the first 12 months is probably the critical time really in a child's life, you know, if we're talking about my client group meaning, children and their parents, the first 12 months is what I perceive, and most people perceive I think, as being the critical time. Um, beyond that they've got over the worst generally speaking, and you can start realising your stuff, you know, well, I say I'll make an appointment in about six months time" (VW 18. My emphasis)*

By recognizing critical times and adding signposts to the trajectory development, health visitors once more are personalizing the service. A norm is being transformed with the intention of meeting specific requirements.

There is a blue print to assess children's life trajectories, which when implemented, is shaped to specific situations.

Roth (1963) has also highlighted that turning points may be used to predict and measure future progress. This is consistent with field observations made during the present research. They show that health visitors quite regularly inform mothers about what to expect from the child in the future. Advice is given regarding present needs or problems as well as future events. By anticipating the next bench mark to be reached by the child, caring activities are directed towards it. This is a way to secure the life trajectory.

Field observations of health visitor's visits to elderly people show that they use a less focused chart to assess the degree of deterioration. Reference points are more diffuse since there is not an established "normal" rate of deterioration. During field work, health visitors commented to the researcher that elderly people were in general unpredictable (Field notes BV August 1990) and therefore it was difficult to anticipate their needs.

In cases where reference points are not clear cut, they must be discovered and interpreted through observation and interaction with other members of the same career group (Roth 1963 p.99). Data from home visits to elderly people and interviews with health visitors suggest that these clients are mostly compared with themselves. That is, once the initial assessment is

made and the baseline situation established, signs of decay will then be perceived when contrasted with this initial picture.

The existence of a chart, turning points and critical times provide the basis for health visitors initiating contact with most of the families. Professional literature refers to this as "Proactive health visiting" (Chapter 2, sections 2.3.1) which is based on the use of an anticipatory framework of care. It is assumed that there is a likelihood of a need or problem developing if intervention does not take place. Proactive action is thus a strategy for prevention.

However, this chart is also used as policy for child surveillance. It gives an "objective reason" for the State to monitor families. Some authors have drawn attention to this State policing of families (Dingwall and Eekelaar 1988, Mayall and Foster 1989) and have highlighted that, in liberal democracies this is an acceptable way for State intervention in family life (Dingwall and Robinson 1990). Other authors (Mayall and Foster 1989) have pointed out that surveillance opens the door to the view that mothers do not know best and do need help with child rearing (p.ix). Hence, surveillance may have the side effect of undermining mothers confidence, it can convey the message that they are not competent enough to be left alone. Moreover, routine visits to a home may also give the impression that mothers do not know even when to ask for help.

Health visitors are very aware of this developmental chart which is also used by management to "Survey" health visiting work. In this sense, it has been proposed to use the turning points in the child trajectory as "Benchmarks" in health visiting practice (Edwards 1986 p.97). However, the tendency to evaluate health visitors work by meeting the child development timetable, has been criticised in the professional literature (Goodwin 1988). During this research practitioners felt quite restricted by this policy. Thus, during an interview a health visitor commented:

> *"Mainly there are certain visits we are expected to do, by this authority. And by expected to do I mean that we have policies, and that tends to restrict our visiting. Because you, we are expected to see babies at certain ages, and because we are expected I try and see children at those ages as well" (TB 10. My emphasis).*

Health Authorities issue policies for child surveillance. Health visitors are expected to visit, at scheduled times, all the children under five years of age included in their caseloads. Thus, health visitors are required to fulfil minimum visiting standards. These are based on the idea of securing a developmental trajectory, for which a blue print is used to decide both the timing and content of the intervention.

Nevertheless, minimum visiting standards could also be interpreted as defensive practice promoted by the Health Authority. Visiting families at regular and established intervals, just in case parents are potential or real child abusers, denotes a defensive style of practice. It can be argued that

this approach intends little more than to protect the professional or the Authority. If policy requirements are met, this acts as a shield against criticisms of malpractice or negligence.

In the next section another important aspect of the policy agenda is examined. That is: "Who is considered to be the client? ".

4.4 WHOSE TRAJECTORY?

The previous sections commented on the health visitor's position between agendas and on the focus of their work, that of securing life trajectories. It can be asked therefore, "Who is the client in health visiting ?". The analysis of data suggests that securing children's developmental trajectories is the core of health visitors' work. This is perceived to be "True" but nevertheless traditional health visiting[6]. Monitoring child development is the main focus of health visitors' work, this is the basic mandate that they have from the policy agenda. This agenda is rooted is the concept of State responsibility in child protection and goes back to the early days of health visiting (Davis 1988, Dingwall and Robinson 1990).

The literature on public health or health visiting has repeatedly stated and advocated the family being the unit of care or the focus of the professional's concerns (WHO 1974, Rcn 1983, Gottlieb and Rowat 1987, Kritstjanson

[6]This point is further discussed in chapter 6 section 6.3.2.4.

and Chalmers 1991). One indication of this interest is the claim made that the health visitor is a "Family Visitor" (Clark 1973). However, as it was commented on chapter 2, this seems to be a "Desire" since research has shown that the predominant approach of health visitors to practice is that of teaching mothers about child care on a one to one basis (Clark 1981, Frances 1985, Twinn 1990, Foster and Mayall 1990). Further, Chalmers (1990) found that the child is the "Primary" client in health visiting practice.

Data from this research is consistent with these views. It shows that although health visitors relate to a range of clients, the focus of their attention is on the individual child. Furthermore, it has been found that health visitors use a "Carer Model" to practice. They tend to intervene through third parties ie: through the carer or person in charge. While they focus on the dependant as the primary client the carer becomes both a secondary client and a "Co Worker" (Twigg 1989).

4.4.1 The primary client

The significance of the child in health visiting work has become very obvious since the early days of field work. Besides the great number of visits paid to this age group and the bulk of the activities in the home tend to be centred around the child's development, there are other factors which show its predominance.

Although the mother is the gatekeeper of family health (Chalmers 1990), the child is the point of entry to the home. For instance, during field work it was noticed that when parents showed some reserve about letting the health visitor into the house, one way of gaining access was by talking and interacting with the child (Field notes CT, LT May 1990; WB August 1990). During an informal interview with a health visitor, when asked about this, she confirmed the role of the child as the point of entry into the home and discussed a case. She related that once a mother would not let her into the house and was a "Bit aggressive towards her". The door was closed and the health visitor was talking to the mother through the letter box. As she was talking, she saw Peter (the child) at the end of the corridor and she started talking to him. The mother, finally, opened the door to the health visitor (Field notes LT May 1990).

Kinship tends to be established around the child. When the researcher was briefed about the families to visit, members of the family were identified in relation to the child. Thus for example, the sister of the mother was introduced as the aunt, the mother's parents as grandparents, and the partner as father. Hence, adult roles were described in relation to the child.

The way in which health visitors speak about clients highlights this focus on children. During fieldwork it was observed that some health visitors gave first names to children but not to parents. They were referred for example, as "Peter's mother" or "Mike's dad" (Field notes RL April 1990). While

children have a clear identity, parents are identified just by the role they play in relation to their children.

Also health visitors are inclined to show possession of clients reflecting as well the distinction between the primary client and the carer. Thus, ownership expresses the relationship that the health visitor has with clients. During field work and in the interviews it was common to hear health visitors talking about "My mum" or "One of my babies". Nurses in hospital also refer to clients as "My patient" (Wolf 1988 p. 289). Due to this practice I, on more than one occasion, became confused and was not sure when some health visitors were talking about clients or their own children (Field notes CR 3 April 1990, LT 2 May 1990). "Owning" the client was also shown during another instance when the health visitor, briefing the researcher about a given family that was going to be visited, concluded by saying "So she (the mother) has two children for us" (Field note LT May 1990). This sentence expressed very well what was the central concern of the visit: Supervising children trajectories.

During the interviews the health visitor's focus on children became very obvious. In one interview discussing work organization a health visitor clearly acknowledged this issue:

> "**Researcher** - *So, from what you are telling me, your work is very much around this new born baby and from here stem all the other activities...*

Health visitor - *That's right, the baby is the centre, the hub of the wheel, and everything else is like the spokes of the wheel of the baby that's in the middle.*

Researcher - *Is that so because you want to reach others through the baby, or is that because you think that the baby has to be the centre of the wheel?*

Health visitor - *Probably that, probably that I feel the baby is the most important." (HR 7)*

Health visitors in general expressed discontent with focusing on the child. What is interesting is to notice that underlying this criticism, the idea of the child being the primary client, appears neatly. Thus, in an interview, a health visitor commenting on traditional practices of the past stated:

> *"...we were just looking at the child, everything else is just sort of a glare in the background. The activities go on, but the health visitor doesn't really take note of them, but it's becoming more and more now the whole family unit. But I've always taken in the family unit, 'cos that reflects on the child's development really..." (DB 6. My emphasis)*

During other interviews the issue of approaching "The whole family" (usually a euphemism to refer to the mother) came up frequently as a way to secure the child's developmental trajectory. Thus a health visitor in her first year of practice commented during an interview:

"**Health visitor** - *...I don't disagree with it (being the baby the centre of the activities), but um, I think it's the adults we should aim at.*

Researcher - *You think then that is the adults?*

Health visitor - *Yes.*

Researcher - *Why?*

Health visitor - *Well, because they're going to be feeding these children for 16 years, aren't they? you know" (CT 17).*

During field work a rather disturbing incident was recorded that shows the consequence of a narrow vision in health visiting work. A health visitor was doing an eye test in a nursery clinic. This test requires an adult collaboration in order to tell the professional if the child is pointing to the right letter on a card. In this case the mother helped in the test. The child was performing well but the mother commented that she could not see the small letters. The health visitor did not respond to the comment and carried on finishing the assessment (Field notes LT 5 May 1990). The apparent visual impairment of the mother was not acknowledged, the health visitor's care was so focused on the child that the parent was ignored. Commenting on this incident with a colleague, the researcher was informed of a similar incident during a hearing test. The mother also expressed that she could not hear some of the sounds made in the test. The health visitor did not take any action regarding this (Memo "Child focus" PA May 1990). These examples show clearly that in some tests, mothers are assessed along with their children. However, since the focus is on securing the developmental trajectory, the mother's personal needs might well be overlooked.

To focus on the child in such a way that it becomes the sole client overshadowing the rest, can be explained by looking at health visiting origins

which are rooted in the development of child welfare services (Chapter 2, sections 2.2.1 and 2.2.2). In the same way that home nursing was in the nineteenth century, an overall technique for intervention in epidemics (Dean and Bolton 1980 p. 93-94) health visiting can be regarded as a crucial element in the State's overall measure for child protection.

4.4.2 Carer as secondary client

In health visiting, securing the life trajectory is a joint enterprise between the carer and the professional. The carers are mostly the actual shapers and managers of life trajectories. This is very obvious when there is a high degree of dependence on the carer as is the case with small children. Health visitors mostly do a supervisory-ensuring work. While they do not give direct care to dependants, they act through the carer. It is in this context that health visitors undertake an advocacy role. This is clearly manifest in the case of children.

The role of health visitors as advocates of children, to protect them against adult mishandling has been stated in other research work (Mayall and Foster 1989) and showed clearly during the present study. Health visitors regarded themselves as sort of guardians of children, whom they were there to protect (Interview RB 38). Their work with mother was for the greater good of the child (Interview WB 2). This perception is also shared by some clients. During field work, a health visitor related to the researcher that they (health

visitors in a health centre) received anonymous phone calls from people who are concerned about children being abused (Field notes TB 4,1. August 1990).

Also during field work it was observed how health visitors during interaction with mothers, put themselves in the baby's place and acted as the "voice" of the baby. For instance, in some home visits health visitors voiced "Baby's point of view" when discussing reactions to being put in bed or the resistance to new tastes in food. (Field notes HR April 1990). During one interview a health visitor, commenting on healthy behaviours, gave a few examples where she interpreted the child's feelings and expressed them to the parents. The issue of her acting as the child defender was raised:

"**Researcher** - *As you just were giving me these examples I was thinking...Am I right to think that the health visitor is somehow the voice of the child?*

Health visitor - *I suppose you could,yes (pause) Maybe it's not really the voice of the child, but the conscience of the child, telling the parent, you know (pause)*

Researcher - *Why the conscience?*

Health visitor - *Trying to look at things from a child's point of view. It could be, yes, you're right" (CA 31).*

Thus, as Mayall and Foster have pointed out (1989 p 77) health visitors on behalf of society, defend the rights of children sometimes against their parents. This fact places health visitors in a difficult position when visiting families. They are expected to preform a dual role, that of policing child care

and that of educating mothers (Mayall and Foster 1989). In their interaction carers are thus both supported and scrutinized. This issue is further discussed in chapter 8 and highlights the health visitor's double function, that of social control and that of support.

During one interview, discussing health visiting in general, a health visitor commented on this dual role:

> *"Yes, they (mothers) must be aware that there are hidden agendas, because, again, I might say 'Well, look, I'm more interested in you than I am in your child, because if you are ill ', and they're the kind of things I mentioned to you already, but at the same time they (mothers) must be aware, and I will sometimes point out that I'm also there to talk about the fireguard,you know, to monitor the child's development." (VW 39. My clarifications)*

The nature of this hidden agenda, ie. the policy agenda regarding child protection, places the carer in a position of third party. That is, health visitors work on behalf of the child through their parents. In this sense, carers are mostly considered to be co-workers and secondary clients.

This point came up during an interview. A health visitor was relating the case of a mother living with her parents and her partner in the same home. The health visitor did a housing report to help them to find a new house and was now encouraging the mother to take up preventive services.

The health visitor commented:

> *"So, therefore,I've got to try to encourage her, to do a bit more. I, if I had to, having held back and given her every opportunity, I've now had to sort of come in and ask for um, a domiciliary visit, as far as family planning is concerned. But obviously I'm going to encourage her to come out and do more for herself. She realises that she's the mother of this baby, she realises that she's got to look after herself, so that looking after herself, she can care for her own baby. (EQ 39. My emphasis).*

As the quotation shows, mothers are co-workers in securing a child's trajectory, as well as their acknowledged caring role in the family. During field work there were also recorded instances of mothers being secondary clients. In one case a mother, who lived under supervised care in a special residence run by the council, mentioned that she needed glasses as she could not see properly. The health visitor said that she would see to it and made the comment that without glasses the mother could not see how she was making the feed for the baby, that she could not properly see the amount of milk powder mix in baby's bottle. (Field notes DB 3, 7. August 1990). This instance shows that, in the same way that pregnancy is defined from the point of view of the baby (Robinson K 1985), so is motherhood. Yet this rule did not apply to mothers at the sight and hearing tests (Section 4.4.1) perhaps because here mothers ability to care for their children was not so obviously hampered.

Graham (1984) has identified the health tasks that families accomplish every day. She identifies five areas of activity: 1) Providing for health, 2) Teaching about health and illness, 3) Nursing the sick, 4) Mediating professional help and 5) Coping with crisis. She has pointed out that the most fundamental responsibility carried out by mothers is that of providing for health and that this is crucial since it provides the setting in which the other health activities take place (p. 153). Land (1978) has also stated that women are overwhelmingly the family carers. It is the caring capability for dependants that makes mothers become secondary clients. While they are at the forefront in the interaction with health visitors, this is usually because of their mediating position between family members and health professionals.

The work of Twigg (1989) also highlights this, she has pointed out that care services are structured around the dependant rather than the carer. She identified three models of relationships between social care agencies and informal carers: carers as resources; carers as co-workers; and carers as co clients. The resource model places its central focus on the dependant and the concern with the carer is marginal. In the co-workers model the agencies work in parallel with the informal sector aiming at co operation. Lastly, in the client model, carers' status as clients is never a fully equal one, "They remain at best secondary clients rather than fully co-clients" (p.60). Intervention in this model aims at relieving carer strain, this is perhaps to avoid a "Secondary patient" (Gaynor 1990). According to this framework, because mothers are resources for child care they can be regarded as the

health visitor's co workers and this situation usually makes them secondary clients. The child is the focus of the policy agenda and health visitors are the guardians of the life trajectory.

When health visitors are involved with clients other than children, they tend to transpose this "Carer model". Thus, in visits to the elderly living with someone such as a spouse or relative, the focus of the visit was around the one who was depending on the other. Carers were approached to see if they were managing and coping well with the situation (Field notes JT May 1990; DB August 1990). Here again is repeated the set up of a primary and secondary client. However, the status of the primary client is lower here compared to that of the child. Supervision of care is delegated to both carers and less qualified personnel. When the primary client is the child this is done directly and periodically by the health visitor.

In the case of elderly people living in sheltered accommodation, the warden is usually identified as co-worker. Thus, during an interview a health visitor discussing her caseload made this point:

"...I have also got sheltered accommodation, where I've got, there is about 50 flats. I work very closely with the warden in that sheltered accommodation,and she will actually ring me up if there are any worries at all. She will ring me and ask me if I can pop in to see such and such." (EQ 49.My emphasis).

Reliance on the warden was also commented on in other interviews and was observed during field work. Health visitors were inclined to see the warden before actually seeing the client and to give her some feed back on the visit; about how the client was and if something was needed (Field notes DB,TB, August 1990). A similar pattern was observed during a few visits to nursery schools, teachers were approached as co workers in securing the child trajectory (Field notes LT, CT May 1990, TB August 1990).

Thus, health visitors act mostly via third parties in order to ensure life trajectories. Because of their role as carers, parties are considered secondary clients and co- workers. In this context their own life trajectories are subordinated to the dependant. They tend to be, in the health visitors point of view, placed in a career: that of caring for others.

4.5 CONCLUSION

The health visitors context of work is that of being between two agendas, that of policy and that of people's. In confronting the client's world, the policy agenda is accommodated.

Health visiting evolves round securing life trajectories. Whist they deal with different types of life trajectories, child development is the main focus of their work. This is the basic mandate from the policy agenda.

The policy agenda is formed by the conditions just described of anticipatory care, child surveillance, health visitors' dual role and the need to gain clients cooperation. They act as one set of conditional factors in health visiting. Basically, when health visitors encounter clients they have to persuade them of the need for taking up the prescribed service which is shaped by the policy agenda. To do this they use an overall strategy identified as "Marketing Health Visiting" which takes into consideration the other set of conditional factors in health visiting; those derived form the client's world. The description and analysis of "Marketing Health Visiting" is the object of the following chapters.

CHAPTER 5

SELLING HEALTH VISITING: MARKETING WORK

5.1 INTRODUCTION

Marketing is the basic process that the health visitor uses to overcome two fundamental problems encountered in practice: 1) That of working in a context where they can exert little control and 2) That of creating a clientele. Marketing is the mechanism by which the health visitor introduces the policy agenda into the client's domain. During this process, the professional agenda is adjusted to fit the client's circumstances.

The concept of "Marketing" arising from this study is far reaching and does not permit it be discussed in one chapter. Thus for the purpose of presentation it is divided into three different chapters. The present chapter focuses on the general conditions under which marketing takes place and on the strategies used. The next chapter discusses an important sub strategy in marketing, that of "Fringe work". Chapter 7 is devoted to the discussion of the consequences of implementing marketing strategies.

As a way to introduce the general concept of marketing the present chapter examines first its role in the health care field with specific mention of health visiting. Then, the focus moves to the conditions under which marketing

takes place. Lastly, three stages used by health visitors to market health visiting services are identified, in each of these different strategies are distinguished.

5.2 MARKETING IN HEALTH VISITING

Health visitors use a combination of tactics to make their services acceptable, relevant and accessible to clients. These have similarities with commercial marketing techniques and intend to portray health visiting as a needed and easy option. Marketing, as a basic process used by health visitors, bridges the gap between the client agenda and the policy agenda. In this way it contributes to the securing of the dependant's trajectory.

5.2.1 Marketing as general concept

Marketing techniques are not foreign to the health care arena. Thus, Strong and Horobin (1978) have suggested that doctor patient relationships are better understood in terms of the classical market; that is, a private contract between individuals where the patient chooses to purchase the services of a professional. According to Grimaldi (1990) it was during the sixties that their application in health care prospered. Along with them were developed special courses, seminars and text books. In 1981 it was stated (Sanchez 1981) that health care marketing was a developing body of knowledge that was implemented by an increasing number of health care organizations.

It was Kotler and Levy (1969) who broadened the concept of marketing by pointing out its use in non business organizations. They regarded it as a social activity that went beyond the selling of traditional consumer goods. The emphasis was put on the other meaning of marketing that of "Serving and satisfying human needs". The consumer orientation of marketing is stressed in this literature. It was proposed to view it not as "Pushing products" but as a "Customer satisfaction engineering" (Kotler and Levy 1969). Its concept embodies the philosophy that the organization should satisfy customers needs and wants in ways consistent with the organization's objectives (Sanchez 1981). In this new concept of marketing services, persons, organizations and ideas are included as products that can be marketed.

The term social marketing was coined and its techniques defined as mechanisms that bridge the possession of knowledge and its socially useful application (Kotler and Zaltman 1971). Broadly speaking marketing is about "Developing the right product, backed by the right promotion and put in the right place at the right price" (Kotler and Zaltman 1971 p.7). Thus, the tools used to make a product acceptable are: product improvement, pricing, distribution and communicating (Kotler and Levy 1969).

A differentiation between generic and social marketing has been made, the difference is in its objectives. Bunton (1991) stated that while both involve creating and maintaining beneficial exchanges and building relationships with

clients, social marketing strategies are directed to improving the target audience or even society in general. Thus, social marketing does not seek selfish material gains but aims at a common good. Further, it is emphasized that in social marketing products are not imposed upon consumers but adapted and changed to meet their needs. Product price, its promotion and the delivery of services are also adjusted to suit the most effective exchange (Bunton 1991).

Contemporary literature on selling coincides with the above view. It is defined as the process of "Identifying and satisfying needs with products and services" (Preston and Nelson 1981 p 2). Also, this literature stresses the "Universality" of selling. It states that whenever a person is trying to convince someone of doing something, that person is engaged in selling (Preston and Nelson 1981 p 3). Mills (1953) pointed out the embracing nature of selling. He believed that selling is an activity unlimited in scope and stated:

> *"The salesman's world has now become everybody's world, and in some part, everybody has become a salesman....The market now reaches into every institution and every relation. The bargaining manner, the huckstering animus, the memorized theology of pep, the commercialized evaluation of personal traits-they are all around us; in public and in private there is the tang and feel of salesmanship" (Mills 1953 p. 161).*

The findings of the present study are consistent with this view, expressed 38 years ago. They also show what Mills (1953) identified as the selling function, which was a "link between mass production and individualized

consumption" (p. 185). However, in this research the idea is expressed as the way to transform a "Case" into a "Client", that is, it is a process by which a personalized service is delivered. This is especially relevant in health visiting since in the human services industries "Nothing is produced unless is it consumed" (Stevenson 1976 p. 186). Thus the product, in these industries (health, education, social service), is not material but a form of interaction between two or more people and a change in one or both of them (Stevenson 1976 p. 186). Hence health visiting does not produce a "Good" unless the client is willing to consume the service. This fact has also been noted by Chalmers (1990) in her research study of health visiting.

Professionals from the marketing discipline have also noted this issue. Thus, Preston and Nelson (1981) stated in a textbook about contemporary salesmanship, that doctors are more successful in convincing patients about a kind of treatment, when they "Assume the 'Seller' role, rather than the more dominant 'Expert' role" (p.73).

5.2.2 Marketing in Health care

The use of marketing techniques had been openly advocated for health education in general (Miaoulis and Bonaguro 1980) and for reducing cigarette smoking in particular (Fox and Kotler 1980). Examples of their implementation had been reported in the literature such as a family planning programme in Louisiana (Grimaldi 1990) and a campaign for coronary

prevention in the UK (Naidoo 1986). However, the impact that this approach has on the understanding of health has been pointed out by O'Brien (1991). He states that health is regarded as a commodity that can be "Sold" to specific client groups. This is consistent with Seedhouse's (1986) suggestion that there is a theory where health is regarded as a commodity that can be bought or given. O'Brien (1991) also states that lifestyles themselves are commodified frameworks that can be sold through social marketing techniques. Thus individuals are persuaded to buy or adopt a different type of lifestyle. Naidoo (1986) has also criticized this approach pointing out that advertising health as a commodity obscures the social construction of health and that the marketing type of health promotion is individualism in a new guise (p. 28).

There are research studies that account for marketing strategies in Community Nursing. Hence, it has been reported that Public Health nurses adjust their styles and interventions to the different contexts where the work takes place (Birk 1988, De Silva 1988, Kristjanson & Chalmers 1991, Zerwekh 1990). Also, in a programme of home visits by nurses to prevent maternal and child health problems, it has been stated that nurses' persistence and showing concern were ways to reach clients otherwise unreachable (Olds 1988 p. 18). Persistence and showing concern can be associated with selling techniques.

In the case of health visitors, Chalmers study (1990) shows that health visitors were using marketing strategies to gain entry although she did not use the term to describe the approach. This has also been acknowledged in another research study, where the need for health visitors being accepted by their clients was made explicit (Cowley 1991). However, in neither of these studies is the concept of marketing developed.

In another study about nurses roles in health promotion (Gott and O'Brien 1990) it was found that lifestyle change was a key issue in the professional agenda and some of the marketing techniques used were pointed out. Among them are those employed to make the client realize the need for the service, those directed at personalizing it, and those that adjust the service to make it acceptable to clients. Lastly, the strategies that Birk (1988) described in her study of public health nurses' home visits, are analogies to those described as marketing.

Further, marketing has been identified as a way to preserve public health nursing (PHN). Archer (1983) states that PHN will disappear unless nurses became much more skilled in developing and marketing their services. According to Archer (1983) the use of marketing approaches will both make a contribution to public health and "Help to ensure that public health nurses do not become an endangered specie" (p. 309).

Health visitors, during the present research study, stated openly that they were like "Sellers". They referred to the need to sell themselves (Field notes JT May 1990) and to be good at selling immunisations (Field notes CA February 1991). They thought that immunization uptake was linked to the selling work that they were doing (Field notes CT 2 May 1990). During an interview discussing the type of relationship that health visitors have with clients, a health visitor made the point of being like a seller:

> "**Health visitor** - *Oh it's not friends, no (pause) I would think (pause)*
>
> **Researcher** - *Professional?*
>
> **Health visitor** - *Well it is professional because you are selling something all the time, that er (pause) you know. Oh it is very much a professional relationship. (PS 56. My emphasis)*

Broadly speaking, the health visitor sells herself and the service that she is offering. The analysis of data from this study suggests two major areas where the health visitor uses marketing techniques: To gain the clientele and to influence or change behaviour.

1) Gain access. While health visitors have no statutory right of entry to a home they are expected to gain access to a family regularly. In the case of a new born baby the period of time is at least five years. Furthermore practitioners equated gaining access to a family with good health visiting practice.

This was stated during one interview:

> **"Health visitor** -*...but in this area probably the core of the people that I would see have had very good health visiting in the past, and know each other, and usually, ther's not very much trouble about getting in, in this area, I would say". (LT 26)*

This quotation shows that when a health visitor visits her caseload and if she is welcome this is equated with good practice.

Dingwall, Eekelaar and Murr (1983 p. 104) discussing child protection in England, point out the fact that to have the monopoly of an activity does not mean the guarantee of a clientele and that for this reason professions have developed marketing strategies.

In health visiting the equivalent of having a clientele, is to gain access. When coming new to a practice area, health visitors are given, by management, a caseload of children under five years of age to work on. In practice, new clients are either transferred from another area or more commonly come to the health visitor's attention via a birth notification. In both instances it is up to health visitors to attract the clientele to the services, to make a prospective client into a real one. This has been noticed in the professional literature, Tourton and Orr (1985) stated that because health visitors initiate the majority of the visits, they have to "Sell" themselves.

However, as it was also found by Chalmers (1990), entry goes beyond the physical entrance into the home. The analysis of the present study's data also suggests different levels of entry. These ranged from the initial entrance into the home, to the advanced entry, and to finally the "Full entry". Full entry means that the health visitor has got a client and hence can come back to the house at almost any time. Having access to a family enables health visitors to accomplish their surveillance role in securing a child's trajectory and the use of marketing techniques helps them to move to the different levels of entry.

2) Influence behaviour. Health visiting incorporates health education activities that, as research has shown (Foster and Mayall 1990) focuses mainly on changing people's behaviour. Influencing client's behaviour is, thus, part of the health visitor's role. Dingwall (1977b) went further, when he stated that health visitors "After all, are in the business of trying to persuade people to change their ways" (p. 53). In an earlier publication (Dingwall 1976a p. 27), he noted that health visitors can be thought of as the enforcer of normal family life, accordingly, their task is to manipulate the situation in order to bring it as close as possible to normality. This is consistent with Stevenson's (1976) and Stacey's (1981) view. They noted that in service work, ie the work that is engaged in Human services industries, the minds or bodies of people are processed (Stacey 1981 p. 175) or, as Stevenson (1976) puts it, the intent of the interaction is "A change in the physical, mental, or emotional state of the consumer" (p.78).

Data from the present study shows that health visitors basically focus on influencing three areas of behaviour: 1) That of caring for others, 2) That of adopting protective measures and 3) That of seeking further help.

As introduced in the previous chapter, health visiting involves clients in dependent situations. Health visitors deal chiefly with the carers, they advice them about trajectory management. When some health visitors were asked in the interviews about what they hoped to achieve by their health visiting activity, their answers related to promoting certain behaviour, like teaching basic parenting skills, coping abilities or improving lifestyles. During an interview the behavioral improvements that a health visitor aimed to achieve were stated clearly:

> **"Health visitor** - *Um, improving their lifestyle as a whole, um obviously things like improving their diet, you know, not letting the kids live on sausage rolls and chips and this sort of things. Getting them to register the child and attend a dentist.I mean, there's children out there, 8,9 or 10 who've never been to the dentist. Um, getting them to come to the clinic." (RB 9).*

Health visitors during the interviews also pointed to the need for the carer to adapt or adjust to a new situation: that of caring for a dependant. For instance, a health visitor commenting on her clients from the middle class stated:

> *"...They are pretty good at adapting to the baby, you know, they are into making their own food and blending it themselves..." (Aw 7)*

In a similar vein, during field work, there were also recorded instances of health visitors giving advice to clients in terms of adjusting their own lives to meet dependant's needs. Advice for example was given about introducing new resting times to meet the baby's demands or to go out and mix with other people to avoid isolation (Field notes DB LT-May and August 1990). Thus health visiting involves a great deal of advice aimed at promoting a specific lifestyle in a carer in order to perform the role of caring for others.

These findings are consistent with Graham (1979) discussion about the implications of prevention. According to her, central to the notion of parental responsibility is the concept of adaptation and sacrifice. Thus, it is expected that parents should adapt and modify their needs to those of their children.

Health visiting also incorporates primary preventive activities. This is the second area of health visitors' concern in changing behaviour. Thus, adding to the difficulty of persuading people to adopt a given lifestyle, the health visitor is faced with the difficulty of advising about what has not happened yet. In medicine, Zola reports a similar situation thus, he stated:

> *"Since the very idea of primary prevention means getting there **before** the disease process starts,the physician must not only seek a clientele but once found must often convince them that they must do something **now** and perhaps at a time when the potential patient feels well or not especially troubled."(Zola 1977 p.53)*

During this research, a health visitor illustrated this difficulty:

> "...they (parents) are more prepared to take your advice if the child, say, has been sick...it is difficult to get over the preventive concept..." (V1 3).

The anticipatory framework that professionals use in Primary care is considered to be fundamental for professional practice (Pridham, Hansen and Conra 1979), but as this quotation shows and Zola (1977) pointed out, it also contributes to the professional and clients experiencing reality differently. Everett Hughes (1971) has also highlighted the differences between professionals and clients. He noted that professionals may see the present in a longer perspective, than their clients and that they also see it in comparison to other clients. This may lead to differences between professionals and clients in interpreting the urgency and cruciality of the presented situation (p. 290). Thus, while for the client an anticipated need or problem might not be seen as relevant, for the professional it might be a priority. In this instance the existence of a policy or professional agenda different from that of the client's agenda becomes obvious. Marketing techniques will help to bridge the gap between agendas.

Lastly, when a health visitor makes a referral she is actually involved in persuading the client to use other services. Thus the third area of health visitors' concern in changing behaviour is that of persuading clients to seek further help. The importance of getting the client to accept the referral has

been pointed out in the literature (Luker and Chalmers 1989, Chalmers 1990).

The techniques that the health visitor uses to persuade a client to go to other services can be identified with that of marketing. During field work it was recorded that, for instance, when clients expressed difficulties in taking up immunisations, the health visitor offered to deliver them in the home, thus increasing their accessibility (Field note JT May 1990). Also there were instances that, when referring a client, the heath visitor made positive comments about the agency that can be identified with, in marketing terms, "Product advertising". Thus, some comments were about how good the professionals in the services were, how friendly the mothers in a play group were, or about the benefits the client will get by joining a slimming group (Field notes TV February 1990; HR April 1990; CT, LT May 1990).

Having discussed in general the role of marketing in health care and its relevance in health visiting, the next section concentrates on depicting the condition under which this basic social process takes place.

5.3 CAUSAL AND INTERVENING CONDITIONS FOR MARKETING

According to Strauss and Corbin (1990), causal conditions are events or incidents that lead to the occurrence or development of a phenomenon. Intervening conditions are the circumstances bearing on the

action/interaction strategies that pertain to a phenomenon. They facilitate or constrain the strategies implemented within a specific context (p. 96).

The analysis of data suggests four causal conditions that lead to marketing. All of them are part of the general context in which health visitors work, that is: "Working between two worlds". Chapter 4 discussed the policy world, this chapter examines the set of conditions derived mostly from the client's world. Thus they are: 1) The hypothetical nature of health visitors' clientele, 2) The private sphere where the services take place, 3) The practical constraints which they face, and 4) The diversity of situations which the health visitors deal with. Also data point to "Having a shape" as an intervening condition in the process of marketing health visiting services.

5.3.1 Causal Conditions

5.3.1.1 Prospective or possible clientele

It has been noted previously that clients do not register with a health visitor as they do with a general practitioner, but they are allocated to these professionals by an administrative procedure. Thus, health visitors' clientele is hypothetical, their services are optional. Clients can refuse both to have a health visitor, or to take up preventive services. One health visitor illustrated this point in a particular way when, during an interview, she stated that contrary to the hospital, in the community people are not a

"Captive audience" (Interview EQ 21). Birk (1988) in her research study also noted that it is crucial for public health nurses to justify their presence "In the lives of their potential clients" (p 1 My emphasis). This circumstance places health visitors in a position similar to that of salesmen, ie: having the need to gain their prospective clientele.

In addition to this, as has been noted, health visitors work with an anticipatory framework. This implies that they have to attract a clientele that might well not see the use or feel need for the service.

The health visitor is placed in a paradoxical situation. While her mandate is to provide a universal service, she has not got the right of entry in the homes or other means to "enforce" compliance. Health visitors can only get others to impose entry. During interviews, health visitors acknowledged this fact. For example this point came up when one health visitor was explaining her visiting schedule, she commented:

> *"I let her (the client) dictate to me how often she wants me to visit...I realize we are offering a service and they do not have to take it up...so, I really try to play it by ear" (V1 2-my emphasis).*

As we will see shortly, the expression of "Play it by ear" is a verbal indication of adjusting or tailoring the service to the client's circumstances or needs.

5.3.1.2 Private sphere

Unlike hospitals, in the community trajectories do not take place in the open and under professional control. They take place in the private sphere of the home and are managed by the carer. This is perhaps the reason for the majority of a health visitor's activity to take place in the home (DOH 1990b)

During one of the interviews the difference of the approach in the home and in the hospital setting was raised:

> **Researcher** - *Why do you have to play it softly?*
>
> **Health visitor** - *Only because it's their ground. You go into their homes and you see, you know, and nobody has a right to go in and start dictating to them....Hospital staff are different in their approach, they are seeing people on their terms and they can say, 'You have got to have your tablets at half past two, you will be having an injection, you're going for an X ray', But it is different out in the community isn't it?" (SD 2 and 4)*

Compared to nurses working in hospitals, health visitors have a more limited control over both the type of care that the dependent receives and the environment in which it takes place. This is why it is essential to gain the carers' co-operation, since they are the actual managers of the dependant's trajectory. In addition to this, health visitors have to deal with hidden parties who will influence the care that the dependant is receiving. Significant others are grandmothers, husbands, or friends. A health visitor during one interview illustrated this point very well.

"I'm just thinking about that situation with one client where the Grandmother said 'No that (juice in baby's bottle) don't rot the teeth' to the mother and the mother has got to sort of see my point of view but she also has to live with the grandmother. This is a particularly, you know, sort of close knit Indian family that you know, it's very difficult for the mother to go against the tradition of what the grandmother has been saying..." (IH 12)

Given this situation the health visitor uses marketing techniques that attempt to reduce the outsider impact and enhance solidarity. In the above example, the impact is reduced by placing herself and her messages close to the family culture, education, and means. This, as is discussed in the following section, is a way to personalize the health visiting service.

5.3.1.3 Practical constraints

Health visitors, when practising, find different types of constraints that affect their work. These stem mostly from two of the conditions just described: that of having to attract a clientele and that of working in a context where they can exert little control. Health visitors refer to these constraints when they differentiate between the ideal and the real world, or when they comment that practice is not as stated in the books (IH, CA interviews). De Silva (1988), in her study, also found that public health nurses worked under the principle of "Working within limitations". However, she referred to the limitations set by the client.

One group of constraints fall into the category of clients' attitudes towards health visiting. During the interviews some health visitors referred to clients as not being "Terribly motivated" or being "Very anti-establishment" (Interview TB 21 and 30), or as in the case of single unemployed adolescents "Being suspicious of authority" (Interview RB 1). During field work other health visitors commented that some clients had prejudices against the health visitor even before they met her (Field notes DB 3 1,2).

Other types of practical constraints are motivated by the clients having their own daily life agenda. The health visitor thus is competing with client's other interests or plans. This point was illustrated during one interview:

> *"...It will be nice to sort of do something maybe with them (pregnant clients) here in the afternoon when it is relatively quiet, probably we could do some more health education, but I think early on, they tend to, because they're by appointment, they tend to be just in and out, and they like it that way, because a lot of the are still working...so you have to go with what they want" (CT 8-my emphasis)*

Lastly, health visitors sometimes face physical constraints and therefore have to make adjustments to the situations. One clear example of this was recorded during field work. A baby clinic was conducted in a church hall that was cold, the health visitor opted for not stripping the babies whist weighing them. The health visitor commented that if she did the mothers would not come to the clinic and she would rather have the mothers coming and seeing them than not at all. (Field note DB 37).

Other types of physical constraints which call for adjustments are those that relate to the client's amount of social, economic and educational resources. During one interview a health visitor made this point clearly. Commenting on Tim, a child from a deprived home, she stated:

> *"...when Tim, this little boy gets 5, (pause) I can't compare him with somebody, a family with a child of 5 that had been stimulating him all the time,taking him to whatever he was going to be, he's being on holidays abroad,he's been shown mountains and he's been shown the countryside, and his vocabulary is perfect, and he's got all these stimulating toys and all that. How can you? This other child is going to be at a permanent disadvantage, is in't he?. So my rule I hope this is that I'm going to do my very best for this child, I cannot change his environment, I cannot change the environment he was born to those parents whereas this other one was born to these parents. You know, but I hope that he has, he will not have a squint that has not been corrected...and his speech is poor because he can't hear, you know, all these things" (PS 38. My emphasis).*

As the quotation shows, the health visitor feels powerless to change major conditions that will affect the child's developmental trajectory. While this statement can be questioned, since there are measures that health visitors can take such as community development tactics, it is important to bear in mind that this belief has real practical consequences (Thomas 1928) ie: health visitors modifying standards according to situations. Chapter 7 (Section 7.4.2) discusses further this issue.

5.3.1.4 Shifting grounds

Health visitors deal with clients from different social classes and backgrounds. During this research it was not uncommon to meet health visitors who had in their caseload a mix of clients with different economic, cultural, and social circumstances.

Situations might change unexpectedly within the same family. This was illustrated during one interview. When a health visitor was asked what she meant by "Playing by ear", she replied:

> *"It's sort of, I might go into a house, I may be going in and er obviously I'm wanting, you know, get her to the clinic for immunisations,it could be whatever, but when arrived there, I might find a mum that is, depressed, that is um, well unhappy, that the relationship between her and her partner, you know, there's marital problems, or whatever. Then, obviously these other things that I'm going about the first in the first place fade into the background, because I've obviously got to address her actual needs at the time." (EQ 30-my emphasis)*

Thus, data shows that health visiting is very dynamic as its focus frequently shifts. Practitioners acknowledged the differences in people in general and make allowances to meet them, thus their practice becomes very contextual.

This was openly acknowledged during an interview, discussing health visiting practice, a health visitor commented:

> *"...you have to be very versatile and very flexible, er (pause) because you are, you are dealing with so many different lots of standards and it doesn't mean that one lot are wrong and the other lot are perfect..." (PS 4).*

Another feature of this condition, is the ambiguity of normality or of what is right and wrong, as the above health visitor put it. To some health visitors normality has no clear boundaries. These health visitors hold what Dingwall (1977b) labelled as latitudinarian beliefs. One of them expressed this view clearly:

> *"I know I can read a book about health visiting, that'll tell me this is absolutely right, this isl, you know. And another book will give you another right,so I'm not absolutely convinced that there is a black and white in this, and I think that one realise that within a normal family, there isn't any black and white at all." (VW 45-my emphasis)*

It seems, then, that while health visitors use a normal framework to assess and anticipate care, in practice this is applied in a flexible way.

To respond to the difficulties and problems posed by this context the health visitor uses different marketing strategies. These aim at getting the client to accept the health visitors' services and ultimately, they contribute to secure the dependent's trajectory. In the process, the standardized health visiting

service, becomes personalized in order to make it appropriate to the client's world.

5.3.2 Intervening condition: Having a shape

In the process of marketing health visitors' services, the image that the health visitor has about the family, the situation or the client act as an intervening condition. There are references in the literature of similar processes taking place in health care. Thus, it has been pointed out that doctors have a vague but unshakeable idea about how a patient should behave when ill (Balint 1957). Hughes (1977) also reported the importance of having a picture about patients in order to recognize or interpret the nature of the problem (p 134).

Strauss, Schatzman and Bunch (1964) in their research study found that nurses working in hospital had a "Shape of the ward". This is like having a mental image of what type of patients and events to expect in different wards (Strauss et al 1964 p. 298). The function of this mental shape is equivalent to that of a picture in clinical medicine as described by Foucault (1975). He stated that while a picture does not make anything known, it makes possible recognition (Foucault 1975 p. 113).

During one interview this point was clearly illustrated, the health visitor was commenting on a visit made to a middle class client:

> *"Now as I walked into the house, er, there is nothing in that house to suggest to me that she's got a child. There's no toys, there are no books, there's no silly little drawings on the fridge. Nothing. Um, apart from a high chair which was folded up under the stairs in the cupboard. I would not think,if I was a salesperson going into the house, I would not assume that woman had children." (RB 13)*

By introducing the example of the salesman, this health visitor is pointing out the consequence of not having a shape about a particular family, that of misinterpreting the situation. Also it shows that a general shape about how a situation ought to be helps the health visitor to recognize something unusual, something that does not fit in.

During this research practitioners expressed having a shape as "Knowing the client". This repeatedly came up in the interviews and its importance for practice was stressed. This is consistent with De Silva's (1988) findings. She points out that through repeated contact the public health nurse builds knowledge of the client and that this serves as a context against which changes are identified.

Having the picture of a client helps the health visitor not only to asses and anticipate care, but also it <u>mediates</u> in the marketing process. This was

clearly illustrated during one interview when a health visitor was discussing the event of a client not wanting to take up immunisations:

> *" There could be other reasons why people will not accept advice at a given time. <u>You've got to know a family</u>, this is where your knowledge of the family is important. Maybe you've come at the wrong time to talk about immunisations. Maybe they've read something in the press, maybe they've had experience of the child not being well, and that's frightened them.....It's the wrong time to approach the subject" (CA 25)*

Knowing the specific family, as the quotation shows, helps to deliver the service effectively. That is, in a way that fits in clients' circumstances. In that way, the closer the health visitor's shape to the reality is, the better for marketing the health visiting service. This point shows the intervening nature of this condition, an accurate shape will guide the marketing techniques whereas a faulty one will misdirect the process.

5.3.2.1 Sources of getting the shape

In the field of Marketing one is recommended to get the client's shape by formal market research and analysis of customers needs and behaviour (Kotler and Levy 1969). Foucault (1975) brought up the importance of observation in the development of knowledge in clinical medicine. He called it the "Observing gaze". According to him thanks to the gaze:

> *"things can be heard at last, and heard solely by virtue of the fact that they are seen" (Foucault 1975 p.109).*

During this research health visitors placed great emphasis of seeing clients as a means of knowing them, specifically seeing them in their homes. For instance one health visitor stated:

> *"...until you've <u>seen</u> where people, how people live, you can't really um (pause) it's like me meeting you, unless I went into your flat or house or wherever you live, <u>I wouldn't feel as though I knew you</u>, do you know what I mean?"(RB 12-my emphasis)*

The analysis of data suggests different sources from which the health visitor draws to obtain a shape of her clients. One major source is experience. The repetitive contact with clients and working in the same area for many years contributed to health visitors knowledge of their clients and area. Also personal experience helps to form an image. For instance, during an interview a health visitor commented that having herself had to go through divorce after a violent marriage, with her husband having alcohol problems, she could see how a client felt in a similar situation (Interview RB) . This is similar to the point made by Hughes (1977) about the role of everyday knowledge in categorizing patients. He found that staff, in a casualty department, draw on everyday and common sense knowledge to form a picture of what was before them.

Connected with experience is the issue of intuition in figuring out what is happening in a given situation. During field work a visit was made to a sick baby. The health visitor thought that the problem was caused by the baby

being overfed. When the researcher asked her why she thought that, she replied by saying that she had previously seen the mother putting the bottle into the babies mouth the minute he was crying. She also added that she felt in her bones that the baby was being overfed (Field note WB 12 August 1990).

Experience provides the heath visitor with types that she can use in other circumstances. During this research, without asking specifically about it, several types of clients came up. For instance, the "Teacher type" came up frequently, referring to a middle aged, middle class mother who was feeling unable to cope with the baby as she was expecting to handle him as she did her class. Also the "Young single mum" type came referring to adolescent mums living with their mothers and having either a honeymoon or tense relationship because the grandmother wanted to interfere with the care of the baby. Lastly, the "Neurotic type" refers to affluent clients with unrealistic expectations of their babies' progress, who needed a lot of reassurance. Prototypes are also provided by the normality framework that the health visitor uses. This framework provides for an assessment tool where reality is contrasted with a normal type, be that of a child, a pregnant woman, or a 75 years old man.

The danger of being misled by these types was acknowledged by the health visitors. During the interviews, they stressed the need to assess each family individually without making presumptions. During one interview a health

visitor depicted rather clearly the process and the interplay of the factors just mentioned:

> *"I think you bring a body of knowledge with you, I mean, I don't know how thorough a grounding we actually get in the University, but you know, certainly over time you learn about how things happen, and you learn to (pause) anticipate things, um you have your own kind of computer here really, your own stress factor chart or whatever, and it's like a filing cabinet, you know, you look at somebody, you talk to somebody, and you put two cards in the cabinet, you know towards being stressed or whatever.....it is like a scoring system really, um, in your head, kind of seeing several factors coming into play at the same time..." (VW 34-35)*

This account leads one to think that getting the clients shape, involves a gestalt process where previous and present information are combined to form a picture that includes more than the sum of its parts. For the practitioner, previous information is used not to overcast reality but to show it clearly. Thus, while there exists a general blue print to secure life trajectories, which is part of the policy agenda (Chapter 4, section 4.3.3), this acts as a general framework that is modified when interacting with specific clients. The modifications that health visitors make to the policy agenda can be thought as constituting the health visitor's own agenda. In that way trajectories are individualized; in other words, cases are transformed into clients. This is the result of some marketing strategies.

The next section describes the major marketing strategies that health visitors use to "Sell" their services and thus secure life trajectories.

5.4 STRATEGIES TO MARKET THE HEALTH VISITING SERVICE

Health visitors use different tactics to fit their services into the specific client context and agenda. They aim at moving clients from being passive or reluctant recipients, when they grant health visitors entry, to an active cooperator in either managing their own care or that of dependants. These tactics can be identified with what the specialized literature defines as marketing tools.

In health visiting the marketing process encompasses three different stages, in each of them health visitors focus on the core process of marketing health visiting services. These stages involve three different strategies which have complementary aims (Figure 2), thus:

1-Promoting the service. It seeks to gain clients receptiveness towards the service. It attempts to make health visiting interesting and relevant for the client to use.

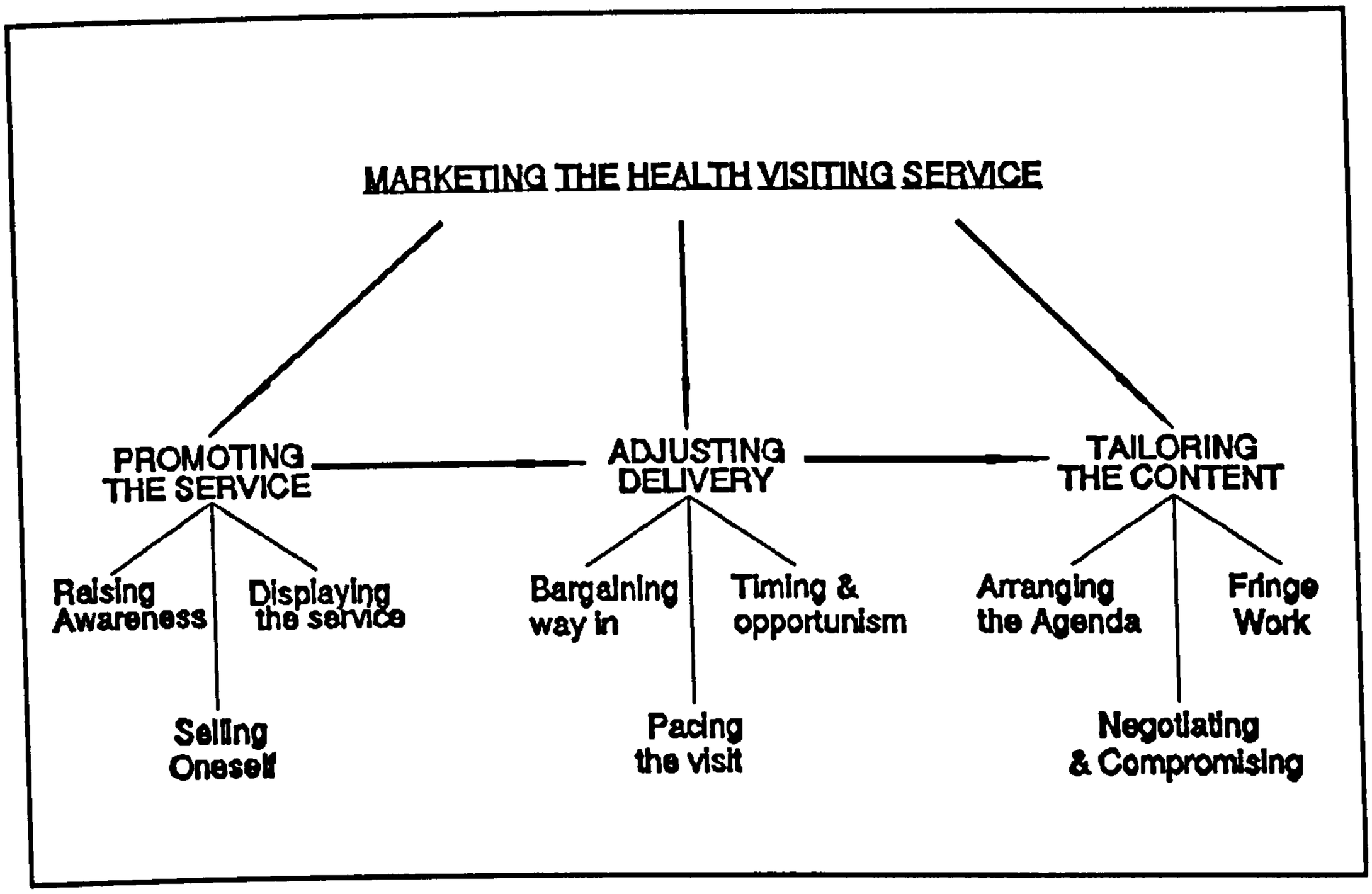
2-Adjusting delivery. Here the delivery of the service is adapted to the client. It aims at making the take up of the service an easy option. It is thus directed at increasing the accessibility of the service.

3-Tailoring the product. This strategy is about adjusting the content of the service to the particular client. Here it is intended to make it acceptable and

feasible for the client to use. It seeks to make the cost affordable, mostly in psychological terms, for the client to take up the services. Adjusting the content of health visiting also involves the development of activities that are not clearly part of the service but they contribute to secure the dependant's trajectory.

These strategies tend to enhance the relevance, accessibility and acceptability of health visiting. They are oriented to adjusting the content, presentation and distribution of health visiting to the particular client or situation. Thus personalizing the health visiting service to specific clients. It is in this process where the health visitor's own agenda emerges which can be regarded as the professional's interpretation of the policy agenda applied to concrete situations. The health visitor's own agenda is a tailored view of the policy agenda. Each of these will be described separately, as follows.

FIGURE 2 - BASIC SOCIAL PROCESS IN HEALTH VISITING



5.4.1 Promoting the service

In marketing literature, promotion is a communication strategy that will make the product familiar, acceptable and desirable to the audience. It involves both the personal presentations and the publicity or advertising (Kotler and Zaltman 1971).

The promotion work is the first step towards the health visitor gaining a clientele. Participants considered that the first encounter with the client was very important. During one interview a health visitor stated that it was in the first visit that she laid down the foundation stone which she will try to build

on later. This promotion work will, thus influence her future relations with the client. Discussing the first encounter with a client a health visitor stated:

> *"I think it's important to make that contact with the parent, as early as possible. And so in a way, that from the time the midwife does, er discharge her, you know them. You know, you are sort of, you've eased your way in and they know you've, um, explained your role, and what the long term, you know involvement would be. And that it is actually a contractual. You know, in other words, we talk to each other about how, you know, what they expect from me, and what I expect from them. And that we sort of more or less, I'll give them an idea of what's to come."(EQ 6)*

As this quotation shows, there are visits in health visiting with a promotional purpose, to transform the prospective client into a real one. Antenatal visits have this objective, they basically aim at introducing both the health visitor personally and the service that will be offered. This ought not to be considered necessarily as a waste of time. Given the context in which health visiting takes place this is a rational option.

Health visitors promote their services basically through three tactics: 1) Raising awareness, 2) Selling of personality and 3) Displaying.

1) Raising awareness. Health visitors attempt to make clients recognize a need or a problem. This practice becomes very obvious when the health visitor meets a client for the first time. In this instance the focus of the interaction usually involves making the client realize the usefulness of and need for health visiting.

The need to persuade the client to use a service is not unique in health visiting. Thus, it has been long recognized that clients seek help from doctors when they perceive a need for help, and have been influenced by relatives and friends, to consult them (Friedson 1960).

In building up client's need for action, the child's health is sometimes used as a mechanism of persuasion. In that way the health visitor is using a moral argument, that of the responsibility that the parent has for her child. This was clearly illustrated during an interview:

> *"If a mother smokes, for example, it's a good idea then to use the child, as an excuse if you like, to get (pause) ' all right you might not be responsible for yourself, but think of your baby, what would you do to your baby by smoking?'.....putting a different stress on smoking, not just on her health, but how she's affecting the passive smokers, and the most important person in her life at the moment is the baby, so trying to get it from their point of view, and then later on saying 'Well what would you do to a child, if a child sees you smoking, children learn by example, you can't then in later years tell the child not to smoke when she sees you smoking'. And then the dangers of playing with cigarettes and fires, all the issues brought up from the one point of smoking, and if she feels then, from then on, 'Oh alright, you know, it is a danger and all that' and might want to give up smoking this is where you can go into your anti smoking and non smoking route" (CAm 17-18-my emphasis)*

This quotation also shows the behavioural model that some health visitors use. The emphasis was placed on altering the behaviour not by trying to understand the reasons for the habit but perhaps by unintentionally, making the client feel guilty or deviant if it is continued. This approach is consistent with the way the principle of prevention has been interpreted. Parental

responsibility is a central concept in the formulation of preventive strategies in pregnancy and child care. When translated into practice the concept is transformed. Thus, "Parent" really means mother, and responsibility is synonymous of sacrifice and culpability (Graham 1979 p. 160)

In the process of raising awareness, health visitors try to get clients to explore solutions before a change is proposed.

During one interview this tactic was highlighted:

> *"...if they are unemployed and money is very short, they live in poor housing, their diet often is chips, a very poor diet, to try and get them to look at what they do give, in the way of cheap meals, but adequate nutrition....try and encourage them to look round, to get cheaper, you know vegetables which make adequate meals...but it's just try and get them to look at their diet" (AW 2)*

Thus by asking clients to examine the possible alternatives, awareness is raised together with the idea of introducing a feasible change.

2) Selling oneself. It was mentioned earlier that promotion also involves personal presentations. Health visitors' personality and appearance can be considered part of the service presentation. In very crude marketing terms it can be said that they are part of the service's "Packaging". So the way they "display" themselves will clearly affect the acceptance of the services.

This, therefore, is the second tactic which health visitors use to promote their services.

The analysis of data suggests that health visitors sell themselves by basically adjusting their approach, physical appearance and language. The aim is to convey a message of being innocent and useful. Ultimately the goal is sought to gain a client's confidence in the service. In marketing terms this makes sense. It has been noted (Hayeck 1945) that markets only work if people have confidence in the signals that the promotion transmits. If that confidence breaks down the market collapses.

Davies (1988) in her account of the development of health visiting between 1900-1914, noted that the health visitor was to achieve her goals by her knowledge and skills but " Also and most importantly through her charm, her persuasiveness and her personality" (p.47). However, according to her these were qualities that any middle class women was considered to posess. The point raised here lead us to the work of Hochschild (1983). This author discusses the emotional labour involved in displaying a given personality[7]. While Mills (1953) coined the concept of selling the personality, he pointed out that kindness and friendliness are aspects of a personalized service "rationalized to further the sale of something" (p. 182), Hochschild (1983) also describes the process, making the point that the personality is not

[7] I thank K. Melia for drawing my attention to this work and for raising the issue of the emotional labour involved in relationships.

simply sold. According to her, feelings are managed in order to make personalities fit for public contact. The possible cost of this work is the estrangement from the aspect of the self being used to do the work.

This emotional labour was clearly depicted during an interview.

A health visitor commenting on her approach to clients, stated:

> *"I couldn't do the job if I had to go in and say 'Right I've got 20 minutes, tell me'. Because they wouldn't do it...you have to <u>show to people</u> a) that you're genuine, b) that you're interested, c) they are the most important person in your life at that time and they are going to get your attention" (RB 40)*

A similar point was made by another health visitor, who commented that in health visiting one has to "Sell oneself". When asked what she meant she replied that she had to be polite, not making people feel that she was intruding, by behaving as a visitor to the house, by encouraging, being positive and by reassuring the clients. (Field note JT 3b-May 1990). Thus it seems that it is important to have or to manufacture a particular personality in health visiting. Indeed, some health visitors believe that the job requires a type of personality and that is why only a certain type of person remains in the job (Field notes Tx. December 1990). Thus, the work involved in a health visitor's adjustment of approach to suit the client, falls into the category of emotional labour described by Hochschild (1983).

Further, during field work it was observed how health visitors acted as if they liked all the mothers they visited. They played with toddlers and gained their cooperation, suppressing feelings of disgust or disapproval. In some ways they strive to show a neutral and open attitude. This will make them appear compatible with the client. Mills (1953) noted that "Sincerity" is detrimental to the job, until the rules of salesmanship and business become a "Genuine" aspect of the person. Thus, to him tact is "A series of little lies about one's feelings until one is emptied of such feelings" (p.183). He pointed to the commercialisation of the smile "Behind the counter" and Hochschild (1983) described the process of producing it. The suppression of feelings was also depicted during an interview, a health visitor commented:

> *"Yes, you don't go in and impose your views on them just um, play it softly, you say it in a subtle way" (SD 2)*

Mayall and Foster (1989) research findings are also consistent with this view. They reported the subtle manners some health visitors used. When discussing immunisations, even the health visitors who appeared to be more prescriptive adopted a 'softer' style. Thus the emotional labour involved is highlighted.

Perhaps, less significant than the adjustments made in the way health visitors feel in given situations, are the physical adjustments they make. Nevertheless, these adaptations contribute to selling the health visitor's

personality. During the interviews, when commenting about adjusting to clients, health visitors discussed this issue. For instance, a health visitor stated that in her area she will never wear a suit (Interview TB 27) and another explained that depending on the area where she is working she will take or not take her briefcase (Interview RB 40).

During one interview the importance of the appearance was openly stated:

> *"I think that it's important that these people (clients) don't see me as too professional person because I think that can be a barrier,um, and I dress in a very relaxed way.....so I deliberately down dress."(VW 14)*

Another physical adjustment is that of speech. De Silva (1988) also reported in her research that public health nurses accommodated their language to their clients. The reason given for accommodating to the language, is that of communicating effectively. However data suggests that it was also a strategy to level down with the client. Thus some health visitors during field work commented that with some clients instead of talking about injections they will speak of "Needles" (Field note VT February 1990; TB August 1990).

The above examples also denote a somewhat patronizing attitude towards clients. Appearance and speech are status symbols, health visitors seem to be concerned with not getting them in the way of the development of

relationships with clients. This concern might well signal condescending attitudes as it does in the above examples.

3) Displaying. The last tactic in promoting health visiting service takes place when health visitors attempt to make services visible.

Instances of displaying the service were recorded during field work. For example, it took place when a health visitor showed a mother her child's percentile chart and hence displayed the need to monitor child's growth (Field notes RL April 1990, TE May 1990, BV August 1990). Another instance was when the health visitor showed the different sections of the child's record and gave explanations about the child's mile stones and the development of activities in the future such as immunisations, assessments and screenings (Field notes S1 February 1990, CT May 1990).

During one of the interviews the tactic of displaying the service was brought up. A health visitor discussing her relationships with clients, stated:

> *"I've invited people to just come along and <u>have a look at what goes on</u>. Um. sit in the waiting room, you know. If they haven't got an appointment for the well woman clinic, they don't really know, they are a bit dubious about the whole business, you know, I'll say, '<u>just come along and see</u>, just come along and sit in the waiting room,have a chat, you know, and if you feel as if though you want an appointment to see the doctor, then we can make an appointment'" (MT 9 My emphasis)*

The quotation shows the way in which the health visitor was displaying a service. She, without naming it, was advertising a product and following one of the principles underlining the concept of promotion in marketing, that is: Making the product familiar to the client (Kotler and Zaltman 1971)

Promotion work leads to the client's readiness to take up health visitor's services. The client's receptiveness towards the health visitor was commented on during field work. One health visitor, for instance, clearly stated that if the client does not want the health visitor in the house it is a waste of time to be there (Field note JT May 1990).

5.4.2. Adjusting delivery

Providing for adequate and compatible distribution and response channels, is another principle to consider in social marketing (Kotler and Zaltman 1971). According to them, it contributes to translating the motivation achieved in the promotion phase into action.

This study shows that health visitors use different tactics to improve the delivery of services. These tactics increase client's accessibility to health visiting services by making them easy to take them up. Thus, by adjusting delivery, it is sought not just to enter but to do it under the best possible conditions. That is when the client will be receptive. The tactics identified are: 1) Bargaining the way in, 2) Timing and opportunism, and 3) Pacing.

1) Bargaining the way in. Health visitors bargain the best conditions for the client to take up the services. In this process the time and place of delivering the health visiting services is negotiated. Negotiating contact is a usual procedure in health visiting. Mayall and Foster (1989) in their study also discussed this point.

The most common manner of bargaining the way in, found in this study, was to let the client choose the best time or day for the contact. During field work instances of negotiating access were recorded. Thus, if the moment of the visit was not convenient to the client, health visitors usually offered to come back later, at a better time. In the meantime they did other visits. Also, if the day was not appropriate they negotiated the visit for an alternative date (Field notes CT, JT May 1990, WB August 1990). A similar process took place in the baby clinics. Here, within the scheduled days, clients were informed that they could come when they felt like it (Field notes RL April 1990, TE May 1990, BV August 1990).

Another form of bargaining the way in is when health visitors give clients the option of choosing the place for the next encounter. Options were usually limited, to be visited at home or to bring the child to the clinic. According to the data, when there is a high priority to get the client to use a service, the flexibility of the place to deliver it increases. An obvious case is with immunisations. During field work it was observed that health visitors

insisted that clients could go anywhere to get them done (Field notes S1 February 1990; CR April 1990, LT, CT May 1990).

Making a compromise about the content of the visit is another way health visitors use to gain entry. During one interview an example of this instance was given. A health visitor commenting about the difficulty of entry into the home of one of her clients said:

> *"I said (to the client) 'Look Ivy, obviously this immunisation issue has caused you a lot of discomfort. Um, you don't like me coming round because you think I'm going to get on to you about the needles'.So she said 'Well that's all you seem to talk about'. So I said 'OK if I promise you that I'll never mention immunisations to you again, do you think we'd get on better ? Do you think that when the new baby comes, I'll be able to come and visit you?..." (RB 42-My emphasis)*

For the health visitor above, it was more important to be granted entry to see a baby than to achieve compliance about immunisations. The health visitor in this case balanced the options and give priority to her access to the house over specific preventive measures. As a consequence of this, the content of the visit was changed, this is a clear example of tailoring the policy agenda and developing health visitor's own agenda. However, as we will see, when discussing the next strategy, negotiations are temporary and are used as a way to win ground.

Negotiating the way in does not only imply that the health visitor has to give up some items on the agenda. It also involves an exchange between the

health visitor and the client. Thus, during field work an instance was recorded where the health visitor was offering a client, who was reluctant to let her come to the flat, help in getting a better house in exchange for letting her in.

2) Timing and opportunism. This is the second tactic in adjusting health visiting service delivery. Health visitors time their interventions by choosing the best moment to introduce them, that is, when clients are likely to be receptive. Health visitors place great importance on timing their actions.

To ascertain the client's readiness to take up the service came up repeatedly during this research and was also highlighted in Chalmers (1990) study. Thus, during an interview, discussing health education issues, a health visitor gives an example of how she will deal with persuading parents about changing behaviour, she commented:

> *"Say, children with lollipops er, well you can mention sugar rotting their teeth and you can mention that um, you know, the longer something stays in the mouth the more likely the teeth will rot and but, I would mention it at a time when I thought the person would probably be more receptive you know...it's sort of like choosing the time and backing it up with may be a leaflet." (IH 12-my emphasis).*

Health visitors also have a typology of circumstances when they believe clients are receptive. This is used as a guideline for health visitors to time their encounter with clients. The most common case is that of antenatal

clients. By timing, the moment is sought when the client will see the relevance of the service.

Opportunism can be regarded as part of timing. Here the health visitors are presented with an opportunity to do something and they take it. Examples of opportunistic action were recorded during field work. For instance, accidental encounters in the street with clients who could not be contacted at home, led to arrangements of home visits (Field notes LT May 1990). It was also observed that health visitors, when out doing home visits, were carrying in their bags all the screening and assessment equipment. When asked why they were carrying things that they did not plan to use, health visitors commented that they need to be always ready as "One never knows when one will need something" (Field note CT May 1990 and WB August 1990).

Also it was quite common during home visits, to observe health visitors taking the opportunity of assessing child development while a child was playing alone and the health visitor was talking to the mother about other issues. Children do not always cooperate with the health visitor in the formal screening sessions. They can refuse when asked to perform certain tasks, like building a tower or drawing. Thus, this opportunistic assessment will enable the health visitor to do her job without disrupting the child (Field notes JT, LT May 1990; TB, DB, WB August 1990)

The need for being alert and ready to take the opportunity as it arose, was illuminated during one interview.

A health visitor discussing health visiting in general stated:

> *"And as a health visitor you have to spot that time you know. If you've been trying to get something across to somebody, and you may meet them in the street, you may meet them in the supermarket, whatever, but they'll say something <u>that would give you a lead in, to what you, the point you've trying to get across to them.</u> It maybe about immunisation, it maybe about their own health, you know, it maybe about family planning, whatever, whatever is hat they've been, um, <u>not open in the past</u>." (MT 8. My emphasis)*

3) Pacing. The last tactic that increases the accessibility of health visitors' services is that of sequencing the amount of the service given to clients. Pacing takes place when the health visitor adjusts the content of her interaction to clients' circumstances. Thus, health visitors "Calibrate" their input to clients. This is another way of personalizing health visiting services.

During one interview a health visitor commented:

> *"So I would try and <u>gear my visit</u> to her needs, so that the information I'm giving her, <u>she can take in a relaxed manner</u>, rather than just be giving her loads and loads of information,and expecting her to remember it all." (TB 7- My emphasis)*

As the quotation shows, an effort is made to adjust the amount of service delivered to the client. Here, it is accessibility in intellectual terms.

In pacing, health visitors use the standardized schedule prescribed by the policy agenda as a guideline. Once they meet the client they adjust the amount to be delivered to client's particular needs. During the interviews this point came up frequently. Hence, one health visitor discussing the way she organized her work, commented:

> *"I you know, if they're coping and everything's OK, I may visit them a little bit later, you know, if I get tied down with other things, um but that's sort of the vague outline that I use to base my visits on, and depending how they are coping. If there's problems, sometimes I'll visit more , sometimes I'll visit less, but I use that as my outline for when to visit." (AW 13- my emphasis)*

The basic aim of this tactic is to "Level up" with clients, to begin where they are and then progress. Health visitors adjust to the distribution of their services to clients' according to their availability and capabilities. As health visitors make these adjustments, they are contributing to clients' acceptance of the service.

Accessibility is a key concept in Primary Health Care or Community work. It has been a major concern since the origins of the "Health for All" movement. Thus, in the Declaration of Alma Ata (WHO 1978) accessibility, together with cultural acceptability are emphasised. These are thought to contribute to reaching equity in health. However, health visitor's adjustments might well lead to perpetuating inequalities in health. This issue will be further explored in chapter 7 (Section 7.4.2).

5.4.3 Tailoring the content of health visiting

Tailoring health visiting content is the third strategy in marketing health visiting, as in previous ones, it is constructed as a marketing technique. Thus, in business marketing, sellers study the needs and wants of target buyers and attempt to design products and services that meet their desires. However, in social marketing, because there is not just one product that can influence the desirable behaviour, various tangible services are created that are "Buyable" and which advance the social objective (Kotler and Zaltman 1971).

Sanchez (1981) has pointed out that when a new product requires a strong behavioral change, the marketing strategy must be employed to minimize the psychological impact associated with the change. He stated that one way of achieving this is by adjusting the product features to be more closely aligned with consumers' behaviour patterns.

This study shows that heath visitors accommodated the content of their services to client's circumstances. In this tailoring process the image that health visitors have about clients plays an important role. Thus, the content of health visiting is adjusted to this image which basically consists of the health visitor's assessment of clients capabilities and situation. Getting the client's shape, as it was earlier in the chapter pointed out (Section 3.2) is

thus an intervening condition in the process of marketing health visiting services.

When using these tactics, the health visiting "Product" is basically negotiated in order to fit into a reality. Negotiations are sequential and enable the health visitor to move forward. When tailoring techniques are employed, the health visiting services are actually "Manufactured". The use of these tactics refer to what Luker (1982b) called "Micro processes" for delivering individualized health visiting (Chapter 4, section 4.2).

Strauss (1978) argues that social orders are, in some sense, always negotiated orders. According to him, negotiation alone does not explain everything as it is with other processes such as persuasion, manipulation and coercion. He stresses that negotiations are ways of getting things accomplished when parties need to deal with each other to get things done. There is evidence in the health care professional literature of negotiating processes. Thus, due to the competing definitions that doctors and patients have about the situation, it has been proposed, to regard their encounter as a process of reality negotiation (Anderson and Helm 1979). This is similar to acknowledging the presence of two agendas, that of the professional's and that of the client's, and the need to accommodate them. Also the negotiations that take place in hospitals between staff and patients, have been highlighted in different studies (Strauss et al 1964, Glaser and Strauss 1965, Strauss et al 1985, Morse 1991). Roth (1963) also points to the

bargaining process involved a career timetables (p. 54). Hence negotiating is not an activity that only takes place in health visiting. It occurs in other areas of health care activity and everyday life.

In the health visiting literature there is evidence of the professionals using negotiating tactics. Thus, Dingwall (1977b) found that health visitors establish the relevance of their tasks to clients and that this has led to a structure where clients could bring a wide range of problems, not necessarily health visiting problems. He argues that in this instance the health visitor responds to them as a "Trade off" with the client in getting the client to permit her to introduce her topics. Thus a process of negotiation is implicitly acknowledged here.

De Silva (1988) in her research noted that public health nurses were aware of having different priorities from the clients and that they could not impose their lifestyles and values on the family, hence negotiating care with the clients was addressed in this study. Mayall and Foster (1989) in their study of health visitors, found they accepted second best options and they stated that in the field of child surveillance factors considered to be desirable are constantly negotiated between interested parties. Lastly, Kristjanson and Chalmers (1991) considered that community nurses need to negotiate with their clients in such a way as to reach an agreement about what are their problems or needs. In more general terms Zerwekh (1990) in her research study stated that public health nurses' interventions were tailored to the

client's context. Further, she emphasized the importance of knowing the client's home in order to adjust professional's activities.

The analysis of the data collected in this study, shows that health visitors use three tactics to accommodate the content of their work to clients' world or reality. The tailoring process takes place when health visitors 1) Arrange their agendas, 2) Negotiate and compromise about issues or situations, and 3) Perform activities that are on the fringe of professional work, thus engage in what is being coined as "Fringe Work". As follows, the three tactics are discussed separately.

1) Arranging the agenda. It was highlighted, in chapter 4 (Section 4.2) that health visitors usually initiate the contact with clients, they had an agenda that might conflict with clients' perceptions of priorities at a given moment. In this instance, health visitors shift their policy related agendas to respond to clients' perceived need. During one interview this issue was raised:

> *"You have to deal with what the mum sees as priority. Once you have dealt with that, you can then do the other bits"(V1 4)*

As the quotation shows, the shift tends to be only temporary. The health visitor hopes to be able to introduce her agenda at a later stage.

2) Negotiating and compromising issues or situations. During the interviews, when health visitors were asked about conflicting situations with clients,

one way of dealing with this was by negotiating openly with their clients. Health visitors aimed at getting the "best" solution given the context. In some instances this involved getting the second best solution or "Settling for the lesser of two evils". During the interviews, this issue was brought up by a health visitor, discussing a mother's habits in feeding her baby, she stated:

> "**Health visitor** - *But if they (clients) say to you: 'After 3 or 4 months, well I started giving him rusks in the bottle'. You can compromise in a way and say: 'Well, no, don't put rusks in the bottle, because you are upsetting the constituency of the milk, and you're going to get more problems with that, but if you insist on giving him rusks, give it in a spoon'. That's the compromise, I don't mind a rusk, but I'd rather she gave the rusk in a spoon than a bottle.*
>
> **Researcher** - *Were you settling for the lesser of two evils?*
>
> **Health visitor** - *That's right whichever is the more dangerous, because if you say to a parent 'No rusks full stop' you are going to upset them so much, that they are not going to listen to you at all and they'll carry on putting the rusk in a bottle, so you don't achieve anything. <u>But you need to find a compromise that's acceptable to both of you. It's acceptable to me that she takes, that she doesn't put the rusk in a bottle, to me that's the more dangerous of the two</u>." (CA 23-24. My emphasis)*

However, negotiations tend to be temporary. In general health visitors consider them as a way of winning ground slowly. This was raised during the interviews. A health visitor commented:

> *"..so it's either,cutting myself off altogether, or getting in under a compromise, or you know <u>work at it slowly</u>" (AW 36- my emphasis).*

This view is consistent with the literature. Strauss et al (1964) stated that negotiation has many dimension and one of them is the temporary nature. They assert that the result of a negotiation is for a limited period, whether or not this period is defined by the involved parties. It has been stated that any negotiation is part of a series of negotiations, that they are linked and do not stand in isolation (Strauss 1978).

Health visitors in this study acknowledged that they were making compromises when dealing with clients. These compromises did not come out of open negotiation with the client but instead the health visitor internally adjusted her standards to meet the situation.

Two variations of these silent compromises were identified. One is that of **"Toning down"** referring to the lowering of health visitor's expectations about what was considered to be a health behaviour; and the second is that of **"Turning a blind eye"** This refers to the health visitor's purposeful overlooking of potentially conflicting or sensitive issues to focus on priority or more neutral matters. Thus adjustments were downwards and usually made in situations of deprivation or conflict of interests.

During field work the adaptability of health visitors to different situations, was discussed. A health visitor acknowledged the fact of changing her standards to meet clients' circumstances (Field note TX December 1990).

Another health visitor during an interview highlighted the issue of compromising:

> *"Well I compromise on my own standards, quite a lot. I compromise (pause) health authorities' expectations (laughter)...I think, you know, on a daily basis, that my work is a compromise, you know, between the absolute ideal, perfect, health visiting that perhaps I perceive, and the absolute ideal that the client perceives perhaps, and you know, the third factor being the authorities if you like you know?...so you learn very well that there's all sorts of horrors going on out there, <u>all you can try and do is adjust what's going on towards the ideal</u>" (VW 36 and 47-My emphasis)*

This quotation also shows the general context of compromising, that of making compatible different conceptions of reality or different agendas: Policy and client's.

However, there are instances where the health visitor does not compromise. She does not alter the product or the content of her practice to fit into the context. This circumstance arises when there is physical harm to the child, when the health visitor is suspicious of the carer, or in extreme life threatening circumstances. Thus, compromise and negotiation have limits or boundaries. These are set by the welfare of the dependant, but the emphasis is on physical integrity. A health visitor made this point clearly when she was commenting on a middle class mother who was preventing her child from socialising:

> "I'm not going to be able to change her attitude. Probably the child will grow, and as it gets older and socialises it will be fine

anyway. That's isn't a life threatening thing. The only time I would um, assume to change a situation is when I think a child is in grave danger..." (RB 15-My emphasis)

This quotation highlights the fact that negotiations and compromises are options the parties take to get things done. When the circumstances change to potentially life threatening situations such as the quotation shows, other courses of action will be followed. These could be coercion, appeal to authority or manipulation.

The limits that the health visitors put to compromises are consistent with health visiting's fundamental mission, that of protecting children, and its core activity that of securing life trajectories. Thus, when marketing the health visiting service what is considered to be the essence of the service is not altered.

3) Fringe work. This is the third tactic health visitors use to tailor their services to meet the client's needs and circumstances. Unlike the previous tactics just described, here a new service or activity is introduced. This work can be regarded as an "Extra service" that health visitors give to clients. It involves work that health visitors are not supposed to do, nor expected to do. In addition, fringe work involves backstage activities that add pressure to health visitors' workload.

It is being labelled "Fringe" as it is work placed mostly on the fringes of professional activity. When Health visitors engage in fringe work they adjust their professional role at its fringes in order to meet client's felt needs or problems.

Due to the volume of data and the density of the analysis, this category while belonging to basic process of "Marketing", is discussed in a separate chapter.

5. CONCLUSION

In conclusion, marketing is a process in which health visitors use a combination of techniques to make their services acceptable, relevant and accessible to clients. The process enables the introduction of the policy agenda into the client's world. There has been identified four conditions that lead to the development of this overall strategy. Thus, 1) The need for the health visitor to gain a clientele, 2) The private nature of the sphere where life trajectories are managed, 3) The practical constrains represented by client's attitudes, own agenda and shortcomings on resources and 4) The variety of circumstances that health visitors encounter. Health visitors' knowledge about clients facilitates or constraint this process.

Marketing health visiting involves basically the implementation of three strategies. The first is that of "Promotion the service" which intends to gain

client's receptiveness towards the service being offered. Secondly there is the "Adjusting delivery" strategy which aims at making the taking up of the service an easy option. Thirdly there is the "Tailoring the content" strategy which aims at making health visiting an acceptable, easy and relevant option. These strategies contribute to the development of the health visitor's agenda and hence to the personalization of health visiting services.

The overall consequence of marketing is that of building a common agenda with clients and thus gaining their active cooperation in securing life trajectories. Consequences are discussed in a separate chapter, before that the next chapter focuses on "Fringe work", a tactic that health visitors use to tailor their services to clients' circumstances.

CHAPTER 6

FRINGE WORK

6.1 INTRODUCTION

This chapter focuses on the category "Fringe Work". It first defines the concept and then examines the conditions under which it takes place. Deficiencies in health care and social systems, and the need to gain the client's trust trigger fringe work.

The different types of work involved in fringe work are examined; these have been defined as: Relief work, Novel work and Surrogate work. Lastly, this chapter identifies three general properties in fringe work. These properties assist in recognising the dimension of fringe work and clarifies its meaning. The consequences of fringe work are examined, together with other marketing tactics, in the next chapter.

6.2 FRINGE WORK

The concept "Fringe work" was constructed during the present research to account for a series of health visitors' activities that ultimately contributed to securing clients' trajectories. The concept, thus, is grounded in the data collected during the research and takes the practitioners' points of view

about the nature of their work. It takes place on the periphery of health visiting, away from the health visitor's core work, that is, the routine work set by the policy agenda. Hence the term "Fringe".

Fringe work is an overall strategy that health visitors develop to meet deficiencies in the service and to make the service relevant to the client's perceived needs. It attempts to create what is needed and to fill in what is missing. It operates by mobilizing existing resources and developing new ones.

Activities can be categorized as "Fringe" when according to the policy agenda : 1) They refer to work that is not supposed to be done by health visitors, and 2) To work that is not expected to be performed by them. In addition to this, fringe work involves a series of backstage activities that arise from both one and two above.

In general terms fringe work relates to a group of activities that involve giving the client a service that is not "Common or standardized". We can think of fringe work as a way of "Stretching" health visiting resources. However, what is common in one area, might not be common in another. For instance, during the study it was learnt that in one area it was accepted that health visitors gave food samples to clients but only on Fridays if there were delays in receiving the social security cheque. This would not be regarded as acceptable in other areas. Thus, the definition of a given activity

as "Fringe" will vary from one setting to another. However, the above characteristics serve as criteria to label activities as fringe. Thus:

1) Work that the health visitor is not supposed to do within a given policy or professional view. There are situations when health visitors interpret or consider that in order to achieve their "Mission" they have to overlook policy rules or some professional principles because they are not relevant, or will create distance in the relationship with clients. Hence, this work is done in a "Covert" way, it is not recorded nor commented upon openly. Examples of these instances are when health visitors bend a rule by giving clothes to clients and when they engage in "Befriending work" such as giving tips to clients about where to buy cheap socks for a school uniform or when they assume the role of a family friend (Field notes WB August 1990).

2) Work that is not expected to be done. This type of work is about doing something beyond the call of duty. Here health visitors judge the situation as requiring an extra effort. This type of work is done covertly, without being stated on the official records. An example in this category is the developmental work that some health visitors have implemented. This includes setting up support groups and the activities that relate to network building such as having clients on a list to be called in case other clients felt lonely.

3) Backstage activities. This refers to activities that take place behind the scene such as phoning, writing letters, taking things such as clothing to pass on, visiting and persuading gatekeepers of services. This work can be regarded as the "bureaucracy" of fringe work.

In this backstage work, health visitors speak to others on the clients' behalf, in order to help them to solve a problem or need. It is done behind the scenes, at the health visitor's office. It is usually unrecognized by the manager. A health visitor discussing her work in general, commented on this point during an interview:

> *"There is a lot of phoning, and I don't think that's recognised really. I don't think it's, you know you just do that in your lunch hour, or you do that in your, in the other time that you're not visiting..." (IH 17)*

Fringe work thus tends to be invisible because it is done either covertly, silently or backstage. It involves unconventional activities which do not usually appear in the statistics related to health visitors' work. Practitioners realize that they are engaged in work that lies on the periphery and is unnoticeable. A health visitor commenting on the fact that she "Stepped outside the realms of traditional health visiting", stated:

> *"If you talk to any of our bosses about health visiting, and lets face it a lot of our bosses aren't health visitors, if you talk to them about health visiting, it's babies and mothers, and it's developmental screenings, and that's what the policies say,*

> *and that's what is recognised as health visiting by those that are in the position to define health visiting, in a formal position to define health visiting, I would say health visitors generally view it very differently....so it seems that there is this kind of core, and there's (pause) everything else kind of revolves around that..." (VW 24. My emphasis)*

Shils (1961) noted that society has a centre. He described it as the zone where the central value system of society lies. He believed that the centre is a structure of activities, of roles and persons within the network of institutions. The values and beliefs that are central to society are embodied and propounded in these roles (p.415-416). The formal definition of health visiting referred to in the above quotation can be interpreted as the central value system in health visiting. Fringe work thus, belongs to the periphery where, according to Shils (1961), policy authority is exercised and the attachment to the central value system becomes attenuated.

Other research studies document fringe activities in nursing. Thus, De Silva (1988) gave some accounts of public health nurses giving personal money to clients, transporting them in their cars although it was against policy regulations, and "Fudging" clients' income a little so they could receive care. Popay and Dhooge (1986) in their study of the impact of unemployment in health and social services, illustrated with examples health visitors' "involvement in charity work" (p. 25) and noted that, health visitors' backstage activities were raised due to the increase of their clients emotional and financial difficulties. They mentioned contacting agencies

such as voluntary welfare rights organisations, Marriage Guidance, Gas and Electricity Boards and the Housing department. Health visitors in this study acknowledged that they were spending more time than before on the phone trying to solve clients' financial problems (p.24). Lastly Morse's (1991) description of the different types of relationships that hospital nurses develop with patients included activities where nurses were bending and breaking rules for patients (p. 458). Accounts of innovations in health visiting work, which were discussed in chapter 2 (Section 2.3.2), can also be regarded as evidence of "Fringe work".

Fringe work traits of invisibility and inexpensiveness are similar to those of "Caring". Caring is regarded as a labour of love invisible, unspoken, unending and devalued (Graham 1983). In fact because it is unofficial care, fringe work can well be considered a form of informal caring. Stacey (1981) points out that many of the activities in the human services were formerly dealt with in the domestic arena. Thus fringe activities can be considered as informal caring transferred to the public arena.

Ward (1991) also sees caring as work and further she estimates its value in money. The amounts calculated represent, according to the same author, a "Subsidy to the social welfare". Thus, fringe work involves costs and they can be considered as a "Gift" to the dependant. In fact later on (section 6.4.1) fringe work is considered to be a sort of "Supplementary benefit" that health visitors give to clients. The "Gift relationship" has been discussed by

Campbell (1984). He presents two complementary views: That of Watson (1980) who believes that social policy depends on grants and gifts based on upon a sense of obligation to fellow human beings, and that of Titmuss (1970) who regards the gift relationship as giving to others beyond the bounds of duty. Watson (1980) argues that social policy must first devise methods to grant to all people their basic rights to a minimum standard of living. On this foundation, policy should provide for the 'ultra obligations' to which Titmuss refers. Fringe work involves both views, sometimes attempts to help clients with basic rights such as food and clothing, and sometimes deals with community developmental activities that goes beyond the basic and universal services of child surveillance.

Having discussed fringe work's major characteristics, the next section focuses on the specific conditions under which it takes place.

6.3 CAUSAL AND INTERVENING CONDITIONS FOR FRINGE WORK

The conditions that precipitate fringe work are part of the "Practical constraints" on the client's world that generate the development of marketing strategies (Chapter 5, section 5.3.1.3). Three groups of constraints had been identified here: relating to clients' attitudes, to their agenda for daily life and to their social and material conditions. It was noted that practitioners refer to them as the difference between the ideal and the real world. Fringe work is motivated by this difference which basically

emanates from the client's attitude towards the service and from a lack of resources. Both are identified, according to grounded theory terminology, as causal conditions.

Further, the analysis of data suggests, in grounded theory terms, four intervening conditions. Thus: 1) Health visitors' position between resources and clients, 2) Resources available, 3) Health visitors' flexibility and 4) Clients' circumstances.

6.3.1 Causal conditions

Fringe work arises in two type of situations 1) when gaps appear 2) When health visitors need to show the value of their service and a commitment to clients. Fringe work is also directed to gain entry. Thus, it has both humanistic and instrumental motives.

6.3.1.1 Presence of gaps

Gaps arise from a mismatch between the client's needs or expectations and the resources or services provided. They are important in health visiting because they may jeopardize the client's trajectory. If a gap is not filled, dysfunction might occur, gaps then are hazards to the trajectory. They might send it off course or interrupt it. For example, a single parent who has not got the necessary economic means or emotional support may have a

reduced capacity for taking care of her child. Similarly, if the health services do not respond to clients' problems of stress and isolation, or if they fail to provide continuity of care, trajectories will be affected. When health visitors are confronted with gaps in resources or services they attempt to respond to them by filling or bridging them and this is the essence of fringe work.

The professional literature has indirectly acknowledged this type of work. Thus, Drennan (1986a) states that " A certain amount of health visiting activity is shaped by a client's perceived needs and the inadequacies of the service". Luker and Orr (1985) recognise that there are gaps in services, and Fox (1990) points out that health visitors are called to "Step into the breach left by social workers off sick, on holidays or simply not there" (p. 216).

Bridging and filling gaps[8] are activities that fit into the tradition of health visiting and nursing. In the technical literature it tends to be referred to as "Coordination" and as a way of contributing health care. Filling certain gaps thus provide opportunities for professional identity on practice. For instance Benner (1984) identified six different domains of nursing practice, in two of them references are made to filling gaps. Thus, one of the arguments given for the nurses' function of teaching and coaching patients is that doctors will not do it. Also within the domain of "Monitoring and Ensuring the Quality of Health Care" it is identified as a nursing activity to provide a back

[8] By bridging gaps is meant when health visitors refer clients to other services or resources. By filling a gap is meant when health visitors themselves are the ones who fill it.

up system to ensure safe medication and nursing care, and to assess what can safely be omitted from or added to medical orders. While these two activities place the nurse in the position of advocacy, they also imply potential gaps in the system and the need for a nurse to be there to meet them. Further, Chambers (1991) considers that nurse practitioners are filling a gap in primary care and asks her self "What other additional contributions could nurses make to fill the gaps and improve the quality of care provided in the practice setting?" (p.4). Thus, for some authors filling gaps is not an undesirable activity but an opportunity for the advancement of a professional role.

In the present study, the type of gap that triggered most of the health visitors' fringe activities was caused by deficiencies in the health care and the social system. The health care system can present two types of deficiencies: those that relate to its referral and liaison mechanisms and those that refer to meeting clients' needs. In these instances a gap in the continuity of care and in its provision may occur. The social system as a provider of material and emotional security can also present deficiencies. These can be due to weaknesses in the social network, like a lack of social contacts or family relationships, and due to insufficient economic resources and basic amenities.

In the following section the specific conditions which generate gaps are discussed.

1) There is a failure or a gap in the health care system . Deficiencies in the health care system will leave a gap between clients and services. These deficiencies might arise from: a) Lack of coordination between services jeopardizing the continuity of care; b) Rules, such as restricted consulting hours, that could make services inaccessible to client; and c) Cut backs in services. In these situations, the system is not providing what is proposed according to its own criteria of universality, continuity of care and accessibility.

An example of a gap left by a lack of coordination between services was recorded during field work: During a home visit to elderly, the health visitor found that although the application for a chair lift had been approved someone had been to measure the stairs long ago but nothing had happened since. The next day, the health visitor phoned Social Services to inquire about the issue and afterwards wrote a report asking the District Nurse to visit the man to do a further assessment of needs (Field notes DB 2- 3. August 1990). This example shows that the health visitor filled a gap, apparently left by social services. Deficiencies in the health care system itself were also pointed out during the interviews. For example, a health visitor discussing the type of clients she is involved with, stated:

"I try not to get involved with school children, but sometimes you can't help that, 'cos they don't see the school nurse for some reason..." (JB 7)

As above, due to a lack of coordination the client is not receiving the service. The health visitor is willing to substitute it and in this case, act as school nurse. In this way she is securing the continuity of care.

Gaps also appear due to receding resources in health or social services. The effect of cut backs in services was discussed by experienced health visitors. During an interview the fact that there are fewer resources than previously emerged clearly:

> "**Researcher** - *Why do you have to bring those things (clothing) to a home...?*
>
> **Health visitor** - *Well at one time, to be honest with you, we wouldn't have to. At one time, if somebody didn't have clothes, you could fill in a form and get them some.....Now one time, when I was health visiting ten years ago, we could just ring up the DHSS and have a clothing allowance given to these children. Now that doesn't happen any more, and that's one of the reasons why there has been a slight change (of policy) over giving." (TB 33-34. My clarification).*

The above quotation shows that the gap left because of cuts in benefits, is filled by the health visitor's fringe activity. Thus, fringe work can be regarded as a way of "Retrieving" policies that practitioners feel are still needed. This point is further discussed in section 4.2.

2) There are evolving needs and no services or resources to meet them. This is the second condition that generates gaps. It occurs when the health

services sector has not developed mechanisms to meet new needs. A gap occurs when the institution does not respond.

A health visitor, discussing her role, commented on this issue during the interview:

> *"Again when you go to an area, and you find that there is a need for a mother and toddler group, then you've got to find the right group of mothers, who are motivated to set it up and keep it going. So you go in and see,...<u>if there's a need there, and if there's another agency who can meet that need, you put the two in touch. But if you go in there and the need is there but there isn't such an agency to help out, if possible we can maybe start one</u>...."(CA 39-my emphasis)*

As the quotation shows, once the health visitor ascertains a gap in services, she either mobilizes or develops resources. If the specific activity is not expected to be done as part of health visitors usual practice, it then becomes fringe.

During the field work it was recorded that health visitors in a health centre reached an agreement with child minders: they can contact the health visitor if they have a problem while looking after the children (Field notes WV April 1991). Child minders are not normally part of a health visitor's caseload. But they are "In loco" secondary clients. By responding to their needs while doing their job, the health visitor is meeting an evolving need, that is, one that has arisen because of mothers working outside the home. More important, by doing this health visitors secure the child's trajectory. In this

situation the health visitor is actually enlarging her caseload by taking in the child minders. Since in health visiting the child is the primary client, this response is consistent with this view, while this work could be acceptable it is not expected to be done.

3) Gap within the family system. The third condition that generates gaps is a failure in the social or family system . Here the system is supposed to work but there is a deficiency leaving a lack of basic needs such as food, clothing and heating. A Health visitor working in a deprived areas revealed this situation during the interview:

> *"Well, say clothes, for instance. Well it might just be that you see a family that, er, appear not to have enough for their children, and if you have got clothes in the clinic, then it's just a case of, um, supplying a need that you see." (LT 17)*

A failure in the social or family system also leads to a lack of emotional support because relatives, partners and friends are absent, if they are present, they do not fulfil these roles. During an informal interview, conducted during field work, this last point became clear. When asked by the researcher why she gave a second hand pram to a client, a health visitor said that it was because the baby needed it and because the mother would not look for one. (Field notes DB 5 August 1990. My emphasis). In this instance, the health visitor was doing fringe work in order to fill a gap

caused by the mother not assuming her expected role, that of protecting and caring for the child.

6.3.1.2 Showing the value of the service and a commitment to clients: Need to gain client's trust or compliance

Clients, because of past experiences, particular needs or circumstances, may be sceptical about the relevance of the health visitor's services to their situation. They may also be suspicious of the health visitor's role. It is in deprived areas where clients are most likely to have this attitude towards health visiting. Here clients tend to depend on State's financial support and health visitors feel that they are regarded as "Authorities" with powers to withdraw this support. Hence, when the basic needs are not met, this service might seem irrelevant unless the client's felt needs are considered. Also, health visitors have reported clients being "Suspicious of authority" because they felt that the health visitor would take their children away, or would tell the police of a given event or report to social security that they are not entitled to certain benefits. It is in these circumstances that fringe work operates as a strategy not so much directed to fill a gap as to build up trust and credibility. In that way fringe work becomes a tactic to gain entry.

A health visitor working in a deprived area put it bluntly:

> *"If I'm writing to the Housing Department, referring to a hospital or whatever, I always make the point of having a copy for the client....And I said 'there's the letter, I've written to X*

(hospital), the housing etc., I want you to see what I've said about you, do you agree with it?' That gives me credibility and builds up the trust, you know?....I have been criticised for getting too involved. I've been criticised for doing social work, but if that's the way in (laughter) I'll carry on, don't mind" (RB 19 and 22. My emphasis).

Fringe work can also be regarded as a way to reciprocate the client's efforts in adjusting to a new role or following advice. It can become part of an exchange or tacit agreement. So it becomes a device to reward or to reciprocate the client's compliance. It might therefore also take place when the client has done, or will do, something suggested by the professional. Thus, during field work, instances of a health visitor giving, without being requested, food samples to parents after being in the baby clinic were recorded (Field notes JT May 1990). The next chapter (section 7.2.2) discusses further fringe work's contribution to build a climate of reciprocal relationship between professionals and clients.

6.3.2 Intervening conditions

In addition to the causal conditions, there are other conditions that facilitate or inhibit fringe activities. Health visitors' position, the resources available in the area, their flexibility and specific clients' circumstances are the major intervening conditions in fringe work.

6.3.2.1 Health visitor position

Here her position is referred to as being between the people and the "World out there". This position enables her to "Know" both ends: the client and what services or resources are available. To know the client, in this context, is to know what support is required to secure the trajectory. A health visitor expressed this convincingly:

> *"...I think we (health visitors) are the ones that have access to, the community if you like. We have access to the GPs, through referrals, we get them to see the people. And there's a lot of people who work in the community who aren't professionals, they are there to work for the community, but they don't always have access to the client, and the client doesn't always have access to them. And I think, health visitors are in a very advantageous position in the sense that we know our clients, and we know also of most of the things, not all of them, of the things that are available, and we can link...by going to the home, being in the home, building our relationship with them, assessing, evaluating their needs, and from the evaluation you can foresee, well what are the outcome, what sort of outcome do you want to achieve and how they can achieve those outcomes" (CA 36. My emphasis)*

The above quotation highlights that the health visitor's position refers to their relationship with clients. This is an important factor since fringe activities, considered as gifts, require client's acceptance. Health visitors need clients to either to let them fill a gap or bridge it. This has been highlighted by Luker and Chalmers (1989) when they discuss the need for the client be ready for a referral.

6.3.2.2 Resources

This is the second intervening condition in fringe work. The accessibility and type of resources will also affect fringe work. Health visitors need not only to know what is available but to have access to gatekeepers. By being in the same area for some time health visitors can build up a network of contacts, and can establish relationships with gatekeepers. They are aware of this. Thus during an interview a health visitor commenting generally about her work, stated:

> *"When you start up in a community, you don't know who to contact when something happens. It's from experience from dealing with one and another, and another, and you build on your link workers" (CA 37)*

Resources need to be of a certain standard because if the client is not satisfied with them the health visitor's credibility will suffer. If health visitors believe that resources or services are not of a acceptable quality, they will not link clients. During field work this point became clear. A newly qualified health visitor was gradually visiting all the resources, from visiting swimming pools to play groups, in her area before she referred the clients to them (Field notes CT May 1990).

If there are no resources in the area, health visitors are still able to do fringe work as they can use themselves as the "Last resort". Health visitors use

also their own personal resources in fringe work (Section 4.1), these can range from personal belongings such as clothing or money, to the use of the self, as is the case of surrogacy work (section 6.4.3). However, the use of health visitor's own resources in fringe work is linked to the next intervening condition, ie: Health visitor's willingness in engaging in fringe work.

6.3.2.3 Health visitor flexibility

The third intervening condition in fringe work is health visitors' flexibility. This is interpreted in two ways: Their willingness to do fringe work and their time availability. Although this might be considered as a necessary condition for fringe work, it is categorized as mediating because of fringe work's double function. Fringe work takes place to fill a gap and to gain entry (Section 6.3.1). Hence it might be the case that fringe work takes place even when the health visitor feels it is not appropriate but needed in order to gain entry or to cement the relationship with the client.

To be willing to do fringe work means that health visitors accept that it is part of their role. If, for instance, health visitors see themselves as link persons, as community catalysts, they will engage to a greater degree on fringe work than others who believe this is not legitimate health visiting work.

Furthermore, there are instances when health visitors feel "It's right" to be involved, that is when clients are prepared to help themselves. This was highlighted during an interview:

> *"I mean if people have housing problems, um I tend not to want to be involved with those, but you know sometimes I feel it's right to be involved with them. So, I in that case I would ask them to go and see the housing themselves, and try and sort it out for themselves, then if they're for some reason not able to I might intervene after that" (JB 6-my emphasis).*

This quotation shows health visitors' commitment to those who help themselves. De Silva (1988), in her research study on public health nursing had the same finding. This points to the fact that a gap not only requires to be present for fringe work to take place, but clients also should "Deserve" a health visitor's extra effort. Popay and Dhooge's (1986) study on the effect of unemployment in health visiting and social work, also found that health visitors were gatekeepers to client's eligibility to obtain second hand clothing from voluntary organizations. This issue is further discussed in next section (4.1).

Further, if health visitors consider that clients are trying to take advantage of the system by getting more than they are entitled to or need, they will be unlikely to respond to their request. During field work instances were recorded of health visitors not responding to client's requests to fill a gap. For instance, during a home visit the health visitor did not give a client a

child's cardigan as requested, as this client had already been given some and the health visitor felt she was not in need (Field notes CT May 1990). Health visitors, then, engage in fringe activities provided there is an acknowledged need. A gap has to be recognised as such by the professional otherwise action will not be taken. This is a reflection of the universalistic concept of the Welfare State. Universalism implies that wherever a person can be categorised as having needs which are officially recognised, then an adequate income is paid as of right and without any test of financial resources. The assessment of need is considered the basis of the Welfare State provision (MacGregor 1981)

Thus, health visitors' willingness in engaging in fringe work involves three interlinked factors: 1) Health visitors' understanding of their role, 2) Health visitors' acknowledgement of client's need or of the presence of a gap, and 3) Clients' eligibility to be helped. Hence health visitors give to clients extra help based on two criteria: a) that of need and b) that of merit. And as Watson (1980) has pointed out, these criteria are means of social control. Health visitors' willingness will influence their readiness to act as the last resort when resources are absent. This leads us to the other aspect of health visitors' flexibility, ie: the use of their own personal time.

As it has been explained, fringe work is a peripheral activity in health visiting and that it is done in addition to the core work. Thus it requires health visitors to have time flexibility to fit it in. It also might require extra time for

the health visitor to be available. A health visitor illustrated this point during an interview:

> *"...I do a lot of evening work. I, I just sort of, counselling sessions, you know, in the evening, and I also do support groups in the evening. And the well women clinic is, that is official, they have to be an evening session some kind of, it's outside the five o'clock boundary, and it's the only way I was able to fit in the support groups, and the client group they couldn't escape their work, or families, er during the day, so it's the evening. So I mean I rather see it outside of normal health visiting" (VW 26-my emphasis)*

Although what is referred to above is not voluntary work, since the health visitor can have this time back, she has to be available out of working hours and thus has to make a personal commitment to her job. While the employer legitimizes this work, there is no indication that it is commonly expected. On the other hand those health visitors who have not such time flexibility could be regarded, by peers, as less committed.

6.3.2.4 Client's context

Lastly, the fourth intervening condition in fringe work is the client's circumstances. In certain contexts gaps are more likely to occur. This is the case in what are called deprived areas. Here three factors tend to go together. These are: A high turnover of clients in the area, social and economic deprivation, and "Extreme" life circumstances. Newcomers are

more exposed than others to isolation and are unaware of the facilities and services in the area. In addition, preventive services like health visiting, tend to take some time to make contact. This is worsened by the fact that clients rarely contact the service themselves in contrast to curative services. This leaves a time gap in which the client may need support. Deprivation obviously generates gaps such as lack of social and material support. "Extreme" life circumstances are referred to as situations of unusual dependency that require extra health or social services support. These can relate to the life cycle such as: Adolescent pregnancies, elderly pregnancies and very old people; or can relate to social disfunction such as physical abuse, unsafe physical environment, and delinquency. Thus, health visitors working in such areas of multiple deprivation, will face greater pressure from the many and different gaps that occur. Watson's (1982) study is consistent with this point. She found that housing and sanitation were the major problems encountered by health visitors working in the inner city and that their ability to mobilize available resources to solve these problems was questionable. Harrison (1988) also found that health visitors working in areas of poverty experienced greater pressure of work than their colleagues working in other areas.

The area in which health visitors' work also prompts them to consider the appropriateness of taking action. Clients' circumstances will thus influence health visitors' willingness to do "Extra" for them. While some health visitors feel that people living in these areas are those "Who need us most" (Field

notes WB August 1990), others consider that it is not their role but that of the social worker.

Nevertheless, the data from this study shows that health visitors respond to deficiencies even when they feel it is not their job. For instance, during an interview this was openly acknowledged by a health visitor when she was comparing her work in two different areas; one deprived and one well off:

> *"...and this is really the first time I've worked in a middle class area. But I would say it is very different. Um I feel now that probably this is the only time I've done* ***true health visiting****. Up to coming into this 10 years ago, it was mostly crisis visiting, and it was really social work" (CR 16. My emphasis).*

Indeed "Doing social work" is another way to see fringe work, and it is motivated by a lack of resources: that of social workers. This has already been highlighted by Fox (1990). Hunt (1972a and 1972b) almost 20 years ago, noted that health visitors were on the fringe of nursing, educational and social work territories. She identified this as the source of the identity dilemma among the health visitors studied. For the quoted health visitor, her "True" work is similar to what has been described as "Core work" in health visiting (Chapter 4, section 4.4), that is to secure children's developmental trajectories. The above comment hints to a discrepancy between the policy agenda, ie: to monitor child development, and the client's world. Confronted with this situation, health visitors use fringe work as a tactic to tailor their services to clients' circumstances to "Market" them. And this implies, as the

quotation highlights, that "True" health visiting takes the back seat in order for fringe work to take place.

From the health visitor's point of view unless basic conditions are met, it is not feasible to engage in routine policy work which is perceived as being "True" health visiting. This point was articulated by a health visitor working in a deprived multiracial area:

> *"I believe that if social conditions are not satisfactory, people can't see beyond this, to think about their own health. I think (pause) it depends on the area you work in. In this area I work and other social areas as well, <u>in the poorer social areas I find it's a struggle to try and bring the principles of health visiting in</u>, basically because, if they've got a decision between, do I have to go to the DHSS (Department of Health and Social Security) or do I go to a clinic, they will choose DHSS first."(CA 1. My emphasis and clarification).*

It appears thus, that extreme circumstances "Force" health visitors to do fringe work otherwise they will not achieve their mission and clients will regard the service as highly irrelevant. This shows that fringe work is a "Tailoring" tactic (Chapter 5, section 5.4.3). In this instance the health visitor compromises her own role. A health visitor gave an illustration of this situation:

> *"...But you get sucked into the same thing, that the priority in the house is the fact that there is no food. The child needs that food, <u>but the food becomes the priority, not the eight month hearing test</u>. You know? and it's awful. I meant really immunisation should be a priority. but there again, if they were burgled that night or (Pause) you know, and everybody's*

sitting there crying, they are not going to go to the clinic for the injection. And you've got to get onto somebody to get the house secure again for that coming night. Instead of criticising them for not going for the injection, you've got to get their life sorted out"(HR 17-my emphasis)

This example shows that by making a compromise between what this health visitor believes is her role and what the situation requires from her, she is achieving two aims: securing the trajectory and building her credibility. However, when this health visitor states that she "Sorts a client's life out" is pointing to the paternalistic dimension of fringe work which fosters client's dependence. This point is further discussed in section 5.

To summarise, while fringe work is motivated by the presence of gaps and the need to establish the value of the service, this does not mean that health visitors will simply engage in fringe activities. Other necessary conditions are required to be present. A gap or need must be recognized as such and health visitors need to be both able and willing to do something about it. To be able to respond to a gap involves health visitors having resources, time and being in a linking position. To be willing, implies that health visitors recognize that doing something falls within their role boundaries or that it is appropriate to take action because of the circumstances.

6.4 TYPES OF FRINGE WORK

It has been stated that the health visitor's activity is fringe when the professional is not supposed or officially expected to undertake an activity. The analysis of data collected during this research suggests three major types of fringe work in health visiting that mobilize, develop and substitute resources. These activities are labelled "Relief work", "Novel work" and "Surrogate work". Each is examined in the following sections.

6.4.1 Relief work

Relief work involves the mobilization of resources. These are material things that health visitors distribute or give spontaneously to clients. It has been called relief work as it occurs in acute or extreme situations and involves giving the basic necessities of every day life such as food, clothing, and money.

There are certain things that health visitors give to clients because it is part of the policy agenda. For instance in the District where the research took place a health education booklet was given to all new mothers. This section will refer to those things that the health visitor is not supposed to give or expected to give to clients. However when engaged in relief work, health visitors are not breaking unacceptable rules in health visiting. Relief work has connections with the Welfare State policies. According to Himmelfarb (1984) the State's "Supplementary benefits" are an euphemism for relief work. This was a 19th Century approach to poverty. Hence health visitors

when engaging in relief work are distributing sort of "Supplementary benefits" to clients. In addition, it must be noted that health visitors' relief work involves goods similar to those necessary for the "Merely physical efficiency" defined by Rowntree in 1901. According to him (Rowntree 1901) food, clothing and shelter were the requirements for the maintenance of merely physical efficiency. Hence the State should ensure that these basic commodities are provided. Thus, it is not surprising to find that while relief work in health visiting is not approved, it is permitted.

Usually the health visitor distributes goods that other clients have given to her. However, goods can range from baby food to equipment such as a pram. Although most of the things given were to be used by children, there were also instances of giving things to adults for example clothing or a pair of sun glasses. The basic principle that guides relief work is to meet a need. Relief work could be regarded as an attempt to rectify inequalities, to alleviate poverty. This was highlighted during an interview with an experienced health visitor, when asked about her reasons for giving things to clients, she stated:

> **"Health visitor -** *Well I give things, I mean, in S (one of the most deprived areas) where I was before, I used to give out samples of food, because sometimes they didn't have any money, or they'd run out of food. And rather than give them something that's not suitable, 'cos they can give them anything, I give them proper things to help them out, to tide them over, to help them out. And also we've got a store of clothes, prams and things, but I (pause) I've got a list of things that someone wants to get rid of. We're trying to find a good home where someone will appreciate er a pram, or something*

that they haven't got enough money. Um a single mum that I managed (pause), she didn't have any clothes, nothing, er, no pram, no carrycot, I managed to scrounge some things, you know, to get some things to give her, so that she had something to dress the baby in, to keep the baby warm, you know, because some people just don't prepare themselves. So it's giving them to help them to cope with the situation. Clothes, some mums will give us clothes, that the children have outgrown, but they 're still good enough for other children to wear. So it's just to help people out, that perhaps haven't got the money or the ability to provide for their child, it's just to help them through (AW 38. My emphasis)

This quotation also highlights the issue of giving to those who deserve it. It was previously pointed out (Section 3.2.3) that in order to make a provision, in the Welfare State, a need ought to be officially acknowledged. Further, Goodin (1988) points out that the Welfare State provides specific goods and services to individuals and families that meet certain criteria of need and entitlement. When the above health visitor is considering if the client will put to good use what is given and if parents have the ability to provide for their children, she is making an assessment of deserving and entitlement to relief. And as it was previously discussed this is part of an intervening condition in fringe work, ie: the health visitor's flexibility (Section 3.2.3).

Berthoud and Brown (1981) stated that at the end of the 19th Century in England, the poor were divided into "deserving" that is people who were poor through no fault of their own, and the "undeserving" whose poverty was due to character defects. While the former might be given sympathetic aid (ie: charity), the latter should be subject to deterrent policies (ie:poor

laws). Although poor people are not divided anymore into deserving and undeserving, Berthoud and Brown (1981) suggest that the character deficiency theory about poverty has re emerged in a new guise as a means of accounting for persistent poverty. The theory of a sub culture of poverty and that of a poverty cycle are, according to them (Berthoud and Brown 1981), manifestations of the character deficiency theory of poverty. On similar lines, Moore (1990) highlights that the idea of the "Underclass"[9] has taken on the older meaning of the "undeserving" poor of the late 19th century society. Also, Macnicol (1987) connects today "problem families" or "problem estates" with ideas of "deserving" and "undeserving" . This argument is consistent with the findings of a survey carried out in the South East of England (Norris 1978) and with another undertaken in different European countries on the perception of poverty (MacGregor 1981). Norris (1978) found that over a quarter of the total sample (3,000) commented that assistance should be based on the merits of the recipients. Norris (1978) adds that recipients were clearly seen as "deserving" or "undeserving". MacGregor (1981) reports on the European study, states that in the UK it was found 43% of the participants cited laziness and lack

---

[9] Halsey (1987) provides a comprehensive view of underclass, he states that " The class structure of industrial societies, including Britain, is developing an under-class of those who can not be placed in the stable work force of the formerly employed...They suffer a cumulation of social pathologies-education failure, illiteracy, broken families, high crime rates, poor housing, and spatial concentration in the inner city. They are disproportionately recruited from the young and ethnic minorities, and they lead a ghetto existence outside of the normal social contract of citizenship and with little or no stake in official society".

of will power as the reason for being in need (p.97). Hence when health visitors distribute relief they reflect these views contained in both the Welfare State and the public in general.

Health visitors give relief when they think it is needed and that there is a chance of it actually being used; that is when the client deserves it. It is reasonable to think that "good" mothers and clients that in general conform are among those who deserve extra help. Hence, relief work, as in the old days (19th Century) is a moralizing device.

The second issue, raised in the above quotation, is that health visitors either actively search for things to give in response to a particular client's need, or distribute what they have already passively acquired. We can call these forms active and passive relief work. An example of passive giving came during one interview with a health visitor working in a deprived area:

> "...but if people say 'I need this for that, that and that' and we have it then we give it, but we don't sort of ask people to donate things to us so that we can give them out, they just appear" (IH 26)

Indeed, passive giving is a less involved way of doing relief work as this quotation well shows. The health visitor is a mere intermediary, others are the ones who are giving charity. Active relief takes place when health visitors ask clients for spare clothing or baby equipment (Field notes DB

August 1990) or when they express that they would keep their eyes open to find what the client needs (Field notes WB August 1990).

Health visitors' resources are also distributed. Here health visitors give their own personal belongings such as money, clothing or other equipment. This was noted during an interview:

> *"Oh I have given money before now (laughter), unofficially,.... But I have on one occasion given them, 'cos they were short, and they had no money for food, again. Er if they need furniture, there's a social services furniture resources centre, so I put them in touch, and they provide basic furniture for them. So there are places, you phone up the DHSS and they get grants and things, for basic furniture. You know, so you just put them in touch with the right Department,send them along to social services. <u>But I have provided a few things for people that needed.</u> (AW 39. My emphasis)*

Here is also highlighted the issue of health visitors being the "Last resort". That is, when there are no resources for health visitors to pull out, they will still be able to do fringe work as they have the "Last resort": their own resources. However, as it was stated (Section 3.2.3) health visitors act as last resorts when they acknowledge the need and that the client deserves their help.

Health visitors operate within the Welfare State. When it falls short in providing for their citizens, health visitors engage in fringe work and adopt the values underlying the Welfare state, that of need and eligibility.

Connected to this, it must be pointed out that relief work indicates the vocational ideology rooted in the development of community nursing, in the late 19th Century when poverty and epidemics were the major public health concerns. Philanthropy and charity were a common response to these problems. Community Nursing developed, attempting to differentiate itself from the philanthropic visitor (Monteiro 1985). However, the philanthropic ideology permeated nursing. Nurses were recruited among women of the middle and upper classes, where charity and philanthropy were important values. They brought with them those values into nursing. Davies (1988) has highlighted that health visiting in the early days bore all the hallmarks of middle class women's philanthropic and religious work. Further, Davies (1988) states that health visitor's early form of organization was a direct line of continuity with philanthropic work. Health visitors' assessment of eligibility in fringe work can be regarded as a trait of philanthropic views. According to Donzelot (1980) the philanthropic agencies used the techniques of moralization based on linking poverty with moral failure, hence help was granted to those who could demonstrate that their situation was not due to their conduct.

6.4.2 Novel work

The second type of fringe work is "Novel work". It develops when the health visitor makes or links resources that would not otherwise be connected. As in relief work it results in mobilizing resources. But the

difference here is that human capabilities rather than material things are mobilized.

An example of novel work is when a health visitor discovers an area of need and takes organized action. During the interviews, health visitors gave several examples of novel work. One of them is quoted here, by a health visitor discussing how she identified needs:

> *"...so we (health visitors) had an opportunity to talk to them, and I was picking up on a lot of stress, strain....and there wasn't a lot of back up then. I mean, things like premenstrual syndrome, menopausal problems (pause) they are not addressed, I don't think, and in this city I couldn't find anywhere. So I started my own group" (VW 27-my emphasis)*

Novel work can be a precursor of policy related work. That is, in the future, it might be accepted as part of a health visitor's core work. Indeed, one of the results of health visitors engaging in fringe work is policy development. However, novel work might also refer to an activity that was previously part of routine health visiting work but is not anymore. This is the case when, for example, making a routine visit to elderly people before winter to warn them against hypothermia (Interview EQ 32). This practice in a particular area has been discontinued because of the pressure on visiting children. If this activity were started again on a health visitor's initiative, it would fall into the definition of "Novel" work. Hence, in fringe work policy related work can be both: Developed and retrieved.

Whether an activity is relegated to the periphery or recently being introduced, the common trait in novel work is that this work remains on the margins of a health visitor's main activity. Novel work is done as an extra activity. This was highlighted during an interview with a health visitor:

> "Health visitor - *When I trained as a health visitor, we were taught through the training that we are a family visitor, to people from the cradle to the grave. In fact, when you actually come to work and you're given a caseload, nobody minds you having dealings with anybody else, provided you do the basic work of your caseload of children of 0-5" (JT 19).*

Within novel work, a less formal type occurs when health visitors generates their own resources to use as support mechanisms when needed. A clear example is the clients' support network that health visitors build up. Here the health visitor has a list of clients who can help each other on issues like child minding, loneliness, depression and isolation (Field notes April 1990, May 1990). This is a sort of "Storage" as in relief work, of people whom the health visitor could call upon in case of another client's need. The resources that are mobilized in novel work thus include clients themselves.

This "bank" of human resources is also made of the health visitor's own personal contacts, that its friends or information networks. During field work this was illustrated when a health visitor informed a client of the details of a nursery owned by a friend (field note LT May 1990) or when a health visitor offered to ask her friend for a very good diet, then pass it to the

client (Field note JT May 1990). Again, as in relief work, the health visitor is personally involved, she also uses her own resources.

Creating and linking resources, both human and material, comprises "Backstage work", these are "Bureaucratic" activities that the health visitor undertakes in order to mobilize and locate resources. These involve actions such as phoning, seeing people, writing letters. This activity was very noticeable during field work in deprived areas. It took a great deal of the health visitor's physical and emotional energy.

6.4.3 Surrogacy work

This is the third type of fringe work. It takes place when clients lack social and emotional support and the health visitor acts as a surrogate relative or friend. Surrogacy work then refers to health visitors substituting for a meaningful relationship in the client's life.

The issue of replacing someone who is not there was clearly evident during an interview, with an experienced health visitor:

> **"Health visitor -...** *I think possibly as a health visitor you're replacing a grandma, you're replacing somebody who they know that their secrets are relatively safe with, and they know they can moan about their husband or they can moan about the woman next door, um whereas a few years ago, grandmas would have had all that unburdened on to her" (CR 15)*

Another example of surrogacy is that of health visitors being surrogate mothers to young adolescent single mothers (Field notes TB, Rb August 1990). During an interview a health visitor commented on replacing someone close in the network who would normally be expected to give care but could not. Thus she stated:

> *"...Sometimes all you can do is listen to somebody, you know. I mean they probably talk the hind leg off everybody else in the family and their friends who are totally sick of them maybe, you know, um, but all they need to do is just talk about whatever their problem is. I mean some problems are not solvable, some people's lives are in such chaos, that you wouldn't know where to start with them. But you know, if it helps for them to come and pour it all out every now and again, it's fair enough"(MT 14)*

Indeed during field work, client's needs for "Someone to talk to" emerged frequently, in health visitors' accounts. The health visitor could just sit and listen or be "A sympathetic ear". Again this instance shows that health visitors perceive themselves as a client's last resort.

The surrogate mother role in nursing has been acknowledged in the literature. Thus, Turner (1987) reports that it is common in the sociology of nursing to find arguments which point to the importance of emotion in the therapeutic tasks of nursing and that these studies suggest that the nurse acts as a surrogate mother where the patient represents a child (p. 150). Further, Schulman (1979) considers the surrogate mother as a role in nursing, and expresses concern at the demise of this function.

6.5 THE DIMENSION OF FRINGE WORK

Fringe work has three general properties: 1) Its connection to the role that the health visitor plays, 2) Its content, and 3) The reference as to who performs the activity or holds the monopoly. In grounded theory, properties are the attributes or characteristics pertaining to a category. These properties vary over a dimensional continuum. The location of the properties along a continuum will give the dimension of the category (Strauss and Corbin 1990 p. 69-72). Hence by linking the different properties of fringe work, the different patterns which form the dimension of fringe work can be identified .

This section examines first the dimension of each of the fringe work properties, then it identifies and discusses the different patterns found in the dimension of fringe work. The patterns found in the data are: Patronage, partnership and self help. Thus fringe work is not only the equivalent of innovative, progressive work, it also contains the more traditional traits in health visiting, those represented by a paternalistic approach to the delivery of health care services.

6.5.1 The health visitors role in fringe work

The three different types of fringe work described in the previous section, point to the roles that the health visitor fulfils in fringe work: Substitute, intermediary-mediator, and catalyst.

The substitute role occurs when health visitors do surrogacy work, when they use themselves as "Gap fillers" or the missing resource, for example in replacing a relative or friend.

The intermediary role takes place when health visitors pass on material things to clients, look for resources, and when they refer clients to other sources of community support. Here the health visitor acts as an intermediary between the client and other services. The intermediary role was highlighted during the interviews, a health visitor commenting on this stated:

> *"...some people need the help of other agencies, but they don't know all the agencies, and this is where we come in the middle. We have access to the other agencies, and we put them in contact with each other..." (CA 37)*

The issue of health visitors as "Middlemen"[10] came up repeatedly during field work. However, health visitors frequently go further than the intermediatory role. They move to the more active mediator role. It takes place when the health visitor mediates between the client and the other party whether this is a resource or a service. In this instance, the professional acts mostly as the client's advocate. Advocacy is recognised as an important role in both nursing (Benner 1984) and health visiting. Thus, the health visiting principle of influencing policies affecting health is an expression of the advocacy role. According to this principle, health visitors seek to exert an influence on policies affecting peoples' health (CETHV 1977 p. 45)

During an interview a health visitor gave an example of advocacy for a client. She was commenting on a client whose children had been taken into care because they were repeatedly left on their own:

> **"Health visitor -...** *and her nursing officer continually phoned me up about knowing that she was working and the children were on their own, and I said 'But you know you should sort out her shifts for her-Oh we can't do that', she said. So I said ' Well you shouldn't keep (pause) you are putting her in that situation, you are giving her those hours to work, but then,you're phoning up to complain to me, knowing that she is virtually a single parent, but surely the hospital should have some loyalty to people and you should work out hours for her" (CR 9-my emphasis).*

---

[10] Although all the participants in the study were women and that in health visiting there is a majority of female health visitors, participants perceive themselves as "Middleman". Thus, in this report it is used the term employed by the participating health visitors.

Clearly in the above quotation, the health visitor is interceding for the secondary client, putting her case forward and highlighting issues that will lessen the client's culpability. The health visitor is working on behalf of the secondary client to prevent harm to the primary client. That is, to prevent in the future the children being left alone in the home.

Mediating, then, takes place when there is or could be a disagreement between the client and the services. In this instance the health visitor will intercede or act as a third party on the client's behalf, and the system somehow requires this role from the health visitor. During field work it was recorded that the health visitor rang a nursery to find out if there were any vacancies. By doing this she was acting on a client's behalf. When asked by the researcher why she did not let the client do it herself, she replied that she could, but the nursery will contact her anyway to verify what the client says. Further, asked whether would she have to do the same thing if the nursery was private, the health visitor replied that she would not and explained that this only happens with public nurseries." (Field notes LT 2 June 1990).

This example highlights the criteria of eligibility in the Welfare State. That is, in systems where some goods and services are paid for by public funds there is a need to have mechanisms that will see that these funds are put to fair and good use. The health visitor is one of these mechanisms, acting as a direct check on eligibility.

Lastly a **catalyst role** takes place when the health visitor develops resources rather than just mobilizing or substituting them. As catalyst, the health visitor fosters the client's self reliance and stimulates changes. A clearer expression of this role is when the professional encourages a client to do things for himself or when, after being instrumental in setting up a group for example, she then withdraws for clients to run it themselves. This point arose during an interview. A health visitor commenting on the toddler group she helped to set up in her area, stated:

> *"...this is exactly what I did. So the mums did actually do it themselves. And that is where it's important. You know, I gave it to the parents. Um, some of those parents, their children are off to school soon, and I'm just hoping that it will continue..." (TB 20-my emphasis).*

In this case the health visitor triggered the clients to create a resource for themselves. Instead of keeping its control, the health visitor "gave it back" to clients. Thus the responsibility to keep it going is theirs. Being a catalyst empowers clients to act and also saves the health visitor time. However, as we will see later, health visitors tend to keep the control of the activity from the distance.

6.5.1 Content

The content of fringe work ranges from a type of work that professionals could be expected to do, to a type of work that they are not supposed to do. It ranges on a continuum that moves from health visitor's activities being close to the policy agenda, to those which are borderline, and on to those which more appropriately form part of a friendship interaction. The dimension of fringe work content is identified as policy, borderline and friend.

The policy property refers to activities that the health visitor undertakes simply because there is no one else to do them or because there is a deficiency in the system. The system implicitly expects the health visitor to meet its failures or deficiencies even though it may not be part of the "Core" policy related work. This point repeatedly became clear during the interviews. Thus a health visitor stated:

> *"Well there are 101 extra things, I mean we're asked to do visits for people who have not had a smear,who've failed to attend for two smear appointments, we follow them up and visit them. Anyone who's not been for the antenatal appointment, we're asked to visit them. Visits come to your desk like that, you know, all the time, for all different sorts of things" (HR 5-my emphasis)*

Here the work is explicitly requested but the health visitor in this case feels it is not part of her core work so she is not supposed to be doing it. Another example recorded during field work was the visits that health visitors are asked to pay to immigrant families. On one of these occasions a health visitor indicated openly that she thought it was work that she ought not been doing.

The "Policy" property also incorporates those activities which although are not expected to be performed by the health visitor, are either endorsed by management or likely to be. Examples of them are: Running or setting up groups, establishing support groups during the evenings, running counselling sessions at a home in the evenings (Field notes KU February 1991). They also included organising home helps for the elderly (Field notes JB 19 August 1990), facilitating equipment for grossly handicapped people by writing to a fund (Interview IH 26); and keeping a list of good child minders and recommending them (Field notes CT 26 May 1990). Thus, fringe work is close to the policy agenda because either this work will keep services running or it meets needs which are becoming part of the health policy.

Borderline content falls between policy and friendly activities. It is sort of a "Less legitimate" professional practice. Many will refer to what practitioners call "Social work". Borderline activities are those that can be regarded as part of the health visitor's work or "Caring work": ie work performed by caring professionals or other persons. Examples of these activities recorded

during field work, included the health visitor writing/phoning to the housing department or the Gas Board on behalf of the client, giving the client a lift in the car for a hospital appointment, matching up elderly or lonely people, organizing raffles, jumble sales and approaching charities for basic items or to get holidays organized. It also included visits over a long period of time to a family with two chronic sick members "Just for a chat" (Field notes WB 3 August 1990) to support the care giver, Although these activities could be regarded as being close to policy related work in as far as they are meeting clients' needs, they are not expected to be carried out, or likely to be endorsed by management.

Lastly, the content of fringe work could be more like that of a friendship than of a professional-client interaction. This property is labelled **"Befriending"**. During field work examples of these activities were recorded. Thus, one health visitor was taking a cookery book to a client (Field notes CT 6 May 1990), another health visitor was informing a client about the availability of a job as "Dinner lady" and giving tips as to where to buy cheap school socks (Field notes WB 4-5 August 1990). In this category there were other examples of a health visitor cooking a meal or cleaning the house while the mother went for a walk or had a rest, even giving her own personal money (Field notes SU February 1991). These activities will not clearly be labelled as being professional work. They could however, be acknowledged as part of a strategy to develop and maintain the relationship

with the client. It must be remembered that fringe work has a double function, that of gaining entry and that of filling a gap.

6.5.3 Who does of the activity

Fringe work may be performed by professionals, by clients or jointly. Thus, the continuum in the dimension of this property moves from professional activity, to shared, to ultimately lay action.

The dimension of **professional activity** occurs when the health visitor or other professional does it all. Examples are when the health visitor gives money or goods to a client. Here the health visitor is in control, the client is the passive recipient of what is being given and is dependent on the professional. The power base of the relationship lies on the professionals's hands.

When the activity is undertaken jointly by the professional and the client the dimension is called **"Shared activity"**, here clients' capability and ability in solving their problems or needs are acknowledged. The need for a joint effort in solving a need became clear during an interview:

> *"What I do say is 'What are you doing yourself about it? I can't write a letter to the housing, and get you a house, unless you are willing to pursue it. You have got to go to the housing, you've got to register your complaints, and you've got to go down there every single day and hound them. It's no good me writing a letter if you are not prepared to do that'. I won't let them let me do all the work (RB 21. My emphasis).*

However as the quotation points out, the health visitor is the one who decides that clients ought to help themselves. It also hints at health visitor's willingness to do fringe work when the client deserve it.

Lastly, **"Lay activity"** takes place when the bulk of the work lies with the client and is the one who mostly controls it. By orientating, supporting and encouraging clients in accomplishing the activity, health visitors act as resources for clients to help themselves. The clear example is when the health visitor initiates a support group and later leaves it or moves into the background. This role was commented on in some interviews. A health visitor, recalling how she started a group in the area, stated:

> *"It was a joke on the area. I kept rounding up mothers and saying to them, 'Come on, you want a mother and toddler group, who's going to run it'. And the attitude was 'Oh, well, Mrs. X, if you start it we'll come along'. And I said to them, 'No, you're the mothers, I will help you, I will go round, I will get all the people for you to come,I will help you with toys..."*
> *(TB 20)*

However, health visitors do not simply refer cases or encourage people. They also tend to assess how things are developing and are on guard in case it is necessary to take any further steps. In this property's dimension clients are not just left to their own devices to cope with the situation. The health visitor monitors and assesses whether the clients need to be supported to enable them to continue to help themselves. Hence health visitors still retain some control of the activity, but this time from a distance.

6.5.4 Patterns in the dimension of fringe work

By linking the different dimensions of fringe work's properties, different patterns of fringe work emerge (Table 1 summarises them). A **"Patronage"** pattern appears when linking the property' dimensions of substituter role, Befriending content and professional activity. It is labelled "Patronage" because it embodies the philanthropic philosophy of the beginning of this century. It can be said that here clients are recipients of a new type of charity or pity. Furthermore, they are expected to be grateful for the extra service that they are receiving. This point was noticed during field work, some health visitors made judgemental comments about clients who did not want second hand things because they wanted, "To have new things, from the catalogue" (Field notes ST February 1990, DB August 1990).

In patronage fringe work health visitors are at the forefront of the activity. They do almost all the work, thus they prevent clients from developing themselves. In this way the professional is disabling the client (Illich 1977). In this work pattern, the health visitor's role is mostly that of "Substituter" or "Gap filler". They use what they have and their personal contacts, to actually give directly to clients. Dependence is promoted.

In this dimension health visiting becomes very similar to the work of a voluntary organization. Berthoud and Brown (1981) had described it as playing a major role in ensuring that people receive their proper entitlement

from social security offices. They pointed out that voluntary organizations might also act on behalf of individuals or families in contact with housing departments, health and social services departments or gas and electricity boards. They stated these organisations complement state provision by "undertaking tasks left undone by statutory organisations and reacting quickly to meet needs or filling gaps" (Berthoud and Brown 1981 p. 277. My emphasis). In social work a similar phenomena has been discussed. Thus, Handler (1968) found that the operative social work principles in the children's department, were similar to those of the Charity Organisation Society that was founded 100 years ago.

Another pattern of fringe work can be found when linking the property' dimensions of an intermediary-mediator role, policy or borderline content, and shared activity. This pattern is named **"Partnership"**, since both professional and client are contributing to solve the problem. Health visitors might initiate a fringe activity but they expect and encourage the client to cooperate. Health visitors move into the background of the activity allowing clients to undertake it. Thus, health visitors enable clients to develop themselves. Independence is promoted.

Close to this pattern there is an advanced type of partnership, that is of **"Self help"**. Here the health visitor's activity is kept to the minimum. The content might be policy or borderline, clients perform the activity and health

visitors act as a catalyst. They remain very much in the background. Thus self reliance is promoted.

Table 1 Summary of fringe work dimension

Domains	Property	Property	Property
Role	Substituter	Mediator	Catalyst
Content	Befriending	Policy/Bordline	Policy/Borderline
Activity	Professional	Shared	Lay
↓	↓	↓	↓
DIMENSION	PATRONAGE →	PARTNERSHIP →	SELF HELP

There are three factors that clearly influence health visitors opting for a given dimension: 1) The area where the health visitor is working, 2) The client characteristics and 3) The seriousness of the situation. Health visitors will try to adjust to these factors and use the approach which best fits the situation. This point highlights that fringe work is a way of tailoring health visiting to the client's world. When discussing the intervening conditions in fringe work (Section 6.3.2.4), it was stated that in very deprived situations health visitors are "Forced" to become, in their interventions, closer to social work than to health visiting. In other instances, although health visitors would like to have a shared or lay activity strategy they cannot because of the type of client with whom they are dealing.

This was highlighted during an interview:

> *"It's very difficult. It's very difficult. <u>And I don't have a clear black line, it's very grey. With one family I might say</u>, 'Now this is what I feel are your problems, first, and you need to tackle those before I can come back and sort the other bits out'. This is your approach, you should, it's given them, trying to give them the power to do it themselves. <u>But when you're dealing with people who've already got social problems, you've also got to accept, that they might not have been taught the power to go</u> (pause) I can say if I don't like this, I'll write in and complain. Somebody in their position would not think about putting it down on paper and complaining..." (CA 3-my emphasis)*

Lastly, if health visitors feel that the situation is grave, and cannot be delayed they might well pull out their own resources and have a "Befriending" approach. For instance a health visitor was telling me about a 16 yrs old Chinese mother who was left alone by her own mother and that she was, in her own words, "Tempted to take her home with me...." (Field notes DB 3. August 1990).

It seems thus, that in "Extreme circumstances" health visitors sacrifice, or give up reluctantly, part of the professional role and step into social work or friendship role with clients. This suggests that in the **health visiting role the boundaries are mobile.** When discussing in the next chapter the role of the relationship in health visiting (section 7.2.2. and 7.2.2.2), the concept of "Role format" is used to explain the mobility in a health visitor's role boundaries. The concept of a role format includes both the stability and the variability in playing a role (Strong and Davis 1977). Thus to draw the line

in the health visitor's professional role, is an issue of concern as it was expressed by participants in this study. A health visitor commenting on this, during an interview, stated:

> *"So although you do a certain amount for them, you can't take away everything from them, you've got to throw it back in their court, so that they're seen to be doing things for themselves and their family. It's difficult, isn't it?, You know what I mean though. I've seen, you know, younger ones come in, and (pause) the people just, all their functions are taken away from them 'cos the health visitor's taken the lot on. She's taken the DHSS on, she's taken the housing on, she's taken this on, the rest on, you know, it is not health visiting. But it is defining that fine line, isn't it? Which is our field and which is throwing back in their court, you know. Difficult at times, I know." (DB 14. My emphasis)*

However, it was also noticed during field work that while a given health visitor might use different fringe work patterns depending on the circumstances, there are some more prone than others to use a patronage or self help pattern. Hence, whereas health visitors tailor their interventions to a client's context, their ideologies about health visiting influence the options they take.

Some roots of fringe work lie in the values embodied in nursing. Originally nursing adopted a role acceptable to the values at the time, that of giving nurture and the role of "Self sacrifice". These were images of womanhood which nursing was able to capitalise on the 19th Century. Women were encouraged to see nursing as their sacrifice. (Whittaker and Olesen 1978 p.

27). Further, Florence Nightingale's activities could be regarded as a constant way of going beyond the call of duty. Her willingness to go to Scutari during the Crimean war and her experience there is clearly a manifestation of this point. Nursing provides a secular equivalent of the religious orders (Dingwall and McIntosh 1978 p.2), and health visitors are the equivalent of missionaries. The values of abnegation, sacrifice, nurturing and ministering are embodied in the vocational nursing ideology. Health visitors engagement in some fringe activities is a manifestation of these values. However, apart from a vocational ideology, there is a professional ideology in nursing (Williams 1978) which rejects the subservient position of nurses and conveys a new conception of the nurse, that of an independent professional with a specific area of competence. It is this ideology which also inspires some fringe activities, particularly those that require independent judgement, activity, and a commitment to empower clients. These are the ingredients found in fringe activities that relate to community development.

Hence, it can be argued that a patronage pattern fits with those health visitors who hold a vocational ideology (Williams 1978), whereas partnership and self help corresponds to those who have adopted a professional ideology (Williams 1978).

By analyzing fringe work in a dimensional continuum its meaning has been further revealed from that given at the beginning of the chapter. It has been

shown that it can be either progressive or regressive work. It can promote client's reliance or foster their dependence. While client's circumstances seems to be the major influence in the adoption of a pattern of fringe work, health visitor's ideology also has a bearing. This ideology, in its turn, contributes to maintain or change the context. This shows the premises underlying grounded theory that of participants influencing contexts when implementing strategies, and the context conditioning the strategies selected by participants. The analysis of the impact of marketing strategies in health visiting context is the concern of the next chapter.

6.6 CONCLUSION

Fringe work is a term coined during this research study to account for a series of activities that health visitors were not expected or supposed to engage in. It is mainly a response to the deficiencies or gaps that health visitors encountered in both the health care and social systems. Filling and bridging gaps helps to secure the dependant's trajectory and highlights to the client the relevance of the health visitor's service. It is another tactic that health visitors use to tailor their services to the client's world. Fringe work involves distributing, developing and substituting resources. It has three patterns of work: Patronage or charity, Partnership and Self help. The context in which health visitors work and their ideologies are determinant factors in the development of a given pattern.

The following chapter examines the consequences of marketing strategies, here fringe work is examined along with the other tactics employed in the process of "Marketing health visiting".

CHAPTER 7

CONSEQUENCES OF MARKETING

7.1 INTRODUCTION

It was pointed out that marketing health visiting basically involves a process whereby the policy agenda is adjusted to fit the client's reality. This adjustment has a major consequence: That of building a shared context of interaction. The creation of this context is crucial in health visiting since accepting health visitors' services implies that clients agree to share with an outsider, in this case the health visitor, the management of the dependant's trajectory.

This chapter will focus on the major consequence of marketing. Hence, the creation of a context in health visiting is examined. Here the relationship that the professional has with the client is recognised as the key factor in the interaction, trust becomes the crucial element for the development of a collaborative relationship between clients and professionals. Next, the specific role of the relationship is examined. It is argued that the relationship is an enabling factor that permits health visitors to know clients, gain and maintain access to the home, and it contributes to the client's commitment towards the health visitor. This main section ends by discussing the

contribution of the different marketing strategies towards the development of the professional-client relationship.

Once the shared context is examined, the chapter discusses the impact of marketing tactics for health visiting and for the professionals. The negative consequences of marketing are explored last in the chapter.

7.2 SHARED CONTEXT: THE MAIN CONSEQUENCE

Marketing strategies contribute to the development of relationships with clients. The relationship is the context where health visitor and client interaction takes place. The implementation of strategies feeds into the context altering the nature of the relationship. To gain the client's cooperation and build a coalition between professional and carer is the goal in marketing health visiting. Ideally a shared context should be developed to facilitate this aim.

7.2.1 Creating context: Building trust in health visiting

The importance of the relationship which the health visitor establishes with the client has been highlighted in the literature (Clark 1985, De Silva 1988, Pearson 1991, Chalmers 1991). Also the role of the relationship in nursing and the emotion involved in developing it has been discussed in the professional literature. Thus, Peplau (1964) regarded the relationship

between nurses and patients as a contributing factor to the solution of a health problem. She clearly differentiated a "Chum" from a professional relationship. Peplau also highlights the use of the self as resource to achieve a professional goal. Morse (1991) researched into the development and types of nurse-patient relationships. She identified the unilateral relationship and four types of mutual relationships: 1) Clinical, 2) Therapeutic, 3) Connected and 4) Over involved. Like Peplau (1964), Morse (1991) is concerned with the risk of the professional being involved in "Friend" relationships. Morse (1991) further suggests the use in nursing of the term "Commitment" instead of "Caring" as it has the connotations of fondness or love. According to her these might not be desirable in a professional relationship.

During this study participants frequently mentioned the issue of the professional-client relationship. The relationship that the professional has with the client is a constant thread running through the interaction. Other studies (De Silva 1988, Chalmers 1990, Pearson 1991) came to a similar conclusion. However, examining the overall function of the relationship, the analysis of the data suggests that the relationship provides the context in which the interaction takes place. This is consistent with Diamond's (1989) suggestion; in his ethnographic study of a nursing home, he concluded that work is not a set of tasks but a "Set of social relations in which the tasks are embedded" (Diamond 1989 p. 500). Thus, for the health visitors in this study, relationships contextualize their work.

When study participants commented on the issue of having a relationship with the client, it was referred to as a medium or a vehicle for achieving certain goals. The ultimate aim of establishing the relationship is to gain the client's cooperation. As we saw, when describing the process of marketing (Chapter 5), health visitors need a degree of cooperation from the client otherwise they will not be able to do their job. From the very start, when they meet the client, cooperation is needed to enter the home and see the child. Health visiting work is dependent on parental participation. This is consistent with the views expressed by Olds and Kitzman (1990), who found that the more effective programmes of home visits were those in which nurses established a "Therapeutic alliance" with the family (p.113). The crucial importance of this collaboration was pointed out during an interview, a very experienced health visitor discussing practice issues stated:

> *"...it doesn't make any difference how experienced you are, how good you are, if you don't build up that relationship. If the two of you are not working together, then you are lost. It's no good, if we can't have a relationship, if we can't discuss things openly, if we can't interact with each other, and have a rapport." (EQ 2. My emphasis).*

However, in order to have a working relationship personal and professional trust ought to be built in advance. Trust acts as a condition which will produce the cooperative relationship that is needed. The fact that health visitors are positioned "Between two worlds", that the core of their work is to secure life trajectories (Chapter 4) and that they act mostly in the private

sphere (Chapter 5) makes trust a much needed element in the interaction. Professional literature on Marketing also emphasizes the importance of a relationship between the salesman and client. Kirkpatrick (1971) points out that a sound relationship between clients and salesmen takes place when costumers confide in them as persons and respect their expertise (p. 349).

Hughes (1971 p. 375) argues that trust is part of the very nature of the professions. He states that since professionals profess to know better than others the nature of certain matters, they ask to be trusted. In health visiting this trust has to be earned.

Participants during the interviews highlighted the need to establish trust as a prerequisite to doing their work. Thus, a health visitor commenting on her work with young single mothers, stated:

> *"Especially when they've just had a baby, they need mothering. Um, and they've got to know that you're on their side, that you're always going to be available for them if there's anything, you know (pause). Once they've learned to trust you, and, you know, they're no longer shocked when you knock on the door, they'll invite you in when the house is a mess, they know you're not going to bother, then is the time to start plugging away..." (RB 7. My emphasis)*

Trust is developed as part of the process of relationship building.

During one of the interviews this was openly acknowledged. A health visitor working in a deprived area commenting on some of her clients, stated:

> *"...well, sometimes they (clients) can resent your presence and so you have got to build relationships with most families before you can even begin to be trusted by them and they know you are on their side really and there to support them" (IH 3. My emphasis)*

By building a trusting relationship with the client, health visitors "Earn their place" in the private sphere, that is: They are accepted in the home and permitted to intervene in certain matters. Data collected during encounters of health visitors with clients shows that in the early stages of the interaction process this tends to be socially centred. That is, the aim seems to be to "Get to know each other". In this situation social conversation has an important role. As the process progresses it becomes professionally centred. That is: A climate has been created that will enable the health visitor to request certain information or perform a procedure.

When the health visitor interacts with a child under five years to perform an assessment the necessity for a trust building process becomes very obvious. Health visitors require children's cooperation in tests .To achieve this, children must be persuaded that health visiting procedures will not harm or frighten them. Establishing rapport with children by talking about their interests, admiring them or their toys, praising them and pacing the rhythm of the test or procedure is a technique that health visitors use to build trust.

Trust is the consequence of a good sell. As we saw, (Chapter 5 section 5.4.1) the strategy of selling oneself contributes to build trust and this involves the use of emotional labour (Hochschild 1983). Bigus (1978) in his study of the milkman also found cultivating trust as a means to acquire clients. Most of the techniques described in the process involved the selling of personality. Among these he identified the "Sincerity act", "Contrived disclosure" and "Accentuated honesty" (Bigus 1978 p. 102-105). Further, he suggests that cultivating techniques in professions which involve expertise are directed mainly at trust maintenance. Strauss et al (1985) also found that building trust in hospital work was important in getting the work done. Sentimental work was identified as the means to build trust.

However, trust also includes professional credibility. If a working relationship is going to be established, there is a need for both personal and professional confidence. A health visitor, during an interview, highlighted this aspect of trust. When asked how she got clients to trust her, she commented:

> *" To trust you um, they can by learning that you don't abuse confidence, that you don't do things that are going to harm them" (SD 26).*

Thus, it seems that the health visitor needs to operate in a context where there is a certain degree of trust. As the above quotation shows, the client needs to know that no harm will result from the encounter but some

benefits. Further, the presence of trust in the interaction can be regarded as the client's right. During one interview this point came up clearly when a health visitor was discussing a client who did not want her, she stated:

> *"So I (the health visitor) said 'Well that's fine, if that's your opinion Ann that's fine'. I said 'but there's no way I can carry on being your health visitor now, <u>because you are entitled to a health visitor that you've got faith in</u>, and through reasons of your own, you've got no faith in me. I'm going to ring my boss, and ask her to appoint you another health visitor' Which I did" (RB 43. My emphasis).*

This shows that health visiting is not a matter of delivering a predetermined service by anyone. To be trusted both as a person and as a professional seems to be an essential element in health visiting work.

7.2.2 The role of the relationship

The context in which the interaction takes place helps or inhibits the introduction of the health visitor's agenda. Because in health visiting interventions are mainly through third parties, ie: The carers or the person in charge (Chapter 4, section 4.4), health visitors establish this relationship mostly with carers who are considered as secondary clients. It was pointed out (Chapter 4, section 4.4.2) that in health visiting to secure the life trajectory is a joint enterprise between the carer and the professional, in this sense the relationship itself becomes a resource in health visiting work. It

will facilitate, promote or inhibit the cooperation that is needed. This view is similar to that held by Strong and Davis (1977). In their study of medical encounters they coined the concept of "Role format" which encompasses both the stability in relationships and the variability for which, according to them, the concept of role does not allow. They found that role formats constitute a resource to which a variety of matters may be brought for settlement (p.784-785).

7.2.2.1 The relationship as an enabling mechanism

Data from this research show that the relationship is a mechanism that will enable health visitors: 1) To know the client and the family, 2) To gain and maintain access to the home, and 3) To produce reciprocity.

1) Know the client and the family. Because of a trusting relationship, clients will volunteer information and will share private matters of concern with the professional. Here the professional will have an insider knowledge. This knowledge is required by health visitors in order to prevent ill health or to take early remedial action. This has also been pointed out by Twinn (1990) when discussing child health surveillance. She stated that the establishment of an effective professional relationship will enable clients to share information and concerns, and this will influence the outcomes of the surveillance programme (p. 231).

During one interview a health visitor commented on the use of being trusted by a client:

> *"I feel in families that I know quite well and hopefully trust me, that um, if I visited them and they were having problems, I would hope that they would feel they could tell me. Um, sometimes you just ask a few leading, I find if I ask a few leading questions, or about er, how are things with the family, that I am told." (LT 3).*

Participants during the interviews commented that being told by clients was one way of identifying needs. To have a client's confidence is very important in health visiting. There are circumstances, such as marital problems or worries about child behaviour, where professionals cannot possibly know about them unless the client discloses them. Also there are instances when health visitors suspect a certain circumstance, but cannot act unless the client acknowledges the existence of the problem. During the interviews this issue was commented on. In one instance a health visitor suspected that the client was a prostitute (Interview V1) and in another that she was an alcoholic (Interview AW). In both cases health visitors felt that they could not act until the client acknowledged the situation publicly and asked them for help. Their interaction with these clients thus focused on building the trust needed in the hope that the professional would be able to act. Hence, having the client's confidence in health visiting cannot be taken for granted, it needs to be earned, worked at. Once achieved, is interpreted by health visitors as good health visiting practice. Hence having achieved a client's confidence is synonymous with good practice.

2) Get and maintain access. Another use of the relationship is to gain access to the client in the first place and maintain it afterwards. Trust leads to private disclosures in terms of the client's personal life and home privacy. During one interview a health visitor discussing general practice issues, pointed this out:

> *"...if you go in there (the home), and you're being dictatorial over things (pause) the next time you go, you'll probably not get in (pause) the door won't be open for you"(MT 30).*

One encounter with the client, if trust has not been lost, will permit access to the next. In that way, by granting access to subsequent encounters, clients are engaging in a collaborative relationship with the professional. This shows, once more, how building trust leads to building a coalition between clients and health visitors.

Once a working relationship has been established with a particular client, health visitors are confident that the client will seek help or contact them if in need or doubt. In this instance, health visitors can relax about a particular client and concentrate on others. Thus, to have a working relationship with a client will save the health visitor's time. There will be no need for routine checks to "See if every thing is OK" or for unexpected calls to see if something is wrong. Establishing a working relationship with carers will cut

down on surveillance work because they can be trusted to assess their children or dependents and report any noticed change to health visitors.

3) To produce reciprocity. Lastly, another use of having a relationship with a client is to effect reciprocity. During one interview this function was highlighted, a health visitor commenting on the purpose of the relationship, stated:

> *"I think, I think this is human um, thing where you feel that you have got a relationship with somebody, they might do things because you're asking them to do it,you know, I think that er (pause) so consequently, you continue um, you know, you visit for the first time, and you visit again, because you show care, by showing care you hope that what you have got to offer, will be taken" (PS 51).*

As the quotation shows, the relationship the health visitor builds permits an exchange. It sets a climate of reciprocity. These findings are similar to those found by Chalmers (1990). She highlighted the enabling role of the relationships in gaining access and discussed the exchange process in professional-client interactions.

Giving extra things or services to clients plays a major role in the development of an "Obligation" relationship. Thus, Bigus (1978) found that milkmen when offering "Specials" and performing "Favours" were in fact effecting an obligation (p. 108). Some fringe work activities have this effect. During field work instances were recorded of health visitors offering extra things in order to gain the client's compliance. For instance, during a home

visit to a handicapped mother the health visitor, who was very concerned about the client's capability of caring for her children and her hostile attitude towards professionals, offered to give her a lift to the hospital, to bring her an application form for a nursery place for one of her children, and to recommend the child for a place in the nursery. All of this took place during one visit. The health visitor was clearly trying to effect obligation. Afterwards, when discussing the case with her, she commented to the researcher that she was trying to get this mother "To my way of thinking" and in this way get the mother to agree on being referred to a social worker (Field notes TB 1/19. August 1990). Distributing relief clearly produces commitment with the person who is giving and keeps the relationship going.

The role of gifts in societies has been studied by different anthropologists. Mauss (1954) has pointed out that in primitive societies gift exchange is a "Total social fact". He asserts that exchange is an event social and religious, magic and economic, utilitarian and sentimental, jural and moral. Levi-Strauss (1965) had also pointed out that goods are not only economic commodities but vehicles for getting influence, power, sympathy, status and emotion (p. 76). Discussing the issue of blood donation Titmuss (1970) echoes these ideas and points out that the gift transaction embeds elements of moral enforcement or bond. Thus, to give is to receive, it compels some return or obligation. According to him this obligation also happens between strangers as is the case of patients and doctors. To donate blood is

interpreted within this framework of gift exchange and moral obligation (p. 70). A similar process takes place in some institutions. Goffman's (1961) study of asylums points out a number of clearly defined rewards or privileges that "Are held out in exchange for obedience to the staff in action and spirit" (p. 51). Schwartz (1967) also makes the connection between gift exchange and social control. Further, he states that the continuing balance of debt insures the continuity of the relationship between the parties "For gratitude will always constitute a part of the bond linking them" (p. 8).

In the present research study, it was pointed out (Chapter 6, section 6.3.1) that fringe work takes the form of a gift that effects obligation and maintains the relationship with clients.

The uses of the relationship just described, lead to an overall position where the client accepts the health visiting service delivered by a named health visitor. A "Good" relationship with clients indicates that clients have "Bought" the health visiting services. The development of a relationship is not a single strategy that health visitors use, but the consequence of the different tactics that they develop to "Sell" their services. This is discussed in another section.

7.2.2.2 The relationship as a mediating factor

The relationship that is established between clients and professionals acts as a mediating factor. Spradley (1979) states that in the same way that there are apparently universal semantic relationships, there are also some universal cultural themes. One of them is that of the cultural contradictions. He points out that often they are resolved by "Mediating themes". Hence, the suggestion of the relationship being a mediating theme is proposed here in the meaning given by Spradley (1979 p. 200), that of avoiding conflict. In this sense, the type of relationship that health visitors have with their clients mediates between the policy agenda, ie: the standard plan for a given case or situation, and the client's agenda, ie: the clients' rights, needs and expectations from the services.

Health visitors deliver a service that has a dual function, both controlling and serving clients. From this stems the dual role that health visitors have, that of policing and that of education (Mayall and Foster 1989) A trusting relationship will mediate between two conflicting roles. It will enable the professional to both survey and intervene with a client's consent.

During the interviews health visitors gave accounts where the dual role of being "mothers' friend" (Davies 1988) and "Professional" was highlighted. A health visitor commented on a conversation with a client who left her small children alone at home, where one of them had an accident:

"I said (health visitor), 'Well you just can't do that'. So she said 'Well I've got to, I've got to', so I said 'Well you know, as a health visitor, I would have to report that'. So she said, er, 'But Ann, you're my friend', so I said 'I'm a professional person' and I said 'you know I visit you as a professional person and I have got certain duties', and I said 'We have had long discussions over you leaving the children, and I feel you've been very lucky up to now." (CR 7. My emphasis).

The relationship this health visitor built with the client enabled her to know about the mother leaving the children alone and gave her grounds to attempt to persuade the client to do otherwise. It was mediating on an important issue for health visiting, that of child safety. Without a relationship where clients feel professionals are on their side, this discussions would not have taken place.

In this context being a professional is interpreted as going against the carer since the child is felt to be in danger. It shows a conflict between primary and secondary clients' needs and clearly shows that the dependant is the health visitor's primary client. Thus, it seems that health visitors build a "Friend" relationship with carers in order to get their collaboration. As the example shows this is just a means to protect the child, the primary client. However, there can be a drawback in this approach. Clients might expect the rules of friendship when interacting with health visitors. Hence clients may be reluctant to give information that concerns, for instance, intimate matters as they might feel that the health visitor is intruding. Alternatively there could be instances where clients might feel that the health visitor despite being perceived as a friend has not been responsive to their personal

matters (Luker 1991). Being both a professional and a friend is a delicate balance, losing the stability will have damaging consequences for the relationship between professionals and clients.

During another interview a health visitor reported an instance where the relationship acted as mediating factor, when previously it did not act in that way, the health visitor commented:

> *"...and it upsets me sometimes that a lot of women that I talk to afterwards, say in a group session, have said, and <u>they have forgotten that I am a health visitor</u> and they have said, 'I was very depressed, you know after the birth of such and such' and I have said, 'well you definitely didn't tell me at the time that you were depressed', and they said 'I know but you might have got the kids taken away from me' and that's, I think that's what a lot of people have thought. That even no matter how nice you've been or whatever that they just couldn't, you know, forget that barrier" (IH 6. My emphasis).*

As the quotation shows, in order to mediate in potentially conflicting situations, the relationship needs more than health visitors being "Nice". This might well be a first stage. They have to show that they are on the client's side, that they will help and not harm them. In that way, carers will "forget" the potential harmful effect that disclosure might have for them. As it has been previously stated a trusting relationship is a key factor in establishing a collaborative relationship with carers.

Here also the concept of role "Format" (Strong and Davis 1977) sheds light on this issue[11]. Since it encompasses the concept of variability in roles, it can be argued that health visitor's role format when interacting with clients, includes both the "Friend" and the "Police" boundaries. Hence the relationship can move within this apparent contradictory context. The role format gives some room for health visitors to manoeuvre their dual roles. In addition to this, because health visiting involves the relationship with primary and secondary clients, it can be thought of as primary and subsidiary roles in health visiting.

The primary role in health visiting is that of protecting children and to secure life trajectories. The subsidiary role is that of gaining carers cooperation. Hence, it can be argued that what varies in the health visitor-client relationship is the subsidiary role. Its boundaries are broken when there is a threat to accomplishing the health visitor's primary role. It is in the context where the relationship serves as mechanism that balances and enables health visitors to undertake both roles simultaneously.

Davies (1988) in her account of the development of health visiting shows that since its beginnings the goal of building a relationship with clients was present. She argues that, at the turn of the century, the "mother's friend" perspective was the most appropriate to hold for a woman who was working outside the home. She noted that women were given regard for

---

[11]I thank M. Pearson for drawing my attention to this issue.

what they could do for public health as women and not with a special training. Davies (1988) points out that it was their natural womanly qualities which came first, qualities which as middle-class women, they brought from the private sphere (p. 57). According to her, the debate about the role of middle class women in the public sphere confirmed health visiting as a woman's work.

Dingwall and Robinson (1990) see the issue of the relationship in a complementary way. They stated that after World War I, health visiting was given an additional impetus as a mechanism of state policy and that the relationship between health visitors and mothers was an instrument to 'bypass the barriers around the family' (p.258). The use of friendship in gaining access is highlighted when they quote Newman (1906) saying that the health visitor is not an inspector but "Her functions are rather those of a friend of the household to which she gains access" (in Dingwall and Robinson 1990 p. 258. My emphasis).

Thus the enabling function of the relationship is present in health visiting since its origins. As Davis (1988) showed it was the proper way for women to enter the paid work sphere and, as Dingwall and Robinson (1990) noted it was also the way by which the state could intervene in the private sphere without stepping over the right of the citizen's privacy. Further, in the United States of America at the turn of the century, Gardner (1924) advised public health nurses to gain the trust of the clients instead of using the

Public Health Law and to avoid being seen as part of the police force (De Silva 1988 p. 253).

Indeed, the present study also demonstrates that, the relationship can be regarded as the substitute for employing coercive measures to make clients comply. Degeling (1986) discussing the management of conflict in health care, notes that the ability of managers to influence what takes place in the organization is not a matter of hierarchy but in his own words it: "Will be a product of how we have gone about building our relations with others" (Degeling 1986 p.11)

Nowadays, health visitors' clients accept preventive and promotive services "Voluntarily". They are persuaded of its desirability and usefulness. Clients take up health visiting services out of goodwill, and the health visitor is the one who builds up this motivation. Kirkpatrick (1971) discussing the building of sound customer relationships, refers to the role of goodwill. He states that the first sale is often made only after goodwill has been won and that repeat sales will not be forthcoming unless the costumer feels goodwill toward the salesman. According to him goodwill is developed out of clients' faith and confidence in the salesman as a person and their respect for his professional competence (p. 373).

Hence, in health visiting the relationship aims to build clients' good will towards the service. And this is crucial when relating secondary clients, as

health visitors require them to become co workers in securing the dependant's life trajectory. To achieve this, the strategies employed in marketing are very useful. This is the concern of the next section.

7.2.3 The relationship as the result of marketing strategies

We have seen that marketing strategies are directed at the client to promote acceptance of the service that health visitors offer. Hence the overall consequence of using them is that the client "Buys" health visiting. In that way the professional can secure the dependant's trajectory. It was noted that in the process a health visiting personalized agenda evolves.

The client's degree of acceptance of the service will vary. Some clients will stay at the superficial level of interaction. That is, they will just allow the health visitor to physically get into the house. Others will give full and active collaboration. However, "Buying health visiting" is a process where ground is given as time passes, and the relationship between the professional and the client develops. A health visitor, commenting on a mother who was reluctant to accept her services, made this point clear during the interview, she stated:

"...I visit that mother now, her children have never been immunized, (laughter) but now she welcomes me in, and I think one day will probably have the children immunised, because she doesn't see me as any threat. Because I came on her side

of the fence and negotiated with her really" (TB 29. My emphasis).

This quotation shows the persevering strategy that health visitors also use. It is hoped that, providing the continuity of contact and consequently the development of trust, the client will increase the acceptance of the service. This is consistent with other studies where it has been noted that the attendance of clients at child health clinics reflect the level of home visits, these lead to clients using clinics (Hart, Bax and Jenkins 1981, While 1990). Thus buying health visiting, also implies accepting and using other health care services.

When health visitors use the marketing strategies previously described, they are influencing the context in which the interaction takes place. The health visitor-client interaction moves through three different contexts: 1) Dissociated, 2) Convergent and 3) Shared. To be sure, some tactics employed by health visitors are directed to create a given climate. Thus, during one interview a health visitor commented:

"...I would go by the client really, I'd try and <u>make the client feel comfortable,</u> and <u>if I need to modify me in order to do that, I'll do it</u>." (TB 25. My emphasis).

This health visitor is prepared to adjust herself in order to establish a relationship with the client. Being comfortable can be interpreted as clients

trusting the health visitor, and as it was pointed out, this is needed for a cooperative interaction to take place.

In the stage of promoting health visiting services, when health visitors show concern or interests for clients they are both selling themselves and building a relationship. The same happens when they employ other promoting tactics. For example, during one interview a health visitor commenting on visits to clients for the first time, stated:

> *"So I try to get to them (parents) that, although, even if they're going to the GP, I will still want to know, you know, where they're up to with their (children) immunisations. Because I actually hold that case sheet. I'm ultimately responsible and accountable for that case sheet. And I think if you get this across to them (parents) at first, and show them (parents) the case sheet and tell them (parents) what you're about and why (pause) then I think that is where you're going to get the cooperation."* *(EQ 14-15. My emphasis and clarifications).*

To get a cooperative relationship requires creating a clientele in the first place. In the above example, the health visitor ensured that the client, in this case the secondary client, continued to visit her in addition to going to see the doctor. She used a displaying tactic by showing a case sheet, and a raising awareness tactic by explaining her responsibility and accountability. The interaction between the professional and the client takes place, at first, in a "Dissociated context", ie: Policy related and client's agendas are separated. As the relationship evolves and other marketing tactics are employed, the interaction moves to another context.

Adjusting the delivery of the service to fit to the clients' circumstances is the second strategy utilized in "Marketing Health Visiting" which will also contribute to the development of the professional-client interaction. This is consistent with Chalmers's (1990) research study. She found that cultural background and social class did not appear to be major barriers in the development of relationships with clients and she added that it depended more on the health visitor's ability "To present herself and her services in a way that the client perceives as helpful." (Chalmers 1990 p 184. My emphasis)

Chalmer's observation above makes reference to what is categorized in the present study as tactics to promote the service and adjust its delivery. It can be argued that the cultural or social class dissonance does not act as such because health visitors accommodate, themselves and the service, to all clients. The mediating role that the relationship plays is once more highlighted.

Another instance of adjusting delivery is when health visitors time the encounter. Timing the visit creates a conducive medium for building a relationship. During one of the interviews this point was raised. A health visitor when asked about the type of relationships that she has with clients, appreciated the positive effect of meeting the client at a receptive moment.

Thus she stated:

> *" I think (pause) yes, in my experience, the people that I have seen, I've built up a relationship with them, from the birth of their child, I have rather more success with than those that I haven't, they've perhaps transferred into the area at some later date (pause). Um I don't think you form quite the same relationship, I think the woman, at the point of, just postnatally, is emotionally vulnerable, and I think somebody sitting in front of them at that stage and saying 'well, you know, here I am, this is what I'm about, you know, I'm here for you' um, I think that they, you get better than those that moved in, perhaps the child's already 12 months old or whatever..." (VW 12).*

The length of the interaction is a factor in developing the relationships. Indeed during the interviews health visitors referred to the continuity of contact as a contributing factor in the development of relationships with clients. However, as the quotation shows, to arrange to meet the client at the most receptive time has a pay off in developing cooperative relationships. When implementing the tactics that adjust the delivery of health visiting services, a "Convergent context" is constructed. The focus of the interaction is that of fitting the professional's agenda into the client's world.

By negotiating and making compromises health visitors maintain the relationships they have established with clients. This is consistent with Degeling's (1986) view. He states that negotiation is about the maintenance of relationships and in that way it contributes to contain conflict in

organizations. In marketing terms, negotiation contributes to maintain "Patronage" to the services offered.

During one interview a health visitor, discussing an unpleasant event with a client, gave an example of compromising in order to keep the relationship going:

> *"I've had a row with this woman, I've had horrendous (pause) she nearly threw me over the balcony one day. And then the next week she came into the clinic asking for me 'cos there was something she wanted. <u>And you've got to forget what happened the week before and just get on with it.</u>" (RB 29)*

In this instance the health visitor turned a blind eye to an unpleasant event. She acted as if nothing had happened, and to do this considerable emotional labour was certainly involved. The example also shows that in health visiting, to deliver the service when requested also involves maintaining the relationship with the client otherwise, as it was commented before, future access might not be granted. Chalmers (1990) noted similar instances in her data. She identified responding to clients' felt needs as a determinant factor in developing effective relationships with them.

While negotiations serve to maintain relationships, fringe work strengthens the relationship as it enhances solidarity. When health visitors engage in relief work by giving things to clients, or when they "Run an extra mile" for

a client by bending a rule, or when they develop a service that was not present in the area, they are not only showing concern but they are doing something about it. Fringe work is a practical way to show clients that health visitors are not insensitive to their unmet needs. By showing solidarity the relationship between the professional and the client is fortified. Also, as it was previously discussed (P. 16), fringe work produces commitment.

It can be concluded that tailoring tactics produce basically a "Shared context", a context in which a degree of cooperation is being achieved. The focus is on building a common ground to achieve collaboration. The importance of having something common with clients was commented upon during the interviews. A health visitor discussing general practice issues stated:

> *"...I still feel that the 0 to 5 is our entry point, into the whole area...if I have a child and you start coming in, it makes you listen, it makes you want to listen to somebody, 'cos they got an interest in your child and <u>you see that as a joint interest.</u> From that point I think, you build up a relationship, on a one to one" (CA 8. My emphasis).*

The quotation also shows that the shared context enables the health visitor to continue developing the relationship with the secondary client which aims at collaborating in securing the dependant's trajectory. The shared context is formed as the health visitor gains gradual access. By clients accepting the

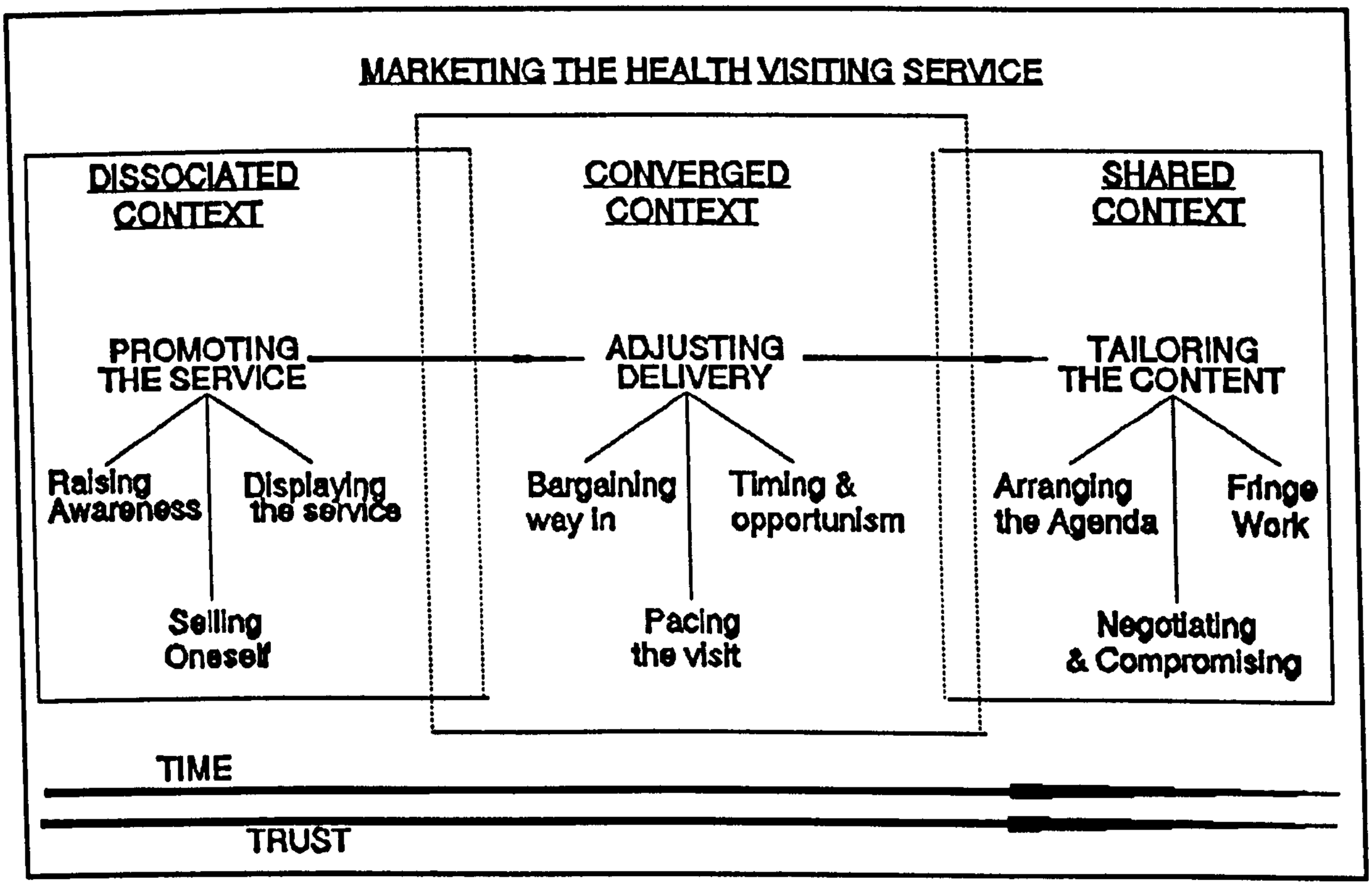
health visitor's role, compliance is achieved. The private sphere becomes permeable and open to scrutiny.

As time passes and the interaction between clients and health visitors takes the form of a stable relationship, health visitors develop a personalized agenda, ie: The health visitor's own agenda where cases are transformed into clients. It is worthwhile noting here that in hospital work, nurses to protect themselves against anxiety, use a contrary strategy, that of depersonalizing patients (Menzies 1960). It appears that ultimately health visitors seek to have secondary clients as "Co-workers" to secure the dependant's trajectory. Some health visitors will see this as a "Partnership" where there is a complementary relationship, while others will settle for an unequal relationship where the carer is supervised in the management of the dependant's trajectory.

Face to face interaction is an evolving process where participants take successive stances, there is a developing or variable character in the interaction (Strauss 1977). The analysis of data from the present study shows that the implementation of different marketing techniques is fed into the context altering its configuration. The client-professional interaction moves through three different contexts. At first it takes place in a "Dissociated" context, then it moves to a "Convergent" context to finally reach a "Shared" context. Figure 3 depicts the connection

between context and strategies. It is worth noting that once a context is built it acts as condition for the subsequent strategy. As it was expressed, the length of time in the interaction is an important factor for forming a relationship with clients and the development of trust is a key element in reaching a "Shared" context.

FIGURE 3 - HEALTH VISITING: BASIC PROCESS, STRATEGIES, TACTICS AND CONTEXTS.



7.3 OTHER CONSEQUENCES OF MARKETING

Although creating a conducive context is the major consequence of developing marketing strategies, there are other additional effects for health visiting. These are: the contextualization of practice and attaining self worth.

7.3.1 Contextualizing practice

When health visiting is adapted to meet the client's different needs, cultures and circumstances, it becomes a service that is versatile and varies according to the circumstances. This accounts for the fact that study participants believe that all are very different in the way they practice. Even health visitors from the same practice area felt very different from their colleagues (Field notes August 1990, March 1991). Hence, they felt that it would be an impossible task to depict health visiting (Field notes, February 1990, April 1990, August 1990). However data suggests, these differences are mostly apparent or formal. Practice is moulded, to a certain extent, by the context in which it takes place. The core of the service is not changed, the change takes place in the way that it is presented and introduced. Also, as was noted when discussing fringe work, the service is expanded.

By contextualizing practice, boundaries in health visiting are mobile and that practice is developed on an empirical basis. What is a fringe activity today

might well be part of the health visitor's core work tomorrow. This could be the case for the novel work that is actually taking place in some areas.

This is consistent with participants comments during field work. Health visitors repeatedly stated to the researcher that they treated clients alike but in different ways. The underlying principle here is what Dingwall (1977b) also noted, according to the health visitor's point of view, clients should not be treated identically but equally. This is consistent with the concept of equity in health as endorsed by the WHO (Whitehead 1990) and highlights the issue that equal treatment (what Dingwall calls "Identical") might lead to inequity. Equity is concerned with creating equal opportunities for health and with bringing health differences down to the lowest level possible. It is defined by three parameters: 1) Equal access to available care for equal need, 2) Equal utilization for equal need, 3) Equal quality of care for all. Equity thus implies that everyone should have a fair opportunity of attaining their full health potential (Whitehead 1990 p.9-11).

It then can be highlighted that by contextualizing their practice, health visitors contribute to reaching more equitable health services. Indeed, tailoring the health visiting service to meet the client's needs and account for circumstances, promotes equity. However, it might well perpetuate inequalities. This issue is discussed in the next section when examining the "Side effects" of using marketing strategies.

7.3.2 Self worth

Delivering a service that responds to client's needs and achieves a degree of compliance conveys feelings of self worth to the health visitor. This is clearly one outcome of fringe work. By doing something extra for clients the health visitor also gets something out of it. During an interview a health visitor openly acknowledged this, commenting on how she started a miscarriage group, she stated:

> *"...one of the doctors referred, that's how it started really, one of the GPs referred a lady to me who was a nurse, and um, I went to see her, and I was there all the afternoon. She was just (pause), she was probably that kind of person anyway, but it was like, the floodgates opened, you know. And um, she came to see me afterwards, she was really nice, and she just sort of said, 'I felt a million times better, 'cos no one wanted to hear' (pause), and that was probably how it (setting up the group) started, and I suppose personally I felt quite, you know, quite good after it, you know (laughter),a bit of job satisfaction..." (CT 11. My emphasis).*

Having a positive feedback from clients boosts the health visitor's morale. Tailoring as a strategy thus makes the services relevant to client's needs and provides practitioners with job satisfaction. Hence it contributes greatly to keeping the service running. If health visiting activities were not moulded to different clients and practitioners did not get some satisfaction, it can be argued that the service would not attract a clientele and practitioners would leave it. Hence the service would be discontinued.

Similarly, frustration is aroused when health visitors are unable to respond to clients' circumstances. Fringe work is, clearly, a way of "Doing something". It can prevent health visitors from feeling powerless. During one interview, a health visitor commented on this feeling, she stated:

> *"I get frustrated at times when I can't give, say the elderly, stuff that I want to give them. I can see they need this, that and the other. It is only going to cost a hundred pounds. Well why can't they find the hundred pounds you know?, And you can't do anything, it's very frustrating" (DB 40. My emphasis).*

Health visitors are professionals who have been trained to respond to needs. In circumstances similar to those above they will feel unable to fulfil a role or accomplish their mandate, a sense of frustration is hence understandable. While they are expected to secure a life trajectory, they do not have always the basic means to achieve it.

Tailoring health visiting services, particularly fringe activities, contributes to the health visitor's satisfaction in two ways: It gives professionals a sense of worth and impedes their frustration. This is especially useful when health visitors work in adverse circumstances or deprived areas. Indeed, it has been pointed out that one of the functions of poverty is to provide the rest of the population with different emotional satisfaction; it evokes compassion, pity, and charity. It thus allows those who help the poor to feel that they are altruistic, moral and practising the Judeo-Christian ethic (Gans 1973 p. 280).

However, health visitors' protection against frustration might have the unwanted effect of not delivering the service that is needed. This is the case when health visitors adjust the service to meet their own needs for self fulfilment. This negative consequence is discussed in the next section.

7.4 SIDE EFFECTS IN MARKETING

The analysis of data suggests that marketing strategies might well lead to unwanted or negative consequences. For the client marketing techniques can create dependence and perpetuate unfair situations. For health visitors, while they might protect professionals from disappointment and frustration, these strategies can produce role disorientation and become a source of strain.

Hence three major negative consequences are identified: 1) Creating dependence, 2) Normalizing deviance, 3) Role disorientation and strain. In the following sections each of them is discussed.

7.4.1 Creating dependence

Marketing after all is about getting people to consume goods, ideas or as in our case, lifestyles. Hence, it conveys the creation of certain dependence on the "Product".

In health visiting some dependence needs to be created in order for the health visitor to come back to the house. The universal and surveillance character of the service determines that all the clients need supervision and support in managing their dependant's trajectory. Thus, it is decided before hand that for a certain period of time a service ought to be "Consumed". Consequently one aspect of marketing the health visiting services is to convince clients of the convenience of using them for a period of time, or under certain conditions. The right to use a service becomes almost, a duty for the carer.

An overemphasis on showing the usefulness of the health visiting service, or a strong need for job satisfaction, might well lead the client to depend on it. Some fringe activities clearly highlighted this point.

During field work, an instance of creating dependence was recorded. A health visitor gave a pram to a poor mother. Next day when the researcher and this health visitor were passing the client's house in the car the health visitor noted the pram outside in the garden. She said 'Oh good she is using the praml' then talking to herself added 'I have to be on the watch for cot sheets and stuff like that'" (Field note DB 4/12. August 1990).

This examples shows how a gift will be followed by others, that the health visitor will continue to engage in relief work instead of encouraging the client himself to provide for what is required.

Health visitor's "Extra mile work" may potentially impede or disable clients from taking charge and doing things for themselves. This dependence is more likely to be promoted when using relief and surrogate strategies as they are not directed at the root of the problem but to treat or palliate its symptoms. They might well contribute to the maintenance of unfair situations.

Health visitors during the interviews expressed concern for this unwanted effect. During an interview discussing the issue of some health visitors giving things to clients, a health visitor commented:

> *"Yes, well I can understand it but I just think that's just fostering that dependence that we shouldn't be fostering. It's not fair on the client eventually because um, it's making them think that, you know, it makes them more impotent, or something, getting their own life sorted out but people do give clothes to this clinic to give out but it's getting into that charity business which as far as I am concerned is health worker and I don't think we should be fostering that dependence at all. (IH 22. My emphasis)".*

Creating dependence presents us with a paradoxical situation. While in hospital nursing it is stressed that the relationship between the nurse and the patient is that of moving from dependence to independence (Peplau 1964), in health visiting it seems to be the other way round. The professional gets her clientele by convincing them of their dependence on the services. That is, by uncovering and pointing out to needs (tactic of "Raising awareness") it is hoped that clients will "Consume" the service.

7.4.2 Normalizing deviance

This is the second negative effect of using marketing strategies. It was pointed out that a marketing approach in health programmes could commodify the concept of health and that a lifestyles focus in health education shifts the attention to cultural issues and individual choices as opposed to economic and collective issues (O'Brien 1991). This shows that the victim blaming ideology (Crawford 1977) permeates health education. Davis (1979) in his analysis of preventive policy, shows that prevention also encompasses this ideology. According to him, it has an individualistic focus which defines responsibility for illness in terms of individual failure of neglect (p. 129). The victim blaming ideology inhibits the understanding of the social causation of disease and substitutes instead an unrealistic behavioural model; it "Minimizes the importance of evidence about the environmental assault on health" (Crawford 1977 p. 671).

The presence of this ideology in health visiting has an impact on practice, that of "Normalizing deviance". Health visitors in many instances see the weaknesses of this approach. When they are exposed to deprived situations they can see how an argument that places the blame for ill health or inequalities in behavioural and individual terms falls short. Confronted with this reality they acknowledge the role played by environmental factors, but instead of attempting to transform them, they adjust them by lowering the standards. So what is abnormal in one context becomes normal and natural

in others. During one interview this point was highlighted. A health visitor commenting on the impact of her work, stated:

> *"You can't change people quickly, it's a slow process, and I think, you know, it takes, perhaps a couple of years, a year or so, to say 'Well, really, you can't solve it'. Sometimes you wonder if your standards, your expectations, sometimes, particularly in problem areas, they drop. And you wonder how low, you know what should you or should you not expect in parenting, in children, you know, for them to do. Um, (pause) the lower social classes, their expectations for their children are low. And I used to think, my friends children were geniuses, because they could draw, or sing nursery rhymes, whereas where I was before I couldn't. But you know it's all normal for that area. And that takes a while to sink in. Because, er, some parents don't teach kids, they don't teach them to draw, or show them, they don't give them an opportunity to draw, to sing nursery rhymes, or to do anything like that. Well, that's normal for that area. You've got to, it depends where you work, you've got to realize what their normal is, for that group."* (Aw 29-30-my emphasis)

In his work O'Brien (1991) also pointed out that there is not one lifestyle but different lifestyles to be "Sold". As the quotation shows, these change according to social class. The above quotation clearly shows that standards are modelled to the situations. One can imagine the possibility of seeing the service so adapted that it ceases to exist, and its delivery becomes a mere ritual: a form with no content. Dingwall et al (1983) when discussing the elements and function of the "Rule of optimism" held by professionals when dealing with cases of child abuse, commented on a similar issue. According to them this rule consists on the combination of two issues, ie: Cultural relativism and natural love. They are accounts which front-line workers can

use to bridge the gap between their own ideals and the realities of practice (P. 90).

By normalizing low standards health visitors are using a "Survival strategy". Standards are lowered so they will not fail in their work. Indeed if, for instance a child is not preforming as expected in a test, the child is not failing, just confirming a type of normality in a given context. The health visitor levels out inequalities, is not judgemental and by doing this, quite unintentionally, is helping to maintain the status quo.

Lowering the standards protects the health visitor from being disillusioned. This is important in health visiting since in this job a strong faith in getting things changed is required. During one interview the continuous effort of boosting up morale came clearly.

A health visitor discussing her work in general terms, stated:

> *"Somewhere along the line, you'll be able to get it in. It might not be six months, a year.....Your job is to give them (clients) the information, and you could be given the information and you'll go (health visitor talking to herself): 'This one is not taking a blind bit of attention and even if she is paying any attention, not doing anything about it'. Nevertheless, you have to give them (clients) the information and <u>you have to tell yourself that somewhere along the line it's going, they (clients) are going</u> to (pause) It may happen, it may not happen, who knows." (MT 27 & 37-my emphasis and clarifications).*

Without this optimistic approach, it will be very hard for a health visitor to get the motivation to return to a house where there have not been any changes. During field work such an instance came up. A health visitor commented about a client who had not changed in 10 years but she kept on trying and added that one day it would come, (Field notes DB August 1990).

Health visitors have little direct control over the factors that affect trajectories, lowering standards thus also protects them from the conflict of getting involved in other types of activities which would imply a different approach in practice and a major change in their jobs. Thus, this strategy allows health visitors to acknowledge that there are other factors apart from behaviour that affect health and at the same time prevents them from doing anthing about it. In this way, health visitors can still do their job with an individualistic and behavioural focus. Also they do not experience conflict when confronted with reality. They have incorporated a broad concept of health that gives them an understanding of the roots of ill health and a core work that prevents them as practitioners from becoming political agitators.

This mechanism, thus, protects health visitors from moral and work related conflicts. The cases of health visitors abandoning practice because of lack of support and because of the conflicts arising when using a community development approach to practice, show the function of this mechanism (Field notes EF February 1990).

Normalizing deviance thus contributes to perpetuating the way the job is done. It apparently reconciles two ideologies that in this case conflict: the professional represented by a commitment to social reform and the organizational represented by the victim blaming approach. It also resolves the tension produced by a health visitor's dual role, that is between delivering a service and surveying families.

Foster and Mayall (1990) in their study also found that health visitors acknowledged the environmental constraints affecting health but they still focused on the failings of the individual. They attempt to change individual behaviour and adjust clients to their circumstances. Indeed normalizing deviance is a form of adjustment to inequalities. It can be regarded as a new form of social control.

By lowering the standards health visitors are still able to provide a universal service. The service is useful under all the circumstances no matter how deprived clients are. It protects the health visitor from having internal conflicts and contradictions. Health visitors avoid being vulnerable to the employer and lastly they can get the work done. Normalizing deviance hence also keeps the service running.

7.4.3 "Role disorientation" and strain

The third negative consequence of marketing strategies are role disorientation and strain, from the practitioners point of view, fringe activities can lead to this.

There are two extreme roles that the health visitor might undertake while doing fringe work, that of becoming a sort of "Family friend" and that of becoming a fringe worker. In the family friend disorientation health visitors lose their professional distance and identity. They behave more like a friend. Instances of this disorientation were recorded during field work. For example a health visitor visited a family for 11 years just for the support (Field notes WB August 1990) and others were identified by their clients as "Welfare ladies" (Field notes May 1990, August 1990).

Discussing the issue of giving things to clients, a health visitor made this point clear. She stated:

"Yes, you have to be a bit careful of that (giving things to clients), seeing it as sort of, your job as a sort of welfare person, and I don't think that's...though there are times when I think it seems to be fairly appropriate. Usually to help people over a bad patch, not as the normal..." (LT 18. My emphasis).

Becoming a fringe worker means that the traditional health visitor core work (monitoring children 0-5 years old) is displaced to the periphery and fringe activities take its place. While the previous disorientation will foster clients' dependence, this will produce strain in health visitors. The strain referred to is both mental and physical. Graham (1984) clearly states that mental strain is a particular side effect of caring. It must be noted here that fringe work has been defined as a way of caring (Chapter 6, section 2). Graham (1984) quotes different studies that found that while caring is physically arduous, it is the emotional demands that "Take the heaviest toll in the carer" (p.83).

Thus, in addition to the mental pressure provoked by some fringe activities, one must bear in mind the strain resulting from the emotional labour involved in selling oneself (Horchschild 1983). In this sense, Zerwekh (1991) described the human cost involved in public health nursing. She found that public health nurses, working in adverse environments, did their work at "The expense of their souls".

The analysis of data suggests that the sources of strain because of fringe activities are those related to the quantity of the work, to management views, and those related to clients' expectations.

Fringe work tends to be extra work that health visitors undertake. They might find themselves accomplishing two jobs: the official and the unofficial. Fringe activities take more time than "Routine" work. This was commented

on during the interviews. For example a health visitor discussing her work in a deprived area, stated:

> *" Well in T and S, I mean, in the morning, (pause) if people come to the clinic and see you and, and they'd say, 'I've got to have a nursery place, because I'm going to kill the children, it's driving me mad, I can't stand it screaming, um it's terrible' (pause) or ' my giro hasn't come, I've got no money, I've got no baby milk' So you spend all your time ringing up, trying to get a nursery place for this child, or trying to get hold of the DHSS, to get them some money, get them a special payment of some description so that they can get some food into the house, um (pause). Those problems obviously take priority over any routine work that you wanted to do, and there are so many of then, it's like that all the time. And my work was like that all the time" (HR 16. My emphasis).*

This is consistent with Harrison's study (1988). She found that in areas of poverty the burden of work upon health visitors was greater that in other areas.

The second source of strain is that the health visitor may not be acknowledged for the work done. Most fringe work is invisible, takes time and is not always part of the official policy work. Thus, health visitors might feel the strain of working and being neither acknowledged by their superiors and peers, nor rewarded for the work done. Even worse, they could be accused of not doing health visiting or achieving the targets set.

Lastly, the other source of strain provoked by fringe work is clients' disappointment and jealousy when health visitors do not respond to their felt

needs. Thus the health visitor's credibility might be impaired. This point was highlighted during an interview. A health visitor discussing about her clients stated:

> *"I think that a lot of the time, they (clients) do sound off to you about it, even if it it's just like accusing you 'cos you can't get them another nursery place or whatever" (CT 21)*

Whilst, being successful in the past might rise clients expectations, doing fringe work for some clients might provoke jealousy in others. During an interview this point was raised, a health visitor commenting a case, stated:

> *"I had a lot of hassle with a client last year, she's a very formidable woman this, and um (pause), I, one woman, went into premature labour, and I had to get her off to hospital, and the ambulance shot off without the person who was going to be with her in labour. And as I was going to Oxford Street (a street just behind the maternity hospital) anyway for a meeting, I said 'oh well, jump in, I'll take you up there 'cos I'm going up there myself'. Now another client saw this through the window, and she rang me, er, 'oh you can do it for others, but if I asked you for a lift' and all this. So I explained to her the circumstances, and I said but, I said 'I have to say it Ann, it's none of your business who I give a lift to'. You know, I said 'I will visit who I please, I will give lifts to who I please...'" (RB 28-my note and emphasis)*

Hence, while routine health visiting is universal, fringe work is selective: not all people get it. This could obviously be a source of conflict with clients.

In conclusion, it is highlighted that, while fringe work could be a developmental tool, to bring about positive outcomes, in doing it the health

visitor risks being the victim of her own success, that is to generate a situation of overwork for herself and discontent in others.

7.5 CONCLUSION

This chapter has explored the effects of developing marketing strategies in health visiting. It has been shown that the major effect is that of creating a conducive medium in which to build a common agenda with clients.

When discussing the context in which health visiting work takes place (Chapter 4) it was defined as working "Between two worlds". Health visitors are placed between the policy and the client's agenda. By implementing marketing strategies it was noted that the service is accepted and collaboration from clients is gained gradually. Different contexts evolve as a consequence of the interaction, the last one is been identified as "Shared Context".

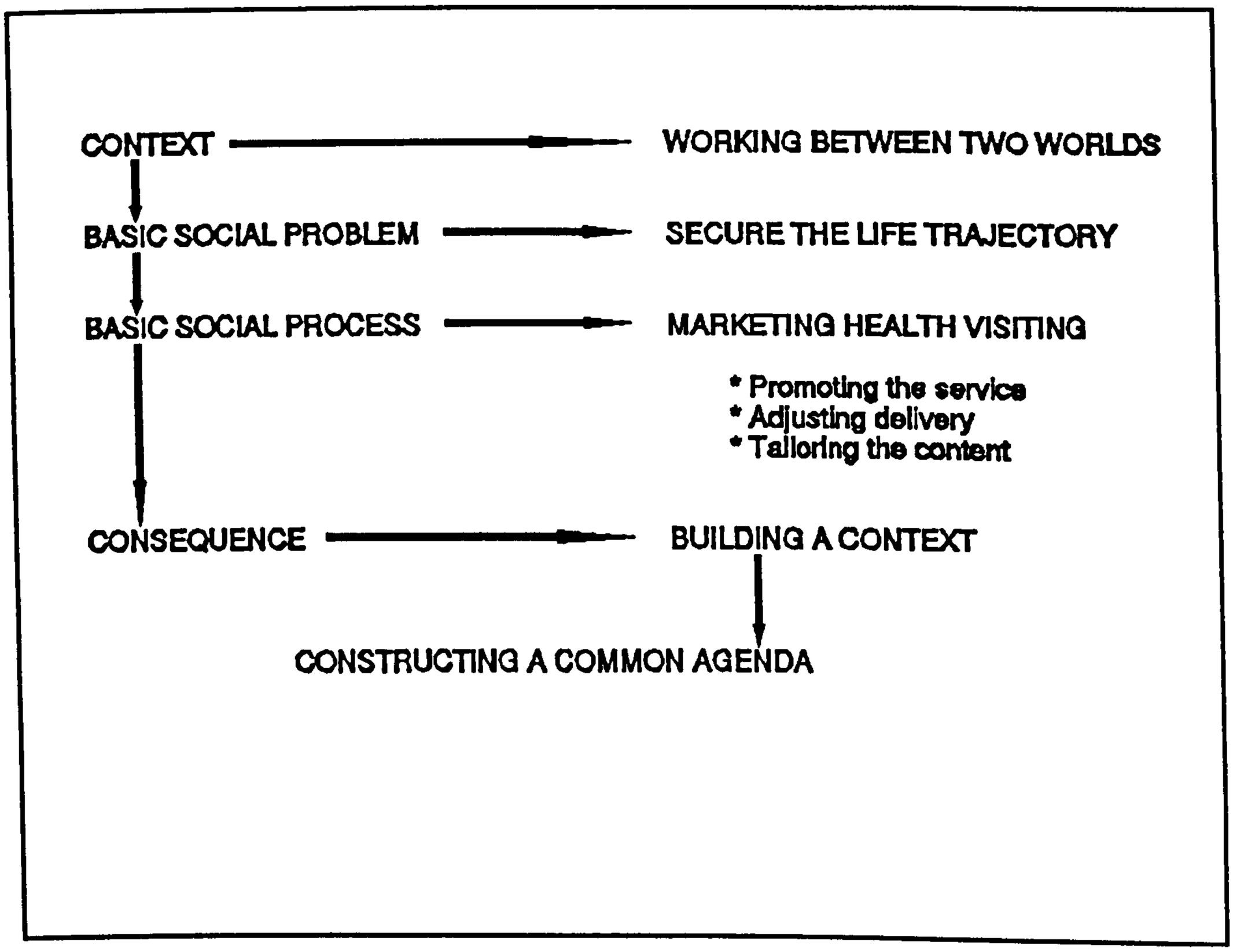
In addition to this, the development of marketing strategies has an impact in health visiting. It contextualizes practice, the service becomes flexible and versatile according to the circumstances, and provides health visitors with job satisfaction.

Lastly it has been shown that marketing tactics might yield negative effects. This study has identified those of creating client's dependence on health

services, promoting inequalities and inciting role disorientation and strain.

Figure 4 summarises the major findings of this research study.

FIGURE 4 - SUMMARY OF MAIN FINDINGS



CHAPTER 8

DISCUSSION

8.1 INTRODUCTION

The overall aim of this study was to gain insight into the processes underlying health visiting. Grounded theory, a qualitative research approach was selected as it brings process into the analysis of data.

The central finding of the study is that a process, called "Marketing" takes place when health visitors interact with their clients. The goal of the interaction is to build a common agenda with clients and hence actualize the policy mandate of securing life trajectories. This process is precipitated by the context in which health visiting takes place, that of working between two worlds, ie: that defined by policy and that demarcated by clients. This situation is well expressed in a government consultative document, here the Secretary of State for Health declares that:

> *"In between Government and individual stands a range of organisations-statutory authorities, voluntary bodies, health professionals and others-whose activities will be more effective if exercised within a broad agreement about goals. You cannot coerce people into good health. That is why we need mutual agreement on priorities and how best to work together to improve our health" (Waldegrave. DOH 1991 p. 3. My emphasis).*

It is assumed, in this quotation that there is a potential conflict of goals between Government and individuals and hence the need for consensus. This, in the present study has been identified as negotiating and compromising tactics. However this is just one aspect of the process. Health visitors are placed in the paradoxical situation of both creating and satisfying a market. It was shown (chapter 5) that a market needs to be created in order to accomplish the policy agenda and that it needs to be satisfied to both enable the introduction of the policy agenda and to account for the client's agenda.

As a way to respond to client's health needs and improve his/her health, changes in health visiting practice have been suggested by professional leaders and organizations. The introduction of a community approach to practice has been advocated but there has not been, as yet, a firm commitment from policy to this approach. Hence health visitors are also placed between the individualistic approaches fostered by the policy agenda and the community oriented advocated by professional leaders and contained in WHO "Health for All" strategy.

This chapter discusses the significance of this study within the actual debate in health visiting about introducing new ways of practice, examines health visitor's overall role and the importance of developing relationships with clients.

8.2 INDIVIDUALISM AND COLLECTIVISM

In the introduction to the area of the study (Chapter 2) the debate within health visiting highlighting that underlying it is the question of individualistic or collectivistic approaches to health care at community level was discussed. The connection was also shown between WHO "Health for All" strategy and the changes proposed in health visiting practice. However, while professionals are advocating new ways of practice, policy rules tend to reinforce traditional ways which are rooted in individualistic approaches to health visiting. Thus, in spite of the exhortations for a change of practice, the means to achieve it had been, if not absent, insufficient to make the suggested shift towards community oriented approaches. Nevertheless, current innovative work in health visiting indicate that the changes advocated are having some response at practice level.

Indeed, the findings of the present study show health visitors combine both approaches. They carry out their core work which is the surveillance of children under five years old, and engage in some fringe activities connected with a collectivistic approach to health care. This is done in the process of tailoring health visiting services to client's needs or circumstances.

However, health visitors' main approach to clients remains individualistic. This is reflected in their overall strategy, ie: marketing. Marketing is an individualistic and personalized process that addresses individual needs, it

tends to place clients in a passive and "Consumer" position and excludes collective action and participation in the "shaping" of the product. Furthermore social marketing could obscure the social construction of health and become individualism in a new guise (Naidoo 1986).

8.2.1 Individualism

The research studies reviewed in chapter 2 (Section 2.3.3.1) showed that in health visiting there are practices that correspond to what is been called "Traditional" ways which reflect an individualistic approach to practice. These traits are: Focus on children under five years of age, individualised home based care, little relevance to client's needs and lack of egalitarian relationships.

This study also found these traits and argues that they are consequences and part of the policy agenda. The overview of the origins and development of health visiting (Chapter 2 sections 2.2.1 and 2.2.2) has shown that this approach has been present in health visiting since its early days and that it served to exert social control. Further it was discussed that "Traditional" ways are still in place because they serve a similar purpose within the Welfare State. By highlighting in this study that health visitors have a basic mandate to secure life trajectories being the most important the child's developmental trajectory, it shows the role of policy in enforcing individualistic approaches in health visiting.

One consequence of the individualistic and child focused approach in health visiting is the unfavourable conditions in which elderly people are placed on health visitors' agendas. The bias of the policy agenda towards the under fives is very obvious. In fact the core of health visiting is the protection of children (Chapter 4 section 4.4). Hence other groups not related to this core work tend to be placed in a second or third position and it is very much up to the individual health visitors to decide on their involvement with elderly people. More specifically it was commented that in the District Health Authority where this study took place, elderly clients were placed in "Dormant" files if their conditions were stable or with no hope of improving. Health visitors during this research spontaneously commented about their "guilty" feelings towards this group of population. They wished they had time to care for them but felt that the demands on child surveillance did not allow them. Health visitors reported they could only respond to general practitioners' (GPs) referrals and delegate the follow up to health visitors' assistants or students (Field notes AW April 1991). However, the absence of proactiveness in the care of the elderly could be due to the lack of an anticipatory framework for deteriorating trajectories. Luker (1978) drew attention to this when she suggested that health visitors do not have a model for working with the elderly.

Further, during this study no signs of health promotion activities with this group of population was found, health visitors' interventions with the elderly were mostly palliative. Data suggests that this is related to a predominantly

child development view in health visiting practice. When discussing this issue with health visitors they commented on health promotion activities before old age (Field notes TB, DB, AW August 1990 and April 1991). It seems then that in health visiting health promotion is linked to life development and that this is not regarded as pertinent in the last of stages of life. In addition to this it can be argued that this group of clients could clearly benefit most from a community oriented approach to their needs which would foster social integration and support. Individualistic approaches with elderly people seem to be out of place, there is no need for their social control but their integration and support.

The new GP contract in the UK (DHSS 1987) opens the possibility for more equity in health care services for this group of people. Yearly assessments would be undertaken and many health visitors would be involved in this activity. However it requires a change of focus within the policy agenda and in the professional's understanding of what constitutes the core of health visiting. Population trends and the need for equity in health care make this change in health visiting imperative.

8.2.1 Collectivism

In addition to the dominant individualistic approach to practice this study also found indications of community oriented practice in the form of group work. In the present research this has been labelled as "Novel work" in

health visiting and has connections with the innovative work that has been reported in the professional literature (Chapter 2, section 2.2).

This activity tends to be up to the individual health visitor, hence it is part of "Fringe work". While it tends to be consented to by management, health visitor practitioners are usually left without real support and must rely on their own devices to set up new activities. Thus, the innovative work that health visitors engage in tends to be done on their own initiative and at their own expense. As one participant reported, management is flexible and allows innovation provided that the core work, ie: policy related work, is accomplished (Field notes JT May 1990). Indeed, during this study a general "Laissez faire" attitude to innovative work was found rather than a real support and commitment from managers. However, as discussed (Chapter 2, section 2.3.1), this does not imply that they lack management skills, but rather there is a lack of policy which is committed to a new model of practice. Traditional ways in health visiting are still relevant for implementing the policy agenda, thus they are supported by management.

A partnership style of interaction between clients and professionals is closely connected to a community oriented approach. While previous research studies tend to highlight professional domination (Wiseman 1979, Orr 1980, Clark 1985, Sefi 1985, Robinson K 1986a, Cameron 1990, Foster and Mayall 1990) this study has shown the dynamic character of relationships and hence suggests that they vary. Thus, once a common

agenda between the professional and the client is built, a certain degree of partnership in the interaction can be expected. In the process of building this common agenda authoritarism or laissez faire can be found as strategies to gain client cooperation. Styles of interaction seem not to be fixed in health visiting but develop and are influenced by the strategies used in marketing the health visiting service. However, it must be considered that since the individualistic approach dominates in health visiting, unequal relationships with clients would be the common feature. The paradox is that while health visitors need to gain client cooperation to carry out their job, their approach involves an ideology that does not promote empowerment and participation.

Indeed ideological and structural barriers to a partnership approach can be found in health visiting. Health visitors' vocational ideology manifested in the "Patronage" style of fringe work is clearly a major one (Chapter 6, section 6.5). Also their tendency to "Possess" their clients by calling them "My" mum or "My" baby, is another ideological barrier. This is similar for nursing in general (Wolff 1988). The major structural restriction seems to be on the health visitor's role, which emanates from the policy agenda, as "Supervisors" of the dependent's trajectory. This places the health visitor in a superior position to carers which clearly inhibits an equal relationship with them.

For partnership to take place in health visiting, health visitors should regard themselves more as carers' supporters than their supervisors or controllers. Thus, a vocational ideology ought to be replaced by a professional ideology (Chapter 6, section 6.5) which involves a commitment to empower both primary clients and secondary clients. If a change of approach is going to take place in health visiting, policy should promote collectivistic values and review those involved in the individualistic approach. Collectivistic and individualistic approaches have a different ideological basis, hence it is contradictory and inefficient to advocate as is the case in the literature (Chapter 2, section 2.3.1) that health visitors would incorporate both approaches in practice. In general, they would opt for one approach or another. Thus, it was shown that a tactic to reconcile an individualistic approach with the evidence of its irrelevance was that of "Normalizing deviance" (Chapter 7 section 7.4.2). Here when facing inequality, the health visitors' individualistic ideology will normally show her/him opting for adjusting clients to an unfair situation instead of promoting social change through other means.

8.3 CONTROL VERSUS SUPPORT

Looking into the health visitor's overall role it seems that the policy agenda places health visitors in a dual role. On the one hand, health visitors are expected to bring a universal service to clients on a voluntary basis, for example with immunizations, and to survey their health. Here it was shown

that child surveillance is a health visitors' major focus. On the other hand, health visitors are expected to prevent ill health and promote good health. Health visitors are thus required to do both: To control and to give a service to clients. Other research has highlighted this dual position, it has been referred to as health visitors having to cope with both a police and educator role (Mayall and Foster 1989).

This is a reflection of the Welfare State internal contradiction. The Welfare State comprises two sets of activities, the provision of health and social services and the regulation of private activities. Hence, it exhibits positive and negative features "Within a contradictory unity" (Gough 1982 p. 11). According to Gough (1982), the welfare state embodies simultaneously both tendencies: To enhance health and social welfare and to repress and control people. This is consistent with other more moderate views expressed about the welfare state. It has been acknowledged that government financed welfare services entail a loss in individual liberty (Sugden 1983) and that the Welfare State must seek a balance among a number of opposed conceptions and principles (Moon 1988). When the consequences of marketing were discussed (Chapter 7), the double effect of health visitors' strategies came to light. They could lead to the creation of a context which gave support to clients and might also have the negative effect of creating dependence, and the adjustment of clients to unequal situations.

It has been stated that health visitors could be regarded as agents of social change, if they enabled clients to make their own choices about health matters, or on the contrary they could be considered as agents of social control (Willis 1982). According to Willis (1982), both positions represent extremes of a continuum and that it is hoped that the reality "Lies somewhere towards the centre" (Willis 1982 p. 36), Clark (1985) sustains a similar view. In her study she concluded that health visitors seemed to adopt a middle position between the extremes of "Professional" and "Friend" relationship. This study offers an alterative explanation. Findings suggest that instead of adopting a balanced position between the two extremes, health visitors adopt a role format which combines both control and change while interacting with clients (Chapter 7, section 7.2.2.2). It is suggested here that this is a reflection of the inherent contradictions of the welfare state.

It appears that organizations such as the HVA and the now discontinued CETHV, had overlooked the above issue. Hence, the CETHV and the HVA regard health visitors as agents of social change (CETHV 1977, HVA 1987a). Further, by applying the health visiting principle of influencing policies affecting health, the CETHV expected that health visitors would:

> *"... engage in <u>political activity</u> designed to support policies conducive to health and to challenge policies not conducive to health" (CETHV 1977 p.45).*

This study has drawn examples of health visitors being agents of social control even when they appear to support parents by, for example, adjusting standards to clients' circumstances (Chapter 7, section 7.4.2). Robinson (1980) also drew attention to the fact that the benevolent image chosen by health visitors of universally dispensing preventive care, has masked some fundamental issues, one of them that of social control.

This research suggests that, due to the context where health visitors work, their role is close to that identified by Szasz (1973) for psychiatrists, ie: Double agents. However, that does not mean that all health visitors "Work" for the system. Those who are involved in novel work can be regarded as being on the client's side and "Working" for them. While they have to perform a double function, they are committed to clients and thus a supporter role predominates. It was suggested (Chapter 6, section 6.5) that this is related to health visitors' ideology. This is consistent with Field's (1983) ethnography of four public health nurses. She found that the most important factor that influenced the model of nursing which each nurse developed was the values they held in relation to their lifestyle and experiences.

Social control is a very obvious issue in health visiting. Here it converges three different sources that relate to social control: 1) The role of the medical profession as an agent of social control, 2) The role of public health

in policing health behaviours and 3) The role of the state in controlling private life.

The fact that medicine is an institution of social control has been widely discussed (Parsons 1951; Friedson 1970; Zola 1972; Illich 1976;). Also it has been emphasized that public health operates as a control agent by setting and enforcing certain standards in the home (Conrad 1979 p.2). In more radical terms, community medicine has been regarded as a cheap and invisible structure of "Concessions" and "Repression" through medicine (Breilh 1982). Breilh (1982) regards community medicine as a new form of police work, more subtle and refined than the "Medical police" of the 18 th Century. On similar lines Foucault (1977) has shown that social control has become more subtle, professionalised and oriented to surveillance of deviant behaviour.

The role of health visitors as instruments of state intervention in family life has been highlighted elsewhere (Dingwall and Eekelaar 1988; Dingwall and Robinson 1990) and discussed in chapter 2 (Section 2). By concentrating on preventing measures to change individual behaviour, health visitors transmit the victim blaming ideology, which, according to Davis (1979) has permeated British preventive policies. This is consistent with Littlewood's (1988) finding about health visitors using a victim blaming approach when evaluating their work. Victim blaming is another form of exercising social control. Crawford (1977) explains it as "Psychological social control". He

argues that under this ideology, which is basically the belief of individual responsibility for health, susceptibility to at risk behaviour if not a moral failure, is a psychological one (Crawford 1977 p. 672).

It seems that the trend of a victim blaming ideology will continue when developing preventive programmes. The document The Health of the Nation (DOH 1991) is heavily weighted on changing people's lifestyles without mentioning the need for developing healthy policies or taking other supportive measures such as manpower development or legislation. It is worth noting that while one of the objectives is to improve environmental quality and housing conditions, in the document it is stated that "Health outcome targets are not possible at this stage." It is also stated that targets for environment quality already exists in several areas mentioning air and water standards that had to comply any way with EC legislation (p. 16, Summary document). Thus, the overall approach in this strategy document is highly individualistic and hence falls short in addressing the factors that cause ill health. The individual is once more left with all the responsibility.

Similar conflicts between controlling clients or giving a service that meet their needs, have been reported in the literature from the USA.

While it is acknowledged that public health nurses are expected to perform as activists and social reformers, their role is:

> *"...to penetrate and alter the client's negative perceptions of the health care system, rather than penetrate and alter the system itself, even though such negative attitudes may well be a realistic appraisal of existing health care." (Dreher 1982).*

Hoping that nurses would simply alter the system, is not only a naive proposal that overlooks the context where professionals work takes place, but also makes unrealistic demands on practitioners. It is almost impossible to achieve change unless the system supports the new approach to some extent.

Indeed, this study shows that by accommodating agendas, via the "Marketing" process, health visitors are able to combine both a supportive and a controller role. Regarding health visitors' supporting role, this study indicates that the tactics employed in marketing health visiting might well lead to developing a policy that responds to clients' needs instead of controlling their behaviour. Novel work is an example of this. The innovative work that had been reported in the literature (chapter 2, section 2.3.2) referring to the introduction of progressive services and community developmental experiences, is an example of health visitors exploiting the supportive side of their roles.

The fact that the Welfare State is not accomplishing all its promises (MacGregor 1981), reinforces the health visitors' adoption of a supporter role. Cutbacks in welfare services show that there is an imbalance between the controlling and the giving service functions of the State. By implementing fringe work activities health visitors attempt to readdress this imbalance. However, fringe work is a double edged concept: it could enforce one or the other function. Hence relief work could be an instrument of social control. By giving on grounds of merit and the health visitors' distinction between those who deserve help from those who do not, they are in fact exerting control.

Hence, health visitors when relating to clients are placed in a contradictory position of both giving a service and controlling clients. Nevertheless, while they cannot escape the controlling functions inherent in their role, they can offer real support to clients and alter the policy agenda towards a more client oriented service. By uncovering, in this study, the existence of the clients' agenda it is hoped that it will persuade practitioners, managers and policy makers of the need for health visitors to develop a supportive or enabling role. Finding out about client's needs and making a community health diagnosis is the start of this task. It means that the accomplishment of a common agenda will dominate the interaction from the onset and this will be relevant to the client.

Indeed, the introduction in health visiting of an assessment of health needs has been repeatedly advocated in the literature. However, the influence of the general context in heath visitors' work has not been described nor discussed in the literature. To assume that to do caseload, profiles and community health diagnoses is just a matter of introducing a technique is naive and puts the blame on practitioners if failure in implementation occurs. The policy agenda clearly needs to shift its values and priorities to accommodate a different way of interaction with clients. The victim blaming ideology that still permeates in health visiting activities of prevention (Littlewood 1988; Davis 1979) and health promotion (Foster and Mayall 1990) needs to be replaced. Thus, it is not a matter of adding more tasks to the already heavy caseloads of health visitors or organizing work differently. It is clearly a redefinition of the professional's role which is required.

8.4 THE DEVELOPMENT OF RELATIONSHIPS WITH CLIENTS

In chapter 5 the relationship that health visitors build with clients is featured as a mediating factor between the policy agenda and client's expectations of the service. This relationship can thus be regarded as mediating health visitors' conflicting roles: that of policing and that of giving a service.

Robinson (1980) has acknowledged that health visitors are expected to be simultaneously a friend of the family and to monitor early deviation from

normal. She suggests that health visitors attempt to solve this conflict by moving towards either a clinical or social science perspective. This study however, does not support this view. The relationship has been identified as a key element in balancing both roles.

Other qualitative studies have shown the importance of the relationship in health visiting. While some of them appear to regard it as an end in itself (Clark 1985, De Silva 1988) others went further and considered it as a means to reach different aims. Hence, Chalmers (1990) found that a positive relationship will permit both the giving of the service and securing the future access to clients. According to her a relationship is needed "For the complete work of the health visitor" (p. 181). The present study acknowledges the importance of relationships in health visiting and highlights its enabling function.

Further, this study has shown that to achieve a cooperative relationship seems to be the ultimate aim of the interaction. The labour employed in this process is highly emotional and hence invisible.

Mills (1953) probably was the first to point out the emotional work attached to jobs. He stated that:

> *"When white collar people get jobs, they sell not only their time and energy but their personalities as well. They sell by the week or month their smiles and their kindly gestures, and they*

must practice the prompt repression of resentment and aggression" (Mills 1953 p. XVII. My emphasis).

Following Mills' insight, Hochschild (1983) uncovered the process of managing feelings and analyzed the emotional labour involved in selling oneself. According to her the emotional labour is required basically to induce or suppress feeling in order to produce in others the sense of "Being cared for in a convivial and safe place" (Hochschild 1983 p. 7). Acting is thus the central activity in managing emotions.

The present study has highlighted the emotional effort that health visitors put into selling themselves in their meetings with clients (Chapter 5 section 5.4.1). This is consistent with Robinson's K findings. (1986a). She reports that health visitors imitated a conversational form of "Friend of the family" in their encounters with clients. Imitating indicates that health visitors were doing acting work and hence managing their feeling to create the impression of being a friend.

However the emotional labour is not only directed towards selling a personality or a given service. In the context of lay carers, Graham (1983) by describing caring as a labour of love shows the nourishing and supportive nature of emotional work. She states that in nursing, social work and primary teaching social relations are mediated through care. These relations are based upon both affection and service. This is consistent with the view

that regards caring in nursing as an interpersonal interaction where the nursing intervention that is "Administered caringly is qualitatively different than a non-caring encounter" (Morse, Bottorff, Neander and Solberg 1991 p 123 My emphasis). Strauss et al (1985) also stressed the positive difference that sentimental work makes in patient care. They stated that malpractice is related not only to definitions of staff negligence and incompetence, but also to the lack of emotional labour necessary to establish and maintain trust (p. 149).

In health visiting the emotional work involved when interacting with clients has been rarely acknowledged. Perhaps this is because caring is invisible, unpaid and devalued (Graham 1983). There is some acknowledgement of health visitor's caring labour when the literature refers to the support they give to clients. In the present study some fringe work activities could be regarded as informal caring, clearly those that relate to surrogacy work (Chapter 6, section 4.3). While fringe work serves the purpose of establishing credibility in health visiting services, it could also be a way of caring for clients.

The study reported here concludes that the relationship which health visitors establish with clients also serves as a substitute for the coercive measures of the past to get the client's compliance. A "Friend" approach to carers has been shown as a key factor for creating a trusting climate and being able to

influence clients. Thus, the emotional labour of "Making friends" with clients is also directed towards gaining their cooperation.

The importance of a collaborative relationship between public health nurses and clients has been stressed in the literature (Kristjanson and Chalmers 1991). This need for the client's cooperation is different from other types of interactions with clients (Mills 1953, Bigus 1978, Hochschild 1983). In these situations clients consume a product already manufactured, that is goods in a shop, a flight or a dairy product. In health visiting although there is a pre determined service, this is shaped to the client's situation. Stacey (1976) depicts the health services as a process of interaction between patients and health care workers. Further, Stevenson (1976) has asserted that in human services occupations the "Product" is a form of interaction and that "Nothing is produced unless it is also consumed" (p. 82). Hence, in health visiting the "Product" takes shape or is "Manufactured" in the very process of the interaction.

Thus, it can be argued that the collaborative interaction that is achieved between health visitors and clients is the means by which professionals actualize their services. Unless the client is willing to "Buy" health visiting, the service does not take place. This accounts for statements made about health visiting being a kind of interaction (Clark 1985, De Silva 1988). Chalmers work (1990) points also in this direction. When she describes health visiting as a process of giving and receiving, she is addressing a

collaborative interaction. In health visiting, as in other service professions, reciprocity is not only desirable in the interaction, but essential if the service is going to ever evolve. Client's willingness to collaborate or accept health visiting "License" its "Manufacturing".

This has been taken for granted in health visiting. It is assumed that clients will readily consume a service. The labour involved in "Winning" clients and keeping them tends to pass unnoticed by management. It has not been documented and hardly discussed in the literature. Health visitor's activity tends to be evaluated by tasks and activities performed such as the number of clients seen, the number of visits made to the different age groups, the number of referrals and health education activities preformed.

Robinson (1980) draws attention to the risk of proving "Success" in health visiting by considering only those factors that can be quantitatively evaluated and ignoring the intangible elements of the health visitor-client interaction (p.31).

It can be concluded that the relationship that health visitors establish with clients can be regarded as the link between the production of a service and its consumption. The nature of health visiting, a human service occupation, makes the relationship the factor that unifies production and consumption of the service. It involves emotional labour, mediates in health visitors' conflicting roles and, as this study has shown, is developed when using a marketing process. By uncovering this process and presenting how it feeds

into the context for introducing the professional agenda, it is hoped that this research has contributed to making health visiting more visible and that this will be considered when appraising health visitors' work.

8.5 CONCLUSIONS

In conclusion, this research has uncovered the basic social process in health visiting. It has highlighted the accommodation process of professional's and client's agendas and made the connection between the policy agenda and the need for health visitors to "Market" their services. A non official type of work, labelled Fringe work, was found and its double function was stressed: That of developing policy towards relevant services for clients and that of increasing the social control components of the policy agenda. Lastly, the role of the relationship as a conducive context for accommodating agendas has also been depicted contributing hopefully to the visibility of a crucial element in health visiting work.

Community services as discussed in Chapter 2 (Section 2.2.2) are undergoing many changes in the UK which would affect health visiting practice. The more obvious is the new GP contract which places them at the heart of PHC team. Health visitors might lose part of their traditional territory with children and mothers and also lose the autonomy they used to have. However, there are possibilities of health visiting widening the scope of their work to other groups especially the elderly.

While this study does not claim generality, it is stressed here that it depicts incidents bound to a given time and place, it is hoped that it will bring understanding into health visiting and hence assist in the development of the services.

From this study it can be concluded that:

1) When introducing innovations into health visiting or new approaches to practice, there is a need to take into account the contradictory position of health visitors and make provisions for this.

2) The policy agenda in health visiting should incorporate the values involved in the advocated changes for practice. Specifically, there is a need for a health visiting policy to incorporate the values involved in the partnership and enabling approach to clients. This is a requisite for health visitors to change their position vis a vis clients.

3) Health visitors should share the values involved in a professional ideology that fosters client's capabilities to bring about change.

4) In order to achieve points 2 and 3, health visitors controlling function should be reassessed and refocused. The universality of the health visiting service does not necessary need to convey universal control which currently tends to happen. Health visitors' controlling functions therefore ought to be more selective.

5) It is necessary to acknowledge and value the role of the relationship within health visiting work. Practitioners should be aware of the

manipulative and supportive character that such relationships might have.

6) Health visiting education could benefit if the elements of social marketing are examined and its potential danger of promoting individualism appraised. This would contribute to preventing practitioners from adopting an approach in which client's needs are disregarded and dependence on a finished product is promoted.

Referring to this study, it seems necessary to undertake additional research into the concept of life trajectories and specifically to further develop the concept of the "Awkward" trajectory. To develop this category, has not been possible during the present study. To proceed with documenting the emotional labour involved in health visiting and assessing its impact on both practitioners and clients appears to be another area where further research is needed.

It would also be useful to continue exploring the concept of "Fringe work", to ascertain whether it takes place under other conditions and if there are additional consequences. To continue examining the role that health visitor's ideology plays in adopting a given work pattern and how it is connected with current health visiting policy is another area that requires further study.

REFERENCES

Anderson W, T. and Helm D, T. (1979). The Physician-Patient Encounter: A Process of Reality Negotiation. In G. Jaco E (eds). Patients, physicians and illness: A source book in behavioural science and health (pp. 259-271). New York: The Free Press.

Antle May, K. (1989). Interview techniques in qualitative research: Concerns and challenges. In M. Morse J (eds). Qualitative Nursing Research: A Contemporary Dialogue (pp. 171-182). Rockville, Maryland: Aspen.

Archer S, E. (1983). Marketing. Nursing Outlook, 31, 6, pages 305-309.

Ashton, J. and Luker, K. (1991). Healthy cities?. Community Outlook, 1, 1, pages 32-34.

Baker, G., Bevan J, M., McDonnell, L. and Wall, B. (eds) (1987). Community Research and Recent Developments. London: Croom Helm.

Balint, (1957) cited in G. Jaco E (ed). Patients, physicians and illness: A source book in behavioural science and health p. 264. New York: The Free Press

Bee, H. (1989). The developing child- 5th Edition. New York:Harper & Row.

Benner, P. (1984). From Novice to Expert. Menlo Park, CA:Addison-Wesley.

Berthoud, R. and Brown J, C. (1981). Poverty and the Development of Anti-Poverty Policy in the United Kingdom. London:Heinemann Education.

Bigus O, E. (1978). The milkman and his costumer: A cultivated relationship. In J. Lofland (eds). Interaction in Everyday Life (pp. 85-119). Newbury Park CA: Sage.

Billingham, K. (1989). 45 Cope Street: working in partnership with parents. Health Visitor, 62, 5, pages 156-157.

Birk, H. (1988). Initiating Outreach Home Visits: Public Health Nurses Approaches. Unpublished doctoral dissertation, Alberta, Alberta.

Blumer, H. (1969). Symbolic Interactionism: Perspective and method. Englewood Cliffs:Prentice Hall.

Bolton, G. (1980). Prevention: An exploratory study of health visiting in England, Wales and Scotland. In A. While (eds). Research in Preventive Community Nursing (pp 168). Chichester: John Wiley & Sons.

Boomer H, J. (1987). Health for All by the Year 2000: The Role of the Health Visitor. Health Visitor, 60, 1, pages 9-10.

Breilh, J. (1982). Community Medicine Under Imperialism: A New Medical Policy?. In V. Navarro (eds). Imperialism, Health and Medicine (pp. 149-168). London: Pluto Press.

Bryant J, H. (1988). From Alma Ata to the year 2000: Reflections at the midpoint on progress and prospects. In WHO (eds). From Alma Ata to the Year 2000: Reflections at the midpoint (pp. 14-18). Geneva: WHO.

Bunton, R. (1991). Marketing the social: Postmodern tendencies in health promotion. Unpublished paper presented at the British Sociological Association Annual Conference. Manchester.

Burgess R, G. (1982a). Some role problems in field research. In G. Burgess R (eds). Field research: A sourcebook and field manual (pp. 45-49). London: George Allen & Unwin.

Burgess R, G. (1982b). Keeping field notes. In G. Burgess R (eds). Field research: A source book and field manual (pp. 191-194). London: George Allen & Unwin.

Burns, J. (1985). The vulnerability factor. Community Outlook. Nursing Times, 81, November, pages 27-30.

Cameron, S.(1990). First time mothers and their health visitors perceptions of a home visit. Nursing Research Unit, University of Edinburgh. Hand out given at presentation at the department of Nursing, University of Liverpool.

Campbell A, V. (1984). Moderated Love: A theology of professional care. London:SPCK.

Child Development Project, (1984). Child Development Project. University of Bristol. Unpublished document.

Chalmers K, I. (1990). Preventative work with families in the community: a qualitative study of health visiting practice. Unpublished doctoral dissertation, University of Manchester, Manchester.

Chalmers K, I. and Luker K, A. (1991). The development of the Health visitor-client relationship. Scandinavian Journal of Caring Science, 5, 1, pages 33-41.

Chambers, N. (1991). Nurse practitioners in primary care. Primary health Care Management, 1, 11, pages 4-5.

Chenitz W, C. (1986). The informal interview. In C. Chenitz W and M. Swanson J (eds). From practice to grounded theory (pp. 79-90). Menlo Park, CA: Addison-Wesley.

Clark, J. (1973). A family visitor. London:Rcn.

Clark, J. (1981). What do health visitors do? A review of the research 1960-1980. London:Rcn.

Clark, J. (1985). The Process of Health Visiting. Unpublished doctoral dissertation, The Polytechnic of Southbank, London.

Clay, T. (1988). Community service left to struggle on. Nursing Times, 84, 6, pages 6.

Connolly, J. (1983). Improving the balance-Part 1. Nursing Times, 79, 37, pages 51-53.

Conrad, P. (1979). Types of social control. Sociology of Health and Illness, 1, 1, pages 1-11.

Copenhall, K. (1990). Raising health visitors profiles. Health Visitor, 63, 1, pages 26-27.

Corbin, J. (1986a). Qualitative data analysis. In W. Chenitz C and M. Swanson J (eds). From practice to grounded theory: Qualitative research in nursing (pp. 91-101). Menlo Park, CA: Addison Wesley.

Corbin, J. (1986b). Coding, writing memos, and diagramming. In C. Chenitz W and M. Swanson J (eds). From practice to grounded theory (pp. 102-120). Menlo Park, CA: Addison-Wesley.

Corbin J. (1980). Protective Governing: Strategies for managing a pregnancy-illness. Unpublished doctoral dissertation, California, San Francisco.

Corbin, J. and Strauss, A. (1990). Grounded Theory Research: Procedures, Canons, and Evaluative Criteria. Qualitative Sociology, 13, 1, pages 3-21.

Council for the Education and Training of Health Visitors (CETHV), (1977). An Investigation into the Principles of Health Visiting. London:CETHV.

Council for the Education and Training of Health Visitors (CETHV), (1982). Health Visiting Principles in Practice. London:CETHV.

Cowley, S. (1991). An awareness context in health visiting. Unpublished paper presented at the Rcn Research Advisory Group Conference. London.

Crawford, R. (1977). You are dangerous to your health: The ideology and politics of victim blaming. International Journal of Health Services, 7, 4, pages 663-680.

Cuff E, C. and Payne G, C. (1984). Perspectives in Sociology 2nd edition. London:George Allen & Unwin.

Cuff E, C., Sharrock W, W. and Francis D, W. (1990). Perspectives in sociolgy. 3rd. Edition. London:Unwin Hyman.

Dauncey, J. (1988) cited in Goodwin S (1988) Wither Health Visiting? Key note speech p. 10. Health Visitor's Association Annual Study Conference. Bournemouth.

Davies, C. (1988). The Health Visitor as Mother's Friend: A woman's place in public health, 1900-14. Social History of Medicine, 1, 1, pages 39-59.

Davis A, G. (1979). An unequivocal change of policy: Prevention health and medical sociology. Social Science and Medicine, 13a, 2, pages 129-137.

Davis M, Z. (1986). Observation in natural settings. In W. Chenitz C and M. Swanson J (eds). From practice to grounded theory (pp. 48-65). Menlo Park, CA: Addison-Wesley.

De la Cuesta, C. (1991). Participacion de los profesionales en el proceso de reforma de la atencion primaria. Notas de enfermeria, 1, 10, pages 634-638.

De Silva P, S. (1988). Public Health Nursing: Phenomenologic meaning and dialectical theory. Unpublished doctoral dissertation, Texas, Austin.

Dean, M. and Bolton, G. (1980). The administration of poverty and the development of nursing practice in nineteenth-century England. In C. Davies (eds). Rewriting Nursing History (pp. 77-101). London: Croom Helm.

Degeling, P. (1986). The management of conflict in health care. Unpublished paper. School of Health Administration. University of New South Wales, Australia.

Denny, E. (1989). The future of health visiting. Health Visitor, **62**, 8, pages 250-251.

Denzin N, K. (1978). The research act. New York:MacGraw-Hill.

Department of Health (DOH), (1989a). Caring for people-Community care in the next decade and beyond. London:HMSO.

Department of Health (DOH), (1989b). Working for Patients: Caring for the 1990's. London:HMSO.

Department of Health and Division of Nursing (DOH), (1989c). A Strategy for Nursing. A Report of the Steering Committee. London:DOH.

Department of Health (DOH), (1990a). Nursing in the Community. Report of the working group. London: HMSO

Department of Health, (DOH), (1990b). Health and Personal Services Statistics. London:HMSO.

Department of Health, (DOH), (1991). The Health of the Nation. London:HMSO.

DHSS, (1986). Neighbourhood Nursing-Afocus for care.Report of the Community Review. London:DHSS.

DHSS, (1987). Promoting Better Health: The Goverment's Programme for Improving Primary Healh Care. London:HMSO.

Diamond, T. (1989). Social policy and everyday life in nursing homes: A critical ethnography. In P. Brown (eds). Perspectives in Medical Sociology (pp. 490-505). Belmont, CA: Wadsworth Publishing Co..

Dingwall, R. (1976a). The social organisation of health visitor training. 1 The social theories of health visitors. Nursing Times, **72**, 7, pages 25-28.

Dingwall, R. (1976b). The social organisation of health visitor training 3. Health visiting as an occupation. Nursing Times, **72**, 9, pages 33-36.

Dingwall, R. (1977a). Collectivism, Regionalism and Feminism: Health Visiting and British Social Policy 1850-1975. Journal of Social Poicy, **6**, 3, pages 291-315.

Dingwall, R. (1977b). The social organization of healh visitor training. London:Croom Helm.

Dingwall R and Robinson, K. (1990). Policing the family?. In A. Gubrium G and Sanhar (eds). The home care experience (pp. 253-273). Newbury Park CA: Sage.

Dingwall, R. and McIntosh, J. (eds) (1978). Readings in the Sociology of Nursing. Edinburgh: Churchill Livingstone.

Dingwall, R., Eekelaar J, M. and Murr, T. (1983). The protection of children: State intervention and family life. Oxford:Blackwell.

Dingwall, R. and Eekelaar J, M. (1988). Families and the State: An historical Perspective on the Public Regulation of Private Conduct. Law and Policy, 10, 4, pages 341-361.

Donzelot, J. (1980). The Policing of Families. London:Hutchinson.

Dreher M, C. (1982). The Conflict of Conservatism in Public Health Nursing Education. Nursing Outlook, 30, 9, pages 505-509.

Drennan, V. (1985). Working in a different way. A research project examining community work, methods and health visiting. Paddington and North Kensington Health Authority. Unpublished report.

Drennan, V. (1986a). Developments in health visiting. Health Visitor, 59, 4, pages 108-110.

Drennan, V. (1986b). Talking to health visitors: Perceptions of their work. In A. While (eds). Research in Preventive Community Nursing Care (pp. 39-49). Chichester: John Wiley & Sons.

Drennan, V. (1988a). Changing Health Visiting Practice. In V. Drennan (eds). Health Visitors and Groups: Politics and Practice (pp. 1-30). Oxford: Heinemann Nursing.

Drennan, V. (eds) (1988b). Health Visitors and Groups. Oxford: Heinemann Nursing.

Dunnel, K. and Dobbs, J. (1982). Nurses working in the community (OPCS). In G. Baker, M. Bevan J, L. MacDonnell and B. Wall (eds). Community Nursing Research and Recent Developments (pp. chapter 5 B3 B2). London: Croom Helm.

Dunscombe, V. (1985). A group with a difference. Nursing Times, 81,1, pages 26-28.

Editorial, (1982). The need for a National Inquiry into the Proper Role and Functions of Healh Visitors and School Nurses. Health Visitor, **55**, 9, pages 445.

Edwards, J. (1986). Benchmarks for health visiting practice. In A. While (eds). Research in Preventive Community Nursing Care (pp. 83-101). Chichester: John Wiley & Sons.

Fagerhaugh S, Y. and Strauss, A. (1977). Politics of Pain Management: Staff-Patient interaction. Menlo Park, CA:Addison-Wesley.

Fagerhaugh S, Y. (1986). Analyzing data for basic social processes. In C. Chenitz W and M. Swanson J (eds). From practice to grounded theory (pp. 133-145). Menlo Park, CA: Addison-Wesley.

Fatchett, A. (1989). Alternative approaches. Nursing Times, **85**, 42, pages 64-65.

Fatchett, A. (1990). Health Visiting: A withering profession?. Journal of Advanced Nursing, **15**, 2, pages 216-222.

Field P, A. (1983). An ethnography: four public health nurses' perspectives of nursing. Journal of Advanced Nursing, **8**, 1, pages 3-12.

Field P, A. (1990) Personal communication.

Field P, A. and Morse J, M. (1985). Nursing Research: The application of qualitative approaches. London:Croom Helm.

Fitton, J. (1980). Health visiting the aged. Health Visitor, **53**, 10, pages 521-523.

Foster M, C. and Mayall, B. (1990). Health visitors as educators. Journal of Advanced Nursing, **15**, 3, pages 286-292.

Foucault, M. (1975). The Birth of the Clinic. New York:Vintage Books.

Foucault, M. (1977) cited in Waitzkin (1989). A Critical Theory of Medical Discourse: Ideology, Social Control, and the Processing of Social Context in Medical Encounters p 226. Journal of Health and Social Behaviour, **30**, 6, pages 220-239.

Fox K F, A. and Kotler, P. (1980-81). Reducing cigarette smoking: An opportunity for social marketing. Journal of Health Care Marketing, **1**, 1, pages 8-17.

Fox, S. (1990). The price of a child's life. Health Visitor, **63**, 7, pages 216-217.

Frances, G. (1985). Priorities and Caseload Management in Health Visiting. Wolverhampton Health District. Unpublished Report.

Friedson, E. (1960). Client Control and Medical Practice. American Journal of Sociology, 65, 4, pages 374-382.

Friedson, E. (1970). The profession of Medicine. New York:Dodd, Mead.

Gans H, J. (1973). The positive function of poverty. American Journal of Sociology, 78, 2, pages 275-289.

Garcia Encabo, M. (1990) Introduccion a las VII Jornadas de debate sobre la Sanidad Publica. Diciembre 1988. Madrid:FADSP

Gardner, (1924) cited in De Silva (1988). Public Health Nursing; Phenomenologic Meaning and Dialectical Theory p. 34. Unpublished doctoral dissertation, Texas, Austin.

Gaynor S, E. (1990). The Long Haul: The Effects of Home Care on the Caregivers. IMAGE Journal of Nursing Scholarship, 22, 4, pages 208-212.

Glaser, B. (1978). Theoretical sensitivity. Mill Valley CA:Sociology Press.

Glaser B, and Strauss A, L. (1967). The Discovery of Grounded Theory; Strategies for Qualitative Research. Chicago:Aldine Press.

Glaser B, and Strauss A, L. (1965). Awareness of dying. Chicago:Aldine.

Glaser B, and Strauss A, L. (1968). Time for dying. Chicago:Aldine.

Goffman, E. (1961). Asylums. Middlesex:Penguin.

Gold R, L. (1958). Roles in Sociological Field Observation. Social Forces, 36, 3, pages 217-233.

Gooch, S. (1989). The health visitor's influence: Imperatives for change. Nursing Standard, 4, 5, pages 36-39.

Goodwin, S. (1988) Wither Health Visiting? Key note speech. Health Visitors' Association Annual Study Conference. Bournemouth.

Gott, M. and O'Brien, M. (1990). The role of the nurse in health promotion. Health promotion international, 5, 2, pages 137-143.

Gottlieb, L. and Rowat, K. (1987). The McGill model of nursing: A practice-derived model. Advance Nursing Science, 9, 4, pages 51-61.

Gough, I. (1982). The political economy of the Welfare State. London and Basingstoke:The Macmillan Press.

Graham, H. (1979). "Prevention and health: Every mother's business". A comment on child health policies in the 1970s. In C. Harris (eds). The sociology of the family: New directions for Britain (pp. 160-185). Keele: University of Keele.

Graham, H. (1983). Caring: A labour of love. In J. Finch and E. Droves (eds). A labour of love: Women, work and caring (pp. 13-30). London: Routledge & Kegan Paul.

Graham, H. (1984). Women, Health and the Family. Brighton:Wheatshead books.

Gregory, D. (1982). Spreading the word- A study of health visitor's consciousness and understanding of collectivism and community work. Unpublished doctoral dissertation, University of Surrey, Surrey.

Griffiths, Sir R. (1988). Community Care: Agenda for Action. A Report to the Secretary of State for Social Services. London:HMSO.

Grimaldi R, D. (1990). Marketing Sanitario y Equidad. In J. Murillo M (eds). Salud y Equidad. VIII Jornadas de Economia de la Salud (pp. 371-385). Madrid: Ministerio de Sanidad y Consumo.

Halsey, (1987) cited in Moore (1990) The idea of an 'Underclass' p 8. Unpublished paper, Department of sociology, The University of Liverpool.

Hammersley, M. and Atkinson, P. (1983). Ethnography principles in practice. London:Tavistock.

Handler J, F. (1968). The coercive children's officer. New Society, 12, 314, pages 485-487.

Harrison J, P. (1986). The workloads of health visitors in Sheffield. Unpublished document. Department of Health Studies. Sheffield City Polytechnic. Sheffield.

Harrison J, P. (1988). The Information and Planning Needs of Health Visitors. Unpublished doctoral dissertation, Sheffield City Polytechnic, Sheffield.

Hart, H., Bax, M. and Jenkins, S. (1981). Use of the child health clinic. Archives of Disease in Childhood, 56, pages 440-445.

Hayek F, A. (1945) cited in Dingwall, R. and Eeekelaar J, M. (1988) Families and the State: An historical Perspective on the Public Regulation of Private Conduct p 358. Law and Policy 10 ,4, pages 341-361

Haylock, M. (1981). A 24 hours health visiting service. Health Visitor, 54, 1, pages 16-18.

Health Visitors' Association (HVA), (1985). Health Visiting and School Nursing: The Future. London:HVA.

Health Visitors' Association (HVA), (1987a). All for Health: Perspectives on Education and Training of Health Visitors. London:HVA.

Health Visitors' Association (HVA), (1987b). Bridging the Gap: Perspectives on Consumer Participation in the Health Visiting and School Nursing Services. London:HVA.

Health Visitors' Association (HVA), (1987c). Health Visiting and School Nursing Reviewed. London:HVA.

Hick, D. (1976). Primary Health Care. London:HMSO.

Himmelfarb, G. (1984). The Idea of Poverty. London:Faber and Faber.

Hiskins, G. (1981). How mothers help themselves. Health Visitor, 54, 3, pages 108-109.

Hobbs, P. (1973). Aptitude or environment. London:Rcn.

Hochschild A, R. (1983). The Managed Heart-Commercialization of Human Feeling. Berkely:University of California Press.

Hughes, D. (1977). Everyday and Medical Knowledge in Categorising Patients. In R. Dingwall, C. Health, M. Rein and M. Stacey (eds). Health Care and Health Knowledge (pp. 127-140). London: Croom Helm.

Hughes E, C. (1971). The Sociological Eye. Chicago:Aldine-Atherton.

Hunt, M. (1972a). The Dilemma of Identity in Health Visiting 1. Nursing Times, 68, 5, pages 17-20.

Hunt, M. (1972b). The Dilemma of Identity in Health Visiting 2. Nursing Times, 68, 6, pages 23-24.

Hutchinson, S. (1986). Grounded Theory: The method. In C. Munhall P and Oiler (eds). Nursing Research: A qualitative perspective (pp. 111-130). Norwalk, CT: Appleton Century Crofts.

Hutchinson, S. and Webb, R. (1989). Teaching Qualitative Research: Perennial Problems and Possible Solutions. In M. Morse, J. (eds) (1989). Qualitative Nursing Research: A Contemporary Dialogue (pp. 285-302). Rockville, Maryland: Aspen.

Illich, I. (1976). The limits to Medicine. Middlesex:Penguin.

Illich, I. (eds) (1977). Disabling professions. London: Marion Boyars.

Illingworth R, S. (1983). The development of the infant and young child: normal and abnormal. Eighth edition. Edinburgh:Churchill Livingstone.

INSALUD, (eds) (1985). I Jornadas Nacionales de enfermeria. Madrid: INSALUD.

INSALUD, (eds) (1988) Subdireccion General de Gestion de Atencion Primaria. Indicadores de actividad de los Equipos de Atencion Primaria. 4 trimestre 1988. Madrid:INSALUD.

Kirkpatrick C, A. (1971). Salesmanship. Cincinnati:South Western.

Kotler, P. and Levy S, J. (1969). Broadening the Concept of Marketing. Journal of Marketing, 33, 1, pages 10-15.

Kotler, P. and Zaltman, G. (1971). Social Marketing: An approach to planned social change. Journal of Marketing, 35, 3, pages 3-12.

Kristjanson M, N. and Chalmers K, I. (1991). Preventive work with families: issues facing public health nurses. Journal of Advanced Nursing, 16, 2, pages 147-153.

Laing, R. (1986). The health visitor's role in child abuse. Child Abuse review, 1, 4, pages 10-13.

Land, H. (1978). Who Cares for the Family?. Journal of Social Policy, 7, 3, pages 257-284.

Levi-Strauss, C. (1965). The Principle of Reciprocity. In L. Coser A and B. Rosenberg (eds). Sociological Theory. New York: Macmillan.

Lincoln I, A. and Guba E, G. (1985). Naturalistic Inquiry. Newbury Park CA:Sage.

Littlewood I J, A. (1988). A study of the work of the health visitor and district nurse with the elderly. Unpublished doctoral dissertation, Polytechnic of the South Bank, London.

Lofland, J. and Lofland H, L. (1984). Analyzing Social Settings. Belmont CA:Wadsworth.

Luker K, A. (1978). Goal attainment: A possible model for assesing the role of the health visitor. Nursing Times, 74,30 pages 1257-1259.

Luker K, A. (1982a). Evaluating health visiting practice. London:Rcn.

Luker K, A. (1982b). An attempt at process evaluation. British Journal of Geriatric Nursing, 2, 1, pages 5-8.

Luker K, A. (1991) personal comunication.

Luker K, A. and Chalmers K, I. (1989). The referral process in health visiting. International Journal of Nursing Studies, 26, 2, pages 173-185.

Luker K, A. and Chalmers K, I. (1990). Gaining access to clients: The case of health visiting. Journal of Advanced Nursing, 15, 1, pages 74-82.

Luker K, A. and Orr, J. (eds) (1985). Health Visiting. London: Blackwell Scientific Publications.

MacFarlane, J. (1982). Responsability for the future development of health visiting. Health Visitor, 55, 6, pages 273-277.

MacGregor, (1981). The politics of poverty. London:Longman.

MacNicol, J. (1987). In Pursuit of the Underclass. Journal of Social Policy, 16, 3, pages 293-318.

Maglacas A, M. (1988). Health for All: Nursing's role. Nursing Outlook, 36, 2, pages 66-71.

Mahler, H. (1985). Nurses lead the way. World Health Organization Features, 97,

Mahler, H. (1987) Address to the Conference Leadership in Nursing for Health for All. Report on a WHO meeting. WHO: Geneva

Mahler, H. (1988). Remarks to the World Health Assembly. In World Health Organization (eds). From Alma Ata to the yer 2000: Reflections at the midpoint (pp. 98-101). Geneva:WHO.

Mauksh O, H. (1966). The Organizational Context of Nursing Practice. In F. Davis (eds). The Nursing Profession: Five Sociological Essays (pp. 109-137). Chichester:John Wiley & Sons.

Mauss, M. (1954). The Gift. London:Cohen and West.

Mayall, B. and Foster, M.C. (1989). Child Health Care: living with children, working for children. Oxford:Heinemann Nursing.

Mead G, H. (1934) Mind, self and society. Chicago: University of Chicago Press, in Denzin (1978) The Research Act. New York: MacGraw-Hill.

Melia K, M. (1981). Student nurses' accounts of their work and training: A qualitative analysis. Unpublished doctoral dissertation, Edinburgh, Edinburgh.

Menzies I, E. (1960). A Case Study in the Functioning of Social Systems as Defense against Anxiety. Human Relations, 13, pages 95-121.

Miaoulis, G. and Bonaguro, J. (1980-81). Marketing Srategies in Health Education. Journal of Health Care Marketing, 1, 1, pages 35-44.

Mills W, C. (1953). White Collar: The American Middle Classes. London:Oxford University Press.

Mills W, C. (1959). The sociological imagination. London:Oxford University Press.

Ministerio de Sanidad y Consumo, (1986). Guia de Enfermeria en Atencion Primaria de Salud. Madrid:Ministerio de Sanidad y Consumo.

Monteiro L, A. (1985). Florence Nightingale on Public health Nursing. American Journal of Public Health, 75, 2, pages 181-186.

Moon D, J. (eds) (1988). Responsibility, Rights, and Welfare. Boulder and London: Westview Press.

Moore R, (1990) The idea of an 'Underclass'. Unpublished paper. Department of Sociology, University of Liverpool.

Morse J, M. (1991). Negotiating commitment and involvement in the nurse-patient relationship. Journal of Advanced Nursing, 16, 4, pages 455-468.

Morse J, M., Bottorff, J., Neander, W. and Solberg, S. (1991). Comparative Analysis of Conceptualizations and Theories of Caring. IMAGE Journal of Nursing Scholarship, 23, 2, pages 119-126.

Naidoo, J. (1986). Limits to individualism. In Rodwell and A. Watt (eds). The politics of health education (pp. 17-37). London: Routledge & Kegan Paul.

Neill, M. (1982). It's nice to know that someone cares. Community Outlook, Nursing Times, 78, September, pages 243-246.

Norris, M. (1978). Those we like to help. New Society, 45, 822, pages 18.

National Standing Conference of Representatives of Health Visitors Education and Training Centres (NSC), (1989). Health Visitor Education and Training: The way forward. Report of a Study Conference Weekend. Unpublished document.

O'Brien, M. (1991) Consuming health and the politics of lifestyles. Unpublished paper presented at the British Sociological Association Annual Conference. Manchester.

Olds D, L. (1988). The Prenatal/Early Infancy Project. In R. Price H, L. Cowen E, P. Lorion R and J. Ramos-McKay (eds). 14 Ounces of Prevention (pp. 9-23). Washington D C: American Psychological Association.

Olds D, L. and Kitzman, H. (1990). Can Home Visitation Improve the Health of Women and Children at Environmental Risk?. Pediatrics, **86**, 1, pages 108-116.

Orr, J. (1980). Health Visiting in focus. London:Rcn.

Orr, J. (1985). Assessing individual and family health needs. In Luker K and Orr (eds). Health Visiting (pp. 67-120). London: Blackwell Scientific Publications.

Orr, J. (1986). Working with women's health groups: The community health movement. In A. While (eds). Research in Preventive Community Nursing Care (pp. 189-203). Chichester: John Wiley & Sons.

Owen, M. (1982). Parents as partners. Health Visitor, **55**, 9, pages 466-469.

Palfreeman, S. (1982). Mother and toddler groups among "at risk" families. Health Visitor, **55**, 9, pages 455-459.

Parsons, T. (1951). The social system. New York:The Free Press.

Paterson, B. (1989) Strategies to prevent or minimize reactivity in qualitative research. Unpublished documment. Faculty of Nursing, University of Alberta.

Pearson, M. (1992) Personal communication.

Pearson, P. (1985). An inner city child health project. Health Visitor, **58**, 8, pages 223-224.

Pearson, P. (1991). Client's perceptions: the use of case studies in developing theory. Journal of Advanced Nursing, **16**, 5, pages 521-528.

Peen Green Whole Health. Undated and unpublished hand out.

Peplau, H. (1964). Professional and Social Behavior: Some Differences Worth the Notice of Professional Nurses. The Quarterly Magazine, November, pages 22-33.

Pettigrew, P. and Falconer, J. (1982). Evaluation of a slimming group. Health Visitor, 55, 2, pages 79-80.

Popay, J., Dhooge, I. and Shipman, C. (1986) Unemployment and Health: What Role for Health and Social Services? Research Report No.3. London:Health Education Council

Preston, P. and Nelson, R. (1981). Salesmanship: a contemporary approach. Reston, Virginia:Reston Publishing Company.

Pridham K, F., Hansen M, F. and Conra, H. (1979). Anticipatory problem solving: Models for clinical practice and research. Sociology of Health and Illness, 1, 2, pages 177-194.

Qvortrup, J. (1990). Childhood as a Social Phenomenon-An introduction to a series of National Reports. Eurosocial, Report 36.

RCN Health Visitors Advisory Group, (1983). Thinking about Health Visiting. London:RCN.

Reid, J. (1986). Alma Ata and after: The background. In J. Fry and J. Hasler (eds). Primary Health Care 2000 (pp. 3-16). Edinburgh: Churchill Livingstone.

Robinson, J. (1985). Health Visiting and Health. In R. White (eds). Political issues in nursing: past, present and future (pp. 67-87). Chichester: John Wiley and Sons.

Robinson J, A. (1980). An evaluation of health visiting. Unpublished doctoral dissertation, University of Keele, Keele.

Robinson K, M. (1986a). The social construction of health visiting. Unpublished doctoral dissertation, The Polytechnic of South Bank, London.

Robinson K, M. (1986b). Accounts of health visiting. In A. While (eds). Research in Preventive Community Nursing Care (pp. 125-133). Chichester: John Wiley & Sons.

Robinson S, E. and Roberts M, M. (1985). A women's health shop: A unique experiment. British Medical Journal, 291, 6490, pages 255-256.

Roth J, A. (1963). Timetables. Indianapolis:Bobbs-Merril Company.

Rowntree, (1901). Poverty: A Study of Town Life. In J. Keating P. (eds). Into unknown England, 1866-1913. Selections from the Social Explorers (pp. 189-190). London: Fontana/Collins.

Sanchez P, M. (1981). Improving Marketing Practice in the Health Care Field. Journal of Health Care Marketing, 1, 4, pages 18-24.

Schatzman, L. (1990). Personal communication

Schatzman, L., and Strauss A, L. (1973). Field Research: Strategies for a natural sociology. Englewood Cliffs:Prentice Hall.

Schulman, S. (1979). Mother Surrogate-After a Decade. In G. Jaco E (eds). Patients physicians and illness: A source book in behavioural science and health (pp. 272-280). New York: Free Press.

Schwartz, B. (1967). The Social Psychology of the Gift. The American Journal of Sociology, 73, 1, pages 1-11.

Schwartz, H. and Jacobs, J. (1979). Qualitative sociology: A method to madness. New York:The Free Press.

Scott Samuel, A. (1989) Personal communication.

Seedhouse, D. (1986). Health: The Foundations for Achivement. Chichester:John Wiley & Sons Ltd.

Sefi, S. (1985). The first visit: A study of Health Visitor/Mother verbal interaction. Unpublished doctoral dissertation, University of Warwick, Warwick.

Sheridan M, D. (1973). Children's developmental progress from birth to five years, the stycar sequences. Windsor, Berks:NFER.

Shils, E. (1961). Centre and Periphery. In P. Worsley, R. Fitzhenry, C. Mitchell J, J. Morgan D H, V. Pons, B. Roberts, W. Sharrock W and R. Ward (eds). Modern Sociology: Introductory Readings (pp. 415-427). Middlesex: Penguin.

Shils, E. (1961). Centre and Periphery. In P. Worsley (eds). Modern Sociology: Introductory Readings (pp. 415-428). Middlesex: Penguin.

Sloan, P. and Webster, S. (1989) The first nine months, Statement for health visiting evaluation, Ancoats Health Community Clinic. Unpublished document.

Smith, V. (1989) The healthy child in Good Practices in Community Nursing. University of Manchester, Department of Nursing. Unpublished document.

Spradley J, P. (1979). The Ethnographic interview. New York:Holt, Rinehart & Winston.

Spradley J, P. (1980). Participant observation. New York:Holt, Rinehart & Winston.

Stacey, M. (1976). The health service consumer: a sociological misconception. In M. Stacey (eds). The sociology of the NHS. Sociological review Monograph 22 (pp. 194-200). Keele: University of Keele.

Stacey, M. (1981). The division of labour revisited or overcoming the two Adams. In P. Abrams, R. Deem, J. Finch and P. Rock (eds). Practice and Progress: British Sociology 1950-1980 (pp. 172-190). London: George Allen & Unwin Ltd.

Stern, P. (1985). Using grounded theory method in nursing research. In M. Leininger (eds). Qualitative research in nursing (pp. 149-160). London: Grune & Stratton Inc..

Stevenson, G. (1976). Social relations of Production and Consumption in the Human Service Occupations. Monthly Review, 28, 3, pages 78-87.

Strauss, A. (1977). Mirrors and Masks. London:Martin Robertson.

Strauss, A. (1978). Negotiations. California:Jossey-Bass.

Strauss, A. (1987). Qualitative analysis for social scientists. Cambridge:Cambridge University Press.

Strauss, A., Schatzman, L. and Buch, M. (1964). Psychiatric Ideologies and Institutions. London:The free press of Glencoe. Collier-Macmillan.

Strauss, A., Fagerhaugh, S., Suczeck, B. and Wiemar, C. (1985). Social Organization of Medical Work. London:University of Chicago Press.

Strauss, A. and Corbin, J. (1990). Basics of Qualitative Research- Grounded theory procedures and techniques. Newbury Park CA:Sage.

Strong, and Horobin. (1978) in Dingwall, R., Eekelaar J. and Murray T. (1983) The protection of children: State intervention and family life. Oxford: Basil Blackwell.

Strong P, M. and Davis A, G. (1977). Roles, role formats and medical encounters: A cross cultural analysis of staff client relationships in children's clinics. The sociological Review, 25, 4, pages 775-800.

Sugden, R. (1983). Who Cares?. London:Institute of Economic Affairs.

Swanson J, M. (1986a). Analyzing data for categories and description. In C. Chenitz W and M. Swanson J (eds). From practice to grounded theory: Qualitative research in nursing (pp. 121-132). Menlo Park, CA: Addison Wesley.

Swanson J, M. (1986b). The formal qualitative interview for grounded theory. In C. Chenitz W and M. Swanson J (eds). From practice to grounded theory (pp. 66-78). Menlo Park, CA: Addison-Wesley.

Szasz, (1973) cited in G. Jaco E. (eds) (1979) Patients, physicians and illness: A sourcebook in behavioural science and health. New York: The Free Press

Thomas, W. I. (1928). The child in America, New York: Knopf. in Schwartz, H. and Jacobs, J. (1979). Qualitative Sociology: A method to madness. New York:The Free Press.

Thomson, A. (1989). Proactive work with clients in need. Queens Nursing Institute Lecture. University of Manchester. Department of Nursing.

Titmuss R, M. (1970). The gift relationship. London:George Allen & Unwin Ltd.

Turner B, S. (1987). Medical power and social knowledge. Newbury Park CA:Sage.

Turner, V. (1982). Does health visitors' training equip them to meet clients' needs?. Health Visitor, 55, 8, pages 279-283.

Turton, P. and Orr, J. (1985). Learning to care in the community. London:Hodder and Stoughton.

Twigg, J. (1989). Models of Carers: How Do Social Care Agencies Conceptualise Their Relationship with Informal Carers?. Juornal of Social Policy, 18, 1, pages 53-66.

Twinn, S. (1990). Nothing to fear from Hall. Health Visitor, 63, 7, pages 230-231.

Vuori, H. (1984). Primary Health Care in Europe: Problems and Solutions. Community Medicine, 6, 3, pages 222-231.

Ward, D. (1991). Gender and Cost in Caring. In M. Neil R and R. Watts (eds). Caring and Nursing: Explorations in Feminist Perspectives (pp. 97-105). New York: National League for Nursing.

Warner, U. (1982). The social organization of health visiting. Unpublished doctoral dissertation, University of Surrey, Surrey.

Watson, D. (1980). Caring for strangers. London:Routledge & Kegan Paul.

Watson, E. (1982). Problems of the health visitor in the inner city. Health Visitor, 55, 11, pages 574-576.

Watson, P. (1976). Personal communication. In R. Dingwall (eds). The social organization of health visiting training London: Croom Helm.

Watson, P. (1981). A time study of health visitors work. Unpublished doctoral dissertation, University of Aberdeen, Aberdeen.

Weber, M. (1947). The Theory of Social and Economic Organization. New York:The Free Press.

West, M. (1989). Innovation in health visiting. Health Visitor, 62, 2, pages 46-48.

WHA 1977, in World health Organization (1988). From Alma Ata to the year 2000. Reflections at the midpoint p. 14 Geneva:

WHA, (1983). Thirty-sixth World Health Assembly. In Forty-second World Health Assembly May 1989. WHO Geneva. Unpublished document.

While, A. (1990). Child Heath Clinic Attendence During the First Two Years of Life. Public Health, 104, pages 141-146.

Whitehead, M. (1990). The concepts and principles of equity and health. Geneva:WHO.

Whittaker, E. and Olesen, V. (1978). The faces of Florence Nightingale: functions of the heroine legend in an occupational sub-culture. In R. Dingwall and J. McIntosh (eds). Readings in the Sociology of Nursing (pp. 19-35). Edinburgh: Churchill Livingstone.

Whyte W, F. (1982). Interviewing in field research. In G. Burgess R (eds). Field research: A sourcebook and field manual (pp. 112-122). London: George Allen & Unwin.

Williams, K. (1978). Ideologies of nursing: their meanings and implications. In R. Dingwall and J. McIntosh (eds). Readings in the Sociology of Nursing p. 36-44. Edinburgh: Churchill Livingstone.

Willis, S. (1982). A sociologist's View of Health Visiting. In CETHV (eds). Health Visiting Principles in Practice (pp. 34-41). London: CETHV.

Wilson H, S. (1989). Research in Nursing 2nd Edition. Menlo Park, CA:Addison Wesley.

Wilson H, S. (1990) Personal communication.

Wilson H, S. and Hutchinson S, A. (1991). Triangulation of Qualitative Methods: Heideggerian Hermeneutics and Grounded Theory. Qualitative Health Research, 1, 2, pages 263-276.

Wiseman, (1979). Health Visiting: The allocation problem. In Clark (1981) What do Health visitors do? A review of the research 1960-1980 p. 125-125. London:RCN.

Wolf Z, R. (1988). Nurse's work: The sacred and the profane. Philadelphia:University of Pennsylvania Press.

World Health Organization (WHO), (1948). Constitution Chart. Geneva:WHO

World Health Organization (WHO), (1974). Community Health Nursing. Report of a WHO Expert Committee. Geneva:WHO.

World Health Organization (WHO), (1978). Alma-Ata 1978; Primary Health Care. Geneva:WHO.

World Health Organization (WHO), (1979). Report of the Workshop on the Role of Nursing in Primary Health Care. Geneva:WHO.

World Health Organization (WHO), (1982). Nursing in suport of the Goal Health for All by the Year 2000. Report of a meeting. Geneva:WHO.

World Health Organization (WHO), (1985). Targets for Health for All. Copenhagen:WHO.

World Health Organization (WHO), (1986). Targets for Health for All; Implications for Nursing/Midwifery. Copenhagen:WHO.

World Health Organization (WHO), Health and Welfare Canada, and Canadian Public Health Association, (1986). Ottawa Charter for Health Promotion. Copenhagen:WHO.

World Health Organization (WHO), (1988). European Conference on Nursing. Report on a WHO meeting. Copenhagen:WHO.

World Health Organization (WHO), (1989). Nursing in Primary Health Care: Ten Years after Alma-Ata and perspectives for the future. Report the joint WHO/ICN consultation. Geneva:WHO.

Zerwekh J V, A. (1990). Qualitative Description of the Competencies of Expert Public Health Nurses. Unpublished doctoral dissertation, Seattle University of Washington, Seattle.

Zerwekh, J.V. (1991). At the expense of their souls. Nursing Outlook, 39, 2, pages 58-61.

Zola I, K. (1972). Medicine as an Institution of Social Control. Sociological review, 20, 4, pages 487-504.

Zola I, K. (1977). Healthism and Disabling Medicalization. In K. Zola I (eds). Disabling Professions (pp. 41-67). London: Marion Boyars.

Zuckermann I, G. (1984). Pathology, Adversity, and Nursing. In A. Strauss (eds). Where Medicine Fails, 4th edition (pp. 203-211). New Brunswick: Transaction books.

APPENDIX 1

TARGETS FOR HEALTH FOR ALL IN EUROPE (WHO 1985)

Target 1: "By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups".

Target 2: "By the year 2000, people should have the basic opportunity to develop and use their health potential to live socially and economically fulfilling lives".

Target 3: "By the year 2000, disabled persons should have the physical, social, and economic opportunities that allow at least for a socially and economically fulfilling and mentally creative life".

Target 4: "By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%".

Target 5: "By the year 2000, there should be no indigenous measles, poliomyelitis, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis or indigenous malaria in the Region".

Target 6: "By the year 2000, life expectancy at birth in the Region should be at least 75 years".

Target 7: "By the year 2000, infant mortality in the Region should be less than 20 per 1000 live births".

Target 8: "By the year 2000, maternal mortality in the Region should be lees than 15 per 100.000 live births".

Target 9: "By the year 2000, mortality in the Region from diseases of the circulatory system in people under 65 should be reduced by at least 15%".

Target 10: "By the year 2000, mortality in the Region from cancer in people under 65 should be reduced by at least 15%".

Target 11: "By the year 2000, deaths from accidents in the Region should be reduced by at least 25% through an intensified effort to reduce traffic, home and occupational accidents".

Target 12: "By the year 2000, the current rising trends in suicides and attempted suicides in the Region should be reversed".

Target 13: "By 1990, national policies in all Member States should ensure that legislative,administrative and economic mechanisms provide broad intersectorial support and resources for the promotion of healthy lifestyles and ensure effective participation of the people at all levels of such policy-making".

Target 14: "By 1990, all Member States should have specific programmes which enhance the major roles of the family and other social groups in developing and supporting healthy lifestyles".

Target 15: "By 1990, educational programmes in all Member States should enhance the knowledge, motivation and skills of people to acquire and maintain health."

Target 16: "By 1995, in all Member states, there should be significant increases in positive health behaviour, such as balanced nutrition, non smoking, appropriate physical activity and good stress management".

Target 17: "By 1995, in all Member States, there should be significant decrease in health-damaging behaviour, such as overuse of alcohol and pharmaceutical products; use of illicit drugs and dangerous chemical substances; and dangerous driving and violent social behaviour".

Target 18: "By 1990, Member States should have multisectorial policies that effectively protect the environment from health hazards, ensure community awareness and involvement, and support international efforts to curb such hazards affecting more than one country".

Target 19: "By 1990, all Member States should have adequate machinery for the monitoring, assessment and control of environmental hazards which pose a threat to human health, including potentially toxic chemicals, radiation, harmful consumer goods and biological agents".

Target 20: "By 1990, all people of the Region should have adequate supplies of safe drinking water, and by the year 1995 pollution of rivers, lakes and seas would no longer pose a threat to human health".

Target 21: "By 1995, all people of the Region should effectively protected against recognized heath risks from air pollution".

Target 22: "By 1990, all Member States should have significantly reduced health risks from food contamination and implemented measures to protect consumers from harmful additives".

Target 23: "By 1995, all Member States should have eliminated major known health risks associated with the disposal of hazardous wastes".

Target 24: "By the year 2000, all the people of the Region should have a better opportunity of living in houses and settlements which provide a healthy and safe environment".

Target 25: "By 1995, people of the Regions should be effectively protected against work-related health risks".

Target 26: "By 1990, all Member States, through effective community representation, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined at the Alma-Ata Conference".

Target 27: "By 1990, in all Member States, the infrastructures of the delivery systems should be organized so that resources are distributed according to need, and that services ensure physical and economic accessibility and cultural acceptability to the population".

Target 28: "By 1990, the primary health care system of all Member States should provide a wide range of health-promotive, curative, rehabilitative and supportive services to meet the basic health needs of the population and give special attention to high-risk, vulnerable and undeserved individuals and groups".

Target 29: "By 1990, in all Member States, primary health care systems should be based on cooperation and teamwork between health care personnel, individuals, families and community groups".

Target 30: "By 1990, all Member States should have mechanisms by which the services provided by all sectors relating to health are coordinated at the community level in a primary health care system".

Target 31: "By 1990, all Member States should have built effective mechanisms for ensuring quality of patient care within their health care systems".

Target 32: "Before 1990, all Member States should have formulated research strategies to stimulate investigations which improve the application and expansion of knowledge needed to support their health for all developments".

Target 33:"Before 1990, all Member States should ensure that their health policies and strategies are in line with health for all principles and that their legislation and regulations make their implementation effective in all sectors of society".

Target 34: "Before 1990, Member States should have managerial processes for health development geared to the attainment of health for all, actively involving communities and all sectors relevant to health and, accordingly, ensuring preferential allocation of resources to health development priorities".

Target 35: "Before 1990, Member States should have health information systems capable of supporting their national strategies for health for all".

Target 36: "Before 1990, in all Member States, the planning, training and use of health personnel should be in accordance with health for all policies, with emphasis on the primary health care approach".

Target 37: "Before 1990, in all Member States, education should provide personnel in sectors related to health with adequate information on the country's health for all policies and programmes and their practical application to their own sectors".

Target 38: "Before 1990, all Member States should have established a formal mechanism use of health technologies and their effectiveness, efficiency, safety and acceptability, as well as reflecting national health policies and economic restraints".

APPENDIX 2

HANDOUT TO HEALTH VISITORS

RESEARCH STUDY: "APPROACHES IN HEALTH VISITING.

Carmen de la Cuesta. Research student, Department of Nursing, The University of Liverpool.

Professional background.

I did my Health Visiting training in Sheffield in 1977. After pursuing other studies in the UK I went back home, to Spain, and I worked there in a Primary Health Care Centre and in Community Health Care management. My recent work experience in Spain has been as nurse adviser for Primary Health Care at the Institute of Health in Madrid. Last year, the Spanish Ministry of Health granted me a fellowship to do a course at the University of Liverpool.

The Research Project.

This research study is part of a PhD course and it is supervised by Dr. Karen A. Luker, Professor of Community Nursing at The University of Liverpool.

The study aims at identifying and describing Health Visitor's approaches to practice. Its concern is with how the service is delivered and not with how much or how well it is preformed. Therefore it will not attempt to evaluate practice but to describe and understand it from the practitioner's point of view. The study will explore approaches currently used in Health Visiting, thus it does not have a hypothesis to test nor variables to measure. It strives to understand an aspect of Health Visiting practice.

To achieve these aims, data will be collected through observation and informal interview. Health Visitors will be invited to participate in this study on a voluntary basis. If you agree to participate it will mean that you consent to me observing your work and discussing approaches to practice with you. However, those who agree to participate can withdraw from the study at any given time. Initially observations will take place in home visits and clinics for a period of five days with each Health Visitor; the days need not be consecutive. The anonymity of participants and the confidentiality of the information given will always be preserved. No data will be collected from clients.

This research study will not be possible without Health Visitors' participation, your collaboration will be very much appreciated. Once the study is finished a report will be available for those interested on the findings.

If you require further clarification or discuss your involvement in this study, you can contact me at:

The University of Liverpool
Department of Nursing
1 Abercromby Square
PO BOX 147
Liverpool L69-3BX
Tel: 051-794 2313

Or at home: 58 Devonshire Road
Liverpool L8-3TZ
Tel: 051-727 0402

Thank you very much for your collaboration.

Carmen de la Cuesta
Liverpool April 1990

APPENDIX 3

LETTER THANKING VOLUNTEERS

Carmen de la Cuesta
58 Devonshire Rd
Liverpool L8 3TZ
UK

Liverpool 5 April 1991

Dear

This is just a short note to thank very much for volunteering to participate in the study I am conducting about approaches to Health visiting.

I have almost finished collecting all the data I require for the research, for this reason it will not be necessary to trouble you and ask for your time. Nevertheless, I am grateful for the interest you showed in the study.

Once the research is finished, a copy of the report will be available at the University Library as well as at the Department of Nursing. It will be towards the end of 1992.

In addition to this, it is most likely that an open seminar will be held to present the results,in this case the announcement will be sent to the Health centres.

Thanks again for your interest on this research.

Sincerely yours

Carmen de la Cuesta

APPENDIX 4

PARTICIPANTS CHARACTERISTICS

Age:

20 to 29 years old: 3 health visitors

30 to 39 years old: 6 health visitors

40 to 50 years old: 11 health visitors

Professional experience:

Less than 3 years: 6 health visitors

3 to 9 years: 8 health visitors

10 and more years: 6 health visitors

Appointment:

Health visitors: 10

Field work teachers or student assessors: 10

Work commitment:

Full time: 18 health visitors

Part time: 2 health visitors

Work organization:

Geographically based: 12 health visitors

GP attached: 8 health visitors

APPENDIX 5

NUMBER AND TYPE OF HOME VISITS AND CLINICS

Table 2 Home visits: Type and number

TYPE	NUMBER
New birth:	21
Follow up new birth:	13
Follow up 0-5 problem:	14
Screening:	34
Follow up other:	6
New to the area:	6
Handicapped:	2
Elderly:	10
Others:	15
Total:	**121**

Table 3 Clinic type, number and clients

TYPE	NUMBER	CLINIC
Screening in clinic:	4 Clinics	13 Clients
Screening in nursery:	2 Clinics	6 Clients
Baby clinics:	7 Clinics	58 Clients
Total:	13 Clinics	77 Clients

APPENDIX 6

FIELD WORK RECORDS OF ACTIVITIES

Daily activity in health centre.

Health centre:

Day:

Activities:

Processing notes: hours

Preliminary analysis: hours

TOTAL ACTIVITIES IN HEALTH CENTRE.

Health centre: Date:

CLINICS

Health visitor:

Screenings in clinic:
Screenings in nursery:
Baby clinic:

Total:

Number of hours observing:

Health centre: Date:

HOME VISITS

Health Visitor:

Handicapped:
Follow up new birth:
Follow up o-5 problem:
Screening:
Follow up other problem
New to the area:
New birth
Elderly:
Others:

Total:

Other visits not at home:
Number of hours observing:

Summary of all field activities

Health centre:

Health visitors in code:

*Number of home visits:

*Number of other visits:

*Number of clinics

*Number of interviews

*Number of discussions at the office:

*Total amount of field work: days/hours

*Time employed in processing notes: hours

*Time employed in preliminary analysis: hours

APPENDIX 7

EXAMPLES OF FIELD NOTES

Theoretical and methodological notes:

4/4/1990 Taking notes after my first two days observation at X health centre.

Theoretical note: It appears to me that CR approach to home visits was a sort of "Assessing" how the client is coping with a given situation. During visits different questions asked are about:

-Coping with a new baby.
-Managing after being in hospital
-How the client is doing in general (mainly in follow up visits

It seems that CR follows the "Anticipatory guidance model". That is: she asks questions and when those are answered she points out at future issues, possible events that most likely occur. Clients also tend to ask several questions.

Comparing this to Z health centre I found that here clients do not ask so much. However, health visitors also ask the "Coping/managing" type of questions and give the anticipatory information...but I feel that this in Z health centre is less specific that in X health centre.

Methodological note: When interviewing CR remember to ask her a) if you were working in Z would you have the same approach to practice? or You mentioned that there were differences of health visiting practice between Z and X areas, in your opinion, what are those differences?

Data and theoretical note:

17/10/90: Processing notes after field observation

Raw data: "After WB weighed the child in the clinic, the mother asked her if the child was too fat. WB answered 'You are not making him fat...we will not let you make him fat'".

Theoretical note: I think that this sentence has a lot on it. 1-It uses the term "We" without saying who they are. One can assume that it refers to "Professionals", 2-Client is "allowed" to do something or not. This implies that the mother is "Controlled" or "Supervised", 3- It creates the illusion that the situation is under the professional's control.

Personal note:

13/2/1990. "Back home after field observations"

PN: I feel exhausted. Meeting so many, new and different people. I have to tell them all the same things about myself. I have to control myself and be nice not showing boredom or whatever...trying to establish a rapport and good relationships with participants in order to promote disclosure. I feel also tired because of coping with new settings and environments...I just wonder if health visitors feel similar fatigue on their jobs, when they visit new and different people in their homes.

Field notes:

TB 7/8/90.

Arrived at 9.30. TB (Health visitor) was working on the computer. I took the opportunity of asking D (Health visitor) to go out with her another day. She agreed and asked me if I wanted to see something specially. I said that when I was reviewing the data I noticed that we went to visit only the under fives and that I would like to take part in a visit to the elderly. I emphasized that I did not want to disrupt her work. D said that I would not and that she would arrange with the health visiting assistant to go herself and see Mr. F. She explained that this was a "fresh one" (meaning she had never visited him before) and added that she did not do so many visits to the elderly as the health visiting assistant does them.

TB came from the computer room and explained the visits that we would make this morning. 1 new birth, 1 6 wks assessment and one "That you will like". This one she explained was a handicapped lady (spina bifida), who had only one leg. She had a family of three children. TB commented that the first time she visited her she did not know all this and how confused she was as the lady was visibly in pain in one side and she did not know whether this was usual or unusual. TB told me that the lady has an appointment to visit the hospital but said that she could not go. TB thinks that she will have to give her a lift. She said that this is something that she does not normally do, but explained: "I will have to do it...I should not do it but I will have to". TB carried on telling me that it is a social services problem but she will have to give this lady a lift. TB recently learnt that the baby was in a baby care unit because of respiratory problems and she supposed that the appointment was a follow up of this problem.

TN- As TB was telling me all this, I thought of the idea of the health visitor filling gaps or being the safety net. It also reminds me of the charity work, I think that in health visiting there is a "charity spirit". Health visitors are not "supposed" to do things but they feel a moral obligation to do them, just as wealthy people feel the "obligation" to give something. It might be also the case of needing to feel that they <u>are doing something at least</u>. This relates

with the idea of giving things that can be regarded also as charity and doing something.

All the three visits planned were not part of TB caseload but of another health visitor who was on sick leave.

Over coffee I talked a bit to R (Health visitor) about the "Loss group" that it is set up in X hospital. R told me that she had shown interest as she thinks that there is nothing for women who had a termination and she felt that this is an important area. I asked her why she thought so and she said because she felt there are important psychological side effects. She said that she had a few women in her patch with this problem and could see how lasting the sequels were. She also mentioned her experience in the hospital ward when she was staff nurse.

TN-As she was speaking I recall the memo about experience: personal and professional and its relation to the years of practice or the career.

1st visit: New Birth.

A teenage girl opened the door. TB said that she was Mrs M., the health visitor and if was she Mrs G. The girl said no and went to fetch Mrs G. In the meantime a little girl appeared at the door and TB asked her to tell her mum that she was there. The girl said no and went off. A while later a young woman came and invited us to came in. We came to the kitchen where the baby was in a pram and a toddler running around. It was obvious that the lady had just get up from bed. Shortly after we sat, Mrs G asked us the time and was surprised to know that it was 10.20 am, TB made the comment "you have to get your sleep when you can".

APPENDIX 8

INTERVIEW GUIDE

Preamble

As I mentioned when we talked earlier I am interested in learning about health visiting practice from the practitioner's point of view. Thus, I would like to know your opinion on what health visiting involves. Perhaps we can start discussing the type of things you do.

Major issues to be discussed initially during the interviews:

1. How do you plan and organize your work?. Here discuss at least the following:

-On what grounds do health visitors intervene
-Sources of information used to intervene if any.
-Who identifies the need for action.

2. What are the things you do? Here discuss at least the following:

-Type and aim of interventions
-To whom are they addressed.
-The relationship with clients.

3. What are the difficulties you face? Here discuss the following:

-Type and source of the difficulty
-How they went about overcoming them

4. Could you tell me about your caseload characteristics? (this could be at the beginning). Here gather information about type of clients and the area where the health visitor work.

Areas discussed after open coding in subsequent interviews:

1. In between. The leading question would be:

I have been told that part of health visitor's work is not for her to solve problems but to find out who can help, someone told me that it is like being a "Middleman". What do you think about this?

2. Trust. The leading question would be:

I have been told that unless the client tells you what the problem is or what bothers her/him you cannot act. Can we discuss to what extent it is important for your work to have clients trusting you?

3. Giving. The leading question would be:

I have also observed that some health visitors give things to clients. How do you feel about this?

4. Differences. The leading question would be:

I have been told that health visiting practice differs according to the area where one works. That practice is different in a deprived and in an affluent areas. What do you think?

5. Negotiations. If they did not arise from above, the leading question would be:

It seems to me that in health visiting one deals with a great variety of clients. Can we discuss how you came about this? or more directly ask: "Do you have to adapt your interventions to clients?"

6. Knowing. Here the leading question would be:

I have observed that in some instances the health visitor knows what would happen in a particular case or situation, that she/ he can anticipate what would evolve. Do you agree with this?

APPENDIX 9

EXAMPLE OF ANALYTICAL MEMOS

General condition in Health Visiting.(1/11/1990)

By open coding 20 days of observation notes and 4 interviews I found the following general condition in health visiting work:

1-AGENDAS

Health Visitors have to deal with different agendas.
There are two broad types of agendas: professional agendas and client agendas. Agendas can be defined as the expectations that different people and the health visitor herself have about her job.

A) Professional agenda.

There is first one type of professional agenda that is sort of "imposed" on the health visitor. It comes from the outside and is predetermined and, according to health visitors accounts, acts as a "restriction". It is inflexible. This professional agenda is the policy directives or guidelines from the Health Authority about child surveillance. It is required that health visitors visit all the under fives on their caseloads at certain times. This guideline is based on a "framework" of a child's normal development. It is a norm standardized for the Liverpool area. In practice some of these norms, although claimed to be inflexible, are not followed by all health visitors. Some are adapted.
There is other type of professional agenda that is more elaborate or developed in practice, that is the health visitor's own agenda . This is about what a client needs, what she has to do in certain circumstances: how to preform her job in the specific situation. Put in another way the health visitor's agenda seems to be a mixture of adapting the normality framework to specific individuals and situations,adapting the policy agenda to practical constrains and the health visitor's responses to client's agenda as well as other professional's agendas like the GP. Here we can start to see other condition of Health visitor's work that is: being in the middle.

B) Client Agenda.

Client agenda is manifested in my data by the questions the client asks the health visitor. Client's agenda is pre established when the client knows that she is going to meet the health visitor (visit with appointment and client coming to the clinic). This type of agenda becomes very obvious during the baby clinics. It is also frequent among the middle-professional class (classes

1, 2, 3). When a encounter is unexpected, the client has rarely an agenda. However, the health visitor's presence, comment or question sometimes tigers off the client's mind and she elaborates an agenda during the encounter. Again this is more frequent among middle class.

It appears that the consequences of this condition is that health visitors, in order to do the job, will sometimes have to negotiate, compromise, adapt, sacrifice some elements of the agendas. For this they will need some flexibility or capacity of manoeuvre.

I have evidence on my data of negotiation processes between health visitors and clients (ex. negotiate the number of visits, when to visit, where to visit) as well as some coercive tactics (ex. to use a terror approach to immunisations). The other strategy, when confronted with the issues of having to respond to several demands, is that one just sacrifices or overlooks something in a given agenda. During one interview a health visitor (JB) says that she does not do the 6 wks. assessment as required by policy. Here what the health visitor is doing is bending the rule because she either feels it is not appropriate (see CT interview) or because she has no time for it.

Sharing the trajectory with an outsider: condition (24-1-91) Memo number 238.

When there is a grandmother or mother of the client nearby, the health visitor "has" to compete with them on the shaping of the trajectory. This means that the health visitor has to share her job with another outsider. This data came during CT interview "running battles with clients" (This is one consequence of sharing trajectory with "outsiders"). During the interview RB spoke of "militant grandmothers". Also in TB and SD interviews came up this point.

These conditions point to the difficulty for the health visitor of keeping the trajectory going as planned.

Consequences of being the child the client (29-1-91) Memo number: 245.

In DB3, field notes p 6. there is a clear example of assessing mother's capability in managing the child trajectory. The client was needing glasses. During the visit she showed sings of being uncomfortable with her eyesight. When DB assessed the client's need for glasses. DB justified it because the mother otherwise would not be able to prepare the correct amount of feeds to her baby.

So: the condition: the child is the client

Consequences of the above condition: Focus on the mother as manager of the trajectory. In the examples of LT (LT Field notes May 1990) and the smoking issue, it became clear that the focus was on the mother as

the shaper of the trajectory but in a negative sense. That is, the mother could give to her child a "bad shape" because of her smoking habit. A child might also have a bad shape because the house environment. In this instances the health visitor intrevened with the mother (See RB interview). However, if the mother does not do anything to solve this problem, the health visitor will probably take over and do it all..**(Theoretical note guiding sampling:** look in MT interview for signs of this "tolerance").

APPENDIX 10

SAMPLE SCREENING FORMS

L.A.H.A.(T) SCREENING FORM

Name . . . . . Date of Birth . . . . . .

EXAMINATION AT SIX WEEKS

CONGENITAL ABNORMALITIES

Physical
Head Circumference
Check for CDH 70° Abduction — Yes/No/D
Symmetry of movement — Yes/No/D

LOCOMOTION AND POSTURE

Lying Prone lifts chin for moment — Yes/No/D
Ventral suspension — head momentarily in line with body — Yes/No/D
Limbs semi-flexed — Yes/No/D
Head control — pulled to sitting position — Yes/No/D
Head lag — falls forward — Yes/No/D
Walking reflex — Yes/No/D
Supporting — Yes/No/D
Primary – stepping — Yes/No/D

VISION AND MANIPULATION

Fixes on dangling object at 10" through ¼ arc on side to midline — Yes/No/D
Grasp reflex — Yes/No/D

HEARING AND LANGUAGE

Blinks, startles or cries to handclap — Yes/No/D

SOCIAL BEHAVIOUR AND SKILLS

Smiles — Yes/No/D

L.H.A. SCREENING FORM

NAME — D.o.B.

ADDRESS — B. Wt.

G.P

EXAMINATION AT EIGHT MONTHS: Date

HISTORY SINCE LAST EXAMINATION

Head circumference
Weight
Length
Convulsions
Illnesses
Hospital admissions

LOCOMOTION AND POSTURE

Sits unsupported — Yes/No/D
Weight bearing — Yes/No/D
Attempting to crawl — Yes/No/D

VISION AND MANIPULATION

Squint — Yes/No/D
Pokes at small pellet with index finger — Yes/No/D
Pincer grasp — Yes/No/D

HEARING AND LANGUAGE

Hearing distraction test at 3'

Response to:	Rt. ear	Lt. ear
High pitch rattle		
Human voice sounds "SS" "S"		
Human voice sounds "OO" "OO"		
Minimal voice		
Vocalisms e.g. shouts for attention		Yes/No/D

SOCIAL BEHAVIOUR AND SKILLS

Drinks from cup-attempts to — Yes/No/D
Feeds himself with biscuit — Yes/No/D
Responds to simple verbal instruction from a parent e.g. waves bye-bye — Yes/No/D

TESTERS COMMENTS

RESULT OF EXAMINATION

SATISFACTORY/DOUBTFUL

1	2	3	4	5

Return visit

Referred for more detailed assessment

Return Visit — Yes/No
Referred for more detailed assessment — Yes/No

TESTERS SIGNATURE

CHS/A93A 2.77

CHS A93C (REV) 5.82