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ILLUMINATING SOCIAL DETERMINANTS OF WOMEN'S HEALTH USING GROUNDED THEORY

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Emphasis in health policy has shifted from curative intervention to prevention and health promotion through personal responsibility for lifestyle choices and, most recently, to the social determination of health. These shifts draw attention to and legitimize women's health research that moves beyond biomedical, epidemiological, and subjective knowledge to question previously unquestioned societal norms and structures that influence women's health. The challenge is to avoid relying solely on population-based studies that support relationships between social determinants and indicators of women's health and to find ways to illuminate the processes by which social determinants interact with the health of specific groups of women. Without such research, our knowledge of how social factors that underpin women's health interact will be faceless and will not address the interplay of health and social policy within women's lives.

One research method that may be useful for exploring the interplay between such policies and women's health is grounded theory. Grounded theory is a widely used approach in women's health research. The goal of grounded theory is the discovery of dominant social and structural processes that account for most of the variation in behavior in a particular situation. Despite the usefulness of this method for capturing the interaction between social conditions and women's health experiences, many grounded theory researchers restrict themselves to women's subjective experiences

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as a source of data for theory development. Consequently, the resultant theory's capacity to illuminate the effects of the social determinants of health is limited. The purpose of this article is to discuss how the grounded theory method can be used in a participatory way to theoretically sample structural conditions at many levels. Using examples from completed and ongoing women's health research where data have and have not been collected primarily from women themselves, we outline the benefits and process for using grounded theory to influence health and public policy in women's health.

Researchers, practitioners, and policymakers in the field of women's health have a common goal of improving women's quality of life. Over the past three decades, the accepted understanding of women's health has expanded beyond singular, individual, biomedical perspectives to include diverse, family, community, population, psychosocial, and cultural understandings. Emphasis in health policy has shifted from curative intervention to prevention and health promotion through personal responsibility for lifestyle choices, and, most recently, to the ways that health is socially determined through dominant social structures in our society. Social determinants of health include such factors as education, income, employment, working conditions, environment, health services, and social support.

As women's health is defined as more than absence of disease, traditional science is insufficient to answer the many questions we have about women's health. Constructivist and critical research methods have been added to our repertoire, allowing us to better understand both subjective experiences and the social construction of women's health. Most recently the demand for greater accountability from research funding agencies has produced a more explicit requirement for deliverables in the form of best practices or policy directives. Indeed, as Sally Thorne (2001) recently pointed out in her keynote address at the Health Care in a Complex World conference in Toronto, what counts as knowledge is being defined in terms of capacity to influence policy. Much of the research that provides support for the effects of social determinants of health is from large population-based epidemiological research studies that show patterns of relationships among multiple factors.

This shift in emphasis toward social determination of health also draws attention to and legitimizes women's health research that moves beyond traditional science and epidemiology to questioning previously unquestioned societal norms and structures that influence women's health. The challenge is to avoid relying solely on population-based studies that support relationships between social determinants and indicators of women's health and to find ways to illuminate the processes by which social determinants interact with the health of specific groups of women. Without such research, our knowledge of how social factors that underpin women's health interact will be faceless and will not address the interplay of health and social policy within women's lives.

One research method that may be useful for exploring the interplay between such policies and women's health is grounded theory. Grounded theory (Glaser, 1978; Glaser & Strauss, 1967) is a widely used approach in women's health research (Benoliel, 2001; Stern, 2001). Despite the usefulness of this method for capturing the interaction between social conditions and women's health experiences, many grounded theory researchers limit their investigations to women's subjective experiences as a source of data for theory development. Consequently, the resultant theory's capacity to illuminate the effects of the social determinants of health as reflected

through social structure is limited. In my own research, however, I[1] have found that the grounded theory method is an effective bridge between population research and studies that focus on individual experience. Through theoretical sampling of policy, services, and sociocultural conditions, grounded theory is an extremely useful method for exploring the explicit ways that social determinants influence the social processes of managing women's health issues.

In the following discussion, I will consider (a) the importance of addressing the social determinants of women's health, (b) grounded theory as a research method, (c) the process of using the grounded theory method in a participatory way to illuminate social determinants of health, (d) examples from completed and ongoing women's health research where data have and have not been collected primarily from women themselves, and (e) strengths of using grounded theory to illuminate determinants of health for influencing health policy.

SOCIAL DETERMINANTS OF WOMEN'S HEALTH

Our comprehension of women's health has evolved over the past three decades away from a medical model in which health was conceptualized as absence of disease particularly as related to reproductive organs and processes. In Canada, the 1974 release of the Lalonde report, *A New Perspective on the Health of Canadians*, changed the focus from solely treatment of disease to prevention. Canadian health policy at that time reflected the assumption that people could control their health status through personal lifestyle choices. This shift in perspective increased awareness of individual responsibility for health and marked the beginning of the health promotion movement. But there were consequences for women. Women, as principle family caregivers, were seen not only as responsible for their own health status but also for that of their children and partners (Armstrong, 1996). If women served the right meals, ensured that family members exercised, and surveyed their families for poor health habits, the nation would be healthy. The unfortunate consequence of such a philosophy is victim blaming, that is, blaming the person who becomes sick for her sickness. In the case of women, the responsibility for illness in family members may also be attributed to her "poor caregiving."

More recently, there has been a shift from the focus on health status as an outcome solely of lifestyle choices to a recognition that health behaviour is also influenced by social, political, economic, and political factors, that is, social determinants of health. The Canadian Federal, Provincial, and Territorial Advisory Committee on Population Health (1994) acknowledged the effects both of individual efforts and of public policy by identifying income and social status, education, social support networks, employment and working conditions, physical environment, biology and genetic endowment, personal health practices and coping skills, health services, and healthy child development as the critical determinants of health.

A population health perspective, then, acknowledges the influence of social, political, and economic factors on individual health behaviours. This perspective was well outlined in Health Canada's 1999 *Women's Health Strategy*. Throughout the world, women's health and their quality of life are determined by their social and economic status. Societies are healthier when women have better education and more

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[1]**Within this paper, "I" refers to the first author, Judith Wuest. "We" refers to Judith Wuest, Helene Berman, Marilyn Ford-Gilboe, and Marilyn Merritt-Gray.**

control over their lives. The traditional roles of women as family caregivers, child bearers, and subsistence providers have restricted their opportunities for education, meaningful work, and access to appropriate health care. We know now that the real determinants of gender, racial, and ethnic differences in health are social, not biological. Although problems vary between countries, issues of access to health care, meaningful work, and education; limited inclusion of women in health research; poor funding for prevention and treatment of diseases that primarily affect women; and lack of appropriate chronic disease care are all indicators that women are undervalued by the societies in which they live. This knowledge compels us to go beyond epidemiological data in considering the status of women's health.

In Canada, health status on many standards such as life expectancy and infant death rates is among the best in the world. However, health is not equally shared by all Canadians: age, gender, race, and socioeconomic status are all associated with poorer health (Health Canada, 1999). We see from simple mortality data that Canadian women live longer than Canadian men, but that does not mean they are healthier. Women also earn less than men, suffer more chronic and disabling illnesses, are more likely to head a single-parent family, and have lower self-esteem. Women who are also poor, aboriginal, and getting older are more likely to be at risk for poor health. We must consider all determinants of health and their interaction in order to understand the health of women.

For example, let us consider cardiovascular disease, the major cause of disability and death in women in Canada. From an individual perspective, the incidence of heart disease suggests the need for investment of health resources in treatment and rehabilitation programs for women with heart disease. A prevention strategy in contrast suggests the need for individual health education whereby women are taught to exercise, eat well, and reduce stress in order to prevent heart disease. But a population health perspective demands that we ask about the social determinants that have produced this change. It forces us to examine patterns of factors that may influence the development of heart disease. But epidemiological patterns are not sufficient. We need to delve more deeply into how such relationships came to be. Can women eat well when their income is used to pay for housing, when poor quality food is most readily available, when due to work and home responsibilities they have little time or energy to devote to cooking? Can women exercise when they have no time due to multiple roles, when the neighbourhoods where they live are not safe for walking, when there is little accessible, affordable recreation, when they have no child care? Can they effectively manage stress when they work in jobs that offer them little control, when they have little hope for change, when they have no personal time for adult relationships? Will women give up smoking, alcohol, or drugs when these seem to be the only sources of relief from stress? To find the answers to these questions, we must consider the social policies that have reduced women's income and made social benefits less available. To address the full range of issues that influence cardiovascular disease in women, our research approaches must go beyond biomedical and behavioural research to also address how the social determinants through social and health policy influence women's cardiovascular health. However, if such research is limited to large population-based correlational studies, we will only know that relationships exist between social determinants. For example, such research might reveal that low-income women are less "compliant" with drug therapy and more likely to be readmitted to hospital after discharge. A different approach is required to investigate why this is so. Failure to discover that due to the absence of

affordable housing women have insufficient funds to pay for housing and medications leaves us with an incomplete understanding of the complex influences of the social determinants. Grounded theory is one approach that can be helpful in revealing such complex interactions.

GROUNDED THEORY

Grounded theory is a research method initially described by Barney Glaser and Anselm Strauss in 1967 in their book *Discovery of Grounded Theory*, and further elaborated by Glaser in his 1978 book, *Theoretical Sensitivity*. Phyllis Noerager Stern made a significant contribution to helping nurses learn to use this research approach in her classic article "Grounded Theory Methodology: Its Uses and Processes" published in *Image: Journal of Nursing Scholarship* in 1980. I initially learned the method from Phyllis Noerager Stern, who was herself a student of Barney Glaser. Over time as I have used this approach for various research projects, my way of using grounded theory has evolved, first by using an explicit feminist perspective (Wuest, 1995), and then by using a participatory approach in theoretically sampling to illuminate social determinants of health. It is this latter approach that I will address.

THE METHOD

But first I will provide some general background on grounded theory as a method that I have derived primarily from the various writings of Glaser, Strauss, and Stern. Grounded theory is a research method that is useful to discover dominant social and structural processes that explain behaviour in the situation under study. Grounded theory allows for exploration of the interaction between subjective experience and social structure. The design is emergent: The study begins with the broad purpose of determining what is going on in a particular area of interest. Data collection and analysis are concurrent, and the specific focus or research question emerges as the analysis proceeds. Data are collected through observation, formal or informal interviews, and written materials. Sources of data are chosen initially for what they can contribute regarding the scene under study. As initial data are analysed, decisions for future data collection are made based upon what particular sources can add to the emerging theory, a process called theoretical sampling.

The goal of data analysis is the discovery of dominant social processes, not a description of phenomena. The process of data analysis includes first coding substantively. Each field note, transcription, or document is read line by line with the questions, "What is this a conceptual indicator of?" "What is going on here?" Code names are assigned to each discrete data bit, which could be a sentence, a paragraph, or even a page. As codes recur, the indicators are compared for similarities and differences. Eventually, codes are grouped together into categories. For example, in a study of women's caring (Wuest, 2000b, 2001), several codes were identified. "Time for self" was the code for data such as "I steal an hour during the day. Yes I do. Sometimes I am just too tired to do anything. I sit down and put my feet up." "Social interaction" was the code for such data as, "I work not only for the money but to get out ... for the social contacts." "Cultivating the marital relationship" was the code for, "So after I get the kids to bed, I usually go downstairs and sit with him (partner) for an hour. Which usually means I get to bed late, but I think it is

important for me." Through the process of constant comparison, it became clear that each of these codes had the ultimate consequence of sustaining or giving something to women to keep them going. Each was a conceptual indicator of a category that I named "replenishing."

The constant comparison of categories results in the formation of hypotheses about the relationships among categories. The grounded theory process requires continual hypothesizing of relationships from the collected data and ongoing checking out of hypothesized relationships through comparison within data already collected or in new data. This fine tuning through constant comparison results in the emergence of a core problem, a core variable or process that deals with the problem, clarification of properties of categories, and illumination of relationships between categories. This ongoing process of confirming and modification is essential to ensure that the emerging framework is grounded in the data. The core category is the one that accounts for most of the variation in behaviour patterns (Glaser, 1978). In the caring study, once the basic social process was identified as *precarious ordering*, it served to focus subsequent data analysis. Data collection and analysis proceeds until no new variation emerges from the data, and the categories are saturated.

A key issue for grounded theorists is raising the level of analysis from the descriptive to the theoretical level by theoretical coding. Theoretical coding is a process of examining the data in theoretical rather than descriptive terms in order to raise the level of abstraction in the emerging middle range theory. I think this process is the most difficult for those learning the process of grounded theory. Glaser (1978) described 18 coding families that may be helpful to clarify relationships between emerging concepts, explicate conceptual properties, and facilitate writing about the data at a conceptual level. Theoretical coding "gets the analyst off the empirical level by fracturing the data, then conceptually grouping the data into codes that then become the theory which explains what is happening in the data" (Glaser, p. 55). One of the most commonly used coding families is known as the 6 C's, which refers to causes, consequences, context, conditions, covariants, and contingencies. In the caring study (Wuest, 2000a), the subprocess of *negotiating* was developed through theoretical coding to explicate relationships between categories. *Adversity with the system* and its consequent disillusionment was a cause of women *reframing responsibility*. A consequence of *reframing responsibility* was *becoming an expert* using strategies such as *networking* and *learning the rules*. As theoretical coding proceeds, data are theoretically sampled to confirm and modify the theoretical relationships among concepts. Moreover, literature is theoretically sampled to reveal linkages with the generated grounded theory and to increase theoretical sensitivity in the continuing analysis (Glaser, 1992). The outcome is identification of a core variable or central process that explains what is problematic in the scene under study. Variation in the process is accounted for by salient conditions that emerge from the data. Often salient conditions in a particular theory are factors that may be also social determinants of health.

FEMINIST GROUNDED THEORY AND WOMEN'S CARING

In 1995, I conducted a feminist grounded theory (Wuest, 1995; Wuest & Merritt-Gray, 2001) study of women's caring (Wuest, 1997a, 1997b, 1998, 2000a, 2000b, 2001) because I believed that a more contextual appreciation of women's caring was necessary given the current societal and political trends toward turning caregiving

back to women (Baines, Evans, & Neysmith, 1998), and the invisibilty of the consequences of caring for women's health. I believed that such a theory might reveal the effects of social determinants on women's health and caregiving and that this knowledge would be useful for influencing health and public policy. I chose an explicitly feminist approach because of the centrality of caring in women's lives and the belief that the research approach should not be oppressive, the knowledge obtained from the research should be useful for women, and that the research process should be reflexive (Acker, Barry, & Essevald, 1991).

In this study (Wuest, 2001), *competing and changing demands* for caring from partners, children, extended family, and self were the basic social problem for women. *Precarious ordering* emerged as the dynamic, recursive two-stage process by which this problem was managed by women. In the first stage of *fraying connections* (Wuest, 1997b), women become frayed by *daily struggles* with caring work, relationships, and adversity with helping systems; *altered prospects* for employment, parenting, and relationships; and *ambivalent feelings* engendered in responding to caring demands. In the second stage of precarious ordering, women become proactive using the intuitively and consciously acquired strategies of *setting boundaries*, *negotiating*, and *repatterning care*. *Setting boundaries* (Wuest, 1998) is the process of putting limits on caring demands and is achieved by *determining legitimacy* of the nature and scope of caring demands and by *attending to one's own voice*. *Negotiating* (Wuest, 2000a) is the process of purposeful interaction and restructuring relationships with lay and professional helpers to limit fraying connections through *reframing responsibility*, *becoming an expert*, *harnessing the system*, and *taking on more*. *Repatterning care* (Wuest, 2000b) is the process of reconfiguring ways of caring to limit caring demands and reduce fraying connections by *anticipating*, *making ground rules*, *juggling time* and *relinquishing and replenishing*. The conditions that influence variation in the process of precarious ordering are *caring ideals*, *caring proximity*, *caring options*, and *caring rewards* (Wuest, 1997a). *Caring ideals* are the constructions of caring that are held by women, their family members, the community, and the system. *Caring proximity* is the geographical, relational and cultural closeness or distance between women and those for whom they care or those from whom they seek help. *Caring options* are the availability and suitability of caring resources such as money, emotional support, and material aid. *Caring rewards* refers to the personal satisfactions gained from caring.

LIMITATIONS TO EXPLAINING THE INTERPLAY OF STRUCTURAL CONDITIONS AND CARING

Within these conditions social structures or social determinants become most visible. For example, in the caring study, *suitability and availability of resources* were identified as structural conditions that influenced variations in *reframing responsibility* and subsequent actions. Depending on the suitability and availability of various resources, women in the study found it more or less necessary to reframe responsibility for caring and were satisfied consumers, comparison shoppers, or risk takers (Wuest, 2000a). This resource typology was extremely helpful for explaining variation in both the subprocesses of *negotiating* and of *repatterning care*. But because the data had only been collected from the women, and not from service providers, program planners, or policymakers, the process of *precarious ordering* is limited to explaining only the interplay of structural conditions and caring from women's

viewpoint. This seemed a basic flaw in my work. Within this study there were data that indicated that social determinants had a great influence on the consequences of caring demands. For example, when the *caring ideal* of a community was that women bottle feed, and a woman's ideal was that she breastfeed, following her personal ideal left her isolated, frustrated, and without social support. Without exploring the policies and programs that contributed to this situation, I had developed a theory that was useful to women for understanding their experience, and helpful to providers by indicating points of intervention, but that lacked the detail needed to really be useful for influencing health and social policy.

RECONSIDERING WHAT THE EXPERTS SAY ABOUT STRUCTURAL CONDITIONS

These reflections sent me back to reexamine the grounded theory method. In early writings by Glaser and Strauss (1967) and Glaser (1978), structure was deciphered in terms of conditions, contexts, and social structural processes. Strauss's later work focussed more explicitly on structural influences offering the "conditional matrix" as a means of guiding the researcher to trace a path from the actions and interactions of the participants through the various conditions in order to determine how they relate (Strauss & Corbin, 1994). The conditional matrix suggests that structural conditions that influence social psychological processes or core variables can be explicitly tracked through various structural levels such as interactions with others, family or group cultures, organizational practices, community cultures, and government regulations so that the final theory can systematically relate the structural conditions to the actions and interactions identified in the study. Strauss and Corbin (1994) noted that without such tracing one can only say that conditions influence, but not how, when, where or with what consequences.

I began to consider how this explicit effort to track structural influences might illuminate social determinants more effectively. A major difference between Glaser's work (1978) and Strauss and Corbin's writings is that Strauss and Corbin tend to use a template approach to grounded theory analysis through the use of such tools as the conditional matrix, whereas Glaser (1992) indicated that such an approach forces the data. Rather, Glaser urged us to be theoretically sensitive to what is emerging in the data and follow what is salient. Given my previous grounded theory experiences, I was confident that salient structural conditions would become readily apparent in data from any grounded theory study and that these salient structural conditions would be most useful in illuminating public policy. Hutchinson (1986) suggested that grounded theory was useful for evaluation research because investigators are not constrained by preconceptions about what programs or policies should be doing but rather are open to what is actually happening to people. Others have recommended grounded theory for policy research because it allows the investigator to see all aspects of the social problem under study (Majchrzak, 1984).

USING GROUNDED THEORY IN A PARTICIPATORY WAY FOR POLICY RESEARCH

As my thinking proceeded, I was beginning to work with colleagues developing a program of research and searching for national funding from agencies that were more likely to fund research considered relevant to policymakers. The outcome was developing a program of grounded theory research with three colleagues: Marilyn

Merritt-Gray from the University of New Brunswick and Helene Berman and Marilyn Ford-Gilboe from the University of Western Ontario. The explicit aim of the program was to demonstrate how public policy influences health promotion processes among single mothers and their children who have left abusive partners.

EXPLICITLY ILLUMINATING SOCIAL STRUCTURES

In developing the research process for engaging in this work, we were influenced not only by Glaser and Strauss, but also by participatory action research perspectives (Wuest & Merritt-Gray, 1997) and by feminist and critical perspectives (Campbell & Bunting, 1991; Ford-Gilboe, Campbell, & Berman, 1995; Wuest, 1995, 2000c). Depending upon who is writing about the method, grounded theory has been labelled as belonging both in postpositivist and constructivist paradigms. Because the outcome of grounded theory research is the development of a framework that may be helpful to predict and control events, it is sometimes labelled postpostivist (Guba & Lincoln, 1994). Others argue that grounded theory is interpretive research because the resultant theory explains how social experience is constructed and takes into account diverse experiences or multiple realities within the social structure (Wuest, 1995).

The explicit goal of research within the critical paradigm is critique and transformation of dominant social structures. Although grounded theory is a starting point for change (Glaser, 1978), change is not normally an explicit goal of the research process. Moreover, some may argue that by producing a theory, a universal narrative that diminishes individual perspectives and contexts is being generated and such theory does not contribute to change. A counterargument to this position is that detailing issues of difference sets individuals apart and may contribute to stereotyping, marginalizing, and victim blaming (Wuest, 1997b). Grounded theory, especially when conducted from a feminist perspective, allows for the inclusion of difference in the development of explanatory frameworks (Keddy, Sims, & Stern, 1996; Stern & Pyles, 1986; Wuest, 1995; Wuest & Merritt-Gray, 2001). Moreover, critical research encompasses a range of participatory, action-oriented research approaches (Fals-Borda, 1996; Small, 1995), all geared toward both dealing with social problems and generating knowledge as part of the research process and as an outcome of the findings (Wuest & Merritt-Gray, 1997b). Although grounded theory has not been documented as being used in a participatory way, I fail to see why it could not be. It seems to me that by engaging relevant stakeholders such as service providers and policymakers in discussion about what we are learning from single-parent families about the conditions that influence health promotion processes, policy could be influenced by the research process, not just by the resultant findings. Moreover, the theory would have greater explanatory power because it would include the provider and policymaker perspective. From a critical participatory stance, the test of the emerging theory is not just in how it explains what is happening but also in how it opens up alternatives for thought and action about how things could be (Kvale, 1995).

OUR PROGRAM OF RESEARCH

The research program that we proposed, had funded, and are currently conducting consists of two studies. The first is a feminist grounded theory study of family health promotion processes among single mothers who with their children left abusive male

partners. The emerging grounded theory explaining health promotion processes of single-parent families generated in the first study is being extended by theoretical integration of new data relevant to salient contexts and conditions gathered from service providers, policymakers, and other relevant sources. The starting point for the second study was what was learned from single mothers and their children about the ways in which social conditions influenced their capacity to promote their own health. By using a participatory research approach, stakeholders (single-parent families, policymakers, civil servants, and service providers) are being actively engaged in creating new understandings about the ways that public policy strengthens, supports, and diminishes health promotion processes.

The Initial Grounded Theory Study

In the initial grounded theory study, single mothers who had left abusive partners were interviewed about family health promotion. The basic social problem identified was intrusion (Wuest, Ford-Gilboe, Merritt-Gray, & Berman, in press). *Intrusion* is defined as interference or external control stemming from (a) continuing harassment and abuse from the former partner, often related to custody and access; (b) health consequences of past and ongoing abuse; (c) costs of seeking help; and (d) undesirable changes to patterns of living consequent to leaving the abusive partner. Our analysis of the basic process of health promotion is preliminary and evolving and has to do with developing ways to limit intrusion and move on with the women's lives. The dimensions of this health promotion process include the following:

1. acquiring resources and skills needed to sustain the family economically,
2. restructuring the changed family unit as a viable team that functions differently and has different relationships,
3. assessing and dealing with the effects of past abuse on individual family members, and
4. promoting safety and a sense of belonging.

While, to some extent, these processes may occur in any single-parent family, what makes the process different for these families is the complex, many-layered nature of the intrusion that persistently influences how families are able to promote their own health (Wuest et al., in press). Intrusion did not ever completely dissipate for these families, some of whom had lived separately from their former partners for more than 16 years.

From the interviews with families, we identified structural domains that were salient to how families experienced intrusion such as housing, child support, custody and access, counselling for children, workforce reentry, and income support. For example, in the domain of child custody, the extent to which the system can assist families to settle issues of child custody and visitation has a direct influence on the degree, nature, and timing of continuing harassment and threats from the former partner. Such intrusion is destructive to recreating a new family unit, to the mother's attempts to include the father in a nurturing way in the child's life, and, most seriously, to the safety of all family members. The domain of housing influences how families acquire things essential for survival and promote safety and belonging. Families struggle to find affordable shelter that provides a physical environment that is safe and offers some protection from ongoing harassment. Moreover, in order to build capacity to provide for themselves into the future by going back to school or entering the workforce, stability in safe housing is essential.

The Research Process for the Participatory Grounded Theory Study

The second study was designed to explore these system domains using grounded theory in a participatory fashion. At the proposal stage, we obtained support for the proposal from key ministers, municipal leaders, and advocates. Most important were letters from ministers who named a liaison person and indicated that they would support us in gathering data related to salient domains from their policymakers and service providers. Our process for dealing with each domain developed as we began data collection in the domains of housing, custody, and child support. Data related to each domain were reexamined first to ensure that we fully understood how the domain influenced the emerging health promotion process. Next, we reviewed public information such as websites, official documents, pamphlets, and legislation available on policy and services relevant to the domain. This was particularly important in fields such as custody and access, where we, as investigators, had little familiarity with the terminology, language, or processes. Based on this general knowledge, and the data from the mothers, we then composed an initial list of questions for service providers to augment the more general list that we had developed in the proposal stage.

The next step involved contacting the designated liaison person to further explain the study and develop a data collection plan. Within government departments, support from the minister engendered cooperation with the research process. We found that when the liaison person made the initial contacts with the related government service agency or policy department, our entry was facilitated and the research process was legitimized. Moreover, liaison people often were able to identify initial key informants at service delivery and policy-making levels. Finally, we discovered that the liaison person was often the best source of relevant documents. Service providers and policymakers who consented to talk to us were sometimes reluctant to provide anything in writing.

Decisions about where and how to collect data were based on salient issues of the single mothers and their children, advice of the liaison person, and theoretical sampling as data were collected. The liaison person helped us to determine what was feasible in the work environment, approaches to recruitment, space for interviews, and ways to review documents. Although the liaison person facilitated our entry, we only interviewed those who gave voluntary consent. This required developing mechanisms, such as a group meeting or individual letters, in each data collection site for explaining the study and the emerging findings such that consent to participate was informed. Sampling was theoretical in that we collected data at the service provider/policymaker level specifically related to salient issues and sources of variation that emerged from data collected from the families, for example, access issues related to rural/urban mix, special populations such as aboriginal groups, or those on income assistance. As well, each interview raised new questions and hypotheses that needed to be followed with data collection from different sources. For example, data collection in the family court system illuminated links between criminal and civil justice systems that required follow-up by interviewing sheriffs and police officers.

We were careful to collect data at the service provider level first. The temptation was to collect data at the policy level first because initial contacts were at that level. However, the participatory process supported a commitment to data collection from the ground up: We shared the broad perspectives of families with service providers and then shared both perspectives with policymakers. This process allowed for a

better sense of policy impact before talking with policymakers. In each contact at each level, we engaged in dialogue in which ongoing findings were shared and perspectives sought. Dialogue was critical to the participatory process as it affords opportunity for changed understandings among all stakeholders (researchers, policymakers, service providers, and single-parent families) along the way. As well, it affords opportunities for change as an outcome of the research process, a hallmark of participatory research. For example, one safety issue for mothers was the availability of the home address on court documents that are publicly accessible. As we interviewed lawyers, it was clear that some, particularly those who had little understanding of woman abuse, had never considered concealing the address on court documents, a process that is easily done. When we told lawyers of the dire consequences for women who are traced in this way, some lawyers became more aware of safety issues and perhaps changed their practice immediately. Similarly, on follow-up interviews with families, we were able to share the insights we had gained from our interviews with service providers, which allowed us to sometimes clarify misconceptions, make women more aware, and contribute to their feeling that participating in the study was having immediate effects.

In order to guide theoretical sampling, data analysis occurred concurrently with data collection and had four main thrusts. First, we found it necessary for our own knowledge to describe the services and policy system in each province. Next, we identified the key properties of services and policy systems that influenced how families promote their own health. These properties included such elements as timeliness, human resources, relationships with providers, access, eligibility, safety, outcomes, client responsibility, and information. By drawing on these properties, it was possible to identify system strengths and limitations at a thematic level. The final step will be theoretical integration of the properties of each domain into the basic social process through constant comparison.

Illumination of Social Determinants

Analysis of data is resulting in a more comprehensive understanding of the interplay between social conditions and the process of health promotion among single mothers and their children than that obtained through more traditional approaches. Some examples from our ongoing analysis may help to illustrate this. In the original analysis, we learned that when women seek a child support order, they want child support income without increased risk or hassle. The extent to which the system facilitates this outcome influences the ways families can get basic necessities and how they create a safe and nurturing environment for themselves. Obviously, the absence of child support limits the financial capacity of the family. Moreover, when obtaining or enforcing child support orders is contentious, safety and security may be threatened. Women found it difficult to work within the system to gain a remedy that would result in regular child support payments. It was hard to access accurate information, and system responsiveness seemed to be related to the amount of time they invested in calling, and locating, the partner. Women who had left abusive partners felt that they no longer wanted to be involved at any level with the former partner, and that there should be mechanisms in the system to ensure that support was paid without necessitating this type of contact. Despite the amount of frustration women endured in this process, having a consistent worker with whom they formed a relationship over time was important in mitigating this frustration.

Data collected from service providers and policymakers provided new insights. In one province, legislation provided for all child support orders to be registered with the Family Court, and fathers make arrangements to comply through garnishment or monthly payments paid to the province. The province, in turn, pays the woman. The intent of this policy is to limit contact between parents and reduce potential for conflict. Policy and literature regarding child support indicates that enforcement is automatic. In fact, due to the large caseload, enforcement officers do not have time to identify defaulters routinely because they are busy dealing with the cases where women have called to complain that their cheque has not arrived. For expediency and because of the limited number of databases accessible for tracing fathers, enforcement officers routinely ask women for information regarding the former partner's locations. This practice, while practical, has the potential to increase involvement and risk for the women. The key issue here for policymakers is that the information provided to women needs to be consistent with the actual service available. If the policy cannot be supported with sufficient human resources, then changes to the policy are warranted.

As another example, women in the study expressed the need for affordable safe housing and many sought assistance through public housing services. Some were able to access social housing that met their needs quickly; others waited for long periods of time, often enduring overcrowded and substandard private sector housing. Data collected from service providers and policymakers revealed a policy that priority be given to women who have left abusive partners. However, in practice, women who apply for housing services are not asked if abuse is a factor; the onus is placed on women to disclose abuse and provide documentation. Further, information about special consideration given to women who have been abused is not publicly available. There is also an unwritten assumption that women who are abused will apply for housing from the shelter system, and this is almost always a necessary condition, but no guarantee, for getting priority. Thus, for over 90% of abused women who do not go to a shelter, access to affordable, safe housing needed to help them develop security and stability is severely restricted, even though policy supports enhanced access.

Completion of the Study

Data collection and description and thematic analysis for the other policy domains is currently underway. Thus far, constant comparison of data is continuing to identify factors related to policy and services being more or less effective for supporting family health promotion. The findings will be integrated at a theoretical level into the emerging theory of health promotion. Finally, our findings will be shared with all participants and implications for service and policy discussed.

Outcomes

We believe that combining this participatory approach with grounded theory is useful for policy research because the research process contributes to shaping services in minor ways and raising consciousness among policymakers regarding how their work plays out in women's everyday lives. The dialogue raises questions about taken-for-granted practices and assumptions with the potential consequence of changing how specific issues are viewed. Ongoing dialogue with providers and

policymakers has resulted in the researchers being called upon for information about what we are learning as we conduct this research. By sharing the perspectives of single-parent families who have left abusive partners regarding the ways that health promotion processes are influenced by practice and policy, their perspectives have the potential to stimulate change in concrete ways. One of our most significant contributions has been introducing the notion that policy and services related to woman abuse in diverse public sectors are women's health issues. Despite increasing recognition of social determinants of health and healthy public policy, many service providers and policymakers in other sectors do not make the health connection. Finally, the emergent theory has the potential to make a meaningful contribution to knowledge development of health promotion by extending our understandings of the social determination of health.

FINAL ISSUES

The final questions then are, "Is it legitimate to use grounded theory this way?" and if so, "Why is it an important method for addressing women's health issues?" Ultimately you must be the judge. Unquestionably, using grounded theory in this way muddies the boundaries of research paradigms put forward in much of the current literature. Also, it may not be consistent with the intentions of the originators of the method, Glaser and Strauss. However, as first articulated, the method of grounded theory was a somewhat revolutionary approach. Currently, there is no universal agreement regarding whether it is a postpositivist or constructivist approach. Once a method is publicly available, researchers will modify and adapt it in ways to make it most useful for them. I try to consider basic canons of research approaches, and ensure that the liberties I take do not violate them. The test for me is whether it works and whether I can justify the credibility. I believe that if we are going to meet today's challenge of providing research evidence to influence women's health policy without negating women's individual experience, we need to find approaches that bring those experiences to policymakers in ways that they can be understood. Finding those approaches undoubtedly involves a little risk-taking!

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